



2010

MEDICARE PART D FROM A TO Z

Your comprehensive guide
to prescription drug coverage.

A PUBLICATION OF:



**National Committee to Preserve
Social Security and Medicare**

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Information contained in this booklet is current as of October 2009. Program rules and regulations may change in the future.

To obtain the most recent information, visit the “Frequently Asked Questions” on our website at www.ncpssm.org or call our toll-free number at 1.800.966.1935

FREQUENTLY ASKED QUESTIONS ABOUT THE MEDICARE PRESCRIPTION DRUG BENEFIT (PART D)

Since 2006, a privatized Medicare prescription drug program has been offered to seniors. The Part D program provides drug coverage through numerous private companies, and it seeks to control prices through competition between the plans. Unfortunately, seniors face a complex and confusing array of choices in this program, and few have been able to effectively “vote with their pocketbooks” for plans that offer the best value. Due to the difficulty involved in comparing plan offerings year after year, only a small percentage of beneficiaries change plans, which undermines market competition. Drug prices continue to increase at alarming rates.

For many years, the National Committee to Preserve Social Security and Medicare has advocated for the provision of universal prescription drug coverage through the traditional Medicare program. This approach would provide seniors a simple, familiar benefit, and it would harness the purchasing power of 44 million Medicare beneficiaries to contain the skyrocketing cost of prescription drugs. We continue to work toward this goal.

Under the current Part D program, however, seniors are given only six weeks each year to make difficult decisions about their prescription drug coverage, and they are then locked into the plans they select for an entire year. This year’s Annual Coordinated Election Period (ACEP) begins on November 15, 2009 and lasts until December 31, 2009. It is only during this open enrollment period that most seniors are permitted to enroll in a Part D plan, drop Part D coverage, or switch to a different plan. While most seniors will be locked into the plans they select for all of 2010, plans are allowed to make significant changes to their prices, formulary, and benefits throughout the year. In addition, many plans have already announced significant changes to their coverage for next year. We strongly encourage you to closely examine how your current coverage will change in 2010. It might be to your advantage to choose another plan that better matches your prescription needs and your cost expectations.

We believe it is essential for seniors to be given the most accurate information possible about Part D so they can make informed decisions about whether to enroll in the prescription drug benefit program and how to pick a plan that best serves their needs. For this reason, we have compiled the best answers available to the questions most frequently asked by seniors and their caregivers in order to help the American public better understand this program. As new information becomes available, we will continue to update this material.

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1. What is the Medicare drug benefit?

The Medicare prescription drug benefit — also known as Medicare Part D — is voluntary insurance that Medicare beneficiaries can purchase to help cover the costs of their prescription drugs. Only private insurance companies can offer Part D plans. It is up to you to decide which plan best fits your needs. Like other insurance plans, you will be responsible for payments such as a deductible, monthly premiums, and co-payments. Unlike other insurance plans, it is likely you will also be exposed to a large coverage gap or “donut hole,” where you continue paying monthly premiums but receive no help with the cost of your prescription drugs.

You can join a Medicare Part D private plan and continue to receive your traditional Medicare benefits for hospitalization (Part A) and doctors’ visits (Part B) directly through the federal government. Or you can join a private insurance Medicare Advantage plan, such as a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), which will provide all of your Medicare benefits, including prescription drug coverage.

2. What are some key dates to remember?

The timeline below provides a summary of key milestones in signing up for Part D coverage for 2010.

October 1, 2009: Plans begin marketing their Part D prescription drug benefits for 2010. Also, plan termination notices are sent. If your

prescription drug plan is being terminated, you will receive a letter notifying you that you will have to choose a new plan for 2010.

Mid-October 2009: By mid-October, you will be able to find and compare plans online at www.medicare.gov or by calling 1-800-MEDICARE (see **question #74**). This is also when the Centers for Medicare and Medicaid Services (CMS) begins reassigning new plans to beneficiaries eligible for “extra help.” You will only be reassigned to a new plan if you are enrolled in a plan that is terminating in 2010, if your premium increased above the regional low-income premium subsidy amount, or if your plan is changing from a standard plan to an enhanced plan. If you receive notice of reassignment, make sure to keep it in your records.

October 15, 2009: The *Medicare & You 2010* handbook is mailed to all Medicare beneficiaries. This handbook contains important information on the Medicare program for 2010.

October 31, 2009: If you are currently enrolled in a Part D plan, you will receive a letter from your plan notifying you of any changes to the plan for 2010. The letter explains how your benefits, premiums, and co-payments will change next year. It will also inform you of the upcoming open enrollment period so you can change plans. Also, CMS stops mailing the *Medicare & You 2010* handbook by this date.

Early November: If you currently receive Part D “extra help” and are automatically

reassigned to a new prescription drug plan, you will receive a blue letter from CMS. Beneficiaries who are receiving “extra help” with their drug costs will only be reassigned to a new plan if they are enrolled in a plan that is terminating in 2010, if their premium increased above the regional low-income premium subsidy amount, or if the plan is changing from a standard plan to an enhanced plan. As with all official notices from CMS or your drug plan, it is important to save this notice in your records.

November 15, 2009: The official open enrollment period for Medicare Part D begins. You will be able to enroll in a Part D plan, drop your Part D coverage, or switch to a different Part D plan. If you want to remain in your current prescription drug plan, you do not have to do anything during the open enrollment period. Your prescription drug coverage will continue with its new benefit and cost design for 2010. If you are thinking of dropping your coverage, be sure to check on the enrollment penalties that would apply if you decide to re-enroll later (see **question #41**).

Early December 2009: It is best to enroll in a Part D plan by early December to ensure that your coverage will go into effect on January 1, 2010. If you wait until later in December to enroll, you may end up without coverage at the beginning of the year until your enrollment is processed.

December 31, 2009: The annual open enrollment period for Medicare Part D drug plans ends. This period is officially called the Annual Coordinated Election Period (ACEP).

January 1, 2010: Part D coverage for the new 2010 plan year begins.

January 31, 2010: New prescription drug plans must have sent evidence of coverage, including “extra help” information, to beneficiaries. It is very important to save this notice in your records.

3. Who is eligible to enroll in Part D?

Any senior who has either Part A or Part B of Medicare is eligible, regardless of health or income. An exception is made for beneficiaries who are incarcerated — they are not eligible to participate in Part D.

4. Do I have to enroll?

No, the Part D benefit is completely voluntary, except for certain very low-income seniors who receive Medicaid benefits and are automatically enrolled in a Medicare prescription drug program. These low-income seniors are given the option to opt-out of Part D, but are not allowed to return to Medicaid for their prescription drug needs. In most cases, seniors who delay enrollment will be subject to penalties when they do sign up. The penalties do not apply if you have other drug coverage that is at least as good as Medicare’s (see **question #41**).

Note: Most people have to sign-up if you want coverage.

5. What will Part D cost?

Your costs will depend on the plan you choose, and your out-of-pocket costs will differ considerably from plan to plan. For this reason, CMS is encouraging beneficiaries

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who currently have plans to reconsider their choice, and all beneficiaries are urged to make careful comparisons.

It is very important to go beyond a comparison of the premiums and deductibles that apply to each plan. You should also look at the co-payments that will be required each time you fill a prescription and whether or not the drugs you take now will be covered by the plan. Most plans also have a coverage gap or “donut hole” and will not cover your drugs between certain cost limits (see **question #34**). In addition, it is important to check if your plan has rules to limit access to certain drugs, such as prior authorization, quantity limit, or step therapy rules.

It is useful to do this comparison shopping during every annual open enrollment period. In 2010, the average Part D plan premium will rise by 11 percent. Plans also change their formularies and the co-payments they charge for drugs. Therefore, it is important that you closely examine the letter from your plan that details how your coverage will change. CMS requires plans to send this letter by October 31st.

Required co-payments for commonly used drugs differ substantially from plan to plan. For example, in 2009, a person with high cholesterol would pay \$21 for a month’s supply of Lipitor under one of the available plans, \$77 under another, or \$96 under one of the plans that did not include the drug on its formulary. Similarly, a person taking Nexium would pay co-payments ranging from \$20 to \$75 under plans that cover this drug, or \$171

under one of the plans that does not include this drug on the formulary.

A few points to remember as you consider your out-of-pocket costs:

- Only qualified drug expenses will count toward getting out of the donut hole. If you use prescriptions not covered by the plan you sign up for, or import drugs from Canada, or receive coverage from a drug company’s patient assistance program — none of those expenses will count toward any of the limits;
- All of the dollar amounts are annual, so CMS will begin counting from zero each year;
- Premiums and co-payments will change from year to year, and will vary from plan to plan; and,
- If your income is limited, you may be eligible for “extra help” to pay these costs.

6. What are the basic benefit design requirements that apply to Part D plans?

The law establishing Part D outlined a standard benefit that is used as the yardstick to measure the overall value a private plan must offer in order to be approved by Medicare. The private insurers participating in the program may structure their benefit differently, as long as the overall value is at least as good as the Medicare basic plan. For example, a plan may have higher premiums but cover more drugs, or offer reduced co-payments, as long as the overall

package of benefits is at least as valuable as the standard plan design. Regardless of their structure, however, plans may not impose a higher deductible (\$310 in 2010) or require a higher out-of-pocket limit (\$4,550 in 2010) than required by the standard benefit.

The standard benefit requires beneficiaries to pay an estimated monthly premium of about \$32 per month (or annual total of about \$384) in 2010. In addition:

- The deductible is \$310 per year.
- The beneficiary then pays 25 percent of the cost of the next \$2,830 in qualified drug expenses (in other words, \$775 in out-of-pocket costs).
- Next, the beneficiary falls into what is known as the “donut hole” or coverage gap. This requires her to pay, out-of-pocket, 100 percent of the next \$3,610 in covered drug costs. In addition, the monthly premium continues to be required. *This brings her to a total of \$6,440 in qualified drug expenses, \$4,550 of which will be out-of-pocket for the beneficiary and \$1,890 of which will be paid by the Part D plan.*
- Then, once the beneficiary reaches \$4,550 in out-of-pocket expenses, catastrophic coverage begins and she pays either 5 percent of qualified costs, or a co-payment of \$2.50 for a generic or preferred drug and \$6.30 for other drugs, whichever is greater, for the remainder of the year.

Note that in 2009, relatively few Part D plans offered a benefit that conformed with the premium, deductible, and prescription co-payment amounts of the standard benefit.

7. How much will I save on prescription drugs?

The majority of beneficiaries eligible for a low-income subsidy will experience substantial savings by enrolling in Part D. The Social Security Administration estimates that “extra help” could be worth an average savings of \$3,900 a year on prescription drugs.

Savings are lower for beneficiaries who do not qualify for “extra help,” and the rate of drug cost inflation may cause these beneficiaries to save much less over the next decade. Out-of-pocket costs can be steep under Part D, and they will rise annually at the rate of drug cost inflation. Drug costs rise faster than health care inflation overall, and both rise faster than general inflation.

Over time, Medicare Part D out-of-pocket increases could rapidly outpace the Social Security Cost-of-Living Adjustment (COLA) which keeps pace with general inflation.

Unlike the Part B program, in which premiums cannot exceed the annual Social Security COLA (except for higher income beneficiaries), the Part D premium is currently not subject to any limits. Without any changes to the program, by 2019 the Part D premium is projected to increase about 73 percent, the deductible will increase about 105 percent, and the donut hole will increase about 98 percent. Such increases will severely crimp seniors’ budgets.

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8. What are my plan choices?

There are two types of Part D plans:

Stand-alone Prescription Drug Plans (PDP):

“Stand-alone” plans only offer prescription drug coverage. If you sign up for one of these, you continue to get all your other medical services, such as doctor visits and hospital stays, through the traditional Medicare program or through some Private Fee-for-Service (PFFS) plans if they do not offer drug coverage.

Medicare Advantage Plans (MA):

“MA” plans are private health plans such as Health Maintenance Organizations or HMOs, Preferred Provider Organizations or PPOs, and Private Fee-for-Service or PFFS plans.

If you sign up for one of these managed care plans to get drug coverage, be aware that you will be required to leave the original Medicare program. All your medical expenses will be covered by the new plan. Before joining a private plan, it is important to make sure that your health care providers are included in the plan’s network and to examine the co-payments the plan will require for all the services you need. Many of these plans offer low premiums and deductibles, but charge high co-payments for certain kinds of services.

If you are in a Medicare cost program or a PFFS plan that does not offer drug coverage, you can enroll in a stand-alone prescription drug plan. However, if you are in an HMO or PPO, you must receive your entire medical *and drug coverage* through that plan. You cannot enroll in a separate stand-alone plan.

There are a number of national stand-alone plans, and dozens of local or regional plans, both stand-alone and managed care. Your number of choices depends on how many plans are approved to offer the drug benefit where you live.

9. Will all the prescription drugs I take be covered?

Not necessarily. Each plan has its own list of covered drugs, called a formulary, that includes both brand-name and generic drugs. Many plans have “tiers” of drugs, which determine how much you will pay for each drug. In addition, plans have coverage rules that limit what they will cover. You should examine all of these features of the plans you are thinking of joining.

Coverage rules are used by the plans to steer beneficiaries toward lower-cost or safer drugs, and collectively they are known as “utilization management tools.” There are a number of techniques that are commonly employed:

- A requirement to contact the plan to obtain prior authorization before a prescription is filled. Most often, you must ask your doctor to contact the plan.
- A requirement to try a lower-cost drug before a more expensive one is approved for coverage (so-called “step therapy”).
- A limit on the quantity of drugs that can be dispensed at one time (or “quantity limit”). Frequently, this is less than a month’s supply.

CMS is requiring the plans to post their utilization management rules on their websites by November 15, 2009. It is valuable to check which rules will apply to the drugs you depend on.

Also, be aware that plans are allowed to change the drugs on their formulary, as well as their prices throughout the year. If a plan decides to remove a drug from its formulary, move it to a more expensive tier, or add utilization management requirements, they are encouraged by Medicare to continue providing the drug at the same cost-sharing level for the remainder of the plan year to those enrollees who were taking the medication at the time of the change. Plans are required to provide beneficiaries currently taking the prescription with a 60-day notice of the formulary change. All other enrollees who may be prescribed the drug in the future would be subject to the new formulary and drug prices. These enrollees will not receive individual notice of the plan changes, but will be subject to the coverage limits and prices listed on the plan website.

Plans may replace brand-name drugs on their formularies with new generic drugs at any time. Plans are required to provide enrollees who are taking the brand-name drug at that time with a written notice at least 60 days before the change. If you receive such a notice, you should talk to your doctor to see if you can take the generic drug or need to stay on the brand-name version. If you need to take the brand-name drug instead of the generic drug, you or your doctor should request an exception to the formulary. Every plan must have a process in place for you to

request an exception to the formulary limits when your plan does not cover a drug, requires trying another drug first, or places a limit on the drug prescribed (**see question #29**).

10. What drugs will Part D cover?

All plans must cover at least two drugs from each therapeutic class of drugs. A therapeutic class contains drugs that are similar based on the disease they treat or on the way they affect the body. Biological products, including insulin and insulin supplies, and smoking cessation drugs are covered under Part D. In addition, plans must cover substantially all of the drugs in certain classes: antidepressants; antipsychotics; anticonvulsants; antiretrovirals; anticancer drugs; and immunosuppressants. *CMS has indicated that they may remove the “substantially all” requirement for certain of these classes in 2010.*

11. Which drugs are not covered by Part D?

There are some drugs that are excluded from Medicare coverage by law. These include drugs for anorexia, weight loss, or weight gain; fertility; cosmetic purposes or hair growth; relief of the symptoms of colds; prescription vitamins and minerals (except prenatal vitamins and fluoride preparations); over-the-counter drugs; and anti-anxiety and anti-seizure drugs that are in the benzodiazepine and barbiturate drug classes. *(Benzodiazepine and barbiturate drugs will be covered beginning in 2013 for beneficiaries who have epilepsy, cancer, or a chronic mental health disorder.)*

Some plans may offer enhanced coverage that includes these excluded drugs. If you have full

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Medicaid, your state may also cover them. However, the amounts you pay for these drugs will not count toward meeting any of your Part D out-of-pocket cost limits.

Many drugs covered by Medicare Part A or Part B are not covered by Part D. Drugs not covered include some oral cancer drugs, immunosuppressants, antivirals, antigens, and anti-emetics. This exclusion applies whether or not you are actually enrolled in either Part A or Part B. The cost of these drugs is not counted toward your out-of-pocket limits under Part D.

12. What costs count as out-of-pocket expenses?

Only payments for drugs on your plan's formulary count towards your out-of-pocket maximum, unless you have received an exception to the plan's formulary (see question #29). Medicare refers to these as True Out-of-Pocket (TrOOP) costs, and they are the costs that count toward getting out of the donut hole (see question #34).

Some examples of payments that DO count toward your out-of-pocket limits are:

- Payments you make yourself, or that are made on your behalf by family or friends as long as you are not reimbursed by an insurer. These include your deductible, co-payments, and what you spend out-of-pocket when you are in the “donut hole.”
- Payments made by a qualified State Pharmacy Assistance Program (SPAP), but only to the extent the money is used to

purchase drugs covered by your plan. Some SPAPs may encourage you to join a particular plan when you seek assistance.

- Payments made by a charitable organization that is not associated with an insurer, your employer, or a pharmaceutical drug manufacturer.
- Health savings, flexible spending, or medical savings accounts.

Remember — only payments for drugs your plan covers (including any “exceptions” you receive) count toward the limits. Your out-of-pocket costs will be calculated by calendar year, and your drug plan will keep track of your expenses for you. If you change your drug plan, your old plan must transfer this information to your new plan.

13. What costs do NOT count as out-of-pocket expenses?

Many drug costs do not count toward getting out of the donut hole (see question #34).

These include the following kinds of payments:

- Group health plans (such as retirement coverage provided by a former employer or union).
- Government programs such as TRICARE, Black Lung, the Department of Veterans Affairs, Indian Health Services, or federally-supported community health centers.
- Workers' Compensation.

- Automobile, no-fault, or liability insurance.
- AIDS Drug Assistance Programs (ADAPs).
- Any other third-party payment arrangement.
- Drugs purchased outside the United States.
- Drugs not on the plan’s formulary (unless you have received an exception).
- Drugs explicitly excluded from Medicare drug coverage, even if your plan has enhanced coverage to include them.
- Drugs provided by a pharmaceutical manufacturer’s patient assistance program.

Note also — the amount you pay for your monthly Medicare Part D premium does NOT count as an out-of-pocket expense.

ENROLLMENT

14. When can I enroll?

If you are not yet eligible for Medicare, your timeframe for enrolling in Part D is the same as for Part B — a seven month period that includes your birth month, plus the three months immediately before and after your birth month. Your benefit begins on your 65th birthday or the first day of the month following enrollment, whichever comes later. You may be subject to a penalty premium if you do not enroll in Part D during this initial enrollment period (see question #41).

If you currently have Medicare, you may enroll

in a prescription drug plan from November 15, 2009 until December 31, 2009. If you did not enroll when you were first eligible for the benefit, you may be subject to a penalty premium (see question #41). Low-income beneficiaries who are eligible for “extra help” will not face this penalty. Drug coverage will begin on January 1, 2010. CMS is encouraging beneficiaries to enroll early to reduce the chance of problems with drug coverage beginning in January.

If you are in a stand-alone drug plan, you can enroll or disenroll from Part D once a year during the Annual Coordinated Election Period (ACEP), which runs from November 15th to December 31st.

If you are in a managed care plan, you can switch to another plan during the ACEP from November 15th to December 31st or during the Open Enrollment Period (OEP) from January through March (see question #15). You may also switch back to original Medicare at these times. If you change to original Medicare during the earlier ACEP period, you will have the option of joining Parts A and B without also joining a stand-alone drug plan. However, if you wait until the OEP, you will be required to join a stand-alone plan when joining original Medicare.

15. When can I change plans?

Most seniors may only switch plans during two periods each year — the Annual Coordinated Election Period and the Open Enrollment Period. There are exceptions, however, known as Special Enrollment Periods.

ENROLLMENT

Annual Coordinated Election Period (ACEP)

During the Annual Coordinated Election Period (ACEP), which runs from November 15th through December 31st each year, you can enroll in or drop Part D, change from one stand-alone plan to another, or change to a managed care plan.

Open Enrollment Period (OEP)

Each year there will also be an Open Enrollment Period, from January through March. During the Open Enrollment Period, you can move between the different types of plans. For example, you can move from a stand-alone plan to a managed care plan, or from a managed care plan to a stand-alone plan, or from a managed care plan to another managed care plan. However, you may not move from one stand-alone plan to another or enroll in Part D for the first time.

Special Enrollment Period (SEP)

There are special time periods during which you may join or change Part D plans outside the ones specified above. Some examples of reasons you might qualify for an SEP include if you:

- move out of your plan’s service area;
- lose your non-employer drug coverage (such as your State Pharmaceutical Assistance Program or SPAP) through no fault of your own;
- lose your employer (current or retiree) coverage for any reason;
- are eligible for the low-income “extra help” subsidy;

- enter, reside in, or leave a long-term care facility;
- lose full Medicaid coverage; or,
- enroll in a Program of All-Inclusive Care for the Elderly (PACE).

In many of the above cases, if you had drug coverage comparable to Part D, you will be given 63 days to enroll in a Part D plan before a penalty applies.

Seniors in long-term care settings can change plans once a month while they remain in a facility. Once you leave, you have 63 days to enroll in a plan without penalty (see **question #66**).

16. How do I sign up for Part D?

You can join a Part D plan by calling 1-800-MEDICARE; by completing an online application on Medicare’s website at www.medicare.gov; or by contacting the plan of your choice at its website or at the phone number provided in its brochure. You may only enroll during certain time periods (see **question #15**).

17. How do I disenroll from a Part D plan?

You may also disenroll from your plan by calling Medicare or contacting your plan directly. If you disenroll from your plan, you cannot enroll in another plan until the next enrollment period. You may be subject to a late enrollment penalty for not maintaining creditable coverage (see **questions #32 and #41**).

18. What if I accidentally sign up for more than one plan?

During an enrollment period, if you already have a plan and sign up for a new one, you will be automatically disenrolled from the first plan. If you make multiple plan selections during a month, the last one you make will become effective on the first day of the following month.

However, you must be in an enrollment period to join a plan or change plans. If you try to do either outside of an enrollment period, you will be denied.

19. Will I need to reapply every year?

No. If you do nothing, your current plan will continue. However, because both your plan and your medical needs change from year to year, it is important to re-evaluate your Part D plan every year to make sure you are receiving the best coverage for your needs. By October 31st, you should have received the Annual Notice of Change from your plan. That letter will explain the prescription drug benefit and formulary being provided in 2010, as well as any changes to premiums, co-payments, and coinsurance the plan has made to the coverage it provided in 2009. You should review this notice to make sure your prescription drug plan still meets your needs.

20. How do I pay my premium?

You can either pay your premium directly to the plan in which you have enrolled or have your premium automatically deducted from your Social Security, Railroad Retirement, or Office of Personnel Management check monthly (in the same way your Part B premium is currently deducted). In recent years, CMS has encouraged

beneficiaries to pay their Part D premium directly to their plan, rather than having it deducted from their Social Security check. There were a number of problems with Part D premiums being inaccurately deducted, and CMS continues to highlight alternatives to Social Security check deductions. However, should you choose to have your premium deducted from your Social Security check, be aware that your first two months' premiums will be combined.

Employers, State Pharmaceutical Assistance Programs (SPAPs), state Medicaid agencies, and charitable organizations can also pay the Part D premium for you.

21. Once I enroll in Part D, when does the coverage begin?

If you join before December 31, 2009, your drug coverage will begin on January 1, 2010. However, the Centers for Medicare and Medicaid Services (CMS) suggests that you enroll in a plan as soon as possible to minimize any potential problems with your coverage beginning on January 1st. In recent years CMS has encouraged beneficiaries to enroll by the first week of December.

If you are currently enrolled in a plan, but have enrolled in a different one for 2010, your current plan will cover your drugs through December 31st and your new coverage will begin on January 1, 2010.

If you enroll or change coverage during a Special Enrollment Period (SEP), the effective date of your coverage will depend on the reason for the SEP.

PHARMACIES

If you first become eligible for Medicare Part D at any other time — for example, if you turn 65 part way through the year — your coverage will start on the month you become eligible if you joined in the first three months of your Initial Enrollment Period, or the month after the one in which you joined, if you sign up during the last four months of your Initial Enrollment Period.

22. Can my application be rejected?

Yes, your application can be denied in a few circumstances, such as if:

- you are not eligible for Medicare drug coverage;
- you are not in the plan’s coverage area;
- you have End-Stage Renal Disease and you are attempting to enroll in a managed care plan;
- you are not eligible for either Medicare Part A or Part B;
- the plan is not accepting new members;
- you are enrolled in a managed care plan while attempting to also enroll in a stand-alone drug plan;
- your application is incomplete and you fail to contact your plan within 30 days after it notified you by mail; or
- you are incarcerated.

23. What can I do if my application is denied?

You can call the plan and attempt to clarify the rejection directly, or you can contact Medicare for assistance. However, beneficiaries who are denied enrollment lack adequate appeal rights to challenge the decision made by private plans. In lieu of appeal rights, beneficiaries can go through a Medicare grievance process which is controlled by the private plans and not subject to independent review.

PHARMACIES

24. Where can I get my prescriptions filled?

Most pharmacies, including both independent and chain pharmacies, are participating in Part D, but not necessarily with all plans. You must use a pharmacy that is included in your plan’s network to fill your prescriptions. Plans are required to provide pharmacies within a reasonable distance from your home, but those who live in rural areas may find themselves traveling considerable distances to reach the pharmacy of a particular plan. If the choice of pharmacies is important to you, or particularly if transportation is an issue, you should make sure to pick a plan that will allow you to use the pharmacies you prefer. If you regularly spend part of the year in another state, you should consider enrolling in a national drug plan that includes pharmacies across the nation. Many plans also offer mail order services.

25. Can I use a pharmacy outside my plan’s network?

Under limited circumstances, you may be allowed to use a pharmacy that is not part of your plan’s network. This exception cannot be

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used on a regular basis, and you will need to show that you cannot reasonably get the necessary drugs from a pharmacy that is in your network — for example, if you need an emergency prescription when you are traveling outside your plan’s service area. You may be required to pay more for drugs purchased at an out-of-network pharmacy, and the plan may also require you to pay for the prescription yourself at the pharmacy and file for a reimbursement.

26. Can network pharmacies charge different prices for the same covered drug?

Yes. What you pay for drugs may vary, depending upon how the plan sets up its network. Plans are allowed to have preferred and non-preferred network pharmacies, and they are allowed to charge more for drugs purchased at the non-preferred locations. They may also charge less if you use a mail order pharmacy.

The pricing difference will be very limited if you are receiving a low-income subsidy. In that case, you will pay no more than \$6.30 for your name-brand drugs (\$2.50 for generics) as long as you go to a pharmacy that is in the plan’s network.

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27. Who keeps track of how much I spend on drugs?

As long as you are using a pharmacy in your plan’s network, the plan will keep track of the amount you spend on your prescription drugs. When you enroll in a plan, you will receive a drug card to use when you fill your prescriptions, and the plan will use the card to keep track of

your expenses. Your plan is required to send you a statement each month showing how much you have spent up to that point, whether or not you are in the “donut hole,” and how close you are to reaching the catastrophic benefit trigger (\$4,450 of total beneficiary out-of-pocket costs in 2010, **see question #34**). You can also request this information from your plan at any time, and many will make this information available on their websites.

If you use out-of-network pharmacies, you will need to send your receipts to your plan so they can credit your account. You can likely do that at the same time that you ask to be reimbursed for the cost of your prescription.

If you change plans, your old plan is required to transfer your spending information to your new plan. Because your out-of-pocket maximum is calculated by calendar year, any amounts you have spent will be carried over to your new plan, and will count toward your out-of-pocket maximum.

28. What if the drug I need is not covered by my plan?

You should request an exception to the plan’s coverage rules and ask your drug plan for a formal coverage determination.

You will need to use special forms to request an exception and a coverage determination. You may use either a standardized form provided by CMS or a form designated by your plan. For your exception request, your doctor must provide a supporting statement in writing or by phone. Your plan is not required to

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consider your exception request until they have received this supporting statement.

Your plan must respond to your request for an exception within 72 hours. If your doctor states that your life, health, or ability to regain maximum function is at risk, an expedited request may be filed. Plans must respond to an expedited request within 24 hours. If a plan denies your request, you may appeal the plan's decision (**see question #29**). Furthermore, plans are expected to provide temporary supplies of non-covered drugs to affected beneficiaries when a plan is unable to meet the imposed timeframes for coverage determinations.

You may request an exception if you are using a drug that isn't on your plan's formulary, or if your doctor prescribes a drug not on the formulary because he believes the drugs on the formulary will not work for you. You may also obtain exceptions from many plan coverage rules: co-payment tiers, prior authorization requirements, "step therapy" requirements, and dose restrictions (**see question #30**).

Your exception must be supported by a statement provided by your doctor. Plans are prohibited from requiring that these statements be provided on a particular form. However, if you later find that you need to resubmit your request or appeal the plan's decision, it is very helpful to have this statement in writing, and CMS provides a standardized coverage determination/exceptions form for doctors. An effective supporting statement will describe the medical reasons why you need the prescribed drug and why no other drug on the formulary

will work as well. The doctor should also list what other drugs have been tried, how well they worked, and how well your current prescription is working for you.

29. Where do I go to appeal a decision by my plan not to cover a needed drug?

When you are unable to get needed medication, you should contact your plan and request an exception and a coverage determination (**see question #28**). The plan then has 72 hours to respond to your request (24 hours for an expedited appeal). Plans are expected to provide temporary supplies of non-covered drugs to affected beneficiaries when a plan is unable to meet the imposed timeframes for coverage determinations, redeterminations, or in forwarding cases to the Independent Review Entity. If you disagree with the outcome of a coverage determination, there are several levels of appeals that can help you obtain your medication.

Redetermination by Plan

The first step in the appeals process is to ask the plan to reconsider its coverage determination. You, your appointed representative, or your doctor can appeal your plan's decision by phone or letter. Your appeal must be requested within 60 calendar days of the plan's coverage determination. The plan then has seven days to respond to your request (72 hours for an expedited appeal). Plans are expected to provide temporary supplies of non-covered drugs to affected beneficiaries when a plan is unable to meet appeal timeframes.

Independent Review Entity (IRE)

If your plan again denies coverage, you can appeal

to the Independent Review Entity (IRE). The IRE is an independent agency that contracts with Medicare to handle these appeals and is not connected to any private drug plan. An appeal to the IRE must be made within 60 days from the date of the redetermination. The IRE has seven days to respond to your request (72 hours for an expedited appeal). You can find more information on appeals to the IRE and relevant forms at www.medicarepartdappeals.com/.

Administrative Law Judge (ALJ)

If you are dissatisfied with the reconsideration by the IRE, you can request a hearing with an Administrative Law Judge (ALJ) from the Department of Health and Human Services. The ALJ hearing request must be made within 60 days of the IRE decision. You can only receive an ALJ hearing if the value of denied coverage exceeds a minimum amount (\$130 in 2010). The ALJ is supposed to make a decision within 90 days, but extensions of the time limit can be granted. ALJ hearings are generally conducted over the phone or through video teleconference.

Medicare Appeals Council (MAC)

If you disagree with the ALJ decision, you can request a review by the Medicare Appeals Council (MAC), which is part of the Department of Health and Human Services. Your request to the MAC must be made within 60 days of the ALJ decision. The MAC will generally decide on your appeal within 90 days.

Judicial Review

If all else fails, and the amount in question exceeds a minimum amount (\$1,260 in 2010), you may request judicial review in federal district

court. Your request for judicial review must be made within 60 days of the MAC decision.

30. What restrictions may a plan impose on my drug coverage?

Plans use a wide range of restrictions to steer beneficiaries toward lower-cost drugs and lower utilization. For example, most plans arrange the drugs they cover in a “tiered” formulary. This means some drugs (typically generics) will cost the least, with preferred drugs costing somewhat more, and non-preferred drugs costing the most. If you need a drug on a high tier, you will pay more for it unless your doctor can show that you need the more expensive drug and the plan grants an exception to its formulary limits.

Another common restriction is “prior authorization,” where your prescription will not be covered unless you contact the plan for permission first. Very often, your doctor will also have to contact the plan to explain the medical reasons why you need a drug.

Plans also often have “step therapy” requirements. Such a limit would first require you to try a less expensive drug in a category and show that it does not work before you can move to a more expensive drug. You may be able to secure an exception to the step requirement if your doctor can show you tried the similar and less expensive drug previously and it did not work.

Some plans may limit the number of pills you can buy at one time, and they may also encourage you to use mail order pharmacies.

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31. What happens if my plan leaves the area?

You will have a Special Enrollment Period (SEP) to find another drug plan that best suits your needs. If you do not sign up for a new plan within 63 days of losing your drug coverage, a late penalty will apply and you will pay higher Part D premiums in the future (see questions #15 and #41).

32. What happens if I lose my current drug coverage and I want to enroll in Part D?

If your current coverage is creditable, meaning it is as good as Medicare's (see question #43), and you lost your coverage through no fault of your own, you will be given a Special Enrollment Period (SEP) in which to enroll in a Part D plan. You will not pay a premium penalty unless you take more than 63 days to enroll. If your current coverage is creditable but you dropped it voluntarily, you will not get a Special Enrollment Period. In this case, you must wait until the next enrollment period to sign up. To avoid paying a premium penalty, make sure you do not voluntarily drop your coverage more than 63 days before you can enroll in Part D.

If your current coverage is not creditable, that is it is not as good as Medicare's, you can enroll in Part D during the next annual ACEP enrollment period (see question #15), but you will have to pay a late enrollment penalty for each month that you did not enroll after you were first eligible (see question #41).

33. What happens if my health changes and I need a drug not on my plan's formulary?

Generally, you are not allowed to change plans

between enrollment periods if your health condition changes. You can request an exception to the plan's formulary, but even if it is denied, you are still locked into your plan until the next annual ACEP enrollment period. None of the money you spend on the non-covered drugs counts toward your out-of-pocket limits.

On the other hand, if you are receiving Medicaid or are living in a long-term care facility, you can switch plans at any time.

34. What is the coverage gap or "donut hole" in a Part D plan?

When the Medicare Modernization Act of 2003 (MMA) established the Medicare Part D prescription drug benefit, it defined a standard benefit that includes a gap in coverage as a way of limiting federal spending. When beneficiaries fall into this so-called "donut hole," they are responsible for the full cost of their prescription drugs plus they must continue paying their Part D premiums even though they are not receiving benefits. While plans are not required to have a donut hole, most of them do have a coverage gap. A few plans offer coverage for drugs in the donut hole, but typically only generics are covered.

Under the standard benefit in 2010, you must pay a \$310 yearly deductible and then 25 percent — or \$775 — of the next \$2,830 in covered drug costs, while your private plan will pay 75 percent — or \$2,055.

Once total spending reaches \$2,830, you fall into the donut hole: prescription drug coverage stops, but monthly Part D premiums must still

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be paid. Many beneficiaries are shocked at how quickly they reach the coverage gap because they don't realize the \$2,830 spending limit includes both the money they spend out of their own pockets as well as the portion of drug costs paid by their private plan.

In 2010, once you are in the donut hole, you are responsible for paying the next \$3,610 of drug costs out-of-pocket. When you reach the catastrophic threshold — which occurs when your Part D out-of-pocket costs total \$4,550 — your prescription drug plan will begin paying 95 percent of your covered drug costs until the end of the year. The entire process starts from the beginning each calendar year, and receiving the benefit of catastrophic coverage will become increasingly harder as the thresholds rise to reflect continued increases in drug costs.

35. What can I do to minimize my out-of-pocket spending in the “donut hole”?

About 25 percent will fall into the hole each year. Since falling into the donut hole may be unavoidable, there are some ways you may be able to reduce your out-of-pocket costs during the large coverage gap. For example, you may wish to talk to your doctor about the drugs you are currently taking to find out if there are generic or less-expensive brand-name drugs that would work just as well as the ones you're taking now. You may also be able to save money by ordering your drugs through mail order pharmacies. It may also be possible to “split pills,” if you are taking a medication that is less expensive in higher dosage pills. It is extremely important, however, to make sure you are taking the full dosage of the medication

prescribed by your doctor. “Pill splitting” that results in lower dosages of needed drugs could be hazardous to your health.

Another way to reduce your out-of-pocket costs is to find out if you are eligible to participate in any national or local charitable programs that help pay for drug costs. Expenses covered by many charities count toward the Part D out-of-pocket costs that help get you out of the donut hole.

Large retail stores often offer discounted drugs, which may be one way to avoid getting into the donut hole in the first place. If you use this option, check to make sure the store's pharmacy is part of your plan's network. If it isn't, your expenditures on these drugs won't count as Part D expenses that will help get you out of the coverage gap. However, it still may be worth it to buy some of your drugs from these stores and have your plan cover others.

Twenty-three states and the U.S. Virgin Islands offer State Pharmaceutical Assistance Programs (SPAPs) which may provide you with help paying drug plan premiums and/or other drug costs. Drug co-payments covered by these programs will count towards getting out of the donut hole. In addition, Patient Assistance Programs (PAPs) run by many of the major drug manufacturers represent another way to get drugs you need. Unfortunately, none of the expenses covered by PAPs will count toward getting you out of the donut hole. SPAPs and PAPs often only provide assistance to low-income households.

Finally, if you have Medicare and have limited

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income and resources, you may qualify for “extra help” paying for your prescription drugs. If you qualify, you could pay between \$1.10 and \$6.30 for each drug. For more information on ways to save money during the donut hole, visit Medicare’s website at www.medicare.gov/bridging-the-gap.asp or call 1-800-MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048).

THE MARKETING OF PART D PLANS

36. How can I avoid Part D scams and protect my identity?

Part D plans may market themselves in several ways, including direct mail, radio, television, print, and website ads. Unfortunately, in recent years, many beneficiaries have complained about inappropriate marketing activities by the plans, often involving telemarketing, door-to-door marketing, and sales pitches at educational events. As a result, Congress passed a law in 2008 that prohibits a number of sales activities. In addition, scammers may pretend to be from a Part D plan in order to get your financial information and steal from you (“identity theft”). In general, you should always be wary of any unsolicited offer, and it is important to know what kinds of sales activities are suspicious:

- **Know the law on how Medicare prescription drug plans can be marketed.** It’s illegal for salespeople marketing Medicare drug plans to come to your door uninvited, to call you about a plan unless you request it, or to send you unsolicited e-mails. Salespeople are also prohibited from distributing plan

applications at educational events, and they may not serve meals at promotional events. If a salesperson violates these rules, you should not do business with him. Furthermore, insurance salespeople are prohibited from selling you non-health care related insurance products if the reason they contacted you was to discuss a Medicare Part D plan.

- **If a plan agent makes a home visit, which is allowed only with your permission, be sure you understand the difference between the two types of Part D plans (see questions #8 and #44).** Do not be talked into enrolling in an insurance company’s Medicare Advantage plan if what you want is to remain in traditional Medicare and purchase a stand-alone prescription drug plan.
- **Medicare prescription drug plans should come with no strings attached.** It’s illegal to require anyone to join a drug plan in order to get a prize or gift.
- **If someone says you must join or you’ll lose your other Medicare benefits, it’s a scam.** The Medicare prescription drug benefit is voluntary. It supplements your other Medicare benefits.
- **Don’t confuse other types of drug coverage with Medicare prescription drug plans.** Only plans approved by Medicare can be marketed as Medicare prescription drug plans. Approved plans will have a seal on their materials with

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“Medicare Rx” in large letters and “Prescription Drug Coverage” underneath in smaller letters. Check with Medicare to make sure that the plan you’re considering is approved.

- **Guard your personal information from identity thieves posing as salespeople.** Legitimate plans may ask for your Social Security number, but only when you are actually enrolling. And they may only ask for your credit card or bank account information if you are arranging to make automatic payments for your drug coverage from that account.
- **If someone claims to be calling from the Social Security Administration (SSA) and asks for your bank account, credit card, or life insurance policy numbers, it’s a scam.** SSA will never ask for that information, and the only time someone calling from the SSA will ask for your Social Security number is if you apply for low-income assistance and the number you put on your application isn’t correct.
- **Don’t be fooled by sales materials that look like they’re from the government.** Con artists often try to impress consumers with official-looking sales materials that look like they’re from a government agency. Because it is private companies that are offering the plans, be skeptical about promotional materials claiming to come from the government.

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37. Do I really need Part D coverage?

Most individuals who enroll in Part D will see significant savings as a result. However, savings will vary for each individual, depending on which medications they take. If you currently have drug coverage under another plan, such as coverage provided by your employer, you should carefully consider how long you will be eligible for that coverage, whether or not CMS considers the coverage “creditable,” the future cost of any Part D enrollment penalties if you lose creditable coverage (**see questions #41 and #43**), and the costs involved with each plan.

The complexity of comparing numerous private plans with different drug coverage and costs certainly makes the decision process much more difficult than if the government had provided a single benefit plan through traditional Medicare. At this time, however, the design of the program is not likely to change dramatically, so seniors will need to decide for themselves whether or not the cost is worth it for them.

38. What if I have limited income and assets?

If you qualify for the program’s low-income subsidies (**see question #48**), it is very likely that you will benefit from Part D, and you should seriously consider enrolling. The only complication is that Part D might affect the amount of food stamps, subsidized housing, or other low-income benefits you may be receiving (**see questions #56 and #57**). According to the Centers for Medicare and Medicaid Services (CMS), even if other benefits are reduced, you will end up better off overall.

LATE ENROLLMENT PENALTIES

39. What if I don't qualify for any low-income subsidy, and I have no other drug coverage today?

You should probably start by calculating your current drug expenses. The break-even point is about \$822 per year, assuming monthly premiums of \$32 and a \$310 deductible. You should also consider the late enrollment penalties CMS will levy if you do not sign up for Part D when you are first eligible (see **question #41**).

If your expenses are higher than the break-even point, you may benefit by enrolling in Part D. Remember, these thresholds are for the “standard” benefit plan — some companies offer lower premiums and deductibles, though they compensate with higher costs (or lower benefits) elsewhere.

40. What if I don't spend much money on prescription drugs today?

If your expenses are under the break-even point (roughly \$822 per year under the standard benefit structure), it may still make sense to sign up for a plan in order to avoid the late enrollment penalty and to obtain insurance in case your expenses increase suddenly. Your decision will likely be based on your ability to pay and your willingness to take the risk that your expenses will stay low. Statistics show that millions of Medicare beneficiaries have low prescription drug expenses when they are below the age of 70. However, statistics also show that older beneficiaries often pay much higher drug expenses. If health problems do appear suddenly, prescription drug costs can rise quickly.

Unless you already have drug coverage that is at

least as good as Medicare's, you will be subject to a late enrollment penalty if you delay signing up for a plan when you are eligible to do so. You will pay this increased premium amount as long as you remain in the program (see **question #41**).

For seniors in this situation, it may make sense to enroll in a very inexpensive plan, if one is available in your area, even if you don't receive an extensive benefit from the plan today. By doing so, you have insurance coverage in case your health needs change suddenly, plus you won't be subject to any late enrollment penalties. You can always switch to a more comprehensive plan during the next available enrollment period.

LATE ENROLLMENT PENALTIES

41. What is the late enrollment penalty?

Although enrollment in Part D is voluntary, you may be subject to a late enrollment penalty. If you do not have drug coverage that is at least as good as Medicare's, you will pay a penalty if you do not enroll when you first become eligible for coverage, or within 63 days of losing your comparable coverage (see **question #14**). This penalty is one percent of the national average premium at the time you enroll for each month you delay enrollment, and you will pay this amount every month you remain in the program. Delaying enrollment for a long time can be very costly.

Because the penalty is calculated at the time you enroll, and premiums are expected to keep rising to reflect inflation in drug costs, this penalty policy will result in a significant cost increase for Part D coverage over time. Although initially it

LATE ENROLLMENT PENALTIES

is not a large amount, the penalty grows quickly.

Example: John was first eligible to enroll in Medicare Part D during the Initial Enrollment Period that began on November 15, 2009. Despite his eligibility for drug coverage, John did not enroll in Part D.

John waits until Nov 2010 to enroll for 2011 coverage (1 year)

- At enrollment, national average premium is \$32.83
- His penalty added to each month's premium is 1 percent of $\$32.83 \times 12 \text{ months} = \3.94

John waits until Nov 2014 to enroll for 2015 coverage (5 years)

- At enrollment, national average premium is \$44.88
- His penalty added to each month's premium is 1 percent of $\$44.88 \times 60 \text{ months} = \26.93

John waits until Nov 2019 to enroll for 2020 coverage (10 years)

- At enrollment, national average premium is \$60.38
- His penalty added to each month's premium is 1 percent of $\$60.38 \times 120 \text{ months} = \72.46
- His premium payment has now more than doubled because of the penalty

42. How does the late enrollment penalty affect beneficiaries with low incomes?

If you are eligible for “extra help” (see question #48), you may sign up to receive Medicare Part D without being charged late enrollment penalties. Congress made this a

statutory policy when it enacted the Medicare Improvements for Patients and Providers Act of 2008.

43. How will I know if my current coverage is as good as Medicare's?

Your current insurer, whether employer, union, or insurance company, is required to send you a letter by November 15, 2009 to let you know whether the coverage you have is “creditable” — or at least as good as Medicare's. If the answer is yes, you can switch to Part D at a later date without paying a penalty. Keep the letter in a safe place, because you may need it to avoid the penalty if you decide to enroll later. You may still want to compare the cost and coverage of your current plan (including premiums, co-payments, and covered drugs) to see which offers you the best coverage. Keep in mind, however, that if you drop your current coverage, you may not be able to get it back. If your current coverage is not “creditable,” that is, it is not as good as Medicare's, you will be subject to an enrollment penalty if you wait until later to enroll in Part D.

If your current coverage is designed to supplement the Part D benefit by subsidizing premiums, deductibles, or co-pays — it is important to keep in mind that amounts paid by your plan provider will not count as Part D costs that will get you out of the donut hole.

If you are considering giving up current coverage to enroll in Part D, be very careful to check the impact on the rest of your health insurance coverage. Some employers, unions, or other insurance providers may disenroll you

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from all of your health care coverage if you disenroll from their drug plan.

PICKING A DRUG PLAN

44. Should I enroll in a stand-alone plan or a managed care plan?

If you are already in a Medicare Advantage plan such as an HMO or local Preferred Provider Organization (PPO) that offers a drug benefit, you must use that plan's drug benefit or drop out of the Medicare Advantage plan if you want to enroll in another prescription drug plan.

If you are not currently in a Medicare Advantage plan, you have a choice. You can remain in traditional Medicare and enroll in a stand-alone drug plan, or you can leave original Medicare and choose among a range of private Medicare Advantage plans (HMOs and PPOs).

There are both pros and cons to joining a managed care plan. On the positive side, a managed care plan might charge lower deductibles and premiums. Furthermore, the drug benefit is integrated into their coverage of other medical services, such as hospital care and doctors' visits, and you would pay only one premium for all your health care needs. On the negative side, managed care plans restrict your choice of hospitals and doctors, and you have to pay more (sometimes a lot more) to see a doctor that isn't in the plan's network. In addition, many plans charge lower deductibles and premiums on the front end, but charge higher co-payments when you actually use services.

It is also important to recall the history of managed

care plans in Medicare. Right now, the federal government is providing generous subsidies to managed care plans in order to entice them into the Medicare market. Because of this, many plans are able to offer very attractive benefit packages, with lower premiums and co-payments for some services. Unfortunately, it can be very hard to accurately compare benefits provided by managed care plans, and many are trading-off increased benefits in some areas for sharp decreases in benefits in others. This is because managed care plans are required to offer all of the same services offered by Medicare, but they are not required to offer them in the same way. So, for example, a plan might provide reduced premiums and free eyeglasses, but significantly reduced coverage for more expensive services such as chemotherapy, extended hospital stays, and home health care.

Seniors frequently are unaware of the restricted coverage until they become sick and require the services, at which point they are already responsible for significant out-of-pocket costs. In addition, the subsidies provided to the managed care companies are not intended to last forever. In 2007, Congress began revisiting whether it is appropriate to overpay private companies an average of \$1,000 each year more than it would cost traditional Medicare to cover the same beneficiary. Congress passed legislation in 2008 to reduce the overpayments made to Medicare Advantage plans by phasing out duplicate payments for medical education. Nonetheless, the managed care companies continue to spend millions of dollars lobbying Congress to continue other unwarranted subsidies. The companies have threatened to cut benefits or withdraw plans from the market

if Congress suspends these extra payments. This situation is not unlike what happened with Medicare+Choice in the late 1990s, when many seniors were left scrambling to find alternative doctors and replacement medical care when their managed care plans left the market.

45. How do I pick a drug plan?

If you have access to the Internet, or have friends or family who have access, there are a number of plan comparison tools available on Medicare's website at www.medicare.gov that will help you pick the best plan. Also, see **question #74** for a description of valuable online tools and where to call if you do not have access to a computer.

If you do not have access to the Internet, you may call Medicare at 1-800-MEDICARE, or your local SHIP (State Health Insurance Program) office for assistance. You can find contact number for your local SHIP at www.medicare.gov/Contacts/staticpages/ships.aspx.

46. What is the National Committee's checklist for making decisions about Medicare Part D?

Medicare prescription drug plans vary in the drugs they cover, their cost-sharing structure and amount, and pharmacy access. It is important that you choose a plan that best meets your needs. Thorough review of available plans is critical and this checklist can assist you in choosing a Medicare prescription drug plan if you decide that Part D prescription drug coverage is a good option for you. If you are already enrolled in a plan, you will likely only need to compile the last

few items on the checklist to confirm it is still the best plan for you.

Compile the following information in preparation for evaluating Medicare prescription drug plans:

- Your personal information such as Medicare claim number, full name, date of birth, effective date for Medicare Part A or B, zip code, and county of residence
- Type(s) and name, if any, of prescription drug coverage that you currently have:
 - No prescription drug coverage
 - Prescription drug coverage through an employer or union retiree health plan
 - Prescription drug coverage through a stand-alone Part D Prescription Drug Plan (PDP)
 - Prescription drug coverage through a Medicare Advantage plan, such as an HMO, PPO, or Private Fee-For-Service Plan
 - Prescription drug coverage through TRICARE (military retiree benefits), Department of Veterans Affairs, or FEHBP (Federal Employees Health Benefits Program)
 - Prescription drug coverage through Medigap first purchased before 2006 (Medicare supplemental insurance)
 - Other
- If you currently have prescription drug coverage, gather the letter that you received from your plan explaining what benefits the plan will cover in 2010 and whether the

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plan is considered creditable by CMS (at least as good as the standard Medicare prescription drug coverage in 2010)

- A letter from either the Centers for Medicare and Medicaid Services (CMS) or the Social Security Administration (SSA) about the low-income subsidy (“extra help”), if applicable
- Name and dosage of medications that you are currently taking. (Note which ones must be brand and not generic)
- Total cost of medications taken
- Names of pharmacies you use regularly
- Mail order information, if applicable

Consider the following questions to compare Medicare prescription drug plans:

- What if I am happy with my current coverage? Should I keep it or should I switch to a different plan?
- What if I don’t take any medications? Should I still sign up for a plan? What would the penalty be if I don’t sign up until later?
- Do I want to keep my original Medicare and add stand-alone Medicare prescription drug coverage or should I consider joining a Medicare Advantage plan (like an HMO or PPO) that includes a prescription drug benefit?

- Will the Medicare drug plan work with my current drug coverage?
- Is the plan offered by a well-known company?
- Does the plan I am considering include all medications or the most important medications I take?
- Does the plan offer alternative medications that would work for me (after consulting my physicians)?
- Does the plan have a “prior authorization” coverage restriction for the drugs I need?
- Does the plan require that I try different medications before giving me needed drugs, so-called step-therapy?
- Will drugs in the same category require different co-payments, known as tiered cost-sharing?
- Will I be limited in the number of prescriptions or the quantity of pills I can get each month?
- What will be my monthly premium?
- What will be my yearly deductible?
- How much will I pay at the pharmacy for each drug (co-pay or coinsurance)?
- Will I have to pay the full cost of my drugs at some point after I have met my

deductible, that is, does the plan have a gap in coverage (the so-called “donut hole”)? If so, how much will I be required to pay out-of-pocket before coverage begins again? Are any drugs (such as generics) covered while I’m in the “donut hole”?

- Can I fill my prescriptions at the pharmacies I use regularly?
- What happens if I go to pharmacies that are not in the network?
- Will the plan cover medications when I travel?
- Does the plan offer a mail order program?
- Should I apply for the low-income subsidy (“extra help”)?

47. How do I decide whether or not to renew my Part D plan for 2010?

Insurance companies are allowed to make changes to their Part D plans from year to year and throughout the year. If you are currently enrolled in a Part D plan, you will receive a letter from your plan notifying you of the changes in coverage the plan currently intends to make for 2010. The letter will explain how your benefits, premiums, and co-payments will change in 2010. It will also inform you of the upcoming open enrollment period so you can change plans. You should carefully review that letter and consider the following questions to decide whether or not to renew your Part D plan in 2010:

- How will the Part D benefits in my current plan change for 2010? How much will I pay for a monthly premium, deductible, and co-pay or coinsurance?
- Does my current Part D plan still cover the drugs I need?
- Does my plan have a coverage gap (also known as a “donut hole”)? Did I fall into it in 2009? Have my drug needs changed or am I likely to fall into it again in 2010? Are any drugs covered in the gap? (Some plans will cover generics.) Are there plans with affordable premiums in my area that have no coverage gap?
- Will my current drug plan continue to honor the exceptions I received to its coverage rules, or will I have to file new exception requests in 2010? Your plan was required to send you written notification of whether or not they will continue your exceptions next year. If they did not do so earlier in the year, they must notify you by the end of October.
- Did my current plan add any utilization management tools (prior authorization, step-therapy requirements, or quantity limits) which make it difficult to get the drugs that I need?
- Are my local pharmacies still in the plan’s network?

Although your plan can make changes to your coverage throughout the year (**see question #9**),

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most seniors will be locked into the plan they select until 2011. We encourage you to carefully review the plan’s significant anticipated changes in the letter they are required to send current enrollees prior to October 31st. This letter will help you make the best decision about your Part D coverage in 2010 based on the most recent plan information.

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48. What is the low-income subsidy (LIS), also known as “extra help?”

The Part D benefit provides financial assistance known as “extra help” to those with limited income and assets. If you are eligible for “extra help” your Part D premiums, deductibles, and co-payments can be eliminated or significantly reduced. In addition, you will not be exposed to the gap in coverage — the period in which seniors must pay for 100 percent of their drug costs — also known as the “donut hole.” About one-third of all Medicare beneficiaries are likely to be eligible for the low-income subsidy. The Social Security Administration estimates that this “extra help” could be worth an average of \$3,900 per year. The National Committee strongly encourages all seniors who think they might be eligible for the “extra help” to apply for this valuable assistance with their drug expenses.

You must have limited income and may have to pass an asset test to be eligible for “extra help.” Medicare Part D provides different levels of financial assistance based on income and asset limits. In general, you are eligible for

some type of assistance if your income is less than \$16,245 for an individual and \$21,855 for a couple, and your assets are less than \$12,510 for an individual and \$25,010 for a couple, including burial expenses. If you become eligible for Medicare Part D during 2010, you will be subject to a slightly higher set of income thresholds. We will publish the new income thresholds as an addendum to this booklet after the data is released in January 2010.

Generally, *income* such as wages, earnings from self-employment, Social Security benefits, and pension payments count for the purpose of determining eligibility for “extra help.” Examples of income that does not count include income tax refunds and foster care payments. Examples of *assets* that count toward determining eligibility for “extra help” include stocks, bonds, and savings bonds. The home you live in and the land it is on, family heirlooms, and wedding or engagement rings do not count as assets. For applicants who file on or after January 1, 2010, CMS will eliminate consideration of non-financial “in-kind support and maintenance” from eligibility determinations. Also exempt, beginning in 2010, is the cash surrender value of a life insurance policy. The Social Security Administration will process all applications in 2009 using the 2009 rules, but all individuals who have been found ineligible due to these two changing provisions will be contacted in early 2010 and encouraged to reapply.

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The table below provides the specific requirements to qualify for the varying levels of assistance.

OVERVIEW OF “EXTRA HELP” IN PART D (2009)

Income & Asset Limits	Monthly Premium	Annual Deductible	Co-payments
Full-benefit dual eligible individual living in a long-term care institution	\$0	\$0	\$0
Full-benefit dual eligible individual with income at or below 100% FPL (\$10,830/individual; \$14,570/couple; no asset test)	\$0	\$0	\$1.10 for generics, \$3.30 for brand names of total drug costs up to \$6,440; no co-pays thereafter
Full-benefit dual eligible individual with income above 100% FPL (Incomes greater than \$10,830/individual; \$14,570/couple; no asset limits)	\$0	\$0	\$2.50 for generics & \$6.30 for brand names of total drug costs up to \$6,440; no co-pays thereafter
Individuals with income less than 135% FPL (\$10,830-\$14,620/individual; \$14,570-\$19,670/couple) & assets between \$8,100 and \$12,570/individual or \$12,910 and \$25,010/couple*	\$0	\$0	\$2.50 for generics & \$6.30 for brand names of total drug costs up to \$6,440; no co-pays thereafter
Individuals with income between 135% and 150% FPL (\$14,620-\$16,245/individual; \$19,670-\$21,855/couple) & assets less than \$12,510 /individual or \$25,010/couple*	Sliding scale up to the base premium \$31.94	\$63	15% of total drug costs up to \$6,440; \$2.50 for generics & \$6.30 for brand names thereafter
People not eligible for “extra help”	Averages about \$32	\$310	25% of total drug costs up to \$2,830; 100% of costs between \$2,830 and \$6,440; 5% of costs thereafter

Notes: Dual eligible individuals are Medicare beneficiaries who also receive full Medicaid benefits. “FPL” is the federal poverty level which is used to determine the annual income limits for the low-income subsidy.

**Those who become eligible for Medicare for the first time in 2010 will be subject to slightly higher allowable resource dollar limits. We will publish the new thresholds as an addendum to this booklet following their release. Asset limits include \$1,500 per person burial expenses.*

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49. What if I have Medicare and Medicaid?

You automatically qualify for the low-income subsidy known as “extra help.” If you received “extra help” in 2009, you should automatically receive it again in 2010 without having to fill out any additional paperwork. If for some reason you are not deemed automatically eligible for “extra help” in 2010, you will receive a letter from Medicare informing you of this fact. If you get this letter, you should still apply for “extra help” at the Social Security Administration because you may still be eligible for some “extra help” even if you were not granted eligibility automatically (see question #55).

You may be able to stay in the Part D plan you joined in 2009. However, many plans that qualified for the low-income subsidy in 2009 will no longer qualify in 2010. Review your plan materials to be sure it still qualifies as a low-income subsidy plan. For 2009 forward, CMS made a major adjustment to the formula determining plan benchmark status. You will be automatically reassigned to a new prescription drug plan in 2010 if your plan is terminating, if your plan’s monthly premium is increasing above the regional low-income premium subsidy amount, or if your plan is switching from a standard to an enhanced plan. You will not be reassigned to a new plan if you select your own plan voluntarily or if you are currently enrolled in a plan with monthly premiums that are at or below the regional low-income premium subsidy amount, and your plan is retaining standard plan status. If you are assigned to a new plan by Medicare, you will be randomly assigned to a basic plan that works with “extra help” so that you do not have

to pay a monthly premium. This random assignment means the plan you are assigned to may not cover all the drugs you need. If none of the basic plans cover your medications, you may decide to sign up for a more expensive plan (plans with premiums higher than the regional average rate or those that offer enhanced coverage) which does cover your medications. If you sign up for an enhanced plan, you will have to pay a premium equal to the difference between the basic plan premium and the enhanced plan premium.

If you don’t like the plan that you chose or that was chosen for you by CMS, you can switch to another plan. You have the ability to switch plans as often as you like, with the new plan becoming effective the first day of the following month.

If you are enrolled in a basic plan, you will pay no monthly premium, no annual deductible, and experience no gap in prescription drug coverage. If you have income at or below 100 percent of the federal poverty level (\$10,830/individual and \$14,570/couple in 2009), you will be responsible for a \$1.10 co-pay for generic drugs and a \$3.30 co-pay for brand name drugs. If you have income above 100 percent of the federal poverty level, you will be responsible for a \$2.50 co-pay for generic drugs and a \$6.30 co-pay for brand name drugs. Once you have over \$6,440 in covered drug costs (the total of what you and the plan have spent), you will no longer have any co-pays for prescription drugs for the rest of 2010.

If you have both Medicare and Medicaid and are

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also living in a nursing home or other long-term care facility, you will pay no monthly premium, will have no annual deductible, and will experience no gap in prescription drug coverage. Further, you will never have a co-payment on any of your prescription drugs. You are also able to switch drug plans at any time.

A drug plan must accept a wide range of documents as proof that you are eligible for “extra help” because of your Medicaid eligibility. Any official letter from CMS indicating that you qualify for “extra help” will be adequate, as will a copy of your Medicaid card, a copy of a state document that shows you have Medicaid, a printout from a state Medicaid system computer, or a bill from your nursing home that shows Medicaid has been paying for your care.

50. What if I have Medicare and a Medicare Savings Program?

Medicare Savings Programs help people with Medicare who do not qualify for Medicaid pay some of the costs of Medicare. There are three Medicare Savings Programs:

- the Qualified Medicare Beneficiary (QMB) program;
- the Specified Low-Income Medicare Beneficiary program (SLMB); and
- the Qualifying Individual (QI) Program.

If you participate in a Medicare Savings Program, you automatically qualify for the low-income subsidy known as “extra help.” If

you received “extra help” in 2009, you should automatically receive it again in 2010 without having to fill out any additional paperwork. If for some reason you are not deemed automatically eligible for “extra help” in 2010, you will receive a letter from Medicare informing you of this fact. If you get this letter, you should still apply for “extra help” at the Social Security Administration because you may still be eligible for some “extra help” even if you were not granted eligibility automatically (**see question #55**).

You may be able to stay in the Part D plan you joined in 2009. However, many that qualified for the low-income subsidy in 2009 will no longer qualify in 2010. Review your plan materials to be sure it still qualifies as a low-income subsidy plan. Unless you chose your own plan in 2009, you will be automatically reassigned to a new prescription drug plan in 2010 if your plan is terminating, if your plan’s monthly premium is increasing above the regional low-income premium subsidy amount, or if your plan is switching from a standard to an enhanced plan.

You will not be reassigned to a new plan if you select your own plan voluntarily or if you are currently enrolled in a plan with monthly premiums at or below the regional low-income premium subsidy amount, and your plan is retaining standard plan status. If you are assigned to a new plan by Medicare, you will be randomly assigned to a basic plan that works with “extra help” so that you do not have to pay a monthly premium. This random assignment means the plan you are assigned to

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may not cover all the drugs you need. If none of the plans with low premiums cover your medications, you may decide to sign up for a more expensive plan (plans with premiums higher than the regional average rate or those that offer enhanced coverage) which does cover your medications. If you sign up for an enhanced plan, you will have to pay a premium equal to the difference between the basic plan premium and the enhanced plan premium.

If you don't like the plan that you chose or that was chosen for you by CMS, you can switch to another plan. You have the ability to switch plans as often as you like, with the new plan becoming effective the first day of the following month.

If you are enrolled in a basic plan, you will pay no monthly premium, no annual deductible, and experience no gap in prescription drug coverage. You will be responsible for a \$2.50 co-pay for generic drugs and a \$6.30 co-pay for brand name drugs. Once you have over \$6,440 in covered drug costs (the total of what you and the plan have spent), you will no longer have any co-pays for prescription drugs for the rest of 2010.

51. What if I have Medicare and Supplemental Security Income (SSI)?

SSI makes monthly payments to people who have low incomes and few resources and who are aged 65 or older, blind, or disabled.

If you receive SSI and do not have Medicaid, you automatically qualify for the low-income subsidy known as “extra help.” If you received “extra help” in 2009, you should automatically

receive it again in 2010 without having to fill out any additional paperwork. If for some reason you are not deemed automatically eligible for “extra help” in 2010, you will receive a letter from Medicare informing you of this fact. If you get this letter, you should still apply for “extra help” at the Social Security Administration because you may still be eligible for some “extra help” even if you were not granted eligibility automatically (see **questions #48 and #55**).

You may be able to stay in the Part D plan you joined in 2009. However, many plans that qualified for the low-income subsidy in 2009 will no longer qualify in 2010. Review your plan materials to be sure it still qualifies as a low-income subsidy plan. You will be automatically reassigned to a new prescription drug plan in 2010 if your plan is terminating, if your plan's monthly premium is increasing above the regional low-income premium subsidy amount, or if your plan is changing from a standard to an enhanced plan.

You will not be reassigned to a new plan if you select your own plan voluntarily, if the plan you are currently enrolled has a premium at or below the regional low-income premium subsidy amount, and your plan is retaining standard plan status. If you are assigned to a new plan by Medicare, you will be randomly assigned to a basic plan that works with “extra help” so that you do not have to pay a monthly premium. This random assignment means the plan you are assigned to may not cover all the drugs you need. If none of the plans with low premiums cover your medications, you may

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decide to sign up for a more expensive plan (plans with premiums higher than the regional average rate or those that offer enhanced coverage) which does cover your medications. If you sign up for an enhanced plan, you will have to pay a premium equal to the difference between the basic plan premium and the enhanced plan premium.

You can switch plans one time during the year, if you were automatically enrolled in a Part D plan by Medicare or if you were not enrolled in a Part D plan when you became eligible for “extra help.” If you were already enrolled in a Part D plan and then became eligible for “extra help,” you are not allowed to change plans until the next open enrollment period.

If you are enrolled in a basic plan, you will pay no monthly premium, no annual deductible, and experience no gap in prescription drug coverage. You will be responsible for a \$2.50 co-pay for generic drugs and a \$6.30 co-pay for brand name drugs. Once you have over \$6,440 in covered drug costs (the total of what you and the plan have spent), you will no longer have any co-pays for prescription drugs for the rest of 2010.

52. If I received “extra help” in 2009, will I be able to keep my current drug plan in 2010?

Effective January 1, 2010, up to a million Part D enrollees who currently receive “extra help” will be automatically reassigned to a new plan unless they choose one themselves by December 31, 2009. This switch will be required because plans have withdrawn from the Part D program or they will charge

premiums that are above the maximum amount allowed for “extra help.”

By early November 2009, CMS should mail blue letters to the beneficiaries receiving “extra help” that will be automatically reassigned. If you receive this letter, it will be important to compare your options.

You may choose a new plan that works with “extra help.” The Medicare Prescription Drug Plan Finder can help you identify these plans in your area (**see question #74**). It is important to compare the available plans to determine how well they cover the medications you take (**see questions #45 and #46**).

You can choose to notify CMS that you would like to remain in your current plan even if it will not work with “extra help” in 2010. You will be required to pay premiums to cover the amount that is over the maximum premium for “extra help.” You could also choose another plan that does not work with “extra help” if you are willing to pay the higher premiums.

Notify CMS of your choice as early as possible in December 2010 to reduce the chances that your coverage will be interrupted.

53. If I received “extra help” in 2009, will I automatically be eligible for it in 2010?

Some people automatically received “extra help” in 2009 without having to fill out an application. If you have both Medicare and Medicaid, belong to a Medicare Savings Program, or receive Supplemental Security Income, it is likely that you will automatically

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qualify for “extra help” again in 2010. This means that you will not have to apply for “extra help” to continue receiving the assistance. If for some reason you do not automatically qualify for “extra help” again in 2010, you should have received a notice in the mail from Medicare by the end of September informing you of the change. (If you don’t receive a notice in the mail, you should get the same level of “extra help” that you received in 2009). You should still apply for “extra help” in 2010 even if you receive this notice because you may be eligible for a different type of “extra help” assistance than you were receiving in 2009. You can apply for “extra help” at SSA or at your state medical assistance office (see **question #55**).

Other people had to apply to receive “extra help” in 2009. If you applied for “extra help” in July 2009 or later, you will automatically keep the assistance through the end of 2010, unless you report a change to your income or resources throughout the year.

If you applied for “extra help” before July 2009, you will receive a letter from either the Social Security Administration or your state medical assistance office, depending on where you applied for the assistance. You will only receive this letter if you applied and qualified for “extra help” prior to July 2009. You should have received a letter in late August or early September containing information on your income, resources, and household size. The letter asks if your income and resources have changed. If they have not changed, you do not need to reply to the letter and you should

continue to receive “extra help” in 2010. If your income and resources have changed, you need to return the letter to SSA within 15 days to request a redetermination form. The redetermination form must be completed within 30 days.

If you are not eligible for the “extra help” assistance and believe that you should be, you can appeal the agency’s redetermination. If you were eligible for “extra help” in 2009, but do not qualify for “extra help” in 2010, you will only continue to receive “extra help” assistance through December 31, 2009.

54. If I didn’t receive “extra help” in 2009, should I consider applying for it in 2010?

According to the Centers for Medicare and Medicaid Services, almost 1 in 3 people with Medicare will qualify for “extra help” with their prescription drug costs. If you are eligible for “extra help,” your Part D premiums, deductibles, and co-payments can be eliminated or significantly reduced (see **question #48**). In addition, you will not be exposed to the gap in coverage — the period in which seniors must pay for 100 percent of their drug costs — also known as the “donut hole.” You should consider applying for the “extra help” if you have:

- Income below \$16,245 for an individual or \$21,855 for a married couple living together. (If you become eligible for Medicare Part D during 2010, you will be subject to a slightly higher set of income thresholds. We will publish the new income thresholds as an addendum to this

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booklet after the data is released in January 2010).

- Assets below \$12,510 for an individual or \$25,010 for a married couple living together. Life insurance policies and support/maintenance provided “in kind” (for example, support you receive from a family member or friend at no charge) will not be counted as part of your assets if you apply in 2010 or after.

Collecting the following documents would help you apply for “extra help”:

- Statements that show your account balances at banks, credit unions, or other financial institutions;
- Investment statements;
- Life insurance policy statements;
- Stock certificates;
- Tax returns;
- Pension award letters; and,
- Payroll slips.

You must apply for “extra help” and enroll in a Medicare prescription drug plan by December 31, 2009 to have drug coverage beginning on January 1, 2010. However, Medicare is encouraging people to enroll in a Part D plan by early December to ensure that your coverage will go into effect on January 1,

2010. After you apply for “extra help” and are determined eligible for the benefit, if you do not join a prescription drug plan, Medicare will randomly enroll you in a plan with premiums at or below the regional average. You can switch plans one time during the year, if you were automatically enrolled in a Part D plan by Medicare or if you were not enrolled in a Part D plan when you became eligible for “extra help.” If you were already enrolled in a Part D plan and then became eligible for “extra help,” you are not allowed to change plans until the next open enrollment period.

Note: Those who become eligible for “extra help” for the first time in 2010 will be subject to slightly higher allowable resource dollar limits.

55. How do I apply for the low-income subsidy (“extra help”)?

If you have limited income and resources but do not have Medicaid, a Medicare Savings Program that helps you pay Part B premiums, or Supplemental Security Income (SSI), you need to apply for “extra help” *in addition* to applying for a prescription drug plan. The “extra help” can help you pay for Medicare prescription drug costs.

If you think you may be eligible for “extra help,” please contact your state Medical Assistance (Medicaid) office or SSA office to apply for “extra help.”

- How to apply for “extra help” at your local Medical Assistance (Medicaid) office: Unlike SSA, state Medicaid offices are required by law to screen your eligibility

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for all other existing programs. Also, a number of states have more generous income and/or asset tests for Medicaid or Medicare Savings Programs, meaning that seniors with incomes and resources above the federal limits could be automatically enrolled into the “extra help.” Contact your local Medical Assistance (Medicaid) office to get more information.

- How to apply for “extra help” at the Social Security Administration (SSA): SSA accepts applications over the telephone (1-800-772-1213), at local SSA offices, and on their website (www.ssa.gov/prescriptionhelp/). On this website SSA even provides online tools to help you determine if you qualify for “extra help.”

56. How does the low-income benefit interact with my food stamps?

The amount of food stamps you are eligible for is determined by your income. For seniors and people with disabilities, medical expenses over \$35 per month are not counted toward your income. If receiving “extra help” reduces your medical expenses and increases your adjusted income, the amount of food stamps you receive may decline. Generally, every \$1 increase in adjusted income results in a \$0.30 decline in food stamps. In other words, your budget will only benefit \$0.70 for each dollar that is saved through your participation in “extra help.” Most beneficiaries will save money overall by receiving Part D’s low-income subsidy. However, if you get the minimum food stamp benefit, your benefits may end. Changes in

your medical expenses resulting from “extra help” will not need to be reported until your food stamp benefit is renewed.

57. How does the low-income benefit interact with my housing assistance?

Unlike food stamps, you cannot lose eligibility for housing assistance because you are receiving the prescription drug subsidy. Your rent may increase, however. CMS informs beneficiaries that if they receive “extra help,” their rental assistance may decrease, but the amount of drug costs covered by Part D is greater than the decrease in rental assistance. In other words, you will save more than you lose. Your rent may increase, but overall you will save money. Your rent should not increase until your next recertification.

This rent increase occurs because the Department of Housing and Urban Development (HUD) adjusts your income to take into account medical expenses over 3 percent of income. HUD does not consider these expenses as part of your income when it determines your rental assistance. However, once Part D starts paying your drug bills, the money saved will count as income for the calculation of your HUD assistance. Generally, as drug spending declines your available income increases: every \$1 increase in adjusted income will result in a \$0.30 decline in housing assistance. Overall, your budget will gain \$0.70 for each dollar of drug cost savings you achieve through participating in “extra help.”

PART D AND MY CURRENT DRUG COVERAGE

PART D AND MY CURRENT DRUG COVERAGE

58. What if I have prescription drug coverage through my former employer or union?

Your current insurer, whether employer, union, or insurance company, is required to send you a letter prior to November 15th of each year to let you know whether the coverage you have is “creditable” — or at least as good as Medicare’s. If the answer is yes, you can switch to Part D at a later date without paying a penalty. Save the letter in a safe place, because you may need it to avoid the penalty if you do decide to enroll at a later date. You have a legal right to this information, so if you did not receive a letter from your insurer, ask for it.

You may still want to compare the cost and coverage of your current plan (including premiums, co-payments, and covered drugs) to see which offers you the best coverage. Keep in mind, however, that if you drop your current coverage, you may not be able to get it back. If your current coverage is not “creditable,” that is, it is not as good as Medicare’s, you will be subject to a late enrollment penalty if you wait until later to enroll in Part D. If you are eligible for Part D’s low-income subsidy known as “extra help,” you will generally receive substantially better drug coverage if you join a Medicare Part D plan than from your employer plan.

Your current provider should also send you information on how your plan works with Part D. For example, some employers may provide

“wrap around” benefits in which you are required to enroll in Part D, but your plan provider supplements the benefit by subsidizing premiums, deductibles, or other out-of-pocket expenses. Keep in mind, amounts paid by your plan provider will not count toward your out-of-pocket costs, even for covered drugs.

You are allowed to give up your employer coverage in exchange for enrolling in Part D, but be very careful to check the impact on the rest of your health insurance coverage with your provider. Some employers, unions, or other insurance providers may disenroll you from all of your health care coverage if you disenroll from their drug plan.

The legislation implementing Part D included significant incentives to employers and unions to continue offering drug coverage to their retirees. While it appears that few of them are dropping their plans in response to the availability of Part D, it is not clear whether that will continue to be the case once the subsidies are phased-out.

59. What if I have Medicare and Medicaid?

If you are eligible for both Medicare and Medicaid, you automatically qualify for the low-income subsidy known as “extra help.” If you received “extra help” in 2009, you should automatically receive it again in 2010 without having to fill out any additional paperwork. If for some reason you are not deemed automatically eligible for “extra help” in 2010, you will receive a letter from Medicare informing you of that fact. If you get this letter,

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you should still apply for “extra help” at the Social Security Administration because you may still be eligible for some “extra help” even if you were not granted eligibility automatically (see **question #55**).

You may be able to stay in the Part D plan you joined in 2009. However, many plans that qualified for the low-income subsidy in 2009 will no longer qualify in 2010. Review your plan materials to be sure it still qualifies as a low-income subsidy plan. You will be automatically reassigned to a new prescription drug plan in 2010 if your plan is terminating, if your plan’s monthly premium is increasing above the regional low-income premium subsidy amount, or if your plan is changing from a standard plan to an enhanced plan.

You will not be reassigned to a new plan if you select your own plan voluntarily or if the plan you are currently enrolled in will have a monthly premium at or below the regional low-income premium subsidy amount, and your plan is retaining standard plan status. If you are assigned to a new plan by Medicare, you will be randomly assigned to a basic plan that works with “extra help” so that you do not have to pay a monthly premium. Because of this random assignment, however, the plan you are assigned to may not cover all the drugs you need. If none of the plans with low premiums cover your medications, you may decide to sign up for a more expensive plan (plans with premiums higher than the regional average rate or those that offer enhanced coverage) which does cover your medications. If you sign up for an enhanced

plan, you will have to pay a premium equal to the difference between the basic plan premium and the enhanced plan premium.

If you don’t like the plan that you chose or that was chosen for you by CMS, you can switch to another plan. You have the ability to switch plans as often as you like, with the new plan becoming effective the first day of the following month.

If you are enrolled in a basic plan, you will pay no monthly premium, no annual deductible, and experience no gap in prescription drug coverage. If you have income at or below 100 percent of the federal poverty level (\$10,830/individual and \$14,530/couple in 2009), you will be responsible for a \$1.10 co-pay for generic drugs and a \$3.30 co-pay for brand name drugs. If you have income above 100 percent of the federal poverty level, you will be responsible for a \$2.50 co-pay for generic drugs and a \$6.30 co-pay for brand name drugs. Once you have over \$6,440 in covered drug costs (total spending by you and your plan), you will no longer have any co-pays for prescription drugs for the rest of 2010.

If you have both Medicare and Medicaid and are also living in a nursing home or other long-term care facility, you will pay no monthly premium, no annual deductible, and will experience no gap in prescription drug coverage. Further, you will never have a co-payment on any of your prescription drugs. You are also able to switch drug plans at any time.

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60. What happens if I have Medigap?

Since January 1, 2006, new Medigap policies have been prohibited from offering prescription drug coverage. If you are currently in a Medigap plan, other than Plans H, I, or J, you should consider signing up for a Part D plan to obtain drug coverage.

If you currently have Medigap Plans H, I, or J, you are allowed to renew your plan and keep your drug coverage. However, not all of these plans provide creditable coverage, that is, some are not as good as Medicare. Therefore, if you keep your Medigap Plan and its drug coverage and later decide to switch to Part D, you will pay the late enrollment penalty (see **question #41**). Premiums for Medigap policies with drug coverage will likely increase faster than Medigap policies that never offered drug coverage, so they can be expected to become uneconomical fairly quickly.

If you have a Medigap H, I, or J policy, you have a number of options.

You can cancel your existing Medigap policy and replace it with another Medigap policy that does not cover drugs, plus enroll in Part D. If you select this option, in most cases, you cannot be charged more because of health issues and you cannot be excluded because of a pre-existing condition if your new Medigap policy is offered by the same company as your previous policy. Check with your state insurance office for information specific to your plan. You can find contact information of your state insurance office at

www.medicare.gov/contacts/static/allStateContacts.asp.

In addition, you can keep your current policy but without the drug coverage and enroll in Part D, or you can cancel your Medigap policy and enroll in a managed care plan. In this case, you will not need your Medigap policy because it cannot pay premiums or co-insurance for managed care plans. Finally, you can continue to receive drug coverage through your current Medigap policy and pay the late enrollment penalty if you change your mind at a later time.

61. What if I have individual drug insurance that I bought myself?

You can keep your coverage and also sign up for Part D. Your insurance company must notify you if your plan provides creditable coverage — that is, if it is at least as good as Medicare's. If it is not creditable and you don't enroll in Part D when you are first eligible, you will be subject to a late enrollment penalty (see **question #41**) if you enroll in the future. If you enroll when you are first eligible, you can use your individual insurance to supplement Part D. But none of the payments made by your insurer count toward your Part D out-of-pocket cost limits.

62. What if I buy my prescription drugs from Canada?

U.S. Customs considers all importation of drugs from Canada by individuals as illegal, but it has articulated a permissive policy of enforcement that allows many prescriptions of 90 days or less into the country. A number of

PART D AND MY CURRENT DRUG COVERAGE

state and local governments also sponsor programs that can help you purchase medications from Canada, which can help you import drugs with less difficulty. Regardless, none of the money you may spend purchasing prescription drugs from abroad will count toward any out-of-pocket limits under Part D.

63. What if I have drug coverage from the Department of Veterans Affairs (VA)?

If you get VA health benefits and decide that VA drug coverage meets your needs, you should probably keep your coverage. CMS states that it will almost always be to your advantage to keep your VA benefits and not sign up for Part D. An exception might be if you are eligible for “extra help” (see question #48). You should contact your local VA facility before making any changes to your coverage.

VA coverage is considered creditable, or at least as good as Part D, so you will not have to pay a late enrollment penalty if you sign up within 63 days of involuntarily losing your VA coverage. If you don’t lose your coverage, and want to join a Medicare drug plan, you must wait for an annual enrollment period.

64. As a military retiree, I already have prescription drug coverage through TRICARE. What should I do?

TRICARE beneficiaries have a robust pharmacy benefit with no monthly premium and minimal co-payments. For nearly all TRICARE-Medicare beneficiaries, under most circumstances, there is no added value in purchasing Medicare prescription drug coverage. The exception to this general rule

may be if you have limited income and assets and qualify for Medicare’s “extra help” with prescription drug plan costs. In that case, you may benefit by enrolling in a Medicare prescription drug plan (see question #48).

TRICARE-Medicare beneficiaries who enroll in a Part D prescription drug plan must pay the monthly Medicare prescription drug plan premium; TRICARE does not reimburse Medicare premium costs. If you are a TRICARE-Medicare eligible beneficiary and enroll in a Medicare Advantage drug plan, you pay the monthly premiums and receive all your medical care and prescription drugs through the Medicare Advantage plan.

If a TRICARE-Medicare eligible beneficiary enrolls in a prescription drug plan that adds prescription coverage to the original Medicare plan, Medicare is primary and TRICARE pharmacy, as second payer, will pay your out-of-pocket costs for TRICARE-covered medications, as well as the Medicare prescription drug plan deductible and cost sharing amounts. If you fall into the coverage gap in Part D, when you become responsible for 100 percent of your drug costs under the Medicare prescription drug plan, the TRICARE pharmacy benefit becomes primary payer and you become responsible for the applicable TRICARE pharmacy cost sharing amounts. TRICARE drug costs do not count toward meeting the Medicare prescription drug plan out-of-pocket limit. Once the TRICARE catastrophic cap (\$3,000/fiscal year for family members and all TRICARE beneficiaries that are not active duty) is met,

RESIDENTS OF NURSING HOMES AND OTHER LONG-TERM CARE FACILITIES

TRICARE pays 100 percent of your prescription drug costs.

TRICARE pharmacy coverage is considered creditable coverage because it pays, on average, at least as well as or better than Medicare prescription drug coverage. Therefore, the late enrollment fee will not apply if you decide to enroll in Medicare prescription drug coverage after the open enrollment period. If you lose your TRICARE eligibility (for example, due to divorce, remarriage, and so forth), you have 63 days to enroll in Part D of Medicare without paying the premium penalty. If you don't enroll in a Medicare prescription drug plan during the 63 day period, you will have to wait to enroll in a Medicare prescription drug plan during the next annual enrollment period.

65. What if I am receiving benefits from the Federal Employees Health Benefits Program (FEHBP)?

The FEHBP is creditable coverage, which means it is at least as good as Medicare's. Unless you are eligible for the low-income subsidy under Part D, it is unlikely that you will find a plan that is as comprehensive as FEHBP's, so you will probably not want to switch plans. If you decide to enroll in Part D later, you will not pay a late enrollment penalty as long as you enroll within 63 days of dropping or losing your FEHBP coverage. If you are eligible for "extra help," you will need to compare the available plans carefully. While your co-payments may be less under Part D, the list of drugs covered under FEHBP may be broader than those under the Medicare plans in

your area. Remember, if you are an annuitant and you terminate your FEHBP coverage, you will not be allowed to re-enroll in any FEHBP plan if you later change your mind.

RESIDENTS OF NURSING HOMES AND OTHER LONG-TERM CARE FACILITIES

66. How does Part D affect residents of nursing homes and other long-term care facilities, including in-patient psychiatric hospitals and intermediate care facilities for the mentally retarded?

Most nursing home residents participate in Medicare and, therefore, are eligible to enroll in Part D.

Two-thirds of nursing home residents are dually-eligible for Medicare and Medicaid. Under Part D, they have no out-of-pocket costs, such as for co-payments, for any calendar month they are in a skilled nursing facility. Dual-eligible residents in nursing homes, who do not choose a Part D plan, will be assigned to one by CMS; they will have no out-of-pocket costs. Residents in nursing homes who receive Medicare premium assistance through the Medicare Savings Program (MSP) will be auto-enrolled in a Part D plan if they do not select one. MSP beneficiaries as well as other Medicare beneficiaries with limited income and resources are encouraged to apply for "extra help" (low-income subsidy). All nursing home residents can switch from one plan to another when they enter a nursing home, at any time during their stay, and when leaving.

RESIDENTS OF NURSING HOMES AND OTHER LONG-TERM CARE FACILITIES

Private pay residents in nursing homes currently pay out-of-pocket or with private insurance for their prescription drugs. They must decide if they want to enroll in a Medicare Part D plan and, if so, which one. They are not automatically enrolled, and they are subject to the late enrollment penalty if they fail to enroll for Part D when they first become eligible. Like all nursing home residents, they can switch plans at any time.

Nursing home residents whose care is being covered by Medicare Part A — skilled nursing and rehabilitation — receive their prescription drugs as part of Medicare’s prospective payment to skilled nursing facilities. There is a daily co-payment for stays beyond 20 days but no separate charge for prescription drugs. This did not change with the implementation of Medicare Part D.

67. How do nursing home residents choose and enroll in a drug plan and apply for “extra help” (low-income subsidy)?

Nursing home residents must go through the same application and selection process as any other Part D applicant, though they are subject to special enrollment periods (see question # 16). They may also face additional difficulty in selecting a plan that contracts with pharmacies the nursing home is accustomed to working with. Because of this, nursing home residents with cognitive and/or physical impairments will find the plan selection process even more difficult and complicated than non-nursing home residents. For this reason, it is important that family members or legal guardians help nursing home residents

enroll in a plan; nursing homes cannot and will not make the decision for residents unless an agent of the nursing home, such as a nurse or case manager, is appointed as a representative for the resident.

68. Will Part D plans pay for all drugs needed by nursing home residents?

It can be difficult for many nursing home residents to know if a particular Part D drug plan provides access to the drugs they need, and includes a long-term care pharmacy the nursing home is accustomed to working with, or whether another plan would be better. While nursing homes can help provide this information to their residents, they cannot and will not make the decision for residents unless an agent of the nursing home, such as a nurse or case manager, is appointed as a representative for the resident. For this reason, it is important that family members or legal guardians help nursing home residents enroll in a plan.

69. What happens if a Part D plan does not cover all of the drugs individual nursing home residents are currently taking?

During the transition period to a new prescription drug plan, nursing home residents may be required to change from one or more drugs they are currently taking to drugs covered by their plan. They will, however, receive up to a 90 day supply of the previous drug to make the transition easier.

PHARMACY ASSISTANCE PROGRAMS

70. How do nursing home residents get coverage for drugs that are not on their plan's formulary?

Nursing home residents have access to the same process to appeal drug coverage determinations as non-nursing home residents (see question #29). At the same time, it can be exceptionally difficult for nursing home residents, particularly those with cognitive impairments, to go through the exceptions process to get coverage for non-formulary drugs without someone acting on their behalf to secure the required information from a physician and to file an appeal if necessary. This makes it especially important that family members or legal guardians help these enrollees go through the appeals process. Nursing homes are required under the 1987 Nursing Home Reform Law to provide the needed prescription drugs whether or not there is a payment source. This ensures a safety net is in place to protect those nursing home residents who are not successful in receiving coverage.

PHARMACY ASSISTANCE PROGRAMS

71. How does Part D interact with State Pharmacy Assistance Programs (SPAPs)?

The Medicare Modernization Act allows State Pharmacy Assistance Programs to “wrap around” the Medicare benefit to fill gaps in coverage. Twenty-three states and the U.S. Virgin Islands offer State Pharmacy Assistance Programs (SPAPs) that can help pay your drug plan premiums and/or other drug costs. To find out about the benefits offered by the SPAP in your state, go to Medicare’s website at

www.medicare.gov/spap.asp or contact your State Health Insurance Assistance Program (SHIP) which has counselors that are available to provide free one-on-one help with your Medicare questions or problems.

If your state offers its own SPAP, Medicare will always pay your drug costs first, and the SPAP can pick up some or all of your out-of-pocket costs. Payments made by an SPAP will count toward your out-of-pocket maximum (\$4,550 in 2010) to reach catastrophic coverage. However, while your state may choose to cover drugs not on your plan’s formulary, or drugs explicitly excluded from Medicare coverage, those payments will not count toward your out-of-pocket limits.

72. How does Part D interact with Patient Assistance Programs?

Some pharmaceutical companies offer assistance programs for the drugs they manufacture. Under these programs, seniors with limited means could receive free or subsidized medication. You may participate in a Part D plan and still receive help with your drugs from a Patient Assistance Program (PAP). However, the help you receive from a PAP must remain outside the Medicare program. In other words, you cannot submit any costs for your subsidized drugs to your Part D plan, and the PAP assistance cannot count towards your True-Out-of-Pocket (TrOOP) cost (the expenses that count toward getting you out of the donut hole). To see if there are any PAPs available for the drugs you are taking, visit Medicare’s website at www.medicare.gov/pap/index.asp or contact Medicare at 1-800-MEDICARE.

ONLINE TOOLS AND RESOURCES

73. How does Part D interact with PACE (Program of All-Inclusive Care for the Elderly) coverage?

If you are enrolled in a PACE plan that offers drug coverage, do not sign up for drug coverage through a Part D plan. If you do, you will lose your entire PACE coverage. Since January 2006, PACE enrollees have received their Medicare drug coverage through PACE, and they do not pay any premiums, deductibles, co-payments, coinsurance, or other out-of-pocket costs for their prescription drugs.

ONLINE TOOLS AND RESOURCES

74. What online tools and resources are available to help me?

Medicare has several Internet-based tools to help beneficiaries understand their prescription drug coverage options. If you — like many seniors — do not have access to a computer, you can call 1-800-MEDICARE and have them insert your information into these tools and mail you a hard copy version of the results. Because information changes often, we encourage you to double-check the information you obtain from these tools (such as premiums, deductibles, co-pays, covered drugs, and participating pharmacies) with the plan directly, before you sign up.

Medicare Prescription Drug Plan Finder

www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/MPDPFIntro.asp

The Medicare Prescription Drug Plan Finder allows you to compare plans offering prescription drug coverage in your area. Both stand-alone prescription drug plans and Medicare Advantage plans can be compared. This tool will provide a chart with premiums, deductibles, and an indication if drugs are covered in the “donut hole.” A personalized list of available plans can also be generated that will allow you to see how much you will pay out-of-pocket for each drug you are taking now. You can also check if there are pharmacies near you that belong to each plan’s network.

Go to the link listed above and then click on “Find & Compare Plans.” Choose either “Begin Personalized Search” or “Begin General Search.” (Either option will allow you to search plans based on the medications you are taking now. The “Personalized Search” option may provide additional advice on picking a plan, and it will require information from your Medicare card.)

You will be asked to provide information about your current insurance situation. Remember to click “Continue” after you have entered all the required information on each page.

Then you will have an opportunity to continue to a general plan list or to enter a list of drugs you are taking now to create a personalized list. The personalized list of plans will allow you to compare prices for specific drugs. Click “Enter My Drugs” and use the search feature to locate the drugs you are currently taking.

Continue to search and add drugs until you have built a list that includes all of the drugs you would like to compare.

Once you enter your list of drugs, a chart will be generated allowing you to compare premiums, deductibles, gap coverage, and other aspects of plans available in your area. Click on the numbers in the “Number of Network Pharmacies” column to link to a list of local pharmacies included in each plan’s network.

The “Plan Name and ID Numbers” column contains links to detailed information about each plan. Click on the name of a plan and you will be sent to a page that lists the plan’s out-of-pocket costs for each drug you are taking. You will also find information here on the plan’s formulary, prior authorization, quantity limit, and step therapy rules for each drug.

Eldercare Locator

www.eldercare.gov/

The Eldercare Locator links people with state and local agencies on aging and community-based organizations that serve seniors and their caregivers.

Go to www.eldercare.gov/. You can follow the 2-step process to locate an agency that can give one-to-one counseling on various topics, often including prescription drug assistance.

Medicare Options Compare

www.medicarecare.gov/

The Medicare Options Compare web tool will allow you to review Medicare Advantage plans available in your area. It will not allow you, however, to compare these plans with stand-alone prescription drug plans. Be aware that the out-of-pocket cost comparisons provided by this tool are estimates based on assumptions about how seniors in general use services. In many cases, these estimates will not reflect your personal situation. It is important to exercise caution in reviewing these numbers. This tool can be accessed from the Medicare.gov website.

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