Thank you for your consideration and understanding during this difficult time. We have implemented new counseling options to protect the health of you and our volunteers. Most of our SHICK counselors are volunteers and are not paid staff. One of our counseling options this year is through the mail or email. This option is not ideal, but we will still be able to show you your most cost effective plan choices. You will receive a comparison of your three most cost effective plans. If you are currently on a Medicare Part D or Part C plan we will include your current plan as one of your choices. If you choose to change plans you will have to contact the plan directly to make the change on or before December 7, 2020. New plans will go into effect on January 1, 2021.

Please complete the enclosed worksheet and return to our office. You will need to provide as accurate information as possible, to allow us to give the most accurate estimate of your 2021 costs. Make sure you spell your medication correctly. Some medications have different names that sound similar, for example: Metoprolol succinate and Metoprolol tartrate. You will need to have the correct dosage and quantities. If you are taking insulin you will need to know how many vials or pens you use in a month. If you use an inhaler, how many inhalers do you use in a month?

Medicare Open Enrollment is from October 15 to December 7. We cannot provide you with details before October 15. Information that we provide cannot be relied upon or construed as legal advice.

Thank you for your understanding during this difficult time. We are hopeful that things will be different next year.

K-State Research & Extension, Harvey County
PRESCRIPTION DRUG COVERAGE WORKSHEET

Name as it appears on your Medicare Card:

__________________________________________

Zip Code: ____________________________

County: ________________________________

Address: __________________________________

City: __________________ State: ___________

Phone: (_____) ____________________________

Email: ___________________________________

Current plan name and plan number:

(Please provide your current plan name and plan number. Without precise information we will not be able to accurately provide you with a plan comparison. The plan number will start with the letter “S” or “H.” Example: Express Silver (PDP) S8571-123 or Great Care (HMO) H1234-123.)

Please select two different pharmacies to compare:

__________________________________________

Race (optional)—Check All that Apply:

☐ Black or African American  ☐ Asian

☐ American Indian or Alaska Native  ☐ Two or more races

☐ Native Hawaiian or other Pacific Islander  ☐ Other

☐ White

Ethnicity:

☐ Hispanic/Latino  ☐ Non-Hispanic/Non-Latino

You may qualify for help paying for your prescription drugs

What best describes your income?

Single: ☐ Less than $19,380 per year  ☐ Greater than $19,380 per year

Married: ☐ Less than $26,011 per year  ☐ Greater than $26,011 per year

What best describes your liquid assets? Total value of savings, investments, and real estate (not your primary home, vehicles, or burial plots).

Single: ☐ Less than $14,610  ☐ Greater than $14,610

Married: ☐ Less than $29,160  ☐ Greater than $29,160

Return worksheet to:

K-State Research & Extension
Harvey County
ATTN: SHICK Program
P.O. Box 583
Newton, KS 67114
316-284-6930

K-STATE Research and Extension
Harvey County
Do you get Extra Help paying for your medications from Social Security?  □ Yes □ No
If yes do you get:  □ Full Extra Help  □ Partial Extra Help
Do you have Medicaid?  □ Yes □ No
Do you have the Medicare Saving Program? □ Yes □ No

Please list prescription drugs you take on a regular basis (daily, weekly, or monthly). Do not list over the counter medications, dietary supplements or vitamins.

When entering your drug information, check to make sure you have spelled the name of the drug correctly and use the entire name of your medication. Make sure that you have entered the proper dosage and the amount that you would fill in a one month period. If you take insulin please indicate the number of pens or vials that you use in one month period. PLEASE PRINT CLEARLY.
ATTACH AN EXTRA SHEET IF NEEDED.

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DOSAGE (mg, mcg, etc..)</th>
<th>30– DAY QUANTITY ONLY (How many do you take or use in a month?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAMPLE: NOVOLOG</td>
<td>100unit/ml solution pen</td>
<td>3ml pen (sold in pack of 5)</td>
</tr>
</tbody>
</table>

The information that you provide will be used to compare plans on the Medicare.gov website. Information provided to you from the Medicare.gov website is an estimate and may be subject to change.

Kansas State University Agricultural Experiment Station and Cooperative Extension Service

K-State Research and Extension is an equal opportunity provider and employer.