

Medicare Part D: Prescription Drug Coverage
This information is provided by Cleveland Clinic Pharmacies.

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Contact Information

Medicare
800/MEDICARE (800-633-4227)

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Ohio State Health Insurance Assistance Program (OSHIP)
800/686-1578
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I. Basic Information

What is Medicare prescription drug coverage?

Medicare prescription drug coverage is insurance that covers both brand-name and generic prescription drugs at participating pharmacies in your area. Medicare prescription drug coverage provides protection for people who have very high drug costs.

Who can get Medicare prescription drug coverage?

Everyone with Medicare is eligible for this coverage, regardless of income and resources, health status, or current prescription expenses.

When can I get Medicare prescription drug coverage?

You may sign up from November 15, 2005 to May 15, 2006. If you join by December 31, 2005, your coverage will start January 1, 2006, and you won't miss a day of coverage. If you don't sign up when you are first eligible or by May 15, 2006, you might have to pay a penalty. Your next opportunity to enroll is from November 15, 2006 to December 31, 2006.

How does Medicare prescription drug coverage work?

Your decision about Medicare prescription drug coverage depends on the kind of health care coverage you have now. There are two ways to get Medicare prescription drug coverage. You can join a Medicare prescription drug plan or you can join a Medicare Advantage Plan or other Medicare Health Plans that offer drug coverage.

Whatever plan you choose, Medicare drug coverage will help you by covering brand-name and generic drugs at pharmacies that are convenient for you.

Like other insurance, if you join, you will pay a monthly premium, which varies by plan, and a yearly deductible (no more than \$250 in 2006). You will also pay a part of the cost of your prescriptions, including a co-payment or coinsurance. Costs will vary depending on which drug plan you choose. Some plans may offer more coverage and additional drugs for a higher monthly premium. If you have limited income and resources, and you qualify for extra help, you may not have to pay a premium or deductible.

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Why should I get Medicare prescription drug coverage?

Medicare prescription drug coverage provides greater peace of mind by protecting you from unexpected drug expenses. Even if you don't use a lot of prescription drugs now, you should still consider joining. As we age, most people need prescription drugs to stay healthy. For most people, joining now means protecting yourself from unexpected prescription drug bills in the future.

What if I have a limited income and resources?

There is extra help for people with limited income and resources. Almost 1 in 3 people with Medicare will qualify for extra help and Medicare will pay for almost all of their prescription drug costs.

II. Things to Consider

Cost

Premium: This is the monthly cost you pay to join a Medicare drug plan. Premiums vary by plan.

Deductible: This is the amount you pay for your prescriptions before your plan starts to share in the costs. Deductibles vary by plans. No plan can have a deductible more than \$250 in 2006.

Co-payment/Coinsurance: This is the amount you pay for your prescriptions after you have paid the deductible. In some plans, you pay the same co-payment (a set amount) or coinsurance (a percentage of the cost) for any prescription. In other plans, there might be different levels or "tiers," with different costs. (For example, you might have to pay less for generic drugs than brand names. Or, some brand names might have a lower co-payment than other brand names.) Also, in some plans your share of the cost can increase when your prescription drug costs reach a certain limit.

Coverage

Formulary: A list of drugs that a Medicare drug plan covers is called a formulary. Formularies include generic drugs and brand-name drugs. Most prescription drugs used by people with Medicare will be on a plan's formulary. The formulary must include at least two drugs in categories and classes of most commonly prescribed drugs to people with Medicare. This makes sure that people with different medical conditions can get the treatment they need.

Prior Authorization: Some drugs are more expensive than others even though some less expensive drugs work just as well. Other drugs may have more side effects, or have restrictions on how long they can be taken. To be sure certain drugs are used correctly and only when truly necessary, plans may require a "prior authorization." This means before the plan will cover these prescriptions, your doctor must first contact the plan and show there is a medically necessary reason why you must use that particular drug for it to be covered. Plans might have other rules like this to ensure that your drug use is effective.

Coverage Gap: If you have high drug costs, you may consider which plans offer additional coverage until you spend \$3,600 out-of-pocket. In some plans, if your costs reach an initial coverage limit, then you pay 100% of your prescription costs. This is called the coverage gap. This "gap" in coverage is generally above \$2,250 in total drug costs until you spend \$3,600 out-of-pocket. Some plans might offer some coverage during the gap. Even in plans where you pay 100% of covered drug costs after a certain limit, you would still pay less for your prescriptions than you would without this drug coverage.

Convenience

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Drug plans must contract with pharmacies in your area. Check with the plan to make sure your pharmacy or a pharmacy in the plan is convenient to you. Also, some plans may offer a mail-order program that will allow you to have drugs sent directly to your home. You should consider all of your options in determining what is the most cost-effective and convenient way to have your prescriptions filled.

Peace of Mind Now and in the Future

Even if you don't take a lot of prescription drugs now, you still should consider joining a drug plan in 2006. As we age, most people need prescription drugs to stay healthy. For most people, joining now means you will pay a lower monthly premium in the future since you may have to pay a penalty if you choose to join later. You will have to pay this penalty as long as you have a Medicare drug plan. If you reach the point where you have spent \$3,600 out-of-pocket for drug costs during the year, the plan will pay most of your remaining drug costs. This protection could start even sooner in some plans.

III. FAQs (from the Medicare Web site)

Q: Can I still use any credits left on my Medicare-approved drug discount card after December 31, 2005?

A. Yes. You can continue to use your Medicare-approved drug discount card and your credit until May 15, 2006, or until you join a Medicare prescription drug plan, whichever is first. After you join a Medicare prescription drug plan, you cannot use your Medicare-approved drug discount card. You also cannot use any of the credit you have left.

Q: I have a Medigap plan that covers prescription drugs. Can I keep that plan and choose NOT to enroll in Medicare's prescription drug coverage?

A. If you have a Medigap policy by December 31, 2005, that also covers prescription drugs (plans H, I, or J), you can keep that policy with the drug coverage, if you do not enroll in Medicare's prescription drug plan that begins in 2006. If you choose to enroll in a Medicare's prescription drug plan, you can keep your current Medigap policy but the drug coverage will be removed from the policy or, for a limited time, you can buy a different Medigap policy that does not cover drugs. You can contact your Medigap insurer to find out more about your options.

If you do not have a Medigap plan H, I, or J by December 31, 2005, starting January 1, 2006, there will be a change in Medigap policies that cover prescription drugs. Medigap plans H, I, and J may still be sold, but without the prescription drug benefit.

Q: I have a Medigap plan that covers prescription drugs. Can I keep that plan and also choose Medicare's prescription drug coverage?

A. No. If you choose to enroll in one of Medicare's prescription drug plans, you won't be allowed to renew a Medigap policy that also covers prescription drugs (plans H, I, or J). However, you can choose another Medigap plan that doesn't offer drug coverage. And, you can choose to stay with your current Medigap policy until Medicare's drug coverage starts in 2006.

Q: Does the new law make any changes to Medigap supplement policies?

A. Yes. Starting in 2006, Medigap supplement policies will include two new kinds of benefit packages that you can choose to buy, to help with out-of-pocket costs. No new Medigap policies with drug coverage (plans H, I, and J) will be sold. However, if you have a Medigap policy with drug coverage, you can choose to renew it. But, if you choose to join a Medicare prescription drug plan in 2006, you won't be allowed to renew your current Medigap policy.

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Q: Are people with Medicare going to have to pay different premiums for Part B in the future?

A: Yes. People with Medicare whose incomes are more than \$80,000 as an individual or \$160,000 as a couple will pay higher Part B premiums than people with lower incomes. This change begins in 2007.

Q: Does the new law change the coverage I have for therapy services?

A: Yes. In September 2003, Medicare started certain limits on what it would pay for occupational therapy, physical therapy, and speech-language therapy services. The new law takes away those limits until January 1, 2006. You still pay the regular coinsurance amount, and Medicare pays its share for your covered therapy services.

Q: Where can I go for the latest, official information about changes in Medicare?

A: For up-to-date information and answers to your questions, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web.

IV. Glossary of Key Terms

Appeal

An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Medicare Advantage Plan or the Original Medicare Plan must use when you ask for an appeal.

Assignment

In the Original Medicare Plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

Authorization

Managed Care Organization (MCO) approval necessary prior to the receipt of care. (Generally, this is different from a referral in that an authorization can be a verbal or written approval from the MCO whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary.)

Catastrophic Limit

The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.

Certificate of Medical Necessity

A form required by Medicare that allows you to use certain durable medical equipment prescribed by your doctor or one of the doctor's office staff.

Coordination of Benefits

Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called crossover.

Cost Sharing

The cost for medical care that you pay yourself like a co-payment, coinsurance, or deductible. (See Co-payment/Coinsurance, Deductible in the Things to Consider section.)

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Creditable Coverage

Any previous health insurance coverage that can be used to shorten the preexisting condition waiting period. (See Preexisting Conditions.)

Dual Eligible

Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

Durable Medical Equipment (DME)

Medical equipment that is ordered by a doctor (or, if Medicare allows, a nurse practitioner, physician assistant, or clinical nurse specialist) for use in the home. A hospital or nursing home that mostly provides skilled care can't qualify as a "home" in this situation. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Drug Tiers

Drug tiers are definable by the plan. The option "tier" was introduced in the plan benefit package (PBP) to allow plans the ability to group different drug types together (i.e., generic, brand, preferred brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the "tier" option is utilized, plans should provide further clarification on the drug type(s) covered under the tier in the PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

Eligibility – Medicare Part A (Hospital Insurance)

You are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if:

- You are 65 or older and you are receiving, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board, or
- You are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or
- You or your spouse had Medicare-covered government employment, or
- You are under 65 and have End-Stage Renal Disease (ESRD).

If you are not eligible for premium-free Medicare Part A, you can buy Part A by paying a monthly premium if:

- You are age 65 or older, and
- You are enrolled in Part B, and
- You are a resident of the United States, and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the 5 years immediately before the month in which you apply.

Eligibility – Medicare Part B (Medical Insurance)

You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible for Part B if you are not eligible for premium-free Part A, but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived in the United States continuously during the 5 years immediately before the month during which you enroll in Part B.

Employer Group Health Plan (GHP)

A GHP is a health plan that:

- Gives health coverage to employees, former employees, and their families, and
- Is from an employer or employee organization.

Enrollment Period

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A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Formulary

A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.

Formulary Drugs

Listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to covered enrollees.

Generic Drugs

A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

Maximum enrollee out-of-pocket costs (TrOOP)

The beneficiary's maximum dollar liability amount for a specified period.

Medicaid

A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary

Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

Medicare Advantage Plan

A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

Medicare Managed Care Plan

A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Part A (Hospital Insurance)

Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)

Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

Medicare Supplement Insurance

Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original

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Medicare Plan. (See Coverage Gap in the Things to Consider section and Medigap Policy.)

Network

A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

Non-Formulary Drugs

Drugs not on a plan-approved list.

Open Enrollment Period

A one-time-only six-month period when you can buy any Medigap policy you want that is sold in your State. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

Qualified Medicare Beneficiary (QMB)

This is a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

State Health Insurance Assistance Program

A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Workers Compensation

Insurance that employers are required to have to cover employees who get sick or injured on the job.