2016 EDITION

A Guide to Choosing a Medicare Advantage Plan

Using the Plan Finder

A complete video program presented by Medicare expert,

Diane J. Omdahl, RN, MS

Customized for i65

"A Guide to Choosing a Medicare Advantage Plan: Using the Plan Finder"

A complete video program presented by Medicare expert, Diane J. Omdahl, RN, MS

This video and supplemental materials serve as a guide to enrolling in Medicare and choosing a health and/or drug plan. In the preparation of this information, *65 Incorporated* has made every effort to include the most correct, current, and clearly expressed information possible. Actual decisions about Medicare coverage depend on the individual's exact circumstances, supporting facts, regional variations, and any future changes.

65 Incorporated encourages those watching this video to contact Medicare (1-800-MEDICARE) or Social Security (1-800-772-1213) for guidance related to their specific situations. *65 Incorporated* disclaims any responsibility for any misunderstanding on the part of viewers.

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About 65 Incorporated

65 Incorporated is an innovative consultative resource to guide you and your family through the Medicare planning process.

Founded in Milwaukee in 2012 by registered nurse and nationally-known Medicare expert Diane J. Omdahl and her daughter, Melinda Caughill, *65 Incorporated* provides you with fast, simple, expert and unbiased Medicare information.

- *Fast: 65 Incorporated* gives you the precise information you need to make the best Medicare decisions — *without hours of painstaking study*.
- *Simple:* Through our consultations or self-guided software, all you have to do is answer a series of easy-to-understand questions to get individualized, step-by-step Medicare guidance.
- *Expert:* Over the last 30+ years, Diane J. Omdahl, RN, MS, has helped our nation's homecare agencies comply with ever-changing Medicare regulations. Now she uses her expertise to help you — the Medicare consumer.
- *Unbiased: 65 Incorporated* makes no money from the sale of insurance products. We are paid on a fee-for-service basis, working directly for you. So, our guidance is always in YOUR best interest.

It's also important to note that *65 Incorporated* is not (nor do we want to be) endorsed by the government.

About Diane J. Omdahl, RN, MS

For more than 30 years, Diane has kept her finger on the pulse of ever-changing Medicare regulations. She's a registered nurse who launched her first company in the basement of her home and grew it into the nation's leading provider of Medicare-related training for home health agencies.

Over the years, Diane has delivered more than 400 Medicare-related audio conferences and 100 in-depth two-day seminars, making her a very experienced and highly-rated speaker.

Today, through her company, *65 Incorporated*, Diane uses her vast wealth of Medicare experience and expertise to provide Baby Boomers and seniors with unbiased, individualized Medicare enrollment guidance through fee-for-service consultations and online software.

She's been featured in publications such as Forbes, The Wall Street Journal Market Watch, CBS MoneyWatch, Kiplinger, American Journal of Nursing, and more. To read the articles featuring Diane, please visit *www.65incorporated.com/press*.

Program Objectives:

Through this video program, you'll learn:

- What Medicare Advantage is
- The different types of Medicare Advantage plans
- The three critical factors in choosing a Medicare Advantage plan
- How to use the Medicare Plan Finder (available at *www.Medicare.gov*)
- How to understand and compare the coverage details of various plans
- The four payment stages of prescription drug coverage
- What the Part D prescription drug coverage gap is and how it affects you

PLEASE NOTE:

- The plan data presented in this video program are fictionalized. Be sure to utilize the information on your own computer screen.
- The costs shown in the Plan Finder are estimates. They are not what you may actually spend.
- Between January and October, information displayed on the Plan Finder is for plans of the current year. Beginning October 15th, the Plan Finder features data for plans that take effect on January 1st of the next calendar year.

Before Watching the Video:

To make the most of this program, please complete the following before starting the video:

- Review the Preface of this booklet
- Gather all prescription medications you take
- Print the Plan Comparison Worksheet
- Point your web browser to *www.Medicare.gov* and wait for Diane to begin her step-by-step guidance in the video

Preface

IMPORTANT:

Please review this section before watching the video to ensure you have an understanding of basic Medicare terms.

Parts of Medicare

Comprehensive Medicare coverage includes three parts:

- *Part A, hospital insurance:* This part of Medicare helps cover the costs of inpatient care in hospitals and skilled nursing facilities, as well as hospice and home health care.
- *Part B, medical insurance:* Part B covers the services that are necessary to diagnose and treat medical conditions. These include doctors' visits, outpatient care, emergency department care, equipment needed in the home, and preventive care, including vaccinations. Anyone who qualifies for Part A is also eligible for Part B.
- *Part D, prescription drug plan:* This is drug coverage provided and administered by private insurance companies. You will learn more about Part D in Video #3 of this series.

The three parts of Medicare come together into two paths. Choosing a path will very likely be the most important Medicare decision you make. This video series focuses on the path of Medicare Advantage, but it's important to understand Original Medicare as well.

- *The Path of Original Medicare*
  Also known as Traditional Medicare, this is the version of Medicare that your parents and grandparents had. On this path, the Federal Government administers Parts A and B are administered by the federal government and you can add Part D drug coverage through a stand-alone plan. For comprehensive coverage, beneficiaries with Original Medicare add a Medicare Supplement insurance plan, also known as a Medigap policy. This is health insurance sold by private companies to fill gaps in coverage of Original Medicare which include Part A and Part B deductibles, coinsurance, and copayments for hospitalization, skilled nursing facility stays, physician visits, equipment, and more.

TIP: You know you have Original Medicare if you use your red, white and blue Medicare card when checking in for a medical appointment.

Additional Resources:

- Medicare.gov www.medicare.gov/what-medicare-covers/index.html
- "Medicare Basics," Centers for Medicare and Medicaid Services, www.medicare.gov/pubs/pdf/11034.pdf

Follow Along With Program

VIDEO #1

The Path of Medicare Advantage (Part C)

Medicare Advantage is Medicare provided by private insurance companies. These plans must provide Medicare Part A and Part B services. Beneficiaries must elect a plan and pay the Part B premium. Once enrolled in a plan, members deal with the insurance company, not the government.

A Medicare Advantage plan that provides prescription drug coverage is known as a MA-PD plan.

TIP: You know you have a Medicare Advantage plan if you use your insurance card when checking in for a medical appointment.

Important Medicare Terms

Other important Medicare terms to become familiar with before you begin the video program include:

- *Creditable Drug Coverage*
  Drug coverage that is considered at least as good as that of the standard Medicare prescription drug plan. This means the drug plan will pay at least as much as the standard Medicare plan. Those who have creditable drug coverage can delay purchasing a Medicare Part D plan until that coverage ends without facing a Late Enrollment Penalty.
- *Coinsurance*
  A predetermined percentage of the total cost of a medication or medical service, such as 10% or 40%, that the plan member pays out-of-pocket.
- *Copayment*
  A predetermined amount that a plan member will pay out-of-pocket for medications or services, such as $5 or $45.

BONUS INFORMATION:

Choosing Your Coverage

Before choosing your Medicare path, it's crucial that you familiarize yourself with Medicare and the enrollment process as it applies to

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TIP: Do not pick plans based solely upon the recommendation of others. A plan that works well for a friend or spouse may not work for you.

If it's important to see the same doctor's you've seen for years, confirm that they are in a plan's network.

you. Engaging an expert in a one-on-one consultation or utilizing an unbiased software system such as *i65* can help you find the right Medicare coverage for your unique needs while avoiding costly enrollment mistakes.

When making your decisions, consider the following questions:

- How is your health?
- What doctors/specialists do you see?
- What medications do you take?
- What pharmacies do you prefer to use?
- How much can you afford to pay in monthly premiums or out-of-pocket costs?
- What healthcare services are most important to you?
- Do you have healthcare coverage you would like to keep?

It's also important to remember that your health, financial and lifestyle needs are unique. A plan that works well for someone else may not work for you. Do not allow an agent or friend to choose a Medicare plan for you without researching a plan's cost, quality and coverage. Also realize that an agent may not sell the plan that will work best for you.

VIDEO #2

Network

1. Medicare Advantage plans use a defined list of healthcare providers that members (those enrolled in the plan) must use.
2. Some types of plans will pay for out-of-network services only in an emergency.
3. Other plans will cover out-of-network services, but they can cost more.

Types of Medicare Advantage Plans

There are several types of Medicare Advantage Plans.

1. *Health Maintenance Organization (HMO)*
   - Requires a member to select a primary physician who will coordinate care.
   - Usually requires a referral to see a specialist.
   - May not pay for care outside the network.
2. *Health Maintenance Organization with a Point-of-service option (HMO-POS)*
   - Works with networks.
   - However, members can choose to see any doctor or provider that accepts Medicare, but they will probably pay more.
3. *Preferred Provider Organization (PPO)*
   - A network of preferred providers under contract for services.
   - However, members may choose any doctor or provider who accepts Medicare, whether in-network or out.
   - A local PPO has a small service area, such as a county or part of a county.
   - A regional PPO has a contracted network that serves an entire region or regions and includes many more providers in its network.
4. *Private fee-for-service Plan (PFFS)*
   - Urban area plans usually have a network; however, members do not have to use it.
   - Members can see any Medicare-approved provider who has agreed to accept the plan's terms, but they will pay up to 15% more than in-network care.
5. *Special Needs Plan (SNP)*
   - For those with chronic conditions, living in a nursing home, or dual-eligible beneficiaries (qualify for both Medicare and Medicaid).

Diane's Tips:

- If you see specialists, consider an HMO-POS or PPO plan.
- If you travel, consider a PPO or PFFS plan.
- If you have a chronic condition, consider an SNP.

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6. Medical Savings Account Plan (MSA)

- Two parts: a health insurance policy with a high deductible (up to $6,000), and a medical savings account to help pay the deductible.
- Only the Medicare Advantage plan can contribute to the medical savings account.

7. Medicare Cost Plan

- Not considered a Medicare Advantage plan, it is a type of HMO.
- Original Medicare covers out-of-network services.

VIDEO #3

Part D Prescription Drug Coverage

Medicare Part D is drug coverage provided and administered by private insurance companies. Part D covers brand-name and generic prescription medications and insulin. Each plan determines the medications it will cover and the costs.

This type of coverage is optional; however, if you delay Part D enrollment, you can face a late enrollment penalty if you want this coverage at a later time.

Creditable Drug Coverage:

This is any type of drug coverage (such as through an employer group health plan or retiree plan) that is considered at least as good as that of the standard Medicare prescription drug plan, meaning the drug plan will pay at least as much as the standard Medicare plan. Those who have creditable drug coverage can delay purchasing a Medicare Part D plan until that coverage ends without facing a Late Enrollment Penalty.

Part D Enrollment Penalty:

If you don't have creditable drug coverage and put off enrolling in a Part D prescription drug plan, you'll face a late enrollment penalty—paying more for drug coverage for life. The late

The Part D penalty is 1% of the national base premium for a Part D plan for every month without credible drug coverage. In 2016, the national base premium is $34.10.

enrollment penalty is calculated as 1% of the cost of Medicare's standard drug plan for each month of delayed enrollment. This penalty is added to your monthly drug plan premium for the rest of your life.

Important Considerations for Choosing a Plan

1. *Coverage: Does the plan cover the services and medications you need?*
   - Check out the plan's network of providers, drug formulary, and network of preferred pharmacies.
   - Determine how the drug plan's coverage rules—quantity limit, step therapy, and prior authorization—will affect your medications.
   - Identify a MA-PD's rules for authorization of services.
2. *Cost: How much will you spend out of your pocket for services and medications?*
   - Go beyond the premiums. Check the deductibles, copayments, and coinsurance for the services and drugs you'll need.
3. *Quality: What will it be like to work with this plan?*
   - Pay attention to the overall star rating for the plan.
   - Check out important points such as customer service and complaints.

BEFORE MOVING FORWARD

Please take a moment now to complete the following:

- Gather your prescription medications
- Print the "Medicare Advantage Plan Benefits & Costs Comparison Worksheet" (pages 21-22)
- Point your web browser to www.medicare.gov

The Plan Finder is at *www.medicare.gov*

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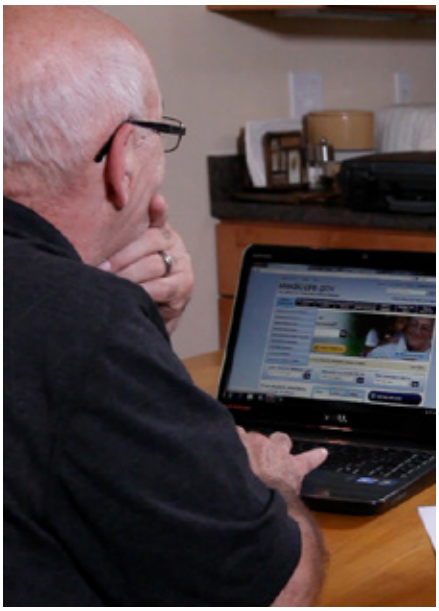

VIDEO #4

The Medicare Plan Finder

At *www.medicare.gov*, Medicare offers a free tool to help you evaluate and choose different types of Medicare plans.

In the next two videos of this series, Diane will walk you through the four steps of using the Plan Finder.

STEP 1 of 4: Enter Information

- *Enter the zip code of the area that you would like to compare plans.* If you have homes in more than one location, use the zip code that you consider to be your permanent residence.

  Please note: The Plan Finder will only show you plans available in that zip code.

- *Question: "How do you get your Medicare Coverage?"* If you are not yet enrolled in Medicare, choose the answer "I don't have any Medicare coverage yet." Otherwise, select the option that best matches your situation.
- *Question: "Do you get help from Medicare or your state to pay your Medicare prescription drug costs?"* Choose the option that most accurately describes you.

If you need help paying for Medicare, download a free PDF resource to learn about financial assistance programs available to you at *www.medicare.gov/Pubs/pdf/10126.pdf*

STEP 2 of 4: Enter Your Drugs

- If you do not take any prescription medications, you may click on the button "I don't take any drugs."
- **If you do take prescription medications, it's important to enter all prescribed medications.** This will allow you to identify the plans that most cost-effectively cover your drugs. Failing to enter even one medication could lead you to pick the wrong plan and cost you thousands of dollars out-of-pocket.

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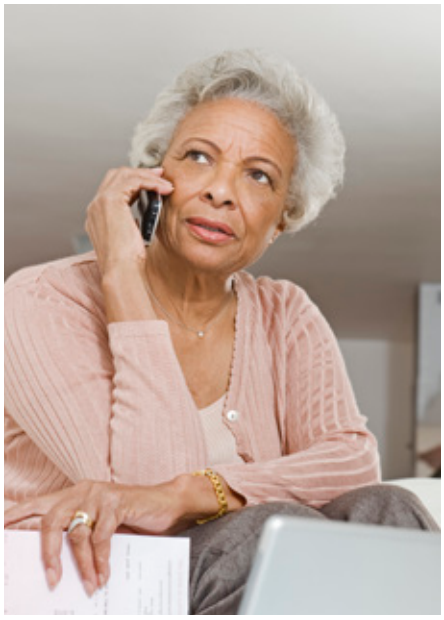
- If you'd like to save your drug list for later use, write down the "Drug List ID" and "Password Date" that appear after you've entered your first drug.

STEP 3 of 4: Select Your Pharmacies

- Select one or two preferred pharmacies. If your preferred pharmacy does not appear in the default listing, try increasing the radius from your zip code.
- In step 4, you'll learn whether these pharmacies are in a plan's network.
- You may not select more than two pharmacies. However, you can step through the Plan Finder multiple times selecting different pharmacies.



VIDEO #5

STEP 4 of 4: Refine Your Results

The first page you'll see on this step is a summary page showing you how many plans of each type are available in your zip code.

- Check the box for "Medicare Health Plans with drug coverage."
- If you'd like to only see those plans that include all of your medications in their formularies, click on the "+" next to "Select Drug Option" in the left hand column. From the options that appear, check the box next to "Have all my drugs on formulary." Please note: If no plan contains all of your medications on their formularies, you may return to this step and uncheck this box.

On the second page, you'll find a list of the results. The plans listed are presented in order of their lowest estimated health and drug costs.

- Select up to three plans to run a side-by-side comparison.

VIDEO #6

On the next page in the Plan Finder, you'll get a list of results presented in order of their lowest estimated health and drug costs.

- Select up to three plans to run a side-by-side comparison.

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The maximum out-of-pocket limit in 2016 is $6,700.

TIP: Determine if your physicians are in a particular plan's network by calling the plan's customer service telephone number or visiting the plan's website.

A copayment is a fixed dollar amount.

A coinsurance is a specific percentage of the cost of the service or medication.

- Begin using the "MA-PD Plan Benefit and Cost Comparison Worksheet" on page 21-22 of this guide.

Comparing Health Plan Benefits

- *Premium:* The monthly charge a plan member pays for the drug plan. The standard premium in 2016 is $34.10, an amount that very few drug plan members will actually pay. Each plan determines its own premium; some plans do not charge one.

- *Out-of-Pocket Spending Limit:* This limit applies to beneficiaries with Medicare Advantage plans. This is the maximum amount a beneficiary will have to pay out-of-pocket for Part A and Part B services in that particular plan during the calendar year. Medicare set a ceiling on this amount of $6,700, but each Medicare Advantage plan establishes its own limit.
  The out-of-pocket spending limit does not include premiums or prescription medications.
  Original Medicare doesn't have an out-of-pocket spending limit.

Click on "View More Detailed Cost & Benefit Information" to review out-of-pocket costs for specific services under a specific plan.

- *Authorization of Services:* Be on alert for authorization rules. These rules require you to get the approval from the insurance company before the plan will pay for certain medical services or supplies. In some cases, a plan may refuse to cover services. You will have an opportunity to appeal these decisions, but such battles are time-consuming and can delay needed medical services.

- *In-Network and Out-of-Network Costs:* At this point, it's important to determine if your physicians are in a plan's network. For some plans, you will not be able to see providers out-of-network. Other plans may allow you to see these providers but will require you to pay higher copays or coinsurance.

Follow Along With Program

VIDEO #7

Drug Costs & Coverage

Click on the tab "Drug Costs & Coverage" to review a plan's specific coverage of prescription medications.

Drug Coverage Rules

These are requirements that plans put into place to control use of medications for safety or cost reasons. These rules can make it difficult to receive a needed medication.

- *Quantity limit:* The drug plan limits the number of pills in a prescription, the number of prescriptions in a month, or the dosage strength.
- *Step therapy:* Before prescribing a certain medication, the physician must order a less expensive but proven effective medication. If the patient experiences any problems, the physician can then order the more costly drug.
- *Prior authorization:* The physician must obtain approval before writing the prescription.

Drug Coverage Tiers

A tier is a level or grouping of medications for cost purposes. Medicare limits plans to six tiers, but most plans only use five. The higher the tier, the more costly the medication will be.

- *Tier one:* Preferred generic drugs
- *Tier two:* Non-preferred generic drugs
- *Tier three:* Preferred brand-name drugs
- *Tier four:* Non-preferred brand-name drugs
- *Tier five:* Specialty medications

When you can, try to avoid plans with many drug coverage rules, especially those with step therapy or prior authorization requirements.

The higher the tier, the more you will have to pay out-of-pocket for a particular medication.

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VIDEO #8

Drug Plan Payment Stages

Over the course of a year, you can pay up to four different prices for a single prescription medication. In each of the four payment stages, the amount you pay changes based upon how much the insurance company pays or how much of a discount you receive.

In 2016, the standard deductible amount is $360.00.

The initial coverage amount is $738.00 in 2016.

The Part D drug payment stages are as follows:

- *Stage One – Deductible:*
  Your out-of-pocket costs in this stage can range from nothing up to the Medicare standard amount.
- *Stage Two – Initial Coverage:*
  In this stage, you pay 25% of the cost of your medications up to the Medicare dollar limit. Some plans charge a set copayment or a coinsurance in this stage.

Drug discounts apply to medications when in the Coverage Gap. In 2016, the discounts are 55% of brand-name drugs and 42% for generic medications.

- *Stage Three – Coverage Gap (donut hole):*
  The insurance company providing your Part D coverage does not pay anything toward medications although some plans may provide additional coverage on some medications in this stage.

  Beginning in 2011, the Federal Government established discounts for medications filled while in the coverage gap. In 2016, people in the donut hole receive a 55% discount on brand-name drugs and a 42% discount on generic medications. When total drug costs reach $4,850 in 2016, a beneficiary moves on to the last payment stage.

Only about 3% of all drug plan members spend enough to reach Catastrophic Coverage.

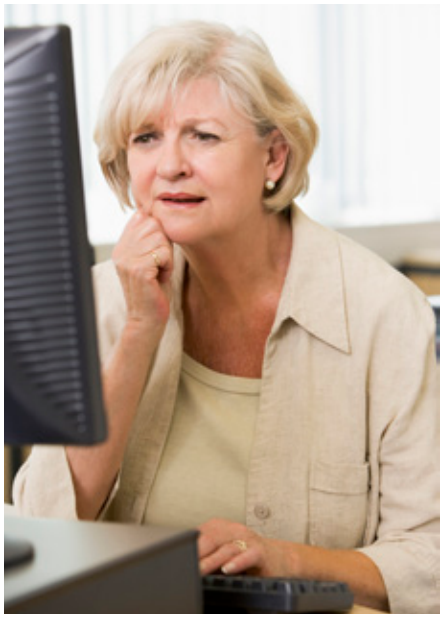
- *Stage Four – Catastrophic Coverage:*
  In this stage, you pay nominal charges for medications. In 2016, you'll pay the greater of 5% of the total cost or $7.40 for brand-name and $2.95 for generic medications while in this stage.

To view the cost of your medications by payment stage, click on "View Drug Cost Summary."

Follow Along With Program

VIDEO #9

Quality Ratings



To compare the quality of plans, click on the "Plan Ratings" tab.

- Medicare uses a five-star rating system to display quality results with 5 stars being an excellent plan and a 1-star plan being poor.
- Medicare evaluates drug plans on customer service, complaints and problems, members' experiences with the plan, and plan pricing and safety.
- Ratings for health plans address managing chronic conditions, plan responsiveness, complaints, and much more.

Important Quality Rating Icons

5-Star Rating Icon:

- Only a handful of plans receive this icon.
- You can enroll in a 5-star plan at any time during the year.

Consistently Low Performer Icon:

- You cannot enroll online in a plan with this icon. You must call the plan directly.

Enrolling in a Plan

When you choose the plan that is best for your unique needs, you can enroll online by clicking on the "Enroll" button next to your plan's listing on the Medicare Plan Finder. You may also enroll through an insurance agent who represents your plan of choice or by calling the insurance company directly.

IMPORTANT

Before enrolling in a plan, contact the plan or an agent to confirm the premium and any other critical copays or coinsurances cited on the Plan Finder. In some rare cases, the data presented through the Medicare Plan Finder may not be up-to-date.

Glossary of Terms

Authorization of Services

In some MA-PD plans, you may be required to receive the approval of the insurance company before the plan will pay for specific medical services or supplies. See also *Prior authorization.*

Catastrophic Coverage

The fourth and last payment stage in a Part D prescription drug plan during which the individual pays only a small coinsurance or small copay for a covered drug. The plan pays the rest of the cost for the remainder of the year.

Coinsurance

A percentage of the cost of the service or medication.

Copayment (copay)

A set amount the beneficiary must pay out-of-pocket, no matter the total cost of the service or medication.

Coverage Gap

The third payment stage in a Part D prescription drug plan, commonly known as the "donut hole." The stage starts when total drug costs—including what the beneficiary and the plan have paid for drugs—reach a certain amount since the start of the calendar year. In this payment stage, the individual would be responsible for all costs. There are discounts on medications.

Coverage rules

Requirements that a drug plan puts into place to control use of medications for safety or cost reasons. There are three rules: prior authorization, quantity limit, and step therapy.

Creditable drug coverage

Drug coverage that is considered at least as good as that of the standard Medicare prescription drug plan. This means the drug plan will pay at least as much as the standard Medicare plan. Those who have creditable drug coverage can delay purchasing a Medicare Part D plan until that coverage ends without facing a Late Enrollment Penalty.

Deductible

The amount an individual must pay out-of-pocket until Original Medicare or the Medicare Advantage plan starts to cover its share.

Also the first stage in a Part D prescription drug plan. Depending on the plan, the deductible ranges from nothing up to the Medicare standard amount.

Donut hole

See Coverage Gap

Evidence of Coverage

An agreement or contract between the Medicare Advantage or prescription drug plan and the individual. It explains benefits, coverage, rights, responsibilities, grievances, and appeals.

Formulary

A listing of medications, including generic and brand-name, that a drug plan will cover. Every plan has a different formulary. Generally, the individual would be responsible for any medications that do not appear on the drug plan's formulary.

Glossary of Terms

Initial Coverage

The first payment stage in a Part D prescription drug plan. The individual pays 25% of the cost of medications up to the limit set by Medicare. Some plans choose to charge set copayments or coinsurance during this stage.

In-network pharmacy

A pharmacy that has agreed to the drug plan's terms, conditions, and payments. The plan will cover medications that its members get at an in-network pharmacy.

Late enrollment penalty

1) For Part B

A late enrollment penalty of 10% of the standard Part B premium ($121.80 in 2016) will be added to your Part B premium for each year of late enrollment. This penalty is added to your monthly Part B premium for life.

2) For Part D

This penalty is paid by those who do not have creditable drug coverage and delay enrollment in a Part D drug plan. The penalty is 1% of the average annual Part D base premium ($34.10 in 2016) for every month the beneficiary went without creditable drug coverage. This penalty is added to your monthly Part D premium for life.

MA-PD plan

A Medicare Advantage plan that includes Part D prescription drug coverage.

Medicare Advantage (Part C)

See Part C, Medicare Advantage.

Member

A person enrolled in a Medicare Advantage plan.

Network

A defined list of healthcare providers or facilities, such as hospitals or pharmacies, that members of a Medicare Advantage plan must use.

Original Medicare

Also known as Traditional Medicare. This is a fee-for-service health plan that allows beneficiaries to see any doctor, hospital, or healthcare supplier who participates in Medicare and is accepting new Medicare patients. It has two parts: Part A, hospital insurance, and Part B, medical insurance.

Out-of-pocket spending limit

Applies to beneficiaries with Medicare Advantage plans. The most a beneficiary will have to pay out-of-pocket for Part A and Part B services during the year. Medicare set a limit of $6,700, but each Medicare Advantage plan establishes its own limit. Original Medicare doesn't have an out-of-pocket spending limit.

Part A, hospital insurance

Medicare hospital insurance that helps cover inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.

Part B, medical insurance

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

Glossary of Terms

Part C, Medicare Advantage

A type of Medicare health plan, also known as a Medicare replacement plan, that is offered by a private company under contract with Medicare to provide all Part A and Part B benefits. Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service plans, Special Needs Plans, and Medicare Medical Savings Accounts.

Part D, prescription drug plan

An optional prescription drug insurance program provided by private companies approved by Medicare.

Prescription drug plan (PDP)

A stand-alone prescription drug plan purchased by beneficiaries who have other creditable drug coverage, such as a retiree health plan.

Preferred pharmacy

An in-network pharmacy that offers covered drugs to plan members at lower out-of-pocket costs than what the members would pay at another pharmacy. Not every drug plan has preferred pharmacies.

Premium

The monthly charge a plan member pays for a Medicare Advantage health plan and/or a Part D prescription drug plan. Each plan determines its own premiums; some plans do not charge one.

Prior authorization

A drug plan coverage rule. The physician must obtain consent from the plan before prescribing a certain medication. This may also apply to certain treatments or services in a Medicare Advantage plan. See also *Authorization of services*

Quantity limit

A drug plan coverage rule. The drug plan's rule limits the number of pills in a prescription, the number of prescriptions in a month, or the dosage strength.

Step therapy

A drug plan coverage rule. In most cases, this means that before prescribing a certain medication (usually a very expensive one), the physician must order a less expensive but proven-effective medication. If the individual experiences side effects or other problems, the physician can then "step up" to or order the more costly drug.

Tier

A level or grouping of medications that determines the out-of-pocket cost for those drugs.

"MA-PD Plan Benefit and Cost Comparison Worksheet"

A Medicare Advantage plan comparison tool created by *65 Incorporated*

On the next two pages, you'll find a worksheet that will help you compare various Medicare Advantage plans.

Please feel free to print out this worksheet and use it as you make your plan comparisons.

However, this worksheet is protected by copyright law that prohibits reproduction without the permission of the copyright owner.

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MEDICARE ADVANTAGE PLAN BENEFITS & COSTS COMPARISON WORKSHEET

Sixty-Five INCORPORATED

		PLANS TO COMPARE				
		CURRENT PLAN		ALTERNATIVE #1	ALTERNATIVE #2	ALTERNATIVE #3
		CURRENT YEAR 20____	NEXT YEAR 20____	NEXT YEAR 20____	NEXT YEAR 20____	NEXT YEAR 20____
Cost	HEALTH PLAN	**HEALTH PLAN COSTS**				
		Total monthly premium				
		Deductible				
		OUT-OF-POCKET LIMITS				
		In-network				
		Out-of-network				
		OPTIONAL COVERAGE COSTS				
		Vision				
		Dental				
		MEDICAL COVERAGE COSTS				
		Inpatient hospital stay				
		Doctors				
		Office visit				
		Urgent care				
		Specialist				
		Outpatient surgery				
		Emergency care				
		Ambulance				
		Urgently needed care				
		Outpatient therapy				
		ADDITIONAL BENEFITS I MAY NEED:				
	DRUG PLAN	**DRUG PLAN COSTS**				
		Total monthly premium				
		Deductible				
		ESTIMATED DRUG COSTS				
		Retail pharmacy				
		Mail order				

MEDICARE ADVANTAGE PLAN BENEFITS & COSTS COMPARISON WORKSHEET

Sixty-Five INCORPORATED

			PLANS TO COMPARE				
			CURRENT PLAN		ALTERNATIVE #1	ALTERNATIVE #2	ALTERNATIVE #3
			CURRENT YEAR 20____	NEXT YEAR 20____	NEXT YEAR 20____	NEXT YEAR 20____	NEXT YEAR 20____
Quality		**PLAN QUALITY RATINGS**					
		Overall plan rating	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
		Health plan rating	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
		Drug plan rating	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Coverage	HEALTH PLAN	**DOCTOR & HOSPITAL NETWORK**					
		My doctors are in-network	Yes No	Yes No	Yes No	Yes No	Yes No
		My specialists are in-network	Yes No	Yes No	Yes No	Yes No	Yes No
		My hospital(s) are in-network	Yes No	Yes No	Yes No	Yes No	Yes No
	DRUG PLAN	**BENEFITS IN COVERAGE GAP**					
		For generic drugs	Yes No	Yes No	Yes No	Yes No	Yes No
		For brand name drugs	Yes No	Yes No	Yes No	Yes No	Yes No
		DRUG FORMULARY					
		All prescriptions are included	Yes No	Yes No	Yes No	Yes No	Yes No
		RESTRICTIONS					
		Quantity limit	Yes No	Yes No	Yes No	Yes No	Yes No
		Step therapy	Yes No	Yes No	Yes No	Yes No	Yes No
		Prior authorization	Yes No	Yes No	Yes No	Yes No	Yes No
		PHARMACY NETWORK					
		My pharmacy is in-network	Yes No	Yes No	Yes No	Yes No	Yes No

NOTES: _____