MEDICARE APPROVED PRESCRIPTION DRUG DISCOUNT CARD

This packet contains information about enrolling in a Medicare-approved prescription drug discount card. This discount card can help you save money on your prescription drugs. It is available to people with Medicare who meet the requirements described below. You will need to access the medicare.gov web site, or call 1-800-MEDICARE for information about the drug card companies available in your area. You will need this information to complete your enrollment form.

Am I eligible for the Medicare-Approved prescription drug discount card?

There are **no income restrictions** for the drug discount card. You **are eligible** to enroll in the Medicare-approved drug discount card if:

- You have Medicare, and
- You **do not** have outpatient prescription drug benefits under your State Medicaid Program (your state may call this Medical Assistance).

  Note: If you are enrolled in a state pharmacy assistance program (not Medicaid), you are still eligible.

To enroll in a Medicare-approved drug discount card, complete and send in the enclosed enrollment form (*Enrollment Form for the Drug Discount Card*). Your information will only be used for eligibility and/or payment purposes in a Medicare program.

Am I eligible for a credit of up to $600 in additional assistance in paying for my prescription drugs?

If your income is below a certain level, Medicare may also give you a credit of up to $600 through your membership in a Medicare-approved drug discount card to help pay for your prescriptions as well as pay for your annual enrollment fee, if any. If you qualify, you will be enrolled in the drug discount card and also receive a credit of up to $600 to help pay for the cost of your prescription drugs. Please see the charts on the next page to help you decide if you may qualify.

You may be eligible for a $600 credit to help pay for your prescription drugs if:

- Your income*, plus your spouse's income* (if you are married), is **no more** than the amount listed in the chart below.

State of Residence	Single Person Income	Married Person Income
48 Contiguous States	$12,569	$16,862
Alaska	$15,701	$21,074
Hawaii	$14,445	$19,386

These amounts are for the year 2004

*(*Income includes money that you receive through retirement benefits from Social Security, Railroad, the Federal government, or other sources, and benefits you receive for a disability or as a Veteran, plus any other sources of the type that you would report for tax purposes.)*

If you qualify, you will pay a coinsurance at the pharmacy for each prescription drug, until the credit of up to $600 is used, based on your income as follows:

State of Residence	Single Person Income	Married Person Income	Coinsurance at the Pharmacy
48 Contiguous States	$12,569 or less	$16,862 or less	10%
	$ 9,310 or less	$12,490 or less	5%
Alaska	$15,701 or less	$21,074 or less	10%
	$11,630 or less	$15,610 or less	5%
Hawaii	$14,445 or less	$19,386 or less	10%
	$10,700 or less	$14,360 or less	5%

These amounts are for the year 2004

Important note: If your state helps pay your Medicare part A or part B premiums you may still qualify even if your income is above $12,569 if single or $16,862 if married (see the chart above for amounts in Alaska and Hawaii). Your coinsurance at the pharmacy would be 10%.

You are not eligible to get the $600 credit toward your prescription drugs if you have any of the following:

- Outpatient prescription drug benefits under your State Medicaid Program
- TRICARE (military health insurance)
- FEHBP (health insurance for Federal employees or retirees)
- Other health coverage that includes outpatient prescription drugs, such as employer or retiree plans*.

*(However, if you have health coverage through a Medicare + Choice (M+C) plan, or a Medigap plan, you are still eligible.)

How can I become a member in a Medicare-Approved Drug Discount Card Program?

To become a member of a Medicare-approved drug discount card program, you must complete the enrollment form on the following page titled, ***Enrollment Form for the Medicare-Approved Drug Discount Card***. Please return the completed enrollment form to the sponsor you have selected.

How can I receive the additional assistance of up to $600 in paying for my prescription drugs?

If you think you may be eligible to receive additional assistance in paying for your prescription drugs, according to the income requirements listed on the previous page, you must complete the ***Enrollment Form for the Medicare-Approved Drug Discount Card*** **and** ***Additional Assistance in Paying for Your Prescription Drugs.*** Please complete, sign, and return this form to the Medicare-approved drug discount card sponsor you have selected.

If I apply for a Medicare-approved discount drug card, when does enrollment begin?

Enrollment in the Medicare-approved drug discount card (including the $600 credit, if you qualify) begins the first day of the month following the month the sponsor receives your completed enrollment form**.**

If you apply early in the month, you may receive your Medicare-approved drug discount card before the first of the following month. Generally, you must wait to use your discount (and the $600 credit, if you qualify for it) until the first of the month. If you apply late in the month, you may not receive your card by the first of the month due to mailing time. You must have your card to take advantage of the drug discounts (and the $600 credit, if you qualify for it).

Why are there 2 different enrollment forms?

The credit of up to $600 to help pay for your prescription drugs is a feature of the Medicare-approved prescription drug discount card program for individuals who meet special eligibility requirements that apply only to this part of the program. If you do not believe that you qualify, or are otherwise not interested in this credit, you do not have to answer these special eligibility questions. You may, of course, still apply for the prescription drug discount card.

How can I get more information?

- Visit www.medicare.gov on the web. Select “Prescription Drug and Other Assistance Programs.”
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP). To find the telephone number for your SHIP, call 1-800 MEDICRE (1800-633-4227). TTY users should call 1-877-486-2048. You can also find these numbers on the web at www.medicare.gov by selecting “Helpful Contacts.”
- Contact the Medicare-approved drug discount card sponsor you have selected.

Standard Enrollment Form for the Medicare-Approved Drug Discount Card

Drug Card Sponsor Name:_____	Drug Card Product Name: _____
Enrollment Fee: $_____	CMS Sponsor ID Number: **D**_____

Step 1: Please answer the following statements:

I have Medicare Part A or Medicare Part B.	□Yes □ No
I **do not** have outpatient prescription drug benefits under my State Medicaid Program.	□Yes □ No

If you answered YES to BOTH of the statements above**, continue to STEP 2.**

If you answered NO to either of the statements above, you may not be eligible for this program. Please see the information on page 1 of the instructions or call the Medicare-approved drug discount card sponsor you have selected for assistance**.**

Step 2: Please complete this information about yourself:

Name: First Middle Initial Last	Birth Date		Sex
Residence Address: Street	City	State	Zip
Social Security Number	Medicare ID number	Telephone Number	

Please continue to the next page

Step 3: Read all the information:

Release of Information: By applying for enrollment for a Medicare-approved drug discount card, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the company of the drug discount card. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B). I also allow the State Medicaid Program or any other agency with relevant information about me to give CMS or CMS's agents the information needed to determine if I am eligible for drug discount card.

Review of Eligibility: I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that by signing this application I am agreeing to a full investigation or review of my eligibility by states, federal agencies, or their contractors and, if requested, I agree to provide the documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents aren't available, I agree to give the name of the person or organization that can provide and release this necessary information.

By signing below, you certify that you have read and understand the information on this enrollment form. If you can't sign, a representative may sign for you. Federal law provides for fine or imprisonment, or both for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

Signature: _____ **Date**: _____

Please return your enrollment form to the Medicare-approved drug discount card sponsor that you have selected

NOTE: If you would like to apply for the Medicare-approved drug discount card AND a credit of up to $600 toward your prescription drugs, please fill out and return the form on the next page instead of this one.

Standard Enrollment Form for the Medicare-Approved Drug Discount Card AND Additional Assistance in Paying for Your Prescription Drugs

Drug Card Sponsor Name:_____ Drug Card Product Name: _____

Enrollment Fee: $_____ CMS Sponsor ID Number: **D**_____

Step 1: Please answer the following statements:

I have Medicare Part A or Medicare Part B.	□Yes □ No
I **do not** have outpatient prescription drug benefits under my State Medicaid Program.	□Yes □ No

If you answered **YES** to BOTH of the statements above, please continue to STEP 2**.**
If you answered **NO** to either of the statements above, you may not be eligible for this program. Please see the information on page 1, or call the Medicare-approved drug discount card sponsor you have selected for assistance.

Step 2: Please complete this information about yourself:

Name: First Middle Initial Last	Birth Date		Sex
Residence Address: Street	City	State	Zip
Social Security Number	Medicare ID number	Telephone Number	

Step 3: Please answer the following questions:

Do you have TRICARE (military health insurance)?	□Yes □ No
Do you have Federal employee or retiree health insurance (FEHBP)?	□Yes □ No
Do you have other health coverage that includes outpatient prescription drugs, such as employer or retiree plans?	□Yes □ No

Note: If your health coverage is through a Medicare + Choice (M+C) plan or Medigap plan, answer "no" to this question.

If you answered YES to any of the statements above, you may not be eligible for the $600 credit. Please see the information on page 2, or call the Medicare-approved drug discount card sponsor you have selected for assistance.

If you answered NO to all of these questions, please continue to the next page.

Step 4: Please answer the following questions about your income.

Does your state help you pay your Medicare part A or part B premiums? □Yes □ No

If you answered **YES**, please complete the following then SKIP to STEP 5:

Please indicate your income here: $_____

Please check one: I am single □ -or- I am married □

If your state helps pay your Medicare part A or part B premiums you may still qualify if your income is above $12,569 if single or $16,862 if married (your coinsurance at the pharmacy would be 10%).

If you answered **NO**, please compete the remaining questions in this box.

I am single and my income is:

- □ $12,569 or less (10% coinsurance at the pharmacy)
- □ $ 9,310 or less (5% coinsurance at the pharmacy)

I am married and my income, including my spouse's income, is:

- □ $16,862 or less (10% coinsurance at the pharmacy)
- □ $12,490 or less (5% coinsurance at the pharmacy)

If married, please include your spouse's Social Security Number: _____

Have you recently (within the last 2 years) retired or been widowed or divorced? □Yes □ No

Step 5: Read all the information and sign your form

Release of Information: By applying for enrollment in this company's Medicare-approved drug discount card, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the company of the Medicare-approved drug discount card. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B). I also allow the State Medicaid Program, Social Security Administration, and Internal Revenue Service, or any other agency with relevant information about me to give CMS or CMS's agents the information needed to determine if I am eligible for the Medicare-approved drug discount card and, if applying, for a credit of up to $600 toward prescription drugs.

Review of Eligibility: I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I also understand that by signing this application I am agreeing to a full investigation or review of my eligibility by states, federal agencies, or their contractors and, if requested, I agree to provide the documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents aren't available, I agree to give the name of the person or organization that can provide and release this necessary information.

By signing below, you certify that you have read and understand the information on this entire enrollment form. If you can't sign, a representative may sign for you.

Federal law provides for fine or imprisonment, or both for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

Signature: _____ **Date**: _____

Your enrollment form is not complete unless it is signed.

Return your completed enrollment form to the Medicare-approved drug discount card sponsor you selected.