

OVERVIEW

MEDICARE

PART D,

3/22/06



Comparison of Qualifications and Benefits

Beginning January 2006 to June 2007

	SeniorCare Cash Assistance	SeniorCare Prescription Drug Assistance
Qualifications	<ul style="list-style-type: none"> Annual Income below 135% of 2005 federal poverty level <ul style="list-style-type: none"> \$15,133 Single \$21,641 Couple Liquid Assets below <ul style="list-style-type: none"> \$6,000 Single \$9,000 Couple 	<ul style="list-style-type: none"> Annual Income below 175% of 2005 federal poverty level <ul style="list-style-type: none"> \$20,913 Single \$28,053 Couple Liquid Assets below <ul style="list-style-type: none"> \$50,000 Single \$100,000 Couple
SeniorCare Benefit January 2006	\$120 a month cash assistance (up to \$1,440 annual)	\$670 Annual Medicare/Comparable Insurance Prescription Drug Premiums and Deductible
Medicare Benefit January 2006	<ul style="list-style-type: none"> Annual Medicare Premiums and deductible covered \$670 Full prescription drug coverage Medicare Part D 	Standard Medicare Part D, prescription drug coverage
Seniors Served (Total 11,000)	7,000	4,000 *

* Estimated number of people served under SeniorCare

State of Alaska
DEPARTMENT OF HEALTH & SOCIAL SERVICES

Frank H. Murkowski, Governor

Karleen Jackson
Commissioner
P.O. Box 110601
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NEWS RELEASE



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FOR IMMEDIATE RELEASE: Jan. 11, 2006

Contact: Jeff Kasper, (907) 465-8194, Cell (907) 321-3158
Sherry Hill, (907) 465-1618, Cell (907) 321-2838

Community volunteers available to assist seniors with Medicare Part D enrollment

(Anchorage, Alaska) — Medicare-trained volunteers throughout Alaska continue to provide information and help seniors with enrollment in the Medicare Part D drug plan. These volunteers have been trained to help guide seniors through the various aspects of the federal drug plan, and provide this service within their own community. A list of volunteers, contact information and the communities served is attached.

The Alaska Department of Health & Social Services SeniorCare Information Office will refer seniors to local community volunteers, as well as help seniors compare all the plans. The seniors will then be able to choose their own Medicare drug plan.

The initial enrollment period for Medicare Part D ends May 15, 2006. Medicare Part D prescription drug insurance coverage is voluntary. Seniors who choose to enroll in Medicare Part D must choose the plan that will best serve their prescription needs. Applications for Alaska's revised SeniorCare benefit are also available now.

For qualified seniors, Alaska's SeniorCare will augment the new Medicare prescription drug plan by covering Medicare prescription drug plan premiums and deductibles. This subsidy will be available for seniors with incomes below \$20,913 for individuals or \$28,053 for couples, with liquid assets of up to \$50,000 for an individual and \$100,000 for a couple.

SeniorCare cash assistance of \$120 a month will continue for seniors who meet income and asset guidelines. Seniors with incomes below \$16,133 for individuals, or \$21,641 for couples are eligible to receive the SeniorCare \$120 monthly cash assistance, with liquid assets of up to \$6,000 for an individual and \$9,000 for a couple.

For Medicare or SeniorCare information, call the SeniorCare Information Office at 1-800-478-6065 (within Alaska), or in Anchorage, 269-3680; visit the DHSS Web site at www.seniorcare.alaska.gov, or reference the attached volunteer list to locate a volunteer in local areas.

2005 State of Alaska Medicare Volunteer Counselor
List By City

	A	B	C	D	E
1	Name	Organization Volunteer Belongs to	Email	Phone	City
2	Juli Quezada	Anchorage Senior Center & Alaska SHIP Medicare Coord	asc-info-assist@ak.net	907-258-7823	Anchorage
3	Lue Rae Erickson	Alaska Native Tribal Health Consortium (ANTHC)	lerickson@anthc.org	907 729-2382	Anchorage
4	Pat Kouris	Access Alaska	pkouris@accessalaska.org	907-248-4777	Anchorage
5	Richard Rainery	Governor's Council on Disabilities and Special Education	richard_rainery@health.state.ak.us	907-269-5703	Anchorage
6	Rita Hatch	Older Persons Action Group (OPAG)	chitina@gci.net	907-276-1059	Anchorage
7	Serena Dowling	Access Alaska, Inc.	sdowling@accessalaska.org	907-248-4777	Anchorage
8	Tami Eller	Volunteers of America	grands@voaak.org	907-522-9866	Anchorage
9	Theresa Pancho	Marlow Manor Assisted Living	theresa@marlowmanor.com	907-338-8708	Anchorage
10	Millie Prokopeuff	Aleutian Pribilof Islands Association, Inc. (APIA)	mdprokopouff@yahoo.com	907-839-2256	Atka
11	Karen Sidell	Yukon Kuskokwim Health Corporation	karen_sidell@ykhc.org	907-543-6389	Bethel
12	Martina Gil	Yukon Kuskokwim Health Corporation	martina_gil@ykhc.org	907-543-6470	Bethel
13	Sophie Jacob	Yukon - Kuskokwim Health Corporation	sophie_jacob@ykhc.org	907-543-2692	Bethel
14	Anne Mauer	AARP	mauer@wildak.net	907-895-4956	Delta Junction
15	Basil Backford	City of Dillingham Senior Center	director@nushtel.com	907-842-2457	Dillingham
16	Janice Rodland	Bristol Bay Area Health Corporation	jrodland@bbahc.org	907-842-9328	Dillingham
17	Kimberly Govig	Marrulut Eniit Assisted Living	marrulut@yahoo.com	907-842-5064	Dillingham
18	Lauralee Mitchell	City of Dillingham Senior Center	director@nushtel.com	907-842-1231	Dillingham
19	Priscilla Dray	Bristol Bay Area Health Corp	pdray@bbahc.org	907-842-5201	Dillingham
20	Charlotte A. Gisvold	Aleutian Pribilof Islands Association, Inc. (APIA)	charlottteg@apiia.org	907-581-2742	Dutch Harbor
21	Mica Dean	Oonalaska Wellness Center	micad@apiia.org	907-581-2742	Dutch Harbor
22	Joaquin M. Barbachano	Retired & Seniors Volunteer Program (RSVP)	joaquin@barbachano.net	907-279-9622	Eagle River
23	Hal Levey	AARP, Interior Community Aging Network (ICAN)	hlevey@gci.net	907-458-7161	Fairbanks
24	Ruth C. L'Hommedieu	ICAN, & Governor's Committee	ruth_fairbanks@yahoo.com	907-479-8514	Fairbanks
25	Valene J. Dewey	Tanana Chiefs Conference	vdewey@tananachiefs.org	907-452-8251 x3322	Fairbanks
26	Theresa Palmer	Access Alaska Fairbanks	tpalmer@accessalaska.net	907-479-7940	Fairbanks
27	Brenda Steenblock	Homer Senior Citizens, Inc.	brenda@cosmichamlet.net	907-235-7655	Homer
28	Charlene Sykes	Southeast Alaska Regional Health Consortium, SEARHC	charlene.sykes@searhc.org	907-364-4465	Juneau
29	Diana Kreick	No organization-Private Individual	kreick@ptialaska.net	907-364-1528	Juneau
30	Julie D. DeLong	Senior & Caregiver Resource Center	julie.delong@ccsjunior.org	907-463-6177	Juneau
31	Sarah Bosma	Southeast Alaska Independent Living	sbosma@sailinc.org	907-586-4920	Juneau
32	Kathy Romain	Kenai Senior Center	senior@ci.kenai.ak.us	907-283-4156	Kenai
33	Elena Rath	Rendezvous Senior Day Services, INC.	rendezvous@kpunet.net	907-247-1961	Ketchikan
34	Nancy Tielje	AARP	nancy@davies-barry.com	907-225-2176	Ketchikan
35	Susan Pickrell	Ketchikan Indian Community	spickrell@kictribe.org	907-228-5227	Ketchikan
36	Wendy Hoppe	AARP	wendylee@bristolbay.com	907-246-7429	King Salmon
37	Dana R. Krawchuk	State of Alaska Office of Rep David Guttenberg	dana_krawchuk@legis.state.ak.us	907-456-8172	Legislative Staff
38	Katie Shows	State of Alaska Office of Representative Paul Seaton	katie_shows@legis.state.ak.us	907-235-2921	Legislative Staff
39	Julie Welch	Ninilchik Senior Citizens, Inc.	seniors@ptialaska.net	907-567-3988	Ninilchik
40	Darlene Dewey	Norton Sound Health Corporation	ddewey@nshcorp.org	907-443-4590	Nome
41	Shellene Castleman	Nome Community Center	seniors@nomecc.org	907-443-4150	Nome
42	Sara Trigg	Arctic Access	Suki@nome.net	907-443-7644	Nome

September 2005

Information for State & Local Government Officials

Providing Information for Dual Eligibles
and their Caregivers about the New
Medicare Prescription Drug Benefit

Medicare_{Rx}
Prescription Drug Coverage _{Rx}

DISCLAIMERS:

This package does not include information for those dual eligibles affected by hurricane Katrina and Rita. For more information, please go to www.cms.hhs.gov/katrina or www.cms.hhs.gov/rita.

Important Dates

September 15–November 15, 2005

- Medigap insurance companies will mail information to Medigap policy holders who have a policy that covers prescription drugs

October 3, 2005

- Begin comparing prescription drug plans
 - ▶ www.medicare.gov
 - ▶ 1-800-MEDICARE (1-800-633-4227)
 - ▶ TTY users should call 1-877-486-2048

October 2005

- “Medicare & You 2006” handbook mailed
- Medicare notifies people with Medicare and Medicaid of the plan they will be automatically enrolled in on January 1, 2006, if they do not enroll on their own
- Employer plans send coverage information to enrollees
- Begin monthly mailing to people with Medicare who newly qualify for the extra help automatically

November 15, 2005

- Initial enrollment period begins

January 1, 2006

- Medicare Prescription Drug Plan coverage begins for enrollees
- Dual eligible coverage begins

May 15, 2006

- Initial enrollment period ends

June 1, 2006

- Facilitated enrollment of people entitled to extra help who did not enroll by May 15, 2006

As a state/local policymaker or an advocate, you are in a key position to inform and educate your constituents, colleagues, friends, family members or other loved ones about the new Medicare prescription drug benefit.

The Medicare Prescription Drug Program takes effect January 1, 2006. The Centers for Medicare & Medicaid Services (CMS) is implementing this important new program. People who assist individuals with both Medicare and Medicaid will play an important role in helping people get information about the new prescription drug coverage. This resource guide provides information you need to help your constituents, colleagues and others better understand the new Medicare prescription drug coverage.

Beginning January 1, 2006, Medicare will provide prescription drug coverage for people with both Medicare and Medicaid.*

Below is a summary of what people who get both Medicare and Medicaid need to know:

- Prescription drug coverage for dual eligibles is changing.
- Beginning January 1, 2006, Medicare, instead of Medicaid, will cover prescription drugs.
- Dual eligibles will have continuous drug coverage during the transition.
- In order for dual eligibles to receive drug coverage, they must join a Medicare prescription drug plan.
- In October 2005, Medicare will automatically enroll dual eligibles in a prescription drug which has been chosen for them.
- Beginning November 15, 2005, anyone who is a dual eligible can switch to a different prescription drug plan if they choose. They may change plans any time after that.
- Medicare prescription drug plans may charge a small co-payment for each prescription—between \$0 and \$5.
- Medicaid will continue to pay for other health costs for dual eligibles, and may choose to pay for non-Medicare covered prescription drugs.
- If a dual eligible is enrolled in a Medicare Advantage health plan, that plan will include prescription drugs beginning January 2006.
- If a dual eligible is enrolled in the Program of All-Inclusive Care for the Elderly (PACE), that program will continue to include prescription drugs after the beginning of January, 2006.

Thank you for your valuable contribution to this important effort. We look forward to working with you in the coming months as we spread the message about Medicare's new prescription drug coverage to America's seniors and people with disabilities.

Please distribute the attached information. We will provide more information to you as it becomes available.

*Dual eligibles are the group of Medicare eligibles who also qualify for Medicaid.

Disclaimer: People with both Medicare and Medicaid who live in American Samoa, Commonwealth of Northern Mariana Islands, Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands can receive "extra help" in paying for their prescription drugs. The "extra help" program may not be the same as provided elsewhere in the United States. To find out more about the Medicare Prescription Drug program in your location, call 1-800-MEDICARE (1-800-633-4227) or the phone numbers listed on page 11 of this package. TTY users should call 1-877-486-2048.

What I Need to Know about the New Medicare Prescription Drug Coverage

What are the Medicare prescription drug plans?

Beginning January 1, 2006, prescription drug coverage will be available to everyone with Medicare. Every person with Medicare, no matter how they get their health care today (including people with both Medicare and Medicaid) will be eligible for drug coverage under a Medicare prescription drug plan. Insurance companies and other private companies will work with Medicare to offer these drug plans. Medicare prescription drug plans will be available in every part of the country, and all plans will cover both brand name and generic drugs.

Drug plans may vary in which prescription drugs are covered. All drug plans will have to provide at least a minimum standard level of coverage, which Medicare will set.

I am enrolled in both Medicare and my state's Medicaid program. How will these changes affect me?

Your prescription drug coverage is changing. Until December 31, 2005, Medicaid will continue to pay for prescription drugs for you. Beginning January 1, 2006, Medicare will start paying for your prescription drugs. Medicare will enroll you in a Medicare prescription drug plan effective January 1, 2006, to make sure you don't miss a day of coverage. The new plan may charge a small co-payment for each prescription—between \$0 and \$5. Medicaid will continue to pay for other health services for you including, at state option, prescription drugs not included in the Medicare program.

When will people with both Medicare and Medicaid join a Medicare prescription drug plan?

In October 2005, Medicare will enroll people with both Medicare and Medicaid in a prescription drug plan so that prescription drug coverage continues without a gap. Medicare will let you know the plan it has chosen for you in October 2005. Beginning November 15, 2005, you can switch to another prescription drug plan and change your plan anytime, for any reason. The change will be effective on the first day of the month following the month you make the change.

Medicaid does not pay for health services for me, but it does pay for my Medicare premiums. How am I affected by the Medicare prescription drug program?

People who get help from their state paying for their Medicare premiums, people in the Medicare Savings Program—QMB, SLMB, and QIs, will continue to receive assistance with their Medicare premiums and will also receive a low income subsidy and can enroll in a Medicare drug plan beginning November 15, 2005. If you receive help through a Medicare Savings Program and do not choose a plan by May 15, 2006, Medicare will enroll you in a plan to make sure that you do not miss a day of drug coverage.



What I Need to Know about Enrolling in a Plan

I have received my plan assignment from Medicare in the mail, what do I do now?

Decide if this plan is the right plan for you. Read the materials your plan sends you about the drug plan Medicare will enroll you in. If you don't like the plan, you can get information about the other Medicare drug plans. For example, find out if the prescription drugs you are currently taking are covered by your assigned plan's list of covered prescription drugs, also called a formulary. Make sure the pharmacy you use works with this plan. If you are happy with the plan you have been assigned to you, need not do anything. Beginning January 1, 2006, you will receive your drugs through that plan and its pharmacy network. If, after reviewing the plan's information and you find that this plan is not right for you, you can switch to another prescription drug plan and change your plan any time, beginning November 15, 2005.

Can someone who makes health care decisions for me enroll me in a Medicare prescription drug plan?

Yes. If someone has the legal right to make health care decisions on your behalf, (such as through a power of attorney), this person can enroll you in a Medicare prescription drug plan that meets your needs. This person is sometimes called an "authorized representative."

If I want to change plans at some other point in the future, can I?

Yes. A person with Medicare and full Medicaid coverage is entitled to a "Special Enrollment Period." This means you can change your prescription drug plan at any time, and as often as each month if you wish.

What should I do if I am now enrolled in a Medicare Advantage Plan?

If you are already enrolled in a Medicare Advantage (MA) plan you will be enrolled in your MA's prescription drug plan. Check with your MA plan to learn more about its prescription drug coverage.

Will people with both Medicare and Medicaid living in a nursing home be enrolled in a Medicare prescription drug plan or will Medicaid continue to cover their drug costs?

People with both Medicare and Medicaid living in a nursing home will be enrolled in a Medicare prescription drug plan. At state option, Medicaid may pay for some non-Medicare prescription drugs.

Will I get a new card when I enroll in a plan?

Medicare prescription drug plans will issue new cards to people enrolled in their plan. The cardholder ID will be assigned by the plan. Plans are not to use an enrollee's Social Security Number as the cardholder ID.

What I Need to Know about How Much I Will Have to Pay

How much will I have to pay?

Medicare will help pay the cost of your prescription drugs. Anyone who is enrolled in both Medicare and Medicaid will not pay a monthly premium. You may need to pay a small copayment for each prescription—between \$0 and \$5.*

How much will people in institutions, like a nursing home, have to pay for prescription drugs?

If you have both Medicare and Medicaid and live in an institution like a nursing home for at least one month, you will pay nothing for your covered prescription drugs.

What I Need to Know about Where I Get My Prescription Drugs

Will my pharmacy and/or pharmacist change?

If you want to make sure you stay with the same pharmacy, you need to contact the Medicare prescription drug plans and choose a plan that works with your pharmacy. You may also want to ask your pharmacist which plans she/he works with.

What is a “preferred” pharmacy? Do I have to use one?

Plans may offer “preferred” pharmacies within their pharmacy networks. Plans may offer lower cost sharing for covered drugs purchased by enrollees at certain pharmacies within their networks (the “preferred” pharmacies) compared to other network pharmacies (“non-preferred” pharmacies).

What happens if I need to go to an out-of-network pharmacy?

There may be instances where you may need to purchase your drugs at an out-of-network pharmacy, like when you are on vacation. Plans are required to assure that their enrollees have adequate access to drugs dispensed at an out-of-network pharmacy.

Will I pay more to use an out-of-network pharmacy?

Ultimately no. Because an out-of-network pharmacy, by definition, does not have a contract with your drug plan, you will be charged more than your normal \$0–\$5 co-payments when you buy your drugs at an out-of-network pharmacy. However, your plan will reimburse you for that cost once it receives your receipt for the prescription drugs. You will still have to pay the normal co-payment amount for that medicine just as if you had purchased it at your home pharmacy.

* If you join a plan that has a premium higher than a standard plan, you will have to pay the difference (for example, if a standard plan costs \$32 per month, and you join a plan that costs \$35 per month, you will have to pay the \$3 difference each month).

Can a plan require me to get my drugs through a mail-order pharmacy?

No. Plans cannot require enrollees to use a mail-order pharmacy. However, because many people like the convenience of mail order, many plans will offer mail-order services.

What I Need to Know about Drug Coverage (Formularies) in the New Medicare Prescription Drug Program

What will my Medicare drug plan cover?

Each Medicare drug plan will have its own list of covered drugs (or formulary) that will include generic and brand-name drugs. Plans may have rules about what specific prescription drugs are covered to treat different medical conditions. Every Medicare drug plan must comply with federal rules about the types and number of drugs covered.

How do I know if my prescription drugs will be covered by a particular Medicare prescription drug plan?

Make a list of all of your current prescription drugs including name, dose size (for example: 2 pills, 300mg in each pill), and dosage frequency (for example: 2 times a day). You can use this information to compare the list of drugs that are covered under each plan. You can get the list of drugs a plan covers by calling the plan, visiting the plan's website, or visiting www.medicare.gov on the Internet. This information will be available from the plans in October 2005. On October 13, 2005, this information will be available on the web at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227).

Can my plan's formulary change?

Yes. A plan's formulary can change when a plan gets new information. But, the new formulary must meet Medicare's requirements and the plans must tell you about any upcoming changes 60 days in advance.

How will I know if my plan discontinues coverage of my drug?

Your plan must let you know at least 60 days before a drug you use is removed from the formulary.

Will I be able to get my drugs on January 1, 2006?

Medicare prescription drug plans must establish a transition process for all Medicare beneficiaries as they enroll in the new Medicare prescription drug coverage from another drug program. These transition processes must show how they will help people who are on a drug either stay on that drug or safely change to another appropriate drug. You should check with your plan to see what their policy is for continuing a particular drug.

Do I have to change my antidepressants, antipsychotics, anticonvulsants, HIV drugs, cancer medications and immunosuppressants?

No. CMS requires that Medicare prescription drug plan formularies include "all or substantially all" of the drugs in the antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS categories. In addition, plans must give special attention to patients already stabilized on drugs in these classes. If you are already on these drugs when you join the plan, the plan usually cannot require preauthorization or ask you to try other drugs first. For individuals who begin treatment with these drugs after they are in the plan, other than HIV/AIDS drugs, plans may use these techniques to manage therapy. However, for HIV/AIDS drugs, these techniques are not allowed.

I've heard that certain prescription drugs are not covered by the Medicare Prescription Drug Program (i.e. barbiturates, benzodiazepines, or prescription vitamins). Will Medicaid still pay for these drugs?

A state Medicaid agency may choose to continue to pay for some or all non-Medicare prescription drugs. Contact your State Medicaid Agency to find out what drugs, if any, they have decided to cover.

What if I am taking a drug that is not on my plan's formulary?

Medicare prescription drug plans must have a process for you to get drugs that are not on the formulary when the drug is medically necessary. If your doctor thinks you need a drug that isn't on the formulary, you or your doctor can apply for an exception. If the exception is denied, you can appeal the decision.

How do I apply for an exception if a drug I need is not on my plan's formulary?

First, you should talk to your doctor and make sure no other drug can be used. If your doctor thinks this is the only drug that is appropriate, then you need to file an exception. To file an exception, you should contact your plan.

If the plan denies an exception, then you can appeal the plan's decision. To file an appeal, follow the procedure described in the handbook you received from your plan, or talk to your plan to find out how to file an appeal.

Who may help me with my exception and/or appeal?

In addition to allowing you to file an exception and/or appeal, prescribing physicians or your appointed representative can file appeals on your behalf.

Are plans required to cover a temporary/emergency supply of non-formulary Medicare prescription drugs while an exception request is being processed?

For people living at home and in the community, you should check with your plan to see its policy on covering drugs while an exception request is being processed. Medicare prescription drug plans must cover an emergency supply of non-formulary drugs for long-care residents.

Can long term care residents receive an emergency supply of medications?

Yes. Medicare prescription drug plans must cover an emergency supply of non-formulary drugs for long-term care residents as part of their transition process.

Where I Can Go for More Information about Medicare Prescription Drug Coverage

For more information on Medicare prescription drug coverage:

- Visit www.medicare.gov on the web and get personalized information.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. When you call, have ready: your Medicare card, a list of drugs you use, and the name of the pharmacy you use.
- Read the "Medicare & You 2006" handbook that will be mailed to you in October 2005.
- Get a free copy of the booklet "Your Guide to Medicare Prescription Drug Coverage," (CMS Pub. No. 11109) on www.medicare.gov or by calling 1-800-MEDICARE.
- Call your State Health Insurance Assistance Program for free personalized health insurance counseling. (Phone numbers are in the back of this package.)
- Check for local events for help joining a plan.
- Contact your local office on aging. For the telephone number, visit www.eldercare.gov on the web or call: 1-800-677-1116.
- Contact your state Medicaid agency if you have any questions about your Medicaid health benefits.

Web Resources for States

MMA States Listserv

- On www.cms.hhs.gov scroll down and click on “Mailing Lists” on the right yellow sidebar. Enter your information in the requested fields and choose the subscribe button for “MMA_States”

State MMA Information

- www.cms.hhs.gov/medicarerreform/states

Beneficiary-Friendly Publications

- www.medicare.gov/publications

Outreach Toolkit

- www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/MPDCoutreachkit.asp

MMA Questions & Answers

- Submit Questions: <http://mmaissuesform.cms.hhs.gov>
- Browse answers: <http://www.cms.hhs.gov/medicarerreform/medicarerreformfaqs.asp>, click on “Prescription Drug Coverage”

State Health Insurance Assistance Contact Information

Your state receives a CMS State Health Insurance Assistance Program (SHIP) grant to support local personalized counseling and assistance to people with Medicare and their families. To contact the SHIP in your state, please consult this listing.

ALABAMA
Ph: (334) 353-9636

ALASKA
Ph: (907) 269-3669

ARIZONA
Ph: (602) 542-6439

ARKANSAS
Ph: (501) 371-2785

CALIFORNIA
Ph: (800) 434-0222

COLORADO
Ph: (303) 894-7552

CONNECTICUT
Ph: (860) 416-7206
Ph: (860) 424-5322

WASHINGTON, DC
Ph: (202) 496-6240
Ph: (202) 727-8367

DELAWARE
Ph: (302) 739-4251
Ext. 174

FLORIDA
Ph: (850) 414-2157

GEORGIA
Ph: (404) 657-5347

GUAM
Ph: (671) 735-7382

HAWAII
Ph: (808) 586-7299

IDAHO
Ph: (208) 334-4350

ILLINOIS
Ph: (217) 524-1631

INDIANA
Ph: (317) 233-3551

IOWA
Ph: (515) 242-5190

KANSAS
Ph: (785) 368-7331

KENTUCKY
Ph: (502) 564-7372

LOUISIANA
Ph: (225) 342-6334

MAINE
Ph: (207) 287-9207

MARYLAND
Ph: (410) 767-1100

MASSACHUSETTS
Ph: (617) 222-7436

MICHIGAN
Ph: (517) 886-1339
Ph: (517) 373-4071

MINNESOTA
Ph: (651) 296-3839

MISSISSIPPI
Ph: (601) 359-5131

MISSOURI
Ph: (573) 893-7900
Ext. 191

MONTANA
Ph: (406) 444-7870

NEBRASKA
Ph: (402) 471-2599
Ph: (402) 471-4506

NEVADA
Ph: (702) 486-3796

NEW HAMPSHIRE
Ph: (603) 223-4158

NEW JERSEY
Ph: (609) 943-3378

NEW MEXICO
Ph: (505) 255-0971

NEW YORK
Ph: (518) 473-7259

NORTH CAROLINA
Ph: (919) 733-0111

NORTH DAKOTA
Ph: (701) 328-9604

OHIO
Ph: (614) 644-3399

OKLAHOMA
Ph: (405) 521-6628

OREGON
Ph: (503) 947-7263

PENNSYLVANIA
Ph: (717) 783-8975

PUERTO RICO
Ph: (787) 725-4300

RHODE ISLAND
Ph: (401) 462-0508
Ph: (401) 222-2894
Ext. 319

SOUTH CAROLINA
Ph: (803) 734-9902

SOUTH DAKOTA
Ph: (605) 773-3656
Ph: (605) 336-6722

TENNESSEE
Ph: (615) 741-3745

TEXAS
Ph: (512) 438-4205

UTAH
Ph: (801) 538-3910

VERMONT
Ph: (802) 748-5182

VIRGINIA
Ph: (804) 662-7050

VIRGIN ISLANDS
Ph: (340) 772-7368

WASHINGTON
Ph: (206) 389-2752

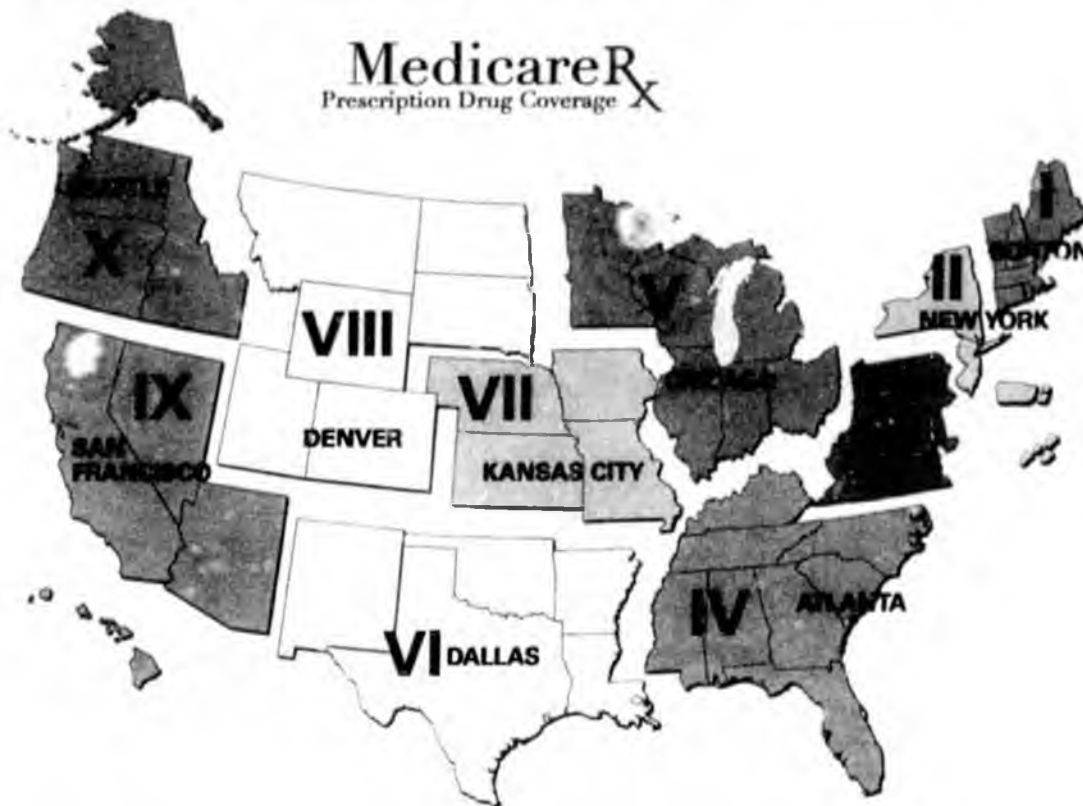
WEST VIRGINIA
Ph: (304) 558-3317

WISCONSIN
Ph: (608) 267-3201

WYOMING
Ph: (307) 777-7401
Ph: (307) 856-6880

Centers for Medicare & Medicaid Services

Regional Map and Contact Information



REGIONAL OFFICES

PHONE NUMBERS

	Centers for Medicare & Medicaid Services	Social Security Administration
REGION I – BOSTON	617-565-1188	617-565-2881
REGION II – NEW YORK	212-616-2205	212-264-2500
REGION III – PHILADELPHIA	215-861-4140	215-597-4456
REGION IV – ATLANTA	404-562-7150	404-562-5500
REGION V – CHICAGO	312-886-6432	312-575-4053
REGION VI – DALLAS	214-767-6401	214-767-4207
REGION VII – KANSAS CITY	816-426-5233	816-936-5740
REGION VIII – DENVER	303-844-2111	303-844-0840
REGION IX – SAN FRANCISCO	415-744-3501	510-970-8431
REGION X – SEATTLE	206-615-2306	206-615-2100

For more information, call 1-800-MEDICARE, or visit www.medicare.gov



Guide to Medicare's Preventive Services

**This official government
booklet explains...**

- What prevention is and why it's important
- Which preventive services are new
- Which preventive services Medicare covers and how often
- Who can get them
- What you pay

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

The best way to stay healthy is to live a healthy lifestyle. You can live a healthy lifestyle by exercising, eating well, keeping a healthy weight, and not smoking.

Another important way to stay healthy is to use preventive services provided by doctors and health care providers. Preventive services can find health problems early when treatment works best and can keep you from getting certain diseases or illnesses. Preventive services include exams, lab tests, and screenings. They also include shots, monitoring, and information to help you take care of your own health. Medicare pays for many preventive services to keep you healthy.

How Can this Booklet Help Me?

The preventive services listed in this booklet are covered no matter what kind of Medicare health plan you have. However, the amount you pay for these services varies depending on the type of health plan. This booklet explains the way preventive services are covered if you have Part B under the Original Medicare Plan (sometimes called fee-for-service). If you have another type of Medicare health plan, call your plan for more information.

This booklet can help you learn...

- How to stay healthy
- About these Medicare-covered services:
 - One-time "Welcome to Medicare" physical exam (if your Medicare Part B begins on or after January 1, 2005)
 - Cardiovascular screening
 - Tests for breast, cervical, vaginal, colorectal, and prostate cancers
 - Flu, pneumococcal, and Hepatitis B shots
 - Bone mass measurements
 - Diabetes screening and self-management
 - Glaucoma testing

Note: The information in this booklet was correct when it was printed. Changes may occur after printing. For the most current information, look at www.medicare.gov on the web. Select "Your Medicare Coverage." Or, call 1-800-MEDICARE (1-800-633-4227). A customer service representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

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Medicare's Guide to Preventive Services isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Why Prevention is Important

You can stay healthy, live longer, and delay or prevent many diseases by...

- **exercising**—Do any physical activity you enjoy for 20–30 minutes 5 or 6 days a week.
- **eating well**—Eat a healthy diet of different foods like fruit, vegetables, protein (like meat, fish, or beans), and grains (like rice), and limit the amount of saturated fat you eat.
- **keeping a healthy weight**—Watch your portions, and try to balance the number of calories you eat with the number you burn by exercising.
- **not smoking**—Talk with your doctor about getting help to quit smoking.
- **getting preventive services**—Delay or lessen the effects of diseases by getting preventive services like shots to keep you from getting dangerous infections and screening tests to find diseases early.

Note: Talk to your doctor about the right exercise program for you.

Newly-covered Preventive Services

Medicare covers many different preventive services. Starting January 1, 2005, Medicare will now cover these three preventive services:

- One-time “Welcome to Medicare” Physical Exam (page 3)
- Cardiovascular Screening (page 4)
- Diabetes Screening to check for diabetes (page 10)

Keep reading to find out how Medicare covers these and other preventive services. You can also look at www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

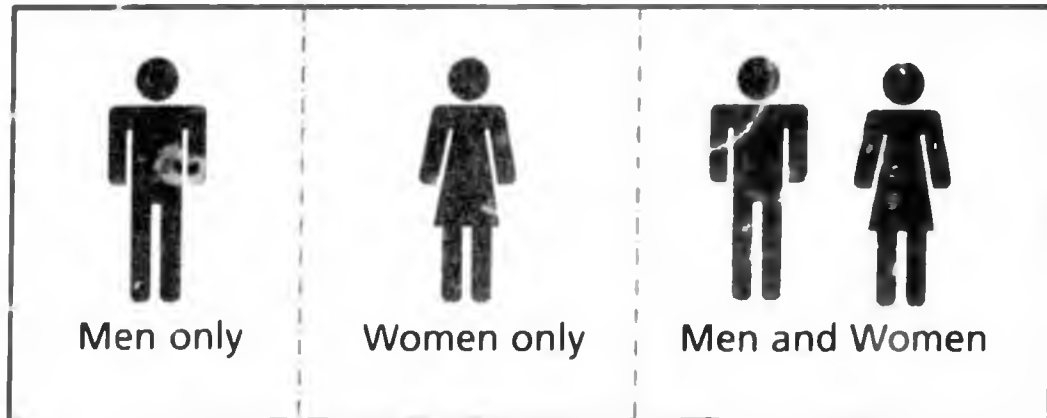
Talk to Your Doctor

In providing good care, your doctor or health care provider may do exams or tests that Medicare doesn't cover. Your doctor or health care provider may also recommend that you have tests more or less often than Medicare covers them. Talk to your doctor or health care provider to find out how often you need these exams to stay healthy.

Things to Know as You Read this Booklet

Symbols

You will see one of the following symbols next to each preventive service. It tells you for whom Medicare covers the test.



Risk Factors

You will also see lists of factors that increase your risk of developing a certain disease. If you're not sure if you're at high risk, talk to your doctor.

Part B Deductible

The Part B deductible in 2004 is \$100 and will increase to \$110 in 2005. This amount may change annually.

Medicare-approved Amount

The Medicare-approved amount is the amount Medicare pays for an item or service.

NEW - One-time "Welcome to Medicare" Physical



If your Medicare Part B coverage begins on or after January 1, 2005, Medicare will cover a one-time preventive physical exam within the first six months that you have Part B. The exam will include a thorough review of your health, education and counseling about the preventive services you need like certain screenings and shots, and referrals for other care if you need it. The "Welcome to Medicare" physical exam is a great way to get up-to-date on important screenings and shots and to talk with your doctor about your family history and how to stay healthy.

How often is it covered? One time only within the first six months that you have Part B

For whom? All people whose Medicare Part B begins on or after January 1, 2005

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

NEW - Cardiovascular Screening



Medicare covers cardiovascular screenings that check your cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase your risk for heart disease and stroke. These screenings will tell if you have high cholesterol. You might be able to make lifestyle changes (like changing your diet) to lower your cholesterol.

What is covered? Tests for cholesterol, lipid, and triglyceride levels beginning January 1, 2005

How often is it covered? Talk with your doctor about how often

For whom? Talk with your doctor to see if you qualify

Your costs in the Original Medicare Plan? You pay nothing

Breast Cancer Screening Mammograms



Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer death in women in the United States. Every woman is at risk, and this risk increases with age. Breast cancer can usually be successfully treated when found early. Medicare covers screening mammograms and digital technologies for screening mammograms to check for breast cancer before you or a doctor may be able to feel it.

How often is it covered? Once every 12 months

For whom? All women with Medicare age 40 and older can get a screening mammogram every 12 months. Medicare also pays for one baseline mammogram for women with Medicare between ages 35 and 39.

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount with no Part B deductible

Are you at high risk for breast cancer?

Your risk of developing breast cancer increases if you...

- had breast cancer in the past
- have a family history of breast cancer (like a mother, sister, daughter, or two or more close relatives who have had breast cancer)
- had your first baby after age 30
- have never had a baby

Cervical and Vaginal Cancer Screening



Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare covers a clinical breast exam to check for breast cancer.

How often is it covered? A Pap test and pelvic exam are covered by Medicare once every 24 months. However, if you are of childbearing age and have had an abnormal Pap test within the past 36 months, or if you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam every 12 months.

For whom? All women with Medicare

Your costs in the Original Medicare Plan? You pay nothing for the Pap lab test. For Pap test collection and pelvic and breast exams, you pay 20% of the Medicare-approved amount with no Part B deductible.

Are you at high risk for cervical cancer?

Your risk for cervical cancer increases if ...

- you have had an abnormal Pap test
- you have had cancer in the past
- you have been infected with the Human papillomavirus (HPV)
- you began having sex before age 16
- you have had many sexual partners
- your mother took DES (Diethylstilbestrol), a hormonal drug, when she was pregnant with you

Colorectal Cancer Screening

Colorectal cancer is usually found in people age 50 or older, and the risk of getting it increases with age. Medicare covers colorectal screening tests to help find pre-cancerous polyps (growths in the colon) so they can be removed before they turn into cancer. Treatment works best when colorectal cancer is found early.

How often is it covered?

- **Fecal Occult Blood Test**—Once every 12 months
- **Flexible Sigmoidoscopy**—Once every 48 months
- **Screening Colonoscopy** —Once every 24 months (if you're at high risk)

Once every 10 years, but not within 48 months of a screening sigmoidoscopy (if you're not at high risk)

- **Barium Enema**—Your doctor can decide to use this test instead of a flexible sigmoidoscopy or colonoscopy. This test is covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.

For whom? All people with Medicare age 50 and older, except there is no minimum age for having a screening colonoscopy

Your costs in the Original Medicare Plan? You pay nothing for the fecal occult blood test. For all other tests, you pay 20% of the Medicare-approved amount after the yearly Part B deductible.

If the flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department, you pay 25% of the Medicare-approved amount after the yearly Part B deductible.

Are you at high risk for colorectal cancer? Risk for colorectal cancer increases if you or a close relative have had colorectal polyps or colorectal cancer, or if you have inflammatory bowel disease (like ulcerative colitis or Crohn's disease).

Prostate Cancer Screening



Prostate cancer can often be found early by testing the amount of PSA (Prostate Specific Antigen) in your blood. Another way prostate cancer is found early is when your doctor performs a rectal exam. Medicare covers both of these tests so that prostate cancer can be detected and treated early.

How often is it covered?

- **Digital Rectal Examination**—Once every 12 months
- **Prostate Specific Antigen (PSA) Test**—Once every 12 months

For whom? All men with Medicare age 50 and older (coverage for this test begins the day after your 50th birthday)

Your costs in the Original Medicare Plan? Generally, you pay 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. There is no coinsurance and no Part B deductible for the PSA Test.

Are you at high risk for prostate cancer? While all men are at risk for prostate cancer, your risk increases if you have a father, brother, or son who has had prostate cancer. The list below shows the people at risk for prostate cancer from higher to lower amount of risk:

- African Americans
- Whites
- Hispanics
- Asians
- Pacific Islanders
- Native Americans

Shots (Flu, Pneumococcal, Hepatitis B)



Medicare covers flu, pneumococcal, and Hepatitis B shots. Flu, pneumococcal infections, and Hepatitis B can be life threatening to an older person. All adults 65 and older should get flu and pneumococcal shots. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot. People at medium to high risk for Hepatitis B should get Hepatitis B shots.

Flu Shot

How often is it covered? Once a year in the fall or winter

For whom? All people with Medicare

Your costs in the Original Medicare Plan? You pay nothing

Pneumococcal Shot

How often is it covered? Most people only need this shot once in their lifetime

For whom? All people with Medicare

Your costs in the Original Medicare Plan? You pay nothing

Hepatitis B Shots

How often are they covered? Three shots are needed for complete protection. Check with your doctor about when to get these shots if you qualify to get them.

For whom? People with Medicare at medium to high risk for Hepatitis B

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Are you at high risk for Hepatitis B?

Common factors that put you at medium to high risk for Hepatitis B include...

- hemophilia
- End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)
- a condition that lowers your resistance to infection

Other factors may increase your risk for Hepatitis B. Check with your doctor to see if you are at medium to high risk for Hepatitis B.

Bone Mass Measurements



Medicare covers bone mass measurements to determine whether you are at risk for a fracture (broken bone). People are at risk for fractures because of osteoporosis. Osteoporosis is a disease in which your bones become weak. In general, the lower your bone density, the higher your risk is for a fracture. Bone mass measurement test results will help you and your doctor choose the best way to keep your bones strong.

How often is it covered? Once every 24 months (more often if medically necessary)

For whom? All people with Medicare who are at risk for osteoporosis

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Are you at risk for osteoporosis?

Your risk for osteoporosis increases if you...

- are age 50 or older
- are a woman
- have a family history of broken bones
- have a personal history of broken bones
- are White or Asian
- are small-boned
- have low body weight (less than about 127 pounds)
- smoke or drink a lot
- have a low-calcium diet

Diabetes Screening, Supplies, and Self-Management Training

Diabetes is a medical condition in which your body doesn't make enough insulin or has a reduced response to insulin. Diabetes causes your blood sugar to be too high because insulin is needed to use sugar properly. A high blood sugar level is not good for your health. For all people with Medicare, Medicare covers screenings to check for diabetes. For people with diabetes, Medicare covers certain supplies and self-management training to find and treat diabetes.

NEW - Diabetes Screening (Fasting Plasma Glucose Test) beginning January 1, 2005

How often is it covered? Talk with your doctor

For whom? Talk with your doctor

Your costs in the Original Medicare Plan? You pay nothing

Diabetes Glucose monitors, test strips, and lancets

For whom? All people with Medicare who have diabetes

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Diabetes Self-Management Training

For whom? This training is for certain people with Medicare who are at risk for complications from diabetes. Your doctor must request this service.

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

For more information, get a free copy of *Medicare Coverage of Diabetes Supplies & Services* (CMS Pub. No. 11022) at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048.

Glaucoma Tests



Glaucoma is an eye disease caused by high pressure in the eye. It can cause you to gradually lose sight without warning and often without symptoms. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

How often is it covered? Once every 12 months

For whom? People with Medicare at high risk for glaucoma

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Are you at high risk for glaucoma?

Your risk for glaucoma increases if you...

- have diabetes
- have a family history of glaucoma
- are African American and age 50 or older

For More Information

You can learn more about Medicare's preventive services by looking at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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Penalty for Private Use, \$300

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Revised August 2004

Medicare is here for you 24 hours a day, every day.

For help with your Medicare questions

- visit www.medicare.gov
- call 1-800-MEDICARE (1-800-633-4227)
- call 1-877-486-2048 (TTY users)

To get this booklet in Spanish, call
1-800-633-4227. TTY users should
call 1-877-486-2048.

Para conseguir este folleto en español llame
gratis al 1-800-MEDICARE
(1-800-633-4227). Los usuarios
de TTY deben llamar al 1-877-486-2048.

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Did You Know...

that Medicare will pay for

- ✓ Cardiovascular Screening
- ✓ Diabetes Screening
- ✓ Physical Examination for New Beneficiaries
- ✓ Diabetes Management Training and Supplies
- ✓ Mammograms
- ✓ Cancer Screenings
- ✓ Bone Mass Measurement
- ✓ Glaucoma Screening
- ✓ Immunizations
- ✓ Prescription Medicines



Medicare Today
www.medicaretoday.org
1001 Pennsylvania Avenue, N.W.
Suite 550 South
Washington, DC 20004



**Medicare has New
Preventive Care Benefits**

Medicare is improving to keep beneficiaries healthier. In addition to prescription drug assistance, Medicare is offering important preventive care benefits.

Every Medicare beneficiary now has access to new Medicare Part B-covered preventive care benefits. This new coverage will help doctors diagnose and treat conditions in the early stages, helping to avoid serious illness. With the new benefits in place, every beneficiary should be aware of the full menu of preventive care services covered by Medicare.

1 Cardiovascular Screenings

Medicare will now pay for blood tests that measure cholesterol, lipid and triglyceride levels. These measurements are used by doctors to help assess risk for heart attacks, strokes and other cardiovascular illness.



2 Diabetes Screening

Medicare will now pay for fasting plasma glucose testing if you are at risk for developing diabetes. Talk to your doctor to determine if you need this screening procedure.



3 Physical Examination for New Beneficiaries

This important new benefit has been called the "Welcome to Medicare Physical." Medicare will now pay for a complete physical anytime during the first 6 months after a person enrolls in Part B Medicare. Health care providers can then make a complete assessment of each new beneficiary and work with them to prevent, manage or treat any and all conditions that are impacting their health.



4 Diabetes Management Training and Diabetes Supplies

Medicare will pay for diabetes monitors, test strips and lancets that are needed by diabetes patients. For those diabetes patients who are at risk of complications from their illness, Medicare will also pay for training to help them better monitor and care for themselves.

5 Mammograms

Medicare pays for annual screening mammograms for all women on Medicare who are over age 40. Medicare pays for a baseline mammogram for female beneficiaries under 40.

6 Cancer Screenings

Medicare pays for various types of procedures that screen for cancers including:

- Cervical and vaginal cancer
- Colorectal cancer
- Prostate cancer

7 Bone Mass Measurements

Medicare pays for bone mass measurements every two years (more often if medically necessary) to determine a patient's risk for broken bones due to osteoporosis, a serious condition in older women.

8 Glaucoma Screening

Medicare pays for annual glaucoma screenings for those who are at risk for developing this condition which can result in blindness.

9 Immunizations

Medicare pays for all beneficiaries to have immunizations to prevent flu and pneumonia. Hepatitis B vaccines are also covered for those at risk.

10 Prescription Drugs

Throughout 2005, Medicare will continue to offer all Medicare beneficiaries (who do not get their medicines through Medicaid) the opportunity to purchase their prescriptions at a discount using one of the Medicare-approved discount cards.



For low income beneficiaries, there is a cash credit of up to \$600 that can be applied to the cards of those who qualify. This credit will help them pay for their medicines.

In 2006, Medicare beneficiaries who choose to do so will have the opportunity to enroll in a Medicare prescription drug coverage plan. Medicare beneficiaries will have a choice of plans and coverage options. Information about the plans that will be offered in your area will be available later this year. Beneficiaries will receive detailed information from Medicare about choices well before the time decisions about enrollment are required.

For more information about the Medicare prescription drug benefit, any of the Medicare preventive benefits discussed in this brochure, or to ask any questions about Medicare, visit www.Medicare.gov or call Medicare at 1-800-Medicare (1-800-633-4227). A trained staff person, not a recording, will answer your call every day, around the clock.

**Additional information: For some of these procedures and tests, beneficiaries are responsible for making a 20% co-payment. The cost of some procedures, including the "Welcome to Medicare Physical" applies to the annual deductible which Medicare beneficiaries are required to meet.*

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How the New
Medicare Drug Plan
Could Help You Save

Medicare **R_x** Made Simple

There is a new benefit to the Medicare you know and trust. Beginning in 2006, Medicare will offer prescription drug coverage to help you cut the cost of your drug bills. The Medicare drug plan passed with support from Republicans and Democrats in Congress, the AARP, physician groups, and hundreds of other health advocates.

The Medicare Rx Made Simple wheel was designed to estimate your out-of-pocket costs in 2006 under this new drug coverage—**assuming you currently lack coverage**. And if you are a person with Medicare that has limited income and resources, there is extra help.



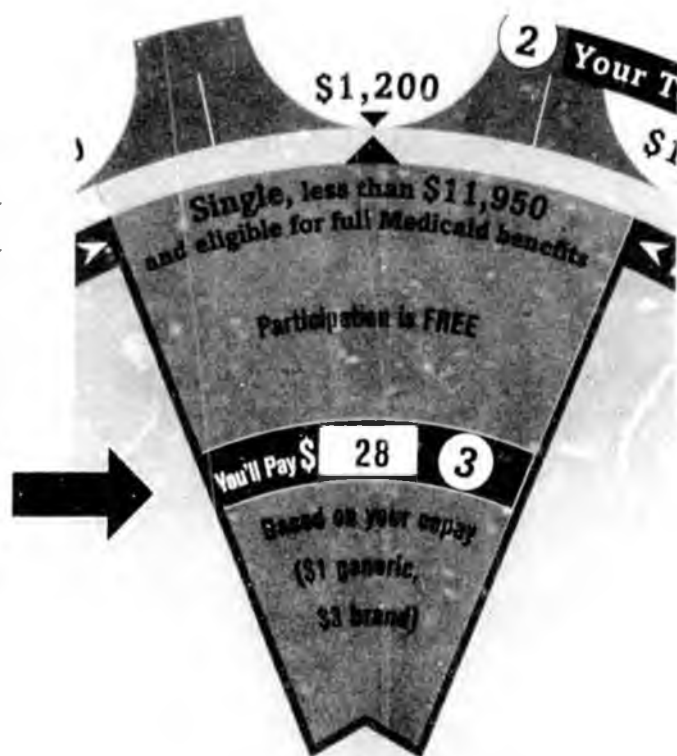
See How This New Medicare Drug Plan Could Help You...

Easy as...

- 1 Find the window for your marriage status and household income.
- 2 Align the annual drug cost arrow with your marriage status and household income. (If you are married, find the drug cost that reflects your individual drug spending only.)

- 3 The number in the window is your estimated share of annual costs under the new drug coverage, including your deductible, copayment, coinsurance and other out-of-pocket costs. Any annual premium should be added to the number that appears in the "You'll Pay" window.

People with limited income will pay low or no annual premiums.



QA Medicare Rx Made Simple

Q. Does the wheel estimate payments just for seniors who currently lack drug coverage?

A. Yes, the wheel estimates out-of-pocket costs under the new Rx coverage for those individuals currently lacking drug coverage.

Q. After using the wheel, what if I decide that I am not interested in enrolling?

A. No problem, participation in the Medicare Rx coverage is *entirely optional*. The wheel provides a better understanding of how the coverage could help you. Because your future drug spending may change over time, you may want to try different annual drug costs to better understand this coverage.

Q. What if my drug costs are less than the annual premiums I will pay?

A. Like home and car insurance the coverage provides protection against high costs. Some people will not use all parts of the coverage right away but can be confident that this coverage will be there if they need it.

Q. Does the wheel factor in discounts on drugs?

A. Yes, the wheel includes estimated drug cost savings of 20% resulting from the ability of your Medicare sponsored plan to negotiate discounts with drug manufacturers. Overall,

the program is estimated to save 10 to 25% on drug costs. The wheel also accounts for the share of discounted costs your Medicare sponsored plan will pay on your behalf.

Q. I hear that the Medicare drug plans include more generous coverage for seniors that have high levels of drug spending. Does the wheel account for this?

A. Yes, it does. The coverage will pay 95% of your drug costs above \$3600 in annual out-of-pocket spending. Although you may not spend at high levels now, the coverage provides peace of mind that this insurance will be there if you need it.

Q. I currently have drug coverage from a former employer. Do I have to drop my coverage?

A. No, if you have drug coverage through a former employer, you can keep it. In addition, by providing financial assistance to employers who offer prescription drug coverage, this law will help many employers continue to provide retiree health coverages.

Q. Will the new Medicare drug plans help people on Medicare with limited income?

A. Yes, seniors with limited income will have low or no annual premiums and low co-payments, depending on income levels.



Medicare **R_X** Made Simple

Timeline

May 2005
Applications for
Extra Financial
Help Available

Oct. 2005
CMS mails
Medicare & You
Handbook with
information on
plans in your area

Nov. 15, 2005
First day you can
join a plan

Jan. 1 2006
Coverage begins
for those who join
by Dec. 31, 2005

May 15, 2006
Last day to join a
plan for 2006

Have Additional Questions?

www.medicare.gov

1-800-MEDICARE (1-800-633-4227)

TTY users should call 1-877-486-2048.

Or call Medicare Today at 1-866-723-0416

www.medicaretoday.org

**THE FOLLOWING DOCUMENT
HAS NOT BEEN FILMED BUT IS
AVAILABLE IN THE ORIGINAL FILE**



Medicare Rx Made Simple

See how this new Medicare Rx plan could help you

Easy as

- ① Find the window that describes your marriage status and total household income.
- ② Align the total annual individual drug cost arrow with your marriage status and total household income.
- ③ The number in the window is your share of annual individual drug costs excluding the premium.

The wheel describes out-of-pocket costs under the new Rx plan for beneficiaries currently lacking drug coverage. It includes estimated savings of 20% on Rx drugs resulting from savings achieved by your insurer.

* For more information on eligibility and benefits call 1-800-MEDICARE (1-800-633-4227).

AK

Marriage Status
Single Married

Prepared by The Lewin Group
THE LEWIN GROUP