Guide to Medicare Prescription Drug Coverage

SHIIP

The Senior Health Insurance Information Program

a service of the State of Iowa Insurance Division

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Introduction

Since 2006 Medicare has provided prescription drug coverage through its Part D benefit. It is important to understand how this benefit works to assure that you are getting drug coverage to meet your needs. Whether you're going on Medicare for the first time, changing who provides your drug coverage, choosing a plan for next year, needing help to pay for your drugs or just have questions, this guide was created for you.

We also want you to know that Medicare drug plans change their costs and coverage from year to year. You need to stay on top of your Part D coverage. Everyone needs to do a review annually to determine if they have the best coverage. It could mean saving hundreds of dollars a year.

You will find in the following pages information to help you understand:

- How the drug benefit works and who is eligible for coverage
- How to get extra help with your drug costs
- When you can join, switch or drop a plan
- How to choose a plan
- Your other drug coverage choices
- Your rights

This guide was created by the **Senior Health Insurance Information Program (SHIIP).** SHIIP is a free, unbiased counseling program provided by the State of Iowa Insurance Division. SHIIP counselors are available across the state to help you:

- Understand the Part D benefit
- Compare Part D plans
- Assist with Part D plan enrollment process
- Apply for Extra Help with Medicare drug costs
- Know when you can enroll in, drop and change plans
- Advocate when you have problems with a plan

Find a SHIIP Counselor…

http://www.therightcalliowa.gov
1-800-351-4664 (TTY 1-800-735-2942)
shiip@iid.iowa.gov

How Does Medicare Prescription Drug Coverage Work?

Types of Plans

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") that offer drug coverage only
- Medicare Advantage Plans (like an HMO or PPO) or other Medicare health plans that offer prescription drug coverage along with medical benefits.

There are several plans to choose from in Iowa. If you join a plan you will pay a monthly premium (some Medicare Advantage plans with Part D drug Coverage do not have a premium) and pay some of the cost of your prescriptions. How much you pay, what drugs are covered, and the pharmacy you use will vary depending on the plan you choose.

Eligibility

To join a Medicare Prescription Drug Plan, you must have Medicare Part A **or** Medicare Part B. 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. If you meet these criteria you can get Medicare drug coverage. You cannot be turned down due to existing health conditions and there is no waiting period for pre-existing conditions. The one exception to this is that a person with end-stage renal disease cannot enroll in a Medicare Advantage plan with drug coverage.

Cost

Your drug coverage costs are affected by the monthly premium, yearly deductible, copayments or coinsurance, coverage gap (also called the "donut hole") and catastrophic coverage. All of these costs can change from year to year because drug plans have annual contracts with Medicare.

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 don't pay your entire Part D premium you may be disenrolled from your plan.

You may have to pay a higher monthly premium based on your 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. 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 this higher premium. The extra premium will get taken out of your monthly Social Security, Railroad Retirement, or Office of Personnel Management check. It is not paid to your drug plan. If you do not draw benefits yet, you will get a bill from Medicare for the extra amount. The drug plan is only responsible for billing you for the monthly Part D premium.

When you enroll in a plan you can choose how to pay your premium. There are four payment methods:

- Withhold funds from your Social Security payment. If you start out paying your plan directly for premiums and decide you later want Social Security withholding, you must contact your plan— not Social Security—to ask for this payment option.
- Have your plan bill you each month directly. Send your payment to the plan—not to Medicare. Contact your plan for their payment address.
- Deduct it from your checking or savings account.
- Charge it to a credit or debit card.

Yearly Deductible

The deductible is what you pay for your prescriptions before your plan begins to pay. In 2016 the deductible can be no more than $360. Some plans charge no deductible.

Initial Coverage Level Copayments or Coinsurance

After you pay the deductible you will pay a copayment (set dollar amount, e.g. $5) or coinsurance (percentage, e.g. 25%) for your prescriptions. You pay this amount to the pharmacy. The Part D plan will pay the remainder.

The amounts you pay vary from plan to plan. Many plans use different "tiers" to determine what you pay. Each plan can divide its tiers in different ways. A drug in a lower tier will cost you less than a drug in a higher tier.

Example:

Tier 1–Generic drugs--$8
Tier 2—Preferred brand-name drugs—$25
Tier 3–Non-preferred brand-name drugs—$40
Tier 4- Specialty drugs—25%

Once **total drug costs** (the amount you pay and the plan pays) reach $3,310 you will enter the Coverage Gap and your costs will change. Not everyone will reach the coverage gap.

Coverage Gap (also called "donut hole")

When Part D first started plan enrollees paid all drug costs when they entered the coverage gap. Now, the gap is gradually being closed and by 2020 there will be no coverage gap. In 2016, once you reach the

gap you pay 58% of the cost for plan covered **generic** drugs and the plan pays 42%. You pay 45% for plan covered **brand** name drugs. The remaining brand drug costs are paid by the drug manufacturers (50%) and the plan (5%).

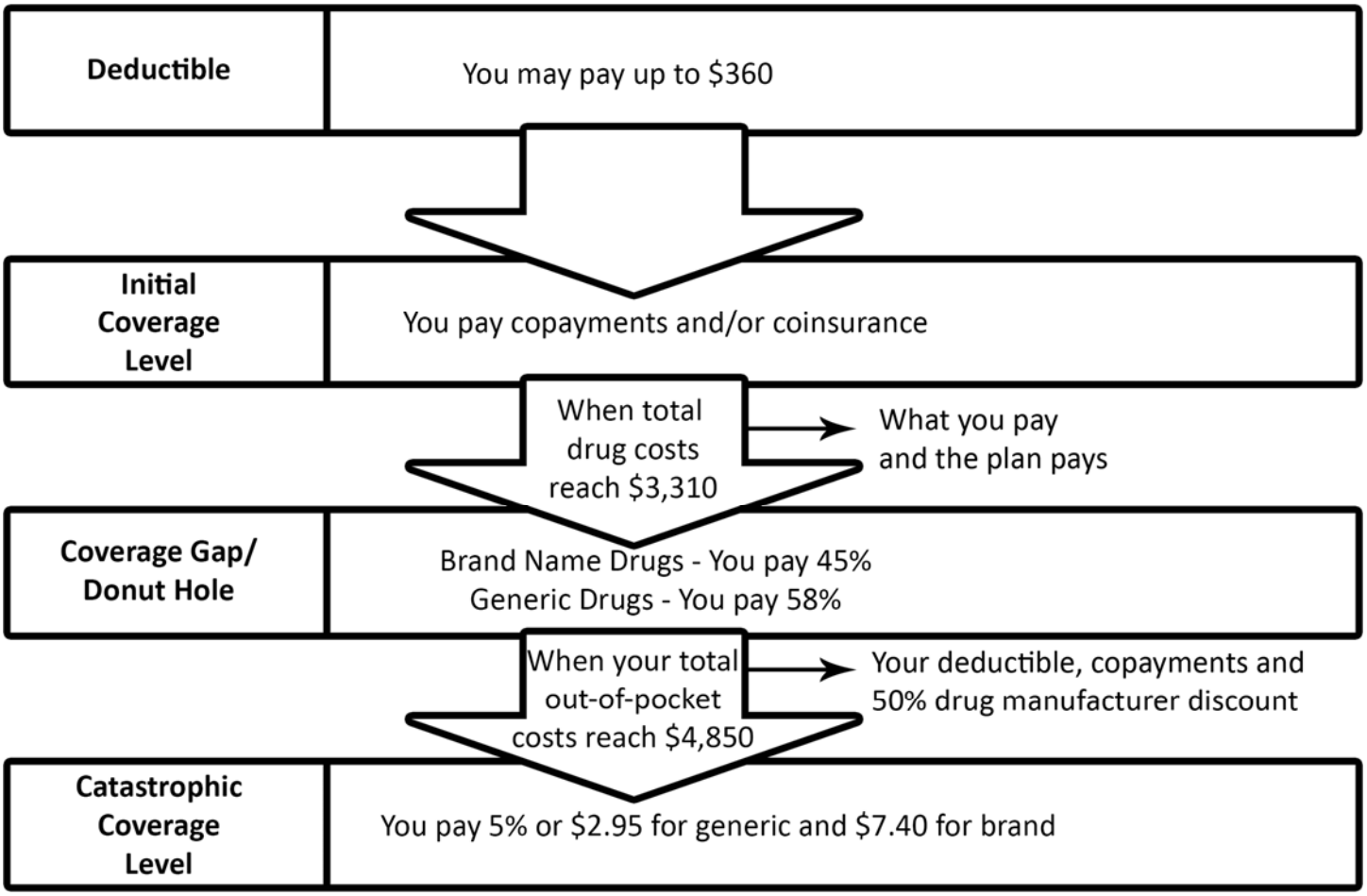
When the amount you have paid out-of-pocket (deductible, co-payments and coinsurance) plus the 50% paid by the drug manufacturer for brand drugs reach $4,850 you leave the coverage gap and move to the Catastrophic Level. Your monthly plan premium and the cost of any drugs not covered by your plan do not count towards the $4,850.

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.

Catastrophic Coverage

Under catastrophic coverage, you only pay a small coinsurance amount or a copayment for the rest of the year. You will pay the greater of 5% or $2.95 for generic drugs and $7.40 for brand-name drugs

2016 Medicare Part D Prescription Drug Benefit



Drugs Covered (Formulary)

Each Medicare drug plan has its own list of covered prescriptions, called a **formulary**. Do not assume a plan will cover all of your prescriptions. You must check each year if a plan will cover your prescriptions. Plans can change their formulary from year to year. If you use a drug not on your plan's drug list, you'll have to pay full price for it.

Plans cover both generic and brand-name prescription drugs. Medicare drug plans aren't required to cover certain drugs, such as drugs for weight loss or gain, and drugs for erectile dysfunction. Some plans may cover these drugs as an added benefit. 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.

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 "What Are Your Rights?" section at the end of this guide). 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.

Restrictions

There are three types of restrictions a plan may place on a drug. It is important to understand what each of these restrictions are and if any of your prescriptions are assigned these restrictions.

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.

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) and if that doesn't work, try 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.

Quantity Limits: For safety and cost reasons, plans may limit the amount of drugs they cover over a certain period of time. 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.

Transition Supply of Drugs

If a drug you are taking is not on your new plan's formulary or is subject to a restriction, your new drug plan will give you a **one-time**, 30 day supply of your current drug during your first 90 days in the 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.

Part D vs. Part B Coverage of Drugs

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. It also covers the flu and pneumococcal shots. Generally, Medicare drug plans cover other vaccines (like the shingles vaccine) needed to prevent illness.

IMPORTANT: 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.

Pharmacy Choices

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. Some plans have "preferred" pharmacies which offer lower costs than other network pharmacies. 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. If you spend part of the year in another state, see if the plan will cover you there.

Quality

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans. A plan can get a rating from one to five stars. A 5-star rating is considered excellent. If a plan has a rating below 3-stars for three consecutive years it is considered to be a low performing plan and you can change to another plan that has a 3-star rating or higher once during the year. To help you compare plans based on quality and performance you can find a plan's star rating on the Medicare website (www.medicare.gov).

How Can You Get "Extra Help" with Your Medicare Drug Costs?

People whose income and resources fall below a set amount will qualify for extra help paying their premium and for some of the cost of their prescriptions. One of the real advantages of extra help is that there is no coverage gap. You can apply for the extra help at any time.
If you are on Medicare you **automatically qualify** for extra help if any of the following are true:

- You qualify for Medicaid benefits
- You get help from the state Medicaid program to pay your Medicare Part B premiums (a Medicare Savings Program)
- You get Supplemental Security Income (SSI) benefits

If you don't automatically qualify for extra help you can **apply** for help by contacting your local Social Security office. Enrollment can be done by mail, telephone (1-800-772-1213; TTY 1-800-325-0778) or online (www.socialsecurity.gov) . SHIIP counselors are also available to assist you with your application (1-800-351-4664; TTY 1-800-735-2942)

Medicare will automatically enroll you in a Part D plan if you qualify for extra help. This plan is randomly chosen for you and may not cover all your drugs. You do have the option of choosing a plan rather than taking the plan Medicare assigns you. When you qualify for Extra Help you can switch plans at any time and your new plan will begin the first day of the next month. You do not have to wait until the open enrollment period to enroll. SHIIP counselors are available to help you compare plans.

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.

What if my application for Extra Help is denied?

You will receive a letter from Social Security letting you know if your application has been approved or denied. If it is denied, you will be told why. 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. To request an appeal, call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Even if you don't qualify for Extra Help now, you can apply or reapply later if your income and resources change.

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.

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

- **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.
- **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 https://www.medicare.gov/pharmaceutical-assistance-program/Index.aspx

When Can You Join, Switch or Drop a Plan?

Enrollment Periods

There are specific times when you can join, switch, or drop a Medicare drug plan.

Initial Enrollment Period— first eligible for Medicare

You can join during the 7-month period that begins the 3 months before you turn 65, the month you turn 65, and the 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 Social Security disability. You will have another chance to join during the 7-month period that begins 3 months before the month you turn 65, the month you turn 65, and the 3 months after the month you turn 65.

Open Enrollment Period— October 15–December 7 each year

This period is especially important because this is the one time each year when everyone on Medicare can change Part D drug plans for the next year. Plans announce their coverage and costs for the next year by October 1. **Because plans can change their premium, deductible, co-payments/coinsurance, drugs they cover and pharmacies in their network every year it is critical to do a Part D comparison during the open enrollment period.** Everyone should compare drug plans during this period to be sure they have a plan that will cover their prescriptions at the lowest cost with the fewest restrictions. The plan you choose will begin January 1 the following year, as long as the plan gets your request for enrollment by December 7. After December 7 most people cannot choose a different Part D plan until the next open enrollment period. During this time you can also join a plan if you did not do so during your initial enrollment period or you can drop Part D coverage.

By September 30 each year you should receive from your current Medicare Part D plan an **Annual Notice of Change (ANOC)**. Watch for this notice! It will explain your plans costs and coverage for the next year. If your plan is no longer being offered you will receive one of the following:

- a notice telling you another plan the company offers into which you will be moved starting January 1 OR
- a notice telling you that you need to choose a new plan (from any Part D company)

IMPORTANT: No matter which type of notice you receive, compare Medicare drug plans every year during the open enrollment period. Plans change costs, drugs covered, restrictions and pharmacy networks each year. You cannot assume that your current plan will be the plan that best meets your needs in the next year.

Any Time if You Qualify for Extra Help

People who have Medicare and Medicaid, belong to a Medicare Savings Program, get Supplemental Security Income (SSI) benefits, and those who apply for Part D "extra help" through the Social Security Administration and qualify can change Part D coverage at any time. The new coverage will begin the first day of the following month.

Special Enrollment Periods

In certain limited circumstances, you may be able to join, drop, or switch to another Medicare drug plan at other times. The following is a list of some of the special enrollment periods. The new coverage begins the first day of the month following enrollment.

- Change in residence—you permanently move out of your plan's service area
- Live in a nursing home—when you move into or out of a nursing home; the entire time you live in the nursing home or skilled nursing facility you can change coverage monthly
- Lose creditable drug coverage (coverage as good as Medicare's)
- Add or lose employer provided drug coverage or any time your employer allows you to change drug coverage
- Enroll in a Part D 5-Star plan once between December 8 and November 30. If you are currently enrolled in a 5-star plan you can switch to a different 5-star plan also.
- If you are enrolled in a plan that receives a rating of less than 3-stars for 3 years in a row, you may move to a plan with a 3-star rating or higher by calling 1-800-MEDICARE (1-800-633-4227).

Disenrollment Period—January 1—February 15 each year

From January 1-February 14 each year, you can disenroll from a Medicare Advantage Plan and return to Original Medicare and enroll in a Part D plan. You cannot use this time to drop Part D coverage. If you make this change, you may also join a Part D plan to add drug coverage.

NOTE: A change in the prescription drugs you take does not qualify you for a special enrollment period to choose a different Medicare drug plan.

Enrolling in Plans

You can enroll in a drug plan in a variety of ways. You can enroll directly at www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). You can also contact the company that offers the plan or enroll through an insurance agent who sells the plan. SHIIP counselors are also available to assist you with enrollment using the Medicare website. Call 1-800-351-4664 (TTY 1-800-735-2942) to find the SHIIP site nearest you.

You don't need to tell your current drug plan you are leaving or send them anything, because joining a different Medicare drug plan disenrolls you from your current drug plan.

Part D Late Enrollment Penalty

The late enrollment penalty is an amount that is added to your Part D premium 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***.

Creditable prescription drug coverage could include drug coverage from a current or 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, include it in a plan booklet 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.

When you join a Medicare drug plan, the plan may send you a letter asking if you had 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.

You will pay 1% more for every month you waited to get a Medicare prescription drug plan after your initial enrollment period and did not have creditable coverage. The penalty is a percentage of the national average premium for Medicare drug plans that year. For example, if you did not enroll in a Part D plan and had no other coverage for 24 months you would pay a 24% penalty (24% times $34.10 in 2016). You will pay this higher premium as long as you have a Medicare drug plan. When you join a Medicare drug plan, the plan will tell you if you owe a penalty and what your premium will be. The penalty will be withheld from your Social Security or Railroad Retirement check or you will be billed by the plan.

If you get "extra help" with your Medicare drug costs you don't pay a late enrollment penalty.

How Do You Choose a Medicare Part D Drug Plan?

You should compare the costs of your prescriptions with the benefits provided by each of the plans to make sure you are making the best choice. Information about the plans is available at www.medicare.gov or at 1-800-MEDICARE (1-800-633-4227). SHIIP counselors are also available across the state to help you compare your choices and understand Medicare drug coverage. Call 1-800-351-4664 (TTY 1-800-735-2942) or go to www.therightcalliowa.gov to find the counselor nearest you.

Things to consider before deciding to get a Medicare drug plan:

- If you have drug coverage now, is it creditable prescription drug coverage—is it as good as, or better than, Medicare prescription drug coverage? Your current plan can tell you.
- 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.
- Can you get Extra Help paying for your prescription drug costs if you join a Medicare drug plan?
- 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?
- How much will you pay for monthly premiums?
- Does the plan have a deductible? How much do you pay toward your prescription drug costs before the Medicare drug plan pays benefits?
- Does the Medicare drug plan cover all the medications you are taking? If not, does it cover the most expensive ones? Are there any restrictions on the drugs you take - for example: quantity limits, step therapy or prior authorization? Each plan will have its own formulary (list of drugs it covers).
- How much will you pay for your prescriptions? Most Medicare drug plans have a tiered formulary. This means your share of the costs will vary depending on the drug.
- Part D plans and drug manufacturers are required to provide some assistance with drug costs in the gap. Some plans may provide additional coverage. How much do your drugs cost when you reach the gap?
- Can you fill your prescriptions at the pharmacy you use regularly? Is a mail order pharmacy available to you? Can you fill your prescriptions when you travel?
- What is the quality (star) rating for the particular plan(s) you are considering?

What Are Your Other Drug Coverage Choices?

Medicare Part D is one option for getting prescription drug coverage. Other alternatives for people on Medicare include the following. Call your local SHIIP counselor if you are not sure which of these apply to you.

Employer or Union Drug Coverage (Current or Former)

Before making a decision about whether to join a Medicare drug plan, find out how your employer or union drug coverage works with Medicare. Your coverage may change if you join a Medicare drug plan. Ask these important questions before making a decision:

- Is your employer or union prescription drug coverage creditable (as good as, or better than, Medicare 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?

Be sure to talk with your employer or union benefits administrator before making any changes to your prescription coverage.

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 Part D 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.

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, you must join a Medicare drug plan when you're first eligible to avoid a late enrollment penalty.

Caution: If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union drug coverage without also dropping your employer or union health coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependents.

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. This means you would have to find other supplemental health insurance or pay all Medicare cost sharing out-of-pocket.

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.

TRICARE or Department of Veterans Affairs (VA) Drug Coverage

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.

You can join a Medicare drug plan and have VA coverage, but you can't use both types of coverage for the same prescription.

For most people with TRICARE it is not cost effective to join a Medicare drug plan unless you qualify for Extra Help. If you have TRICARE and join a Medicare drug plan, your Medicare plan pays first, and TRICARE pays second.

If you join a Medicare Advantage (MA) 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.

Medicaid and Medicare Drug Coverage

If you are on Medicaid and become Medicare eligible, your drug coverage will shift to the Medicare prescription drug benefit. Medicaid is no longer your primary drug coverage. You will automatically qualify for Extra Help with your drug costs (see *How Can You Get "Extra Help" with Your Medicare Drug Costs?* section of this guide).

If you live in a nursing home and have full Medicaid coverage, you pay nothing for your covered prescriptions after Medicaid has paid for your stay for at least 1 full calendar month. Note: Institutions don't include assisted living, adult living facilities, residential homes, or any kind of nursing home not certified by Medicare.

If you don't join a Medicare drug plan, Medicare will enroll you in a drug plan to make sure you have drug coverage. These plans are randomly selected and another plan may better meet your needs. It is important to have a comparison of drug plans done and for you to choose a plan that covers all your drugs at the lowest cost with the fewest restrictions. SHIIP can help you with this comparison. Call 1-800-351-4664 (TTY 1-800-735-2942) for more information.

Once Medicaid drug coverage ends, if you fill any covered prescriptions before your Medicare drug plan coverage starts, you may be able to get back some of the money you spend. Call Medicare's Limited Income Newly Eligible Transition (NET) Program at 1-800-783-1307 (TTY 1-877-801-0369) for more information.

If you don't want Medicare prescription drug coverage and you don't want Medicare to enroll you in a Medicare drug plan (for example, because you have other creditable prescription drug coverage), call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048) and tell them you want to opt out of (decline) Medicare prescription drug coverage. Caution: If you call 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.

PACE

PACE programs are a joint Medicare and Medicaid option available in a few Iowa counties. 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. If you also have full Medicaid coverage, you get prescription drugs at no cost to you through your PACE plan.

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.

Indian Health Service, Tribe or Tribal Health Organization

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 get health care from the Indian Health Service, Tribal Health Program, or Urban Indian Health Program, you have creditable prescription drug coverage.

Medicare Supplement Insurance (Medigap) with Drug Coverage

Before 2006, some Medigap policies included prescription drug coverage. If you still have a Medigap policy with 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.

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 drug plan.

What Are Your Rights?

Medicare wants to protect your rights and prevent fraud and identity theft in the Part D program. Become familiar with the following protections and if you have questions or concerns call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048) or SHIIP at 1-800-351-4664 (TTY 1-800-735-2942).

Drug Exceptions and Appeals

If your plan will not cover a drug you need, you, your representative or your doctor/prescriber, may ask for a "coverage determination" or "exception."
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.
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.

If the exception is not approved, you can appeal the decision. There are five levels of appeal:

1. Request an appeal through your plan -- The first level of appeal is called a "redetermination." You must request this appeal within 60 calendar days from the date of the coverage determination notice.
2. Review by an Independent Review Entity (IRE)--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 must file your written request within 60 calendar days from the date of the plan's redetermination decision.
3. Request a hearing with an Administrative Law Judge (ALJ)--You or your representative must make the request in writing within 60 calendar days from the date of the IRE's reconsideration notice.
4. Request 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.
5. Request a review by a Federal court— The request must be made within 60 calendar days from the date you get the MAC's decision.

Late Enrollment Penalty Reviews

You have the right to ask Medicare to review your late enrollment penalty. This is called a "reconsideration." 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.

Plan Marketing

Medicare drug plans and the people who work for them are NOT 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.
- 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.

SENIOR HEALTH INSURANCE

SHIIP

INFORMATION PROGRAM