★ ★ TIP SHEET ★ ★

Information Partners Can Use on:

THE PLAN BENEFIT STRUCTURES

New Medicare Prescription Drug Coverage **As of November 2005**

When helping people with Medicare make a decision about which Medicare drug plan to join, you should consider the following key factors:

- Cost
- Coverage
- Convenience
- Peace of Mind Now and in the Future

Listed below are different ways plans can provide Medicare prescription drug coverage. Understanding the available structures may help you explain the differences between plans to people with Medicare.

1. Medicare's Standard Level of Coverage

This is the minimum coverage drug plans must provide to meet Medicare's standards.

The beneficiary pays

- Premium (monthly amount varies depending on the plan)
- Deductible = $250 each year
- Cost-sharing each calendar year=
  - – between $250 and $2,250 in total covered drug costs ($2,250 is called the initial coverage limit):
    - 25% of drug costs, or
    - different amounts for different drugs on the formulary based on a drug's cost-sharing level or "tier" as long as the overall cost-sharing, on average, is 25%. For example, a plan could require a $0 copayment for generics, a $15 copayment for preferred brand names and a $25 copayment for non-preferred brand names.

      Note: plans with different levels or tiers of cost-sharing can mix copayments and coinsurance. For example, you pay the greater of $15 or 15%.

  - –after $2,250 in total covered drug costs, 100% of covered drug costs until beneficiary has spent $3,600 in true out-of-pocket costs, then
  - –above $3,600 in out-of-pocket costs:
    - 5% of drug costs (or a small copayment) for the rest of the calendar year, or

- varying tiers of copayments as long as the overall cost-sharing, on average, is equal to the 5% cost-sharing (or small copayment) described above.

Note: in 2006, most plans will charge 5% coinsurance (or a small copayment).

2. Basic Alternative to Medicare's Standard Level of Coverage

What is different?

Plans can offer different types of coverage that may better meet the needs of people with Medicare. These plans are of equal value to coverage as number 1, but may have different cost-sharing. In addition, the value of coverage provided between $0 and $2,250 in total covered drug costs is no less than the standard level of coverage:

- Deductible: plans can lower the deductible. (Deductibles can never be higher than $250.)
- Cost-sharing between the deductible (if any) and $2,250: plans can have cost-sharing that, on average, differs from 25%.
- Different cost-sharing after the beneficiary pays $3,600 out-of-pocket.

3. Enhanced Alternative to Medicare's Standard Level of Coverage

What is different?

Plans can offer a more comprehensive level of coverage, with lower cost-sharing and/or additional coverage of certain drugs excluded from the standard level of coverage and basic alternative coverage. Premiums may be higher for these plans, but they offer more coverage.

- Covered Drugs: plans can cover drugs that aren't part of standard Medicare prescription drug coverage, like benzodiazepines. Medicare can't pay any amount toward these drugs.
- Cost-sharing: plans can lower cost-sharing amounts, such as reducing or eliminating the deductible, reducing cost-sharing between the deductible (if any) and $2,250 in total covered drug costs, increasing the initial coverage limit to above $2,250 or eliminating the initial coverage limit, paying all or a part of the costs after the initial coverage limit but before the beneficiary pays $3,600 in true out-of-pocket costs, and/or reducing cost-sharing after the beneficiary pays $3,600 in true out-of-pocket costs. For example, plans might continue to cover generics or continue tiered cost-sharing after $2,250 in total covered drug costs.

Note: This tip sheet is for partners to use as a basic guide for how plans can offer coverage. It isn't a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.