TO: Outreach Partners and Interested Parties

FROM: ***Prescription Advantage***

Date: November 23, 2015

BULLETIN

This bulletin is one in a series of routine updates regarding Prescription Advantage. These notices are designed to inform a broad network of outreach partners and other interested parties about Plan updates affecting both current and future Plan members.

2016 Plan Benefit Letters

This week Prescription Advantage will begin mailing letters to all members that explain the benefits for Plan year 2016. Each member will receive a letter that is specific to that member's category.

.

Attached:

- Sample letter – Medicare member – Category S2
- Sample letter – non-Medicare member – Category 2

November 2015 ID Number: <ID Number>

<FName> <LName>
<ARFName> <ARLName>
<AddressLine1> <AddressLine2>
<City>, <State> <Zipcode>

Dear <FName> <LName>:

This letter provides information about your 2016 Prescription Advantage benefits. Your benefits are based on membership category and information we receive from Medicare.

Your current Prescription Advantage Membership Category is **S2.**

Your Prescription Advantage benefits begin when the total cost of your covered prescription drugs in calendar year 2016 reaches **$3,310.** Total cost is the amount your drug plan pays and the amount you pay in co-payments for prescription drugs.

- Once your drug costs reach **$3,310**, Prescription Advantage will pay for prescription drugs covered by your drug plan. You will pay the following Prescription Advantage co-payments:
    - No more than $7 for a 30-day supply of generic drugs
    - No more than $18 for a 30-day supply of brand name drugs
- Your benefits also include an annual out-of-pocket spending limit of **$1,765**. This means that once you spend **$1,765** in co-payments, you will pay **$0** for covered drugs.
- As a member of Prescription Advantage, you are entitled to a one-time Special Election Period (SEP) each year that allows you to join or change a Medicare drug plan outside of Medicare's open enrollment period.

To receive coverage from Prescription Advantage, you must be enrolled in a Medicare Part D plan, a Medicare Advantage plan that includes drug coverage, or a plan offering creditable coverage.

Be sure to remind the pharmacist that Prescription Advantage is your secondary prescription drug coverage. Always present your Prescription Advantage card along with your Medicare drug plan or other prescription insurance card when you fill your prescriptions. If you use mail order, you must let your mail order company know that you are a Prescription Advantage member.

If you have questions, please contact Prescription Advantage Customer Service
at 1-800-AGE-INFO (1-800-243-4636) and press 2, or TTY (toll free) for the deaf
and hard of hearing at 1-877-610-0241.

Sincerely,
Prescription Advantage

Helpful Resources

There are organizations available to help you compare Medicare drug plans and to answer questions that you may have about your drug coverage.

- **SHINE** (Serving the Health Insurance Needs of Everyone)
  1-800-AGE-INFO (1-800-243-4636) and press 3; TTY users call 1-800-872-0166
  A SHINE Counselor can also be reached by contacting your local Council on Aging or Senior Center.

- **MCPHS University Pharmacy Outreach Program**
  1-866-633-1617; TTY users should ask the operator to call the MCPHS University Pharmacy Outreach Program toll-free number

- **Medicare**
  1-800-MEDICARE (1-800-633-4227); TTY users call 1-877-486-2048

November 2015 ID Number: <ID Number>

<FName> <MI> <LName>
<ARFName> <ARLName>
<AddressLine1> <AddressLine2>
<City>, <State> <Zipcode>

Dear <FName> <LName>:

The new Prescription Advantage plan year begins on January 1, 2016. This letter explains your 2016 Prescription Advantage benefits.

Prescription Advantage regularly reviews rates paid by members toward premiums, deductibles, and co-payments. Rates are based on gross annual household income and are adjusted as necessary to meet the needs of the Plan and its members.

The following chart explains what your rates will be as of January 1, 2016 based on your membership category. You are currently enrolled in **Membership Category 2.**

With Prescription Advantage, you will pay…	
Monthly Premium	$0
Quarterly Deductible	$0
Co-Payments - 30-day supply purchased at a retail pharmacy Level 1 - Generic Drugs Level 2 - Brand Name Drugs Level 3 - Additional Brand Name Drugs	 $7 $18 $40
Co-Payments - 90-day supply purchased through mail service Level 1 - Generic Drugs Level 2 - Brand Name Drugs Level 3 - Additional Brand Name Drugs	 $14 $36 $80
Annual Out-of-Pocket Spending Limit*	$1,590
*Once the total spending for co-payments reaches **$1,590**, you will not be required to pay anything toward your prescription drugs. Prescription Advantage will cover any co-payments for the remainder of the Plan year for all drugs covered by Prescription Advantage. The Plan year runs from January 1, 2016 through December 31, 2016.	

If the out-of-pocket spending limit creates a financial hardship for you, you may request Reconsideration by completing the enclosed form.

You are responsible for reporting any changes to the information provided in your application such as address changes, income changes, or Medicare status, to Prescription Advantage. Failure to do so may result in termination of your benefits.

If you have any questions, please call Prescription Advantage Customer Service at 1-800-AGE-INFO (1-800-243-4636) and press 2, or TTY (toll free) for the deaf and hard of hearing at 1-877-610-0241.

Sincerely,
Prescription Advantage

Reconsideration of Out-of-Pocket Spending Limit

Upon receipt of this form, Prescription Advantage will review your request. A decision will be made regarding your request within 15 business days of receipt. Please complete all required information and sign where indicated.

"Meeting the $1,590 annual out-of-pocket spending limit creates a financial hardship for me because…" Please check one of the reasons listed below.

☐ **I earn no income and receive financial support from another source.**

☐ **Other** *(Please explain why this annual out-of-pocket spending limit would create a financial hardship for you in the space provided below, or use a separate sheet of paper, if necessary. Include any documentation that would support your claim and be sure to include your signature on the line indicated.)*

____

____

____

X ____ **Date:** ______________

Signature of member (or Authorized Representative if the member is unable to sign)

If you selected **"I earn no income"**, please provide the name and address of the person who provides your financial support.

Name____

Address____

City, State, Zip____

If you are the person financially responsible for the member, please read the following and sign where indicated.

I hereby certify, under the pains and penalties of perjury, that I am financially responsible for the member submitting this form and will provide any documentation to Prescription Advantage that may be requested to substantiate this claim.

X ____ **Date:** ______________

Signature of individual providing financial support for the member