

Prescription Drugs – Medicare-Eligible Participants

As a Medicare-eligible participant in the State Retiree Health Benefits Program, what are my choices regarding outpatient prescription drug coverage?

- **Medicare Part D coverage through the State Retiree Health Benefits Program:**

As a result of the Medicare Prescription Drug and Modernization Act of 2003, Medicare beneficiaries became eligible for Medicare Part D, an outpatient prescription drug benefit, on January 1, 2006. In response to this Medicare benefit, the state program offers a Medicare Part D plan as the outpatient prescription drug benefit option under its Medicare-coordinating plans. New Medicare-eligible participants in the retiree group or existing participants who are newly eligible for Medicare and who elect the Advantage 65 or Advantage 65 + Dental/Vision Plans will be submitted for enrollment in the program's Part D coverage as a part of those plans. There is no other prescription drug option available to Medicare-eligible retiree group participants in the state program.

- **Medicare Part D coverage through a plan outside of the state program:**

Medicare-eligible participants in the State Retiree Health Benefits Program also have the option to select the Advantage 65—Medical Only (or Advantage 65—Medical Only + Dental/Vision) Plan, which provides the same medical benefits (and dental and vision benefits, if elected) as the Advantage 65 Plan, but does not provide an outpatient prescription drug benefit. Participants who choose medical-only coverage may select from Part D plans offered outside of the state program. If a Medicare-eligible State Retiree Health Benefits Program participant elects medical-only coverage upon initial enrollment in the program or upon initial eligibility for Medicare, or he/she drops or is disenrolled from prescription drug coverage at any time, he/she will not be able to elect Medicare-coordinating prescription drug coverage through the state program at a later date.

In summary, when electing Medicare-coordinating coverage under the State Retiree Health Benefits Program, participants must decide whether they wish to get outpatient prescription drug coverage through the state program or through a separate, non-state-sponsored Medicare Part D plan. For more information about non-state-sponsored Medicare Part D plans, contact Medicare by calling 1-800-MEDICARE or going to the Medicare Web site at www.medicare.gov.

Medicare must approve coverage in the Medicare Part D plan that is offered through the state program. If Medicare denies a participant's enrollment or disenrolls a participant at any time, he/she will be moved to medical-only coverage. The state plan is generally unable to override a denial by Medicare.

The state program's plan is an enhanced Medicare Part D plan, approved by Medicare and administered by Express Scripts. Plan benefits are summarized later in this fact sheet.

Please refer to Retiree Fact Sheet "***Medicare and the State Retiree Health Benefits Program***" for more information about the interaction of the state program with Medicare and a summary of what you need to do to ensure a smooth transition to Medicare primary coverage.

If I decide to elect the Advantage 65 or Advantage 65 with Dental/Vision Plan, how will my prescription drug benefit work?

Medicare may approve or deny enrollment in the state program's Part D plan. However, if enrollment is approved, following are the provisions of the enhanced Medicare Part D coverage that is a part of the Advantage 65 and Advantage 65 + Dental/Vision Plans for 2015:

Formulary – A critical part of this coverage is the formulary (the list of covered drugs). Generally, only drugs included on the plan's formulary will be covered. However, participants may apply for formulary exceptions. There are also appeal processes that may be exercised if the exception or coverage review is not decided in your favor. Your *Evidence of Coverage*, provided by Express Scripts, will have additional information regarding coverage reviews, exceptions and appeals.

All prescription drug formularies offered by Medicare Part D Plans, including the state program's enhanced Medicare Part D plan, are approved by the Centers for Medicare and Medicaid Services (CMS). Most generic drugs (except those excluded by Medicare Part D) are covered under the state plan's Medicare Part D formulary, and, as required by law, there are at least two drugs in every therapeutic category and class (unless there are not two drugs in that category/class). Participants have significant protections provided by law.

Drug Tiers – Each covered drug will be assigned to either tier 1, 2, 3 or 4. The tier dictates the amount that you pay for the drug at each coverage stage, whether it is coinsurance (a percentage of the cost of the drug) or copayment (a flat amount that you pay for the drug).

Coverage Stages – These are the stages defined by the amount that the plan and/or you have spent on covered drugs. The tier of the drug within the coverage stage dictates the amount that must be paid for covered drugs.

Deductible Stage

A \$360 deductible will apply to all covered drugs except generics. This means that you will pay the first \$360 for covered brand-name drug cost before you get the benefit of the co-payment or coinsurance level indicated in the chart below. **There is no deductible associated with covered generics, so you will immediately get the benefit of the generic co-payment when you fill covered generic prescriptions.**

Initial Coverage Stage

Once your deductible has been met for covered brand drugs (and immediately for covered generics), your copayments/coinsurance will remain as follows until your total covered drug cost reaches \$3,310.

Initial Coverage Stage - Covered Tier 1 (generic) Drugs	2016 Copayment
Per one-month (up to 34-day) supply at a retail network pharmacy	\$7
Per up to a 90-day supply through the mail-order service	\$7

Initial Coverage Stage - Covered Tier 2 (preferred brand) Drugs	2016 Copayment
Per one-month (up to 34-day) supply at a retail network pharmacy	\$25
Per up to a 90-day supply through the mail-order service	\$50

Initial Coverage Stage - Covered Tier 3 (non-preferred brand) Drugs	2016 Coinsurance
Per one-month (up to 34-day) supply at a retail network pharmacy	You pay 75%
Per up to a 90-day supply through the mail-order service	You pay 75%

Initial Coverage Stage - Covered Tier 4 (specialty) Drugs	2016 Coinsurance
Per one-month (up to 34-day) supply at a retail network pharmacy	You pay 25%
Per up to a 90-day supply through the mail-order service	You pay 25%

Coverage Gap Stage

While your benefit under the state plan generally does not change, once your total drug cost (the amount paid by you and the plan) exceeds \$3,310, you move from the Initial Coverage Stage into the Coverage Gap Stage, and the way that your claim is paid changes. You will get the benefit of the Medicare Coverage Gap Discount Program, which pays 50% of the cost of any covered brand drug manufactured by a program participant. This means that:

- Plan costs are further reduced by the discount, which helps to control premium costs.
- The amount that participants pay in co-payment/coinsurance PLUS the amount paid by the discount program will count toward reaching the Catastrophic Coverage Stage.
- If the balance of the drug cost after the discount is less than the coinsurance due based on the coverage tier of the drug, you will pay less than you paid in the Initial Coverage Stage.

Health Care Reform requires that in 2016 beneficiaries pay no more than 45% of the cost of brand drugs in the Coverage Gap Stage. While generic drugs are not a part of the Medicare Coverage Gap Discount program, your cost for generic drugs will be no more than 58% in this stage. In most cases, this plan provides a greater benefit.

Catastrophic Coverage Stage

In 2016, if your annual true out-of-pocket drug expense (including deductible, co-payments, coinsurance, and the contribution from the Medicare Coverage Gap Discount Program, but not including the cost of non-covered or excluded drugs) reaches \$4,850, you will pay the greater of either 5% coinsurance or a co-payment of \$2.95 (generics or drugs treated as generics) or \$7.40 (brand-name drugs). You will remain in this stage for the remainder of the year.

Your Medicare Explanation of Benefits (EOB) – To help you track your coverage stages, you will receive an EOB directly from Express Scripts for any months during which you use your benefit.

Is this Medicare Part D Plan “creditable coverage?”

Yes, this Medicare Part D plan is considered creditable coverage because the benefit is at least as good as Medicare’s basic benefit. This means that if you terminate this prescription drug coverage and enroll in another Part D plan with less than a 63-day break in coverage, you will not pay any additional premium amount based on the time you were covered under this plan.

What do I need to do to ensure that my existing prescriptions transition to my new Medicare Part D coverage in the State Retiree Health Benefits Program when I move to the Advantage 65 or Advantage 65 with Dental/Vision Plan?

Check the plan's formulary or contact Express Scripts once your enrollment has been approved by Medicare to determine whether your existing medications are included on your new Part D plan's formulary. You may need to get new prescriptions from your doctor if you want to use Express Scripts' mail service. If your drugs are not included on the formulary, you may wish to discuss possible changes with your doctor or seek an exception.

Will My Out-of-Pocket Prescription Drug Costs Change When I Move to Medicare Primary Coverage?

Yes, as described previously, copayments and coinsurance differ between non-Medicare plans and the Advantage 65 Plans. You must review the drugs you are taking to be sure they are covered on your new plan's formulary, and in which cost-sharing tier, to determine the difference in benefits. Those participants using generic drugs and some brands may realize a decrease in their copayment expense under the Advantage 65 Medicare Part D plan as compared to non-Medicare-coordinating coverage in the state program. However, the cost for non-preferred brands, specialty drugs, non-formulary or non-covered drugs may result in substantial increases.

If you are enrolled in the Healthy Insights Program and receiving designated diabetes, hypertension, or COPD drugs for \$0 copayment, your eligibility for that benefit will terminate upon your move to the Advantage 65 Plan. Check your formulary to determine the cost of these drugs under your Medicare Part D plan.

Are There Drugs That Require Approval in Advance?

Some drugs will require prior authorization from your doctor before the prescription can be filled. These requirements are indicated in the formulary, or you or your doctor may contact Express Scripts Customer Service for additional information.

Are There Drugs That Have Quantity Limitations?

Some drugs do have limitations on quantities dispensed within designated time frames. You or your doctor may check on any quantity limitations by contacting Express Scripts Customer Service. Quantity limitations are also indicated in the formulary.

How do I obtain a formulary?

Upon enrolling in the Advantage 65 or Advantage 65 with Dental/Vision Plans and being approved by Medicare, you will receive a partial formulary as a part of your *Welcome Kit* from Express Scripts. You will receive an update of this partial formulary with your *Annual Notice of Change* from Express Scripts as long as you continue coverage. If you need additional information, you may contact Express Scripts at

1-800-572-4098 or you may check the status of individual drugs by going to www.Express Scripts.com.

May I go to any pharmacy to get my prescriptions filled?

You must use a retail pharmacy that participates in the plan's network. Contact Express Scripts at 1-800-572-4098 to confirm that your pharmacy participates or to identify a participating pharmacy in your area. You will receive a pharmacy directory based on your home address as a part of your *Welcome Kit*. Generally, prescriptions filled at non-participating pharmacies will not be covered. There may be exceptions in emergency situations or if there is no accessible network pharmacy to fill your prescription. Contact Express Scripts Customer Service if you need assistance.

This plan also includes a mail service option. Contact Express Scripts Customer Service for more information.

What is an exception, and how do I request an exception to the formulary?

If you have been prescribed a drug that is not on the plan's formulary, you may request an exception to the formulary by calling 800-935-6103. If Express Scripts determines that it is medically necessary for you to take a drug that is not on the formulary, an exception may be granted. If the exception is approved, you will pay the Tier 3 coinsurance cost, and your out-of-pocket expense will count toward your deductible and your true out-of-pocket expense/catastrophic benefit accrual.

You may also request an exception if you are taking a Tier 3 drug and are unable to take a therapeutic equivalent in Tiers 1 or 2. If the exception is granted, you will pay the Tier 2 co-payment for the Tier 3 drug.

You may also request an exception to quantity limitations.

If exceptions are denied, you may exercise additional appeal levels. Your *Evidence of Coverage* (provided by Express Scripts) will include more information about appeal processes that are available.

Generally, exceptions will not be granted for excluded drugs, but contact Express Scripts Customer Service if you need additional information.

What is Express Scripts Medicare?

Express Scripts Medicare for the Commonwealth of Virginia Retiree Health Benefits Program is the name of the enhanced Medicare Part D plan that is available to eligible state program participants. It is administered by Express Scripts. Please be aware that Express Scripts offers an Express Scripts Medicare Plan that is not associated

with the state program, so be sure that you have identified the coverage that is brought to you by the Commonwealth of Virginia Retiree Health Benefits Program when you are seeking plan information.

Are any drugs excluded from coverage?

Medicare excludes the following categories of drugs from Medicare Part D plan coverage:

- Drugs for anorexia, weight loss or weight gain
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs for symptomatic relief of cough and colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered part D drugs)
- Non-prescription drugs, also known as over-the-counter drugs
- Drugs for treatment of sexual or erectile dysfunction
- Over-the-counter diabetic supplies
- Federal Legend Part B medications such as oral chemotherapy agents

These drugs are not covered under the state program's Part D plan, and the cost of these drugs will not count toward your deductible or catastrophic benefit accrual. You will usually not be granted an exception for excluded drugs, but contact Express Scripts Customer Service if you need additional information.

If I become eligible for Medicare, enroll in the Advantage 65 Plan and then find that drugs that I am already taking are not on the formulary, what are my options?

You may want to discuss this with your doctor to determine if there are generic or therapeutic equivalent drugs that are included on the formulary and will meet your needs. However, if your doctor indicates that the non-formulary drug is the only appropriate medication for your individual circumstance, you may request a coverage review. If a formulary exception is approved, you will get the Tier 3 benefit for the approved drug.

Tiering exceptions may also be available. For example, you may request an exception for a Tier 3 drug and, if determined to be medically necessary, pay the Tier 2 co-payment for the Tier 3 drug. However, there are generally no exceptions for excluded drugs. Also, exceptions will not generally be granted for drugs in Tier 4 or moving drugs into Tier 1. If your exception is denied, there are additional appeal levels available to you. See your *Evidence of Coverage* for more information on coverage reviews, exceptions and appeals, or contact Express Scripts at 800-935-6103.

If there is a generic equivalent to your prescribed drug, your network pharmacy will automatically dispense the generic unless your doctor has indicated that the brand prescription may only be dispensed as written.

Some drugs that are not covered under Medicare Part D are covered by Medicare Part B in certain circumstances. These could include durable medical equipment supply drugs, drugs furnished incident to a physician service, immunosuppressant drugs, oral anti-cancer drugs, oral anti-emetic drugs, erythropoietin, prophylactic vaccines or parenteral nutrition. Contact Medicare for more information.

How Can I Reduce My Out-of-Pocket Expense for Prescription Drugs?

Use generic drugs. Covered generic drugs are in Tier 1 and have the lowest co-payment level. The Centers for Medicare and Medicaid Services indicates that, “The Food and Drug Administration ensures that a generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken, and the way it should be used. Generic drugs use the same active ingredients as brand-name drugs and work the same way. This means they have the same risks and benefits as the brand-name drugs.”

If your doctor prescribes a brand-name drug when there is a generic equivalent available, network pharmacies will automatically give you the generic version unless your doctor has indicated that you must take the brand drug.

Use the Mail Service. Tier 1 and 2 copayments are lower if you order your maintenance prescriptions through Express Scripts’s mail service pharmacy. Contact Express Scripts at 1-800-572-4098 if you need additional information or enrollment materials for this program.

Use Network Pharmacies. Except in emergencies, you will not be covered if you fill your prescriptions at a non-participating pharmacy.

Check Your Formulary. When you go to the doctor, take your formulary with you so that your doctor will know what drugs are covered and most cost-effective for you. However, if it is not possible to prescribe a formulary drug, remember that there are exception/appeal processes available to you.

Compare Plans. There are a number of non-state-program plans available to Medicare beneficiaries. Compare formularies, benefits and premium cost to determine what plan is best for you. However, if you leave the state program’s Medicare Part D plan, you may not return in the future.

Is the Mail Service Pharmacy Safe?

Prescriptions ordered through Express Scripts' mail service are delivered in protective shock and tamper-resistant packages with no indication that medications are enclosed. Dispensing systems are utilized to assist pharmacists in filling each prescription accurately and efficiently. The mail service uses the same database to verify eligibility and monitor drug utilization as the retail pharmacies, and it is subject to the same degree of regulation and scrutiny as retail pharmacies.

The Express Scripts mail service has developed special processes for handling and shipping medications that are temperature sensitive.

Express Scripts has identified those medications that may lose potency when exposed to extreme temperatures. While housed in Express Scripts pharmacies, medications that are sensitive to heat are kept in refrigerated areas, and when mailed, they are placed in special insulated packages with gel packs designed to maintain the correct temperature.

Certain controlled medications will not be available through the mail service.

Are My Diabetes Supplies Covered Under My Prescription Drug Program?

Syringes are covered under the Advantage 65/Medicare Part D prescription drug benefit. They fall under Tier 2, so you would not pay more than \$25 for up to a 34-day supply at a participating retail pharmacy or \$50 for a 90-day supply through the mail service. Test strips, lancets and blood glucose monitors are covered under Medicare Part B and can be obtained through a Medicare-participating provider of durable medical equipment. Contact Medicare for more information about this Part B benefit. Once Medicare has paid the primary benefit under Part B, you can file for secondary coverage under the Advantage 65 program's medical benefit.

Will I Have A Separate Prescription Drug Card?

Advantage 65 and Advantage 65 with Dental/Vision participants will receive a separate ID card from Express Scripts. Present this card at participating pharmacies to use your benefit. This also applies to grandfathered participants in the Option II plan.

If I choose one of the Advantage 65-Medical Only plans, may I add prescription drug coverage again in the future?

No, once you have dropped or failed to elect Medicare-coordinating prescription drug coverage under the state program, you may not elect it in the future. As a Medicare

beneficiary, you may choose from other Medicare Part D plans that are available to all Medicare beneficiaries. Contact Medicare for additional information.

It is important to maintain Medicare Part D or other creditable coverage once you are eligible. If you are eligible but fail to enroll in Medicare Part D or other creditable coverage for 63 or more days, you will have to pay more for Part D coverage when you do enroll, and the increase will be forever. (Veterans benefits and TRICARE are creditable.) Also, there may be limited opportunities to enroll, so be sure to exercise your rights immediately upon eligibility.

Do I need to notify Medicare about my Medicare Part D coverage under the Advantage 65 Plan?

When you enroll in the Advantage 65 Plan or the Advantage 65 with Dental/Vision Plan, the state program will automatically submit your Part D enrollment to Medicare since the outpatient prescription drug coverage offered under these plans is a Medicare Part D plan. If you are eligible for Medicare at the time of your retirement (or start of long-term disability or survivor coverage), be sure to contact the Social Security Administration at 1-800-772-1213 and Medicare at 1-800-MEDICARE to advise of your change in employment status (or that you are no longer covered based on current, active employment). If Medicare is not aware that you are no longer covered by your health plan based on current employment (or your spouse's current employment), Medicare may not assume primary responsibility for your claims. You may also contact the Medicare Coordination of Benefits contractor to confirm that your employment status is accurate with Medicare. See page 12 for contact information.

Can I enroll in more than one Medicare Part D plan?

You may not be enrolled in more than one Medicare Part D plan at a time. If you are enrolled in the state program's Medicare Part D coverage and then enroll in another, non-state-program-sponsored Medicare Part D plan (including any employer plan that receives the Medicare retiree drug subsidy), you will be disenrolled from the state's enhanced plan and moved to medical-only coverage. If you do not notify the state program of your other election, Medicare will do so. Once disenrolled from the state's Part D plan, you may not re-enroll at any time in the future.

If you enroll in a Part D plan that is not a part of the state program before you are submitted for the state program's Part D plan, your enrollment in the state plan will result in your disenrollment from the other coverage.

Be sure not to allow multiple enrollments to result in termination of coverage that you may wish to keep.

Are there other reasons for disenrollment from the state program's Medicare Part D plan?

Initially, enrollment in the state's enhanced Medicare Part D plan for outpatient prescription drug coverage is contingent upon approval by the Centers for Medicare and Medicaid Services. The State Retiree Health Benefits Program must remove prescription drug coverage from the plan of any participant whom Medicare has advised is not eligible for coverage. This could be due to conflicting coverage in another Medicare Part D plan, loss of eligibility for Medicare, or any reason determined by Medicare. If Medicare disenrolls you from the state program's Medicare Part D plan, you will be moved to either the Advantage 65—Medical Only Plan or the Advantage 65—Medical Only Plan with Dental/Vision (depending on your existing dental/vision enrollment status). There are no medical-only plan options under the Medicare Supplemental/Option II Plans.

How can I assure that my Medicare Part D coverage is approved?

Only Medicare can determine your eligibility for Medicare Part D; however, following are a few steps to take that will foster a successful enrollment:

- Be sure that you have enrolled in Medicare Parts A and B. While entitlement to either creates eligibility for Part D, the state program requires enrollment in A and B (the Original Medicare Plan) to properly coordinate with Advantage 65. Your Medicare coverage should be in place on the date of your move to retiree group coverage or on the date of your Medicare eligibility if you are already enrolled in the retiree group.
- Confirm that your name, date of birth and Medicare Claim Number, as they appear on your red, white and blue Medicare ID card, match the information on your retiree group enrollment form. If the information submitted by the state program does not match Medicare's, it may result in denial of your Medicare Part D coverage. If you have not received your Medicare ID card, confirm this information when you enroll in Medicare. Submission of an incorrect Medicare claim number can result in loss of eligibility for this Medicare Part D plan. If you are contacted by Express Scripts or Medicare regarding your claim number, you must respond immediately.
- Be sure that Medicare knows that you are no longer going to be covered based on current employment (or the current employment of your spouse).
- If you wish to get your Medicare Part D coverage through the state program, DO NOT enroll in another Part D plan. Enrollment in other Part D coverage (including Medicare Advantage plans that include drug coverage) will generally result in your disenrollment from the state program's Part D plan. If you are disenrolled by Medicare from the state program's Medicare Part D plan, you may not re-enroll.

I am enrolled in the Option II Plan. Do I have prescription drug coverage?

Participants who are grandfathered in the Option II or Option II with Dental/Vision Plans have the same Medicare Part D prescription drug coverage as participants in the Advantage 65 Plans (contingent upon Medicare approval). Option II participants who wish to get prescription drug coverage through a non-state-sponsored plan may elect the Advantage 65—Medical Only or Advantage 65—Medical Only with Dental/Vision plan. However, once prescription drug coverage under the state program is terminated, it may not be elected at any time in the future. There is no medical-only Option II plan available. Option II participants who drop or are otherwise disenrolled from the state program’s Medicare Part D plan will be moved to medical-only coverage under Advantage 65.

State Retiree Health Benefits Program Prescription Drug Claims Administrator

Drug coverage administrator for Advantage 65, Advantage 65 with Dental/Vision, Option II and Option II with Dental/Vision	Call or Visit the Web Site:
Express Scripts Medicare, Medicare Part D for the Commonwealth of Virginia Retiree Health Benefits Program	Express Scripts Customer Service: 1-800-572-4098 www.Express-Scripts.com Exceptions/Coverage Determinations/Appeals: 1-800-935-6103

Listed below are resources for Medicare information:

For Medicare Information	Call or Visit the Web Site
Medicare	1-800-MEDICARE www.medicare.gov
Social Security Administration	1-800-772-1213 www.ssa.gov
Medicare Coordination of Benefits (COB) Contractor	1-800-999-1118