

# Module 9 – Medicare Part D – Prescription Drug Coverage

## Section Objectives

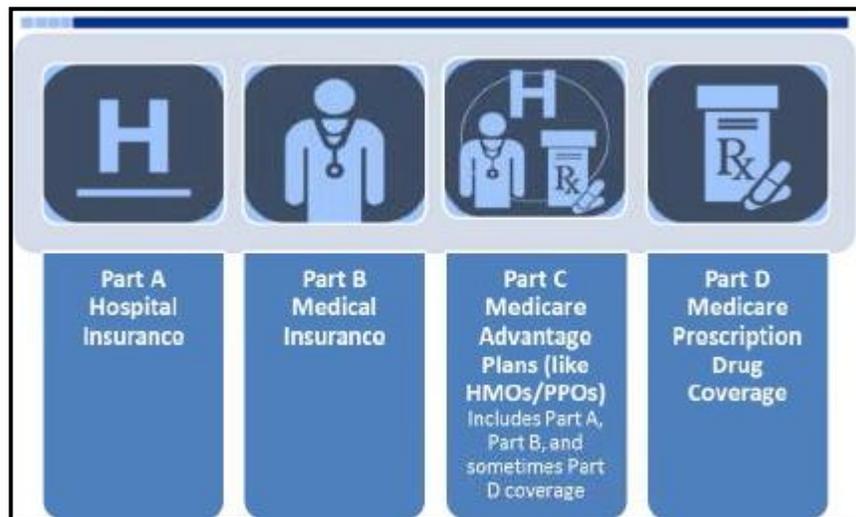
- Differentiate Medicare Part A, Part B, and Part D drug coverage
- Summarize Part D eligibility and enrollment requirements
- Compare and choose drug plans
- Describe Extra Help with drug plan costs
- Explain coverage determinations and the appeals process

## Lesson 1: The Basics

### *The Four Parts of Medicare*

Medicare covers many types of services, and you have options for how you get your Medicare coverage. Medicare has four parts:

- **Part A (Hospital Insurance)** helps pay for inpatient hospital stays, skilled nursing facility care, home health care, and hospice care.



- **Part B (Medical Insurance)** helps cover medically-necessary services like doctor visits and outpatient care. Part B also covers many preventive services (including screening tests and shots), diagnostic tests, some therapies, and durable medical equipment like wheelchairs and walkers.
- **Part C (Medicare Advantage [MA])** is another way to get your Medicare benefits. It combines Part A and Part B, and sometimes Part D (Medicare prescription drug coverage). MA Plans (like Health Maintenance Organizations and Preferred Provider Organizations) are managed by private insurance companies approved by Medicare. These plans must cover medically necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services than Original Medicare.
- **Part D (Medicare Prescription Drug Coverage)** helps pay for outpatient prescription drugs and may help lower your prescription drug costs and protect against higher costs in the future.

## *Medicare Prescription Drug Coverage*

Whether prescription drugs are covered under Medicare Part A, Part B, or Part D depends on several factors:

- Medical necessity
- The health care setting (for example, home, hospital [as inpatient or outpatient], or surgery center) where the health care is provided
- The medical indication or reason why you need medication (for example, for cancer treatment)
- Any special coverage requirements, like those for immunosuppressive drugs that would be used following an organ transplant

This information applies if you have Original Medicare, fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

If you have a Medicare Advantage (MA) Plan (Part C) (like a Health Maintenance Organization or a Preferred Provider Organization) with prescription drug coverage, you get all of your Medicare-covered health care from the plan, including covered prescription drugs. Most MA Plans offer prescription drug coverage.

### *Part A Prescription Drug Coverage*

You may get drugs as part of your treatment during a covered inpatient hospital or skilled nursing facility (SNF) stay. Medicare Part A payments made to hospitals and SNFs generally cover all drugs given during an inpatient stay.

You may get drugs for symptom control or pain relief while receiving Part A covered hospice care. You may be charged up to \$5 for each outpatient prescription drug or other similar products for pain relief and symptom control.

Hospices must give virtually all care that terminally ill individuals need. Because hospice care is a Part A benefit, Part D doesn't pay for drugs covered under the Medicare Part A per diem payment to the hospice.

**NOTE:** If you don't have Part A coverage, Medicare Part B can pay hospitals and SNFs for certain categories of Part B-covered drugs. If you do have Part A, Part B may pay if the Part A coverage for your stay has run out, or if your stay isn't covered by Part A.

Also, when receiving Part A covered SNF care, the SNF's bundled per diem payment excludes certain costly and intensive chemotherapy drugs. They are billed separately under Part B.

### *Part B Prescription Drug Coverage*

Medicare Part B gives limited prescription drug coverage. It doesn't cover most drugs you get at the pharmacy. Nearly all Part B covered drugs fall into the following categories:

- Most injectable and infusible drugs that aren't usually self-administered and that are given in a doctor's office (for example, an injectable drug used to treat anemia that's administered at the same time as chemotherapy). However, if an injection is usually self-administered (like Imitrex® for migraines) or isn't given as part of a doctor's service, it isn't covered by Part B.
- Drugs and biologicals used for the treatment of End-Stage Renal Disease (ESRD) are furnished by the ESRD facility responsible for the person's care. For example, any drug and biological used for anemia management is covered under Part B when furnished by an ESRD facility.
- Drugs administered through Part B covered durable medical equipment (DME) in your home (like a nebulizer or infusion pump). To get drugs covered by Medicare Part B, choose a pharmacy or supplier that's a participating DME provider. You may have to use a contract provider in certain areas and for certain DME products. For more information or to find contract providers in your area, visit the Medicare Supplier Directory at [Medicare.gov/supplierDirectory](https://www.medicare.gov/supplierDirectory).
- Three categories of oral drugs with special coverage requirements: certain oral anti-cancer, oral antiemetic (to treat nausea), and immunosuppressive drugs (under certain circumstances).
- A limited number of other types of outpatient drugs. There may be regional differences in local Part B drug coverage policies in cases where there isn't a national coverage decision.

**NOTE:** For the covered drugs with special coverage requirements, visit the Medicare Claims Processing Manual Chapter 17—Drugs and Biologicals at [CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf).

### *Part B Immunization Coverage*

Medicare Part B covers certain immunizations as part of Medicare-covered preventive services. If you meet the criteria, Part B covers the influenza virus vaccine (flu shot), a pneumococcal shot (to prevent certain types of pneumonia), a Hepatitis B shot (for individuals at high or intermediate risk), and other vaccines (like a tetanus shot) when you get it to treat an injury or if you've been exposed directly to a disease or condition.

Generally, Medicare drug plans cover (Part D) other vaccines (like the shingles vaccine) needed to prevent illness.

### *Self-Administered Drugs in Hospital Outpatient Settings*

There may be a need for self-administered drugs (drugs you'd normally take on your own) in hospital outpatient settings, like the emergency department, observation units, surgery centers, or pain clinics. For example, you may need daily blood pressure medication while in the emergency room for a sprained ankle. Medicare Part A and Part B wouldn't cover the medication because it's not related to the outpatient services you're getting to treat your ankle. If you get self-administered drugs that aren't covered by Medicare Part A or Part B while in a hospital outpatient setting, the hospital may bill you for the drug.

However, if you're enrolled in a Medicare Prescription Drug Plan (Part D), these drugs may be covered. You'll likely need to pay out of pocket for the drugs and send in a claim to your drug plan for a refund.

- Generally, your Medicare drug plan won't pay for over-the-counter drugs, like Tylenol®.
- The drug you need must be on your drug plan's formulary (list of covered drugs).
- You can't get your self-administered drugs in an outpatient or emergency department setting on a regular basis.
- Your Medicare drug plan will check to see if you could've gotten these self-administered drugs from an in-network pharmacy.
- If the hospital pharmacy doesn't participate in Medicare Part D, you may need to pay out of pocket for these drugs and submit the claim to your Medicare drug plan for reimbursement.

**NOTE:** Visit [Medicare.gov/Pubs/pdf/11333.pdf](https://www.medicare.gov/Pubs/pdf/11333.pdf) to download the tip sheet "How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings" (CMS Product No. 11333).

## **Lesson 2: Medicare Part D Benefits and Costs**

### *Part D Medicare Prescription Drug Coverage*

Medicare prescription drug coverage (Part D) adds to your Medicare health care coverage. It helps you pay for medically necessary brand-name and generic prescription drugs. Medicare drug plans are offered by insurance companies and other private companies approved by Medicare. All people with Medicare are eligible to enroll in a Medicare drug plan. To get coverage, you must join a plan (enrollment isn't automatic for most people).

There are 2 main ways to get Medicare prescription drug coverage:

- Join a Medicare Prescription Drug Plan (PDP). These plans add coverage to Original Medicare, and may be added to some other types of Medicare health plans (but not Medicare Advantage [MA] Plans).

- Join an MA Plan with prescription drug coverage (MA-PD) (like a Health Maintenance Organization or a Preferred Provider Organization) or another Medicare health plan that includes Medicare prescription drug coverage. You'll get all your Medicare coverage (Part A and Part B), including prescription drug coverage (Part D) through these plans.

The term "Medicare drug plan" is used throughout this presentation to mean both PDPs and MA-PDs or other Medicare plans with prescription drug coverage.

**NOTE:** Some Medigap (Medicare Supplement Insurance) policies offered prescription drug coverage before January 1, 2006. This isn't Medicare prescription drug coverage.

### *Medicare Drug Plans*

Medicare drug plans may be different from each other in terms of which prescription drugs they cover, how much you have to pay, and which pharmacies you can use. All Medicare drug plans must give at least a standard level of coverage set by Medicare. However, plans offer different combinations of coverage and cost sharing. Plans may offer more coverage and additional drugs, generally for a higher monthly premium.

Most plans continue to offer different benefit structures, including tiers, copayments, and/or deductibles. Enhanced plans may offer additional benefits, like coverage in the coverage gap or coverage for drugs that Medicare Part D doesn't traditionally cover.

Plan benefits and costs may change each year, so it's important to look at and compare your plan options annually.

### *Medicare Drug Plan Costs*

Your costs for prescription drug coverage will depend on the plan you choose and some other factors, like which drugs you use, which Medicare drug plan you join, whether you go to a pharmacy in your plan's network, and whether you get Extra Help paying for your drug costs.

Most people will pay a monthly premium for Medicare prescription drug coverage. You'll also pay a share of your prescription costs, including a deductible (if applicable), copayments, and/or coinsurance.

Contact your drug plan (not Social Security) if you want your premium deducted from your monthly Social Security payment. Your first deduction will usually take 3 months to start, and 3 months of premiums will likely be deducted at once.

After that, only one premium will be deducted each month. You may also see a delay in premiums being withheld if you switch plans. If you want to stop premium deductions and get billed directly, contact your drug plan.

When you are in the coverage gap, you pay 45% for covered brand-name drugs, and 65% for covered generic drugs.

With every plan, once you've paid \$4,700 out of pocket for drug costs in 2015 (including payments from other sources, like the discount paid for by the drug company in the coverage gap) you leave the coverage gap and pay 5% (or a small copayment) for each drug for the rest of the year.

### Standard Structure in 2015

Ms. Smith joins a prescription drug plan. Her coverage begins on January 1, 2015. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.			
1. Yearly deductible	2. Copayment or coinsurance (what you pay at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first \$320 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches \$2,960.	Once Ms. Smith and her plan have spent \$2,960 for covered drugs, she's in the coverage gap. In 2015, she pays 45% of the plan's cost for her covered brand-name prescription drugs and 65% of the plan's cost for covered generic drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.	Once Ms. Smith has spent \$4,700 out of pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.

Here's an example showing what you'd pay each year in a standard Medicare drug plan. Very few plans actually follow this design. Your drug plan costs will vary.

- **Monthly premium**—Most drug plans charge a monthly fee that differs from plan to plan. You pay this in addition to the Part B premium (if you have Part B). If you belong to a Medicare Advantage plan (like a Health Maintenance Organization or a Preferred Provider Organization) that includes drug coverage, the monthly plan premium may include an amount for prescription drug coverage.
- **Yearly deductible (you pay up to \$320 in 2015)**—This is the amount you pay each year for your prescriptions before your plan begins to pay. No Medicare drug plan may have a deductible more than \$320 in 2015. Some drug plans don't have a deductible.
- **Copayments or coinsurance (you pay approximately 25%)**—These are the amounts you pay for your covered prescriptions after you pay the deductible (if the plan has one). You pay your share and the drug plan pays its share for covered drugs.

- **Coverage gap**—The coverage gap begins after you and your drug plan have spent a certain amount of money for covered drugs (\$2,960 in 2015). In 2015, once you enter the coverage gap, you pay 45% of the plan’s cost for your covered brand-name drugs and 65% of the plan’s cost for covered generic drugs until you reach the end of the coverage gap. Certain costs count toward getting out of the coverage gap, including your yearly deductible, coinsurance, and copayments, the discount you get on covered brand-name drugs in the gap, and what you pay in the gap. However, the drug plan premium, what you pay for drugs that aren’t covered, and the discount for covered generic drugs in the coverage gap don’t count toward getting you out of the coverage gap.
- **Catastrophic coverage (you pay 5%)**—Once you reach your out-of-pocket limit (\$4,700 in 2015), you leave the coverage gap, and automatically get catastrophic coverage, where you only pay a small coinsurance or copayment for covered drugs for the rest of the year.

### *Improved Coverage in the Coverage Gap*

Year	What You Pay for Covered Brand-Name Drugs in the Coverage Gap	What You Pay for Covered Generic Drugs in the Coverage Gap
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

Once you reach the coverage gap in 2015, you'll pay 45% of the plan's cost for covered brand-name prescription drugs. You get these savings if you buy your prescriptions at a pharmacy or order them through the mail. The discount will come off of the price that your plan has set with the pharmacy for that specific drug. In 2015, 95% of the price—what you pay plus the 50% manufacturer discount payment—will count as out-of-pocket costs, which will help you get out of the coverage gap. What the drug plan pays toward the drug cost (5% of the price) and what the drug plan pays toward the dispensing fee (55% of the fee) aren't counted toward your out-of-pocket spending.

In 2015, Medicare will pay 35% of the price for generic drugs during the coverage gap. You'll pay the remaining 65% of the price. What you pay for generic drugs during the coverage gap will decrease each year until it reaches 25% in 2020. The coverage for generic drugs works differently from the discount for brand-name drugs. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap.

Visit [www.Medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html](http://www.Medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html) for examples of what you pay for generic or brand-name drugs. If you have a Medicare drug plan that already includes coverage in the gap, you may get a discount after your plan's coverage has been applied to the price of the drug. The discount for brand-name drugs will apply to the remaining amount that you owe.

**NOTE:** Visit [CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11522-P.pdf](http://CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11522-P.pdf) to download the publication, “Information Pharmacists Can Use on Closing the Coverage Gap” (CMS 11522-P), and [CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11495-P.pdf](http://CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11495-P.pdf) to download the publication “Information Partners Can Use on Closing the Coverage Gap” (CMS 11495-P).

### *True Out-of-Pocket (TrOOP) Costs*

True out-of-pocket (TrOOP) costs are the expenses that count toward your Medicare drug plan out-of-pocket threshold of \$4,700 (for 2015). TrOOP costs determine when your catastrophic coverage begins. Your drug plan will keep track of your TrOOP costs. Each month that you buy prescriptions covered by your plan, your drug plan will mail you an Explanation of Benefits (EOB) showing your TrOOP costs to date.

For payments to count toward your TrOOP costs, payments must be made by you or on your behalf, not be covered by other insurance, and be for certain types of costs according to your plan rules (for example, drugs that are on the plan's formulary or filled at a pharmacy in the plan's network).

If you switch plans during the year, your TrOOP balance transfers to the new Medicare drug plan. Medicare has put processes in place for transferring the TrOOP balance. The transfer begins when you disenroll and join a new plan. If you think there's a mistake in the TrOOP balance that is transferred, you may need to give a copy of your most recent EOB to the new plan to show the current TrOOP balance.

**NOTE:** Visit [CMS.gov/Outreach-and-Education/Outreach/Partnerships/Publications-for-Partners.html](http://CMS.gov/Outreach-and-Education/Outreach/Partnerships/Publications-for-Partners.html) to download the tip sheet, “Information Partners Can Use on Understanding True Out-of-Pocket (TrOOP) Costs” (CMS Product No. 11223-P).

### *What Payments Count Toward TrOOP*

Payments made for covered prescriptions before your drug plan begins to pay (the annual deductible, if applicable), for each covered prescription after your drug plan begins to pay (copayments or coinsurance during initial coverage period), and any payments made for a covered prescription drug during your coverage gap, if the plan has a coverage gap, count toward your TrOOP costs if they're made by any of these:

- You (including payments from your Medical Savings Account [MSA], Health Savings Account [HSA], or Flexible Spending Account [FSA])[if applicable])
- Family members or friends
- Qualified State Pharmacy Assistance Programs (SPAPs)
- Medicare's Extra Help (low-income subsidy)
- Indian Health Service (IHS)

- Most charities (unless they're established, run, or controlled by the person's current or former employer or union or by a drug manufacturer's Patient Assistance Program operating outside Part D)
- Drug manufacturers providing discounts under the Medicare coverage gap discount program
- AIDS Drug Assistance Programs (ADAPs)

Certain conditions must be met for a payment to count toward TrOOP. These include that the payments must be for drugs that are on the plan's formulary or those drugs treated as being on the formulary because of a coverage determination, exceptions process, or an appeal. The drugs must be purchased in a network pharmacy or the drugs must be purchased at an out-of-network pharmacy in accordance with the plan's out-of-network policy.

### *What Payments Don't Count Toward TrOOP*

These payments **don't** count toward your TrOOP costs:

- The share of the cost of the drug paid by a Medicare drug plan
- Monthly drug plan premium
- Drugs purchased outside the United States and its territories
- Drugs not covered by the plan
- Drugs that are excluded from the definition of Part D drug, even in cases where the plan chooses to cover them as a supplemental benefit (like drugs for hair growth)
- Over-the-counter drugs or most vitamins (even if they're required by the plan as part of step therapy)

Payments don't count toward your TrOOP costs if they're made by (or reimbursed to you by) any of these:

- Group health plans like the Federal Employees Health Benefit Program (FEHBP) or employer or union retiree coverage
- Government-funded health programs like Medicaid, TRICARE, Workers' Compensation, the Department of Veterans Affairs (VA), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), the Children's Health Insurance Program (CHIP), and black lung benefits
- Other third-party groups with a legal obligation to pay for the person's drug costs
- Patient Assistance Programs (PAPs) operating outside the Part D benefit
- Other types of insurance

### *Part D Monthly Premium and Income-Related Monthly Adjustment Amounts (IRMAA)*

A small group—less than 5% of all people with Medicare—may pay a higher monthly premium based on their income (as reported on their IRS tax return from 2 years ago). If your income is above a certain limit, you'll pay an extra amount in addition to your plan premium. Social Security uses income data from the Internal Revenue Service to figure out whether or not you have to pay a higher premium. The income limits are the same as those for the Part B income-related monthly adjustment amount (IRMAA).

Usually, the extra amount will be taken out of your Social Security check. If you don't have enough money in your Social Security check, or don't get a Social Security check, you'll be billed for the extra amount each month by either Medicare or the Railroad Retirement Board (RRB). This means that you'll pay your plan each month for your monthly premium and pay Medicare or RRB each month for your IRMAA amount. (In other words, you'd pay the Part D–IRMAA amount directly to the government and not to your plan.) This also applies if you get Part D coverage through your employer (but not through a retiree drug subsidy or other creditable coverage).

If you don't pay, you'll be disenrolled from your Medicare drug plan, even if you get your Part D coverage through a Medicare Advantage Plan or through an employer.

You must pay both the extra amount (the Part B IRMAA) and your plan's premium each month to keep Medicare prescription drug coverage.

If you have to pay an extra amount and you disagree (for example, if you have a life event that lowers your income), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. For more information, visit [socialsecurity.gov/](http://socialsecurity.gov/).

**SOURCE:** SSA Publication No. 05-10536, "Medicare Premiums: Rules for Higher-Income Beneficiaries" at [SSA.gov/pubs/EN-05-10536.pdf](http://SSA.gov/pubs/EN-05-10536.pdf).

### *Income-Related Monthly Adjustment Amount (IRMAA)*

Your Yearly Income in 2013 Filing an Individual Tax Return	Your Yearly Income in 2013 Filing a Joint Tax Return	In 2015 You Pay Monthly
\$85,000 or less	\$170,000 or less	Your Plan Premium (YPP)
Above \$85,000 Up to \$107,000	Above \$170,000 Up to \$214,000	YPP + \$12.30*
Above \$107,000 Up to \$160,000	Above \$214,000 Up to \$320,000	YPP + \$31.80*
Above \$160,000 Up to \$214,000	Above \$320,000 Up to \$428,000	YPP + \$51.30*
Above \$214,000	Above \$428,000	YPP + \$70.80*

IRMAA is adjusted each year, as it's calculated from the annual beneficiary base premium.

You pay only your plan premium if your yearly income in 2013 was \$85,000 or less for an individual, or \$170,000 or less for a couple.

If you reported a modified adjusted gross income of more than \$85,000 (individuals and married individuals filing separately) or \$170,000 (married individuals filing jointly) on your Internal Revenue Service (IRS) tax return 2 years ago (the most recent tax return information provided to Social Security by the IRS), you'll have to pay an extra amount for your Medicare prescription drug coverage, called the income-related monthly adjustment amount (IRMAA). You pay this extra amount in addition to your monthly Medicare drug plan premium.

If your income has gone down due to any of the following situations, and the change makes a difference in the income level Social Security considers, contact them to explain you have new information and may need a new decision about your IRMAA:

- You married, divorced, or became widowed
- You or your spouse stopped working or reduced your work hours
- You or your spouse lost income-producing property due to a disaster or other event beyond your control
- You or your spouse experienced a scheduled cessation, termination, or reorganization of an employer's pension plan
- You or your spouse received a settlement from an employer or former employer because of the employer's closure, bankruptcy, or reorganization

## **Lesson 3: Medicare Part D Drug Coverage**

### *Part D – Covered Drugs*

Medicare drug plans cover generic and brand-name drugs. To be covered by Medicare, a drug must be available only by prescription, approved by the U.S. Food and Drug Administration (FDA), used and sold in the United States, and used for a medically-accepted indication.

Medicare covers prescription drugs, insulin, and biological products (e.g., antibodies, proteins, cells, etc.). Medicare also covers medical supplies associated with the injection of insulin, like syringes, needles, alcohol swabs, and gauze.

To make sure people with different medical conditions can get the prescriptions they need, drug lists (formulary) for each plan must include a range of drugs in each prescribed category. All Medicare drug plans generally must cover at least 2 drugs per drug category, but the plans may choose which specific drugs they cover. Coverage and rules vary by plan, which can affect what you pay.

Even if a plan's prescription drug list doesn't include your specific drug, in most cases, a similar drug should be available. If you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes none of the drugs on your plan's drug list will work for your condition, you may ask for an exception.

## *Required Coverage*

Medicare drug plans must cover all drugs in 6 protected categories to treat certain conditions:

- Cancer medications
- HIV/AIDS treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for epilepsy and other conditions
- Immunosuppressants

Also, Medicare drug plans must cover all commercially available vaccines, including the shingles shot (but not vaccines covered under Part B, like the flu and pneumococcal shots). You or your provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.

For more information visit [CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf).

## *Drugs Excluded by Law Under Part D*

By law, Medicare doesn't cover the following drugs:

- Drugs for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose [i.e., morbid obesity]).
- Erectile dysfunction drugs when used to treat sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which use the U.S. Food and Drug Administration approved the drugs. For example, a Medicare drug plan may cover an erectile dysfunction drug when used to treat an enlarged prostate (also known as benign prostatic hyperplasia, or BPH).
- Fertility drugs.
- Drugs for cosmetic or lifestyle purposes (e.g., hair growth).
- Drugs for symptomatic relief of coughs and colds.
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations).
- Non-prescription drugs.

Plans may choose to cover excluded drugs at their own cost or share the cost with you. Visit [CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf) (42 CFR 423.100) for more information on excluded drugs.

## *Formulary*

Each Medicare drug plan has a formulary, which is a list of prescription drugs that it covers. Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form its tiers in different ways.

Here's an example of how a plan might form its tiers:

- **Tier 1—Generic drugs** (the least expensive)—Tier 1 drugs are generic drugs and are the same as their brand-name counterparts in safety, strength, quality, the way it works, how they're taken, and

Tier Structure Example		
Tier	You Pay	Prescription Drugs Covered
1	Lowest copayment	Most generics
2	Medium copayment	Preferred, brand name
3	High copayment	Non-preferred, brand name
Specialty	Highest copayment or coinsurance	Unique, very high cost

the way they should be used. They use the same active ingredients as brand-name drugs. Generic drug makers must prove that their product performs the same way as the corresponding brand-name drug. They're less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the U.S. Food and Drug Administration (FDA). Today, almost half of all prescriptions in the United States are filled with generic drugs. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your prescriber.

- **Tier 2—Preferred brand-name drugs**—Tier 2 drugs cost more than Tier 1 drugs.
- **Tier 3—Non-preferred brand-name drug**—Tier 3 drugs cost more than Tier 2 drugs.
- **Tier 4—(or Specialty Tier)**—These drugs are unique and have a high cost.

**NOTE:** In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can request an exception and ask your plan for a lower copayment.

### *Formulary Changes*

Medicare drug plans may only change their therapeutic categories and classes in a formulary at the beginning of each plan year, or to account for new therapeutic uses and newly approved Part D-covered drugs. A plan year is a calendar year, January through December.

Medicare drug plans can make maintenance changes to their formularies, like replacing brand-name drugs with new generic drugs or changing their formularies as a result of new information on drug safety or effectiveness. Those changes must be made according to the prescribed approval procedures, and plans must give 60 days' notice to CMS, State Pharmacy Assistance Programs, prescribing doctors, network pharmacies, pharmacists, and people covered under the plan. You may be able to use the drug until the end of the calendar year. You may ask for an exception if other drugs don't work.

Under Part D, no plan members should have their drug coverage discontinued or reduced for the rest of the plan year. However, this isn't the case when a drug is removed from the formulary due to a U.S. Food and Drug Administration decision or when the manufacturer takes the drug off the market. In those cases, Medicare drug plans aren't required to get CMS approval or give 60 days' notice.

### *How Plans Manage Access to Drugs*

<b>Prior Authorization</b>	<ul style="list-style-type: none"> <li>▪ Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered</li> </ul>
<b>Step Therapy</b>	<ul style="list-style-type: none"> <li>▪ Must first try similar, less expensive drug</li> <li>▪ Doctor may request an exception if               <ul style="list-style-type: none"> <li>• Similar, less expensive drug didn't work, or</li> <li>• Step therapy drug is medically necessary</li> </ul> </li> </ul>
<b>Quantity Limits</b>	<ul style="list-style-type: none"> <li>▪ Plan may limit drug quantities over a period of time for safety and/or cost</li> <li>▪ Doctor may request an exception if additional amount is medically necessary</li> </ul>

Medicare drug plans manage access to covered drugs in several ways. These are known as "Coverage Rules." These include prior authorization, step therapy, and quantity limits.

You may need drugs that require prior authorization. This means before the plan will cover a particular drug, your doctor or other prescriber must first show the plan you have a medically necessary need for that particular drug. Plans also do this to be sure you're using these drugs correctly. Contact your plan about its prior authorization requirements, and talk with your prescriber.

Step therapy is a type of coverage rule. In most cases, you must first try a certain less expensive drug on the plan's drug list that has been proven effective for most people with your condition before you can move up a step to a more expensive drug. For instance, some plans may require you first try a generic drug (if available), then a less expensive brand-name drug on their drug list before you can get a similar, more expensive brand-name drug covered.

However, if you've already tried a similar, less expensive drug that didn't work, or if the doctor believes that because of your medical condition it's medically necessary to take a step-therapy drug (the drug the doctor originally prescribed), with your doctor's help, you can contact the plan to request an exception. If the request is approved, the plan will cover the originally prescribed step-therapy drug.

For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time. If your prescriber believes that, because of your medical condition, a quantity limit isn't medically appropriate, you or your prescriber can contact the plan to ask for an exception. If the plan approves your request, the quantity limit won't apply to your prescription.

For more information visit [www.CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf](http://www.CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf) (see Section 30.2.2).



### *Requirement for Prescribers*

CMS is using prescription drug event data to guide efforts to combat fraud and abuse and sharing the results of data analysis with Part D plan sponsors, law enforcement agencies, and pharmacy and physician licensing boards, as appropriate. A key fraud and abuse provision in the CY 2015 policy and technical changes to the Medicare Advantage (MA) and prescription drug program final rule requires prescribers of Part D drugs to enroll in Medicare. CMS finalized CMS-4159-F “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs” on May 23, 2014.

This rule requires doctors and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file with an A/B Medicare Administrative Contractor (MAC) for their prescriptions to be covered under Part D. The final regulation stated that the effective date for this requirement would be June 1, 2015, but CMS delayed enforcement of the requirements in 42 CFR 423.120(c)(6) until December 1, 2015. CMS is published an interim final rule with comment (IFC) that makes changes to a final rule that was published on May 23, 2014, changing the enforcement date to January 1, 2016. CMS-6107-IFC allows people with Medicare benefits to continue receiving medications prescribed by individuals permitted to prescribe by state law but who are prevented from enrolling in or opting-out of Medicare by statutory provisions that govern the types of individuals who can enroll. View the IFC at [federalregister.gov/articles/2015/05/06/2015-10545/medicare-programs-changes-to-the-requirements-for-part-d-prescribers](http://federalregister.gov/articles/2015/05/06/2015-10545/medicare-programs-changes-to-the-requirements-for-part-d-prescribers).

Note that enrollment functions for doctors and other prescribers are handled by Part B MACs. To prepare the prescribers and Part D sponsors for the January 1, 2016, enforcement date, CMS is making available an enrollment file that identifies doctors and eligible professionals who are enrolled in Medicare in an approved or opt-out status. The first iteration of the enrollment file is now available at [data.CMS.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx](http://data.CMS.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx). For more information visit [CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1434.pdf](http://CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1434.pdf).

### *If Your Prescription Changes*

Plans can change their drug list and prices for drugs. Call your plan's customer service center, or look on your plan's website to find the most up-to-date Medicare drug list and prices.

Your doctor or other prescriber may need to change your prescription or prescribe a new drug. If your doctor prescribes electronically, he or she can check which drugs your drug plan covers through his or her electronic prescribing system. If your doctor doesn't prescribe electronically, give him or her a copy of your Medicare drug plan's current drug list (formulary).

If your doctor needs to prescribe a drug that's not on your Medicare drug plan's drug list and you don't have any other health insurance that covers outpatient prescription drugs, you or your doctor can ask the plan for an exception.

If your plan still won't cover a specific drug you need, you can appeal. If you want to get the drug before your appeal is decided, you may have to pay out of pocket for the prescription. Keep the receipt and give a copy of it to the person deciding your appeal. If you win the appeal, the plan will pay you back.

### *Medicare Therapy Management*

If you're in a Medicare drug plan and take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a Medication Therapy Management program. This program helps you and your doctor make sure that your medications are working to improve your health. A pharmacist or other health professional does a comprehensive review of all your medications and talks with you about how to get the most benefits from the drugs you take; any concerns you have, like medication costs and drug reactions; how best to take your medications; and any questions or problems you have about your prescription and over-the-counter medication.

You'll get a written summary of this discussion, including an action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

Your drug plan may enroll you in this program if you meet all of these conditions:

- You have more than one chronic health condition (like hypertension; heart failure; diabetes; dyslipidemia; respiratory disease (like asthma, chronic obstructive pulmonary disease [COPD], or chronic lung disorders; bone disease-arthritis (like osteoporosis, osteoarthritis, or rheumatoid arthritis); or a mental health condition (like depression, schizophrenia, bipolar disorder, or chronic and disabling disorders).
- You take several different medications.

- Your medications have a combined cost of more than \$3,017 per year. This dollar amount (which can change each year) is estimated based on your out-of-pocket costs and the costs your plan pays for the medications each calendar year. Your plan can help you find out if you may reach this dollar limit.

For more information visit [CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter7.pdf](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter7.pdf), Section 30.

## **Lesson 4: Part D Eligibility and Enrollment**

### *Part D Eligibility Requirements*

To join a Medicare Prescription Drug Plan, you must have Medicare Part A and/or Part B. To join a Medicare Advantage Plan with prescription drug coverage, you must have both Medicare Part A and Part B. To join a Medicare cost plan with prescription drug coverage, you must have Medicare Part A and Part B, or have Medicare Part B only.

Each plan has its own service area, which you must live in to enroll. People in the U.S. territories, including Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa can enroll. If you live outside the United States and its territories, if you're incarcerated, you're not eligible to enroll in a plan, and therefore, can't get Part D coverage. *Effective January 1, 2016, you must be lawfully present in the United States to be eligible to enroll in a plan.*

Medicare drug coverage isn't automatic. Most people must join a Medicare drug plan to get coverage. So while all people with Medicare can have this coverage, you need to take action to get it. If you qualify for Extra Help to pay for your prescription drugs, Medicare will enroll you in a Medicare drug plan unless you decline coverage or join a plan yourself. You can only be a member of one Medicare drug plan at a time.

### *Creditable Drug Coverage*

Creditable prescription drug coverage could include drug coverage from a former employer or union, TRICARE, Veterans Affairs, the Federal Employee Health Benefits Program, or the Indian Health Service. If you have other prescription drug coverage, you'll get information each year from your plan that tells you if the plan is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. We call this "creditable coverage." Your plan may send you this information in a letter or include it in its newsletter. Keep this information, because you may need it if you join a Medicare drug plan later.

If you have this kind of coverage when you become eligible for Medicare, you can generally keep that coverage and won't have to pay a penalty if you decide to enroll in a Medicare drug plan later, as long as you join within 63 days after your other drug coverage ends.

**NOTE:** Most Medigap (Medicare Supplement Insurance) policies that have drug coverage don't meet Medicare's minimum standards (it's not creditable). If you have a Medigap policy that covers drugs, you can keep your policy, but you may have to pay a penalty if you wait to join a Medicare drug plan. If you decide to join a Medicare drug plan, you'll need to tell your Medigap insurer when your coverage starts, so your insurer can remove prescription drug coverage from your Medigap policy.

### *Initial Enrollment Period*

When you first become eligible to get Medicare, you have a 7-month Initial Enrollment Period (IEP) for Part D:

- You can apply as early as 3 months before your month of Medicare eligibility. Coverage will start on the date you become eligible for Medicare.
- If you apply during your month of eligibility, then your Medicare drug coverage begins the first day of the following month.
- You can apply during the 3 months after your month of eligibility, with coverage beginning the first day of the month after the month you apply.

Some groups of people who become eligible to get Medicare will be enrolled in a Medicare drug plan by CMS unless they join a plan on their own. We'll discuss these groups in Lesson 5.

**NOTE:** If you get Social Security or Railroad Retirement benefits when you turn 65, you'll be enrolled automatically in Medicare Part A and Part B. However, you'll still need to choose and enroll in a Part D plan during your IEP if you'd like to have Medicare drug coverage. If you enroll later, you may pay a penalty.

### *When You Can Join or Switch Plans*

- Medicare's Open Enrollment Period runs from October 15–December 7 each year with changes going into effect on January 1
- January 1–February 14
  - If you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare. If you switch, you have until February 14 to also join a Medicare drug plan to add drug coverage. Coverage starts the first day of the month after the plan gets the enrollment form.
- April 1–June 30 (limited)
  - If you don't have Medicare Part A coverage, and enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan from April 1–June 30. Your coverage begins July 1.

## Special Enrollment Period (SEP)

You can make changes to your Medicare prescription drug coverage when certain events happen in your life. These chances to make changes are called Special Enrollment Periods (SEPs). Each SEP has different rules about when you can make changes and the type of changes you can make. These chances to make changes are in addition to the regular enrollment periods that happen each year. The SEPs listed below are examples. The list doesn't include every situation:

- If you permanently move out of your plan's service area
- If you lose your other creditable prescription drug coverage
- If you weren't properly told that your other coverage wasn't creditable, or that the other coverage was reduced so that it's no longer creditable
- If you enter, live at, or leave a long-term care facility like a nursing home
- If you qualify for Extra Help, you have a continuous SEP, and can change your Medicare drug plan at any time
- If you belong to a State Pharmaceutical Assistance Program
- If you join or switch to a plan that has a 5-star rating
- Other exceptional circumstances, like if you no longer qualify for Extra Help

**NOTE:** It's important to remember that the SEPs for Part B and Part D have different time frames for when you need to sign up for coverage. You may be eligible for a Medicare Part B SEP if you're over 65 and you (or your spouse) are still working and have health insurance through active employment. Your Part B SEP lasts for 8 months and begins the month after your employment ends. However, your Part D SEP lasts for only 2 full months after the month your coverage ends.

SEP options will display for you if you enroll through the Medicare Plan Finder on Medicare.gov. By checking any of the listed SEPs, you're certifying that, to the best of your knowledge, you're eligible for an enrollment period. If at a later time it's determined that this information was incorrect, you may be disenrolled from the plan.

## 5-Star Special Enrollment Period (SEP)

Plans are assigned their star rating once per year, in October. However, the plan won't actually get



Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles: [?] and Drug Copay [?] / Coinsurance: [?]	Drug Coverage [?], Drug Restrictions [?] and Other Programs:	Overall Star Rating: [?]	Enroll
Retail Annual: \$1,546 Mail Order Annual: N/A	\$31.90	Annual Drug Deductible: \$160 Drug Copay/ Coinsurance: \$0 - \$35, 29% - 50%	All Your Drugs on Formulary: No Drug Restrictions: No Lower Your Drug Costs MTM Program [?]: Yes	★ This plan got Medicare's highest rating (5 stars)	

this rating until the following January 1. To find star rating information, visit the Medicare Plan Finder at [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan). Look for the Overall Plan Rating to identify 5-star plans that you can change to during this Special Enrollment Period (SEP). The "Medicare & You" handbook doesn't have the full, updated ratings for this SEP.

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from 1 to 5 stars. A 5-star rating is considered excellent.

At any time during the year, you can use the 5-star SEP to enroll in a 5-star Medicare Advantage (MA)–only plan, a 5-star MA plan with prescription drug coverage (MA-PD), a 5-star Medicare Prescription Drug Plan (PDP), or a 5-star Cost Plan, as long as you meet the plan’s enrollment requirements (for example, living within the service area). If you’re currently enrolled in a plan with a 5-star overall rating, you may use this SEP to switch to a different plan with a 5-star overall rating.

CMS also created a coordinating SEP for prescription drug plans. This SEP lets people who enroll in certain types of 5-star plans without drug coverage choose a PDP, if that combination is allowed under CMS rules. You may use the 5-star SEP to change plans one time between December 8 and November 30 of the following year. Once you enroll in a 5-star plan, your SEP ends for that year and you’re allowed to make changes only during other appropriate enrollment periods. Your enrollment will start the first day of the month following the month in which the plan gets your enrollment request.

For more information, please see the “5-Star Enrollment Period Job Aid” at [CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2014-5-Star-Plan-Ratings-Overview-Job-Aid.pdf](https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2014-5-Star-Plan-Ratings-Overview-Job-Aid.pdf).

**NOTE:** You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that has no drug coverage. You’ll have to wait until the next applicable enrollment period to get drug coverage and may have to pay a penalty.

### *Low Performing Plan*

A contract that gets less than 3 stars for its Part C or D summary rating for at least the last 3 years (i.e., rated 2.5 or fewer stars for the 2013, 2014, and 2015 Plan Ratings for Part C or Part D), will be marked with the above icon  on Medicare Plan Finder. Medicare sends the “Important Information About Your Medicare Plan Options,” CMS Product Number 11633, to members of these plans giving them a one-time option to switch to another Medicare drug plan with 3 stars or better. Visit [CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/Feb2015\\_LPI\\_Notice\\_CMS-11633.pdf](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/Feb2015_LPI_Notice_CMS-11633.pdf) to view the notice in English and Spanish.

The summary rating gives an overall score on the drug plan’s quality and performance in many different topics that fall into 4 categories:

- Drug plan customer service—Includes how well the plan handles member appeals.
- Member complaints and changes in the drug plan’s performance—Includes how often Medicare found problems with the plan, and how often members had problems with the plan. Includes how much the plan’s performance has improved (if at all) over time.

- Member experience with the plan’s drug services—Includes ratings of member satisfaction with the plan.
- Drug safety and accuracy of drug pricing—Includes how accurate the plan’s pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is considered safer and clinically recommended for their condition.

This information is gathered from several different sources. In some cases it is based on member surveys. In other cases, it is based on reviews of billing and other information that plans submit to Medicare results from Medicare’s regular monitoring activities.

### *Part D Late Enrollment Penalty*

If you choose not to join a Medicare drug plan at your first opportunity, you may have to pay a higher monthly premium (penalty) if you enroll later. If you have creditable coverage when you first become eligible for Medicare, you can generally keep that coverage and won’t have to pay a penalty if you choose to enroll in a Medicare drug plan later, as long as you join within 63 days after your other drug coverage ends. Also, you won’t have to pay a higher premium if you get Extra Help paying for your prescription drugs. We’ll talk about Extra Help in Lesson 5, starting on slide 47.

The late enrollment penalty is calculated by multiplying the 1% penalty rate times the national base beneficiary premium (\$33.13 in 2015) times the number of full, uncovered months you were eligible to join a Medicare drug plan but didn’t and went without other creditable prescription drug coverage. The penalty calculation isn’t based on the premium of the plan in which you are enrolled. The final amount is rounded to the nearest \$.10 and added to your monthly premium. The national base beneficiary premium may go up each year, so the penalty amount may also go up each year. You may have to pay this penalty for as long as you have a Medicare drug plan.

After you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be. You may have to pay this penalty for as long as you have a Medicare drug plan. If you don’t agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You’ll need to fill out a reconsideration request form (that your plan will send you), and you’ll have the chance to provide proof that supports your case.

### *Part D Penalty Example*

Ann didn’t join when she was first eligible—by June 2012. She doesn’t have drug coverage from any other source. She joined a Medicare drug plan during the 2014 Open Enrollment Period. Her coverage began on January 1, 2015.

She was without creditable prescription drug coverage from July 2012–December 2014. Her penalty in 2015 is 30% (1% for each of the 30 months) of \$33.13 (the national base beneficiary premium for 2015), which is \$9.93. The monthly penalty is rounded to the nearest \$.10, so she’ll be charged \$9.90 each month in addition to her plan’s monthly premium in 2015.

**Here's the math:**

**.30** (30% penalty) × **\$33.13** (2015 base beneficiary premium) = **\$9.93**

**\$9.93** (rounded to the nearest \$0.10) = **\$9.90**

**\$9.90** = Ann's monthly late enrollment penalty for 2015

After she joins a Medicare drug plan, the plan will tell her if she owes a penalty, and what her premium will be. She may have to pay this penalty for as long as she has a Medicare drug plan. If she had to pay a Part D late enrollment penalty before she turned 65, the penalty would be waived once she reaches 65.

The base beneficiary premium will change each year. This means that each year Medicare will use the current coverage year's amount to calculate a person's new penalty amount. If she becomes eligible for Extra Help, she would no longer have to pay the penalty.

## **Lesson 5: Extra Help With Part D Drugs Costs**

### *What Is Extra Help?*

Getting "Extra Help" means Medicare helps pay your Medicare prescription drug coverage monthly premium, any yearly deductible, coinsurance, and copayments. If you have limited income and resources, you may get Extra Help paying for your Medicare prescription drug costs. Extra Help is also called the low-income subsidy.

If you have the lowest income and resources, you'll pay no premiums or deductible, and have small or no copayments. If you have slightly higher income and resources, you'll have a reduced deductible and pay a little more out of pocket.

If you qualify for Extra Help, you won't have a coverage gap or late enrollment penalty. You'll also have a continuous Special Enrollment Period and can switch plans at any time, with the new plan going into effect the first day of the next month.

To find your level of Extra Help, visit [Medicare.gov/your-medicare-costs/help-paying-costs/extra-help/level-of-extra-help.html](https://www.Medicare.gov/your-medicare-costs/help-paying-costs/extra-help/level-of-extra-help.html).

**NOTE:** Residents of U.S. territories aren't eligible for Extra Help. Each of the territories helps its own residents with Medicare drug costs. This help is generally for residents who qualify for and are enrolled in Medicaid. This assistance isn't the same as Extra Help.

## 2015 Extra Help Income and Resource Limits

You may get Extra Help if you have Medicare, income below 150% of the federal poverty level (FPL), and limited resources. You may qualify for Extra Help if your income and resources are below the limits shown on the slide for 2015. If you're married and live with your spouse, both of your incomes and

- Income limits
    - Below 150% of the federal poverty level
      - \$1,471.25\* per month for an individual or \$1,991.25\* per month for a family size of 2
    - Based on family size
  - Resources limits
    - Up to \$13,640\* for an individual, or \$27,250\* for a married couple
      - Includes \$1,500/person for funeral or burial expenses
      - Counts savings and investments
      - Real estate (except your home)
- \*Higher amounts for Alaska and Hawaii

resources count, even if only one of you applies for Extra Help. If you're married and don't live with your spouse when you apply, only your income and resources count. The income is compared to the FPL for a single person or a married person, as appropriate. Whether you and/or your spouse have dependent relatives who live with you and who rely on you for at least half of their support is also taken into consideration. This means that a grandparent raising grandchildren may qualify, but the same person might not have qualified as an individual living alone.

Only 2 types of resources are used to see if you're eligible for Extra Help:

- Liquid resources (like savings accounts, stocks, bonds, and other assets that can be changed into cash within 20 days)
- Real estate, not including your home or the land on which your home is located

Items like wedding rings and family heirlooms aren't counted when seeing if you qualify for Extra Help.

**NOTE:** The income and resource levels listed are for 2015 and can go up each year. Income levels are higher if you live in Alaska or Hawaii, or you or your spouse pays at least half of the living expenses of dependent family members who live with you, or if you work. Updated resource limits are usually released each fall for the next calendar year. Updated income limits are usually released each February for the same calendar year.

### *Qualifying for Extra Help*

You automatically qualify for Extra Help (and don't need to apply) if you have Medicare and get full Medicaid coverage, Supplemental Security Income (SSI) benefits, or help from Medicaid paying your Medicare Part B premiums (Medicare Savings Program [MSP]).

If you don't meet one of these conditions, you may still qualify for Extra Help, but you'll need to apply for it. If you think you qualify but aren't sure, you should still apply. You can apply for Extra Help at any time, and if you're denied, you can reapply if your circumstances change. Eligibility for Extra Help may be determined by either Social Security or your state Medicaid agency.

You can apply for Extra Help by

- Completing a paper application you can get by calling Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
- Applying online at [socialsecurity.gov/medicare/prescriptionhelp](http://socialsecurity.gov/medicare/prescriptionhelp).
- Applying through your state Medicaid agency.
- Working with a local organization, like a State Health Insurance Assistance Program.

You can apply on your own behalf, or someone with the authority to act on your behalf can file your application (like with Power of Attorney), or you can ask someone else to help you apply.

If you apply for Extra Help, Social Security will transmit the data from your application to your state Medicaid agency to also initiate an application for MSP, which can help you pay for your Medicare premiums.

### *Automatic and Facilitated Enrollment*

People With Medicare and...	Basis for Qualifying	Data Source	Enrollment
Full Medicaid benefits	Automatically qualify	State Medicaid agency	<b>Automatic enrollment in Part D drug plan (unless already in a drug plan)</b> <ul style="list-style-type: none"> <li>▪ Letter on <b>YELLOW</b> paper</li> <li>▪ Coverage starts first month eligible for Medicare and Medicaid</li> <li>▪ Continuous Special Enrollment Period (SEP)</li> </ul>
Medicare Savings Program	Automatically qualify	State Medicaid agency	<b>Facilitated enrollment in Part D drug plan</b> <ul style="list-style-type: none"> <li>▪ Letter on <b>GREEN</b> paper</li> <li>▪ Coverage starts 2 months after CMS receives notice of your eligibility</li> <li>▪ Continuous SEP</li> </ul>
Supplemental Security Income benefits	Automatically qualify	Social Security (SSA)	
Limited income and resources	Must apply and qualify	SSA (most) or state Medicaid agency	

## 2015 Extra Help Copayments

Institutionalized	\$0
Receiving Home and Community-Based Services	\$0
Up to or at 100% Federal Poverty Level (FPL)	\$1.20/\$3.60
Full Extra Help – up to 135% FPL	\$2.65/\$6.60
Partial Extra Help (Deductible/Cost-Sharing)	\$66/15%

(Generic/Brand Name)

### Reassignment Notices

In the fall, the Centers for Medicare & Medicaid Services (CMS) will reassign certain people who qualify for Extra Help into new Medicare Prescription Drug Plans to make sure they continue to pay \$0 premium for their drug coverage. CMS will reassign people who get Extra Help if their Medicare drug plan or Medicare health plan is leaving the Medicare program as of December 31, 2015. These people will be reassigned into a new Medicare drug plan regardless of whether they joined their current plan on their own, or Medicare enrolled them in a plan. People affected by reassignment will get a notice on BLUE paper in the mail from CMS by early November. There are 3 versions of the notice. Two versions are for people whose plans are leaving the Medicare program.

- CMS Product No. 11208—informs people who qualify for Extra Help and whose Medicare Prescription Drug Plan (PDP) is leaving the Medicare Program that they'll be reassigned to a new Medicare drug plan if they don't join a plan on their own by December 31, 2015.
- CMS Product No. 11443—informs people who qualify for Extra Help and whose Medicare Advantage Plan is leaving the Medicare Program that they'll be enrolled in a Medicare PDP if they don't join a new plan on their own by December 31, 2015.

One version is for people whose premiums are increasing above the regional low-income premium subsidy amount (CMS Product No. 11209).

The notice tells people which plan they'll be reassigned to, explains how to stay in their current Medicare drug plan if available, and lets them know how to join a new plan. The notice also includes a list of plans in the region available for \$0 premium and their phone numbers. If people who get a notice don't tell their current plan that they want to stay or join a new plan on their own by December 31, 2015, Medicare will reassign them into a new plan with coverage effective January 1, 2016.

**NOTE:** Visit [CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11221-P.pdf](https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11221-P.pdf) to download the tip sheet, "Information Partners Can Use on: Reassignment" (CMS Product No. 11221-P).

## *Changes in Qualifying for Extra Help*

Every August, Medicare reestablishes Extra Help eligibility for the next calendar year if you automatically qualify. Your Extra Help continues or changes depending on whether you're still eligible for full Medicaid coverage, get help from Medicaid paying Medicare premiums, or get Supplemental Security Income (SSI). Any changes go into effect the next January.

If you were automatically eligible in a year, then you continue to qualify for Extra Help through December of that year. If you become no longer eligible, your automatic status ends on December 31 of that year. If you no longer automatically qualify for Extra Help, you'll get a letter from Medicare on gray paper with an Extra Help application from Social Security.

When people who no longer automatically qualify regain their eligibility for full Medicaid coverage, a Medicare Savings Program, or SSI, Medicare mails them a new letter on purple paper informing them that they now automatically qualify for Extra Help.

Also, you may continue to qualify automatically for Extra Help, but your copayment level may change due to a change from one of the following categories to another: you're institutionalized with Medicare and Medicaid, you have Medicare and full Medicaid coverage, you get help from Medicaid paying Medicare premiums (belong to a Medicare Savings Program), or you get SSI benefits but not Medicaid. In those cases, you'll get a letter from Medicare on orange paper telling you about the change in your copayment level for the next year.

**NOTE:** [CMS.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11232-P.pdf](https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11232-P.pdf) to download the tip sheet "Changes in Qualifying for Extra Help" (CMS Product No. 11232-P).

## *Redetermination Process*

There are 4 types of redetermination processes for people with Extra Help:

- Initial redeterminations—To redetermine eligibility, Social Security (SSA) selects a group of people who are eligible for Extra Help, but their eligibility may have changed due to a change in circumstances. These people get a redetermination form in the mail in September. They must complete and return the form within 30 days, even if nothing has changed, or SSA may end their eligibility for Extra Help, starting January 1 of the next year.
- Cyclical or recurring redeterminations—Each year, SSA also selects a random group of people with Extra Help to redetermine their eligibility for the following year. These people get a redetermination form in the mail in September. They must complete and return the form within 30 days of receiving it, even if nothing has changed, or SSA may end their eligibility for Extra Help, starting January 1 of the next year.

- Subsidy-changing event (SCE)—People with Extra Help may experience events that can change how much Extra Help they can still get, like marriage, divorce, separation, annulment, or the death of a spouse. They're required to report these events to SSA and complete and return the SCE redetermination form or they may lose their eligibility for Extra Help. Any change will take effect as of the first day of the month following the month of initial report of change.
- Other events—Eligibility for Extra Help may also be redetermined by SSA based on other changes, besides SCEs, like a recent decrease in income due to a cut in work hours.

### *Medicare's Limited Income Newly Eligible Transition (NET) Program*

Medicare's Limited Income Newly Eligible Transition (NET) program is designed to remove gaps in coverage for low-income individuals moving to Medicare prescription drug coverage. Humana, Inc., a contractor, has been operating the program for the Centers for Medicare & Medicaid Services (CMS) since 2010.

Enrollment in Medicare's Limited Income NET program is temporary and ends once a low-income person with Medicare gets coverage through a Medicare drug plan. The program gives point-of-sale coverage to people with Extra Help who don't yet have a Medicare drug plan. It also gives retroactive coverage to people who have full Medicaid coverage or get Supplemental Security Income (SSI) benefits.

The Limited Income NET program has an open formulary (Part D–covered drugs), doesn't require prior authorization, includes standard safety and abuse edits (like “refill too soon, or “therapy duplication”), and has no network pharmacy restrictions. However, CMS can't require a pharmacy to use this program.

To be eligible to use Medicare's Limited Income NET program, you must meet certain criteria:

- Have a valid Health Insurance Claim Number, which is on your Medicare card
- Be eligible for Medicare Part D
- Not be enrolled in a Part D plan
- Not be enrolled in a retiree drug subsidy plan
- Not be enrolled in a Part C plan that doesn't allow associated enrollment in a Part D plan
- Haven't opted out of auto-enrollment
- Have a permanent address in the 50 states or the District of Columbia

The Limited Income Newly Eligible Transition (NET) Outreach Team is run by Humana, Inc. It provides live webinar training to State Health Insurance Assistance Program counselors and pharmacy providers. To schedule a webinar or for more information, email [linetoutreach@humana.com](mailto:linetoutreach@humana.com). Visit [humana.com/pharmacy/pharmacists/linet](http://humana.com/pharmacy/pharmacists/linet) for more information and supporting documents like the Limited Income NET brochure and 4 Steps for Pharmacists.

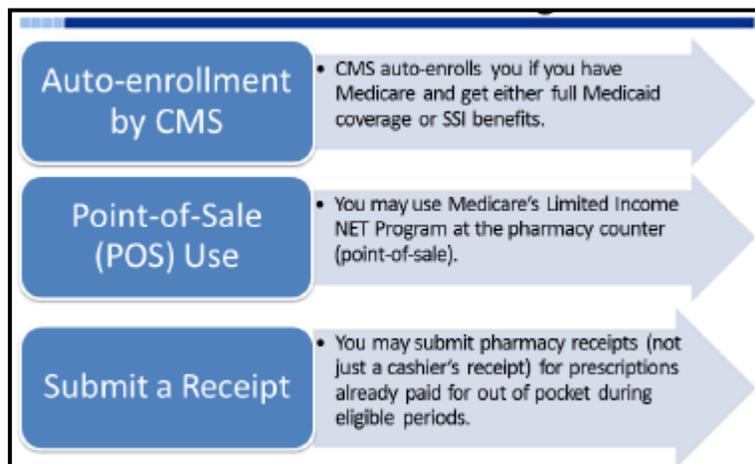
## How do you Access Medicare's Limited Income NET Program?

There are 3 ways you can access Medicare's Limited Income Newly Eligible Transition (NET) program:

- **Auto-enrollment by the Centers for Medicare & Medicaid Services (CMS).** CMS auto-enrolls you in this program if you have Medicare and get either full Medicaid coverage or Supplemental Security

Income (SSI) benefits. You're not automatically enrolled if you get help from your state Medicaid agency paying your Medicare Part B premiums (in a Medicare Savings Program [MSP]) or have applied and qualified for Extra Help. If you're auto-enrolled by CMS, your Medicare's Limited Income NET program coverage starts when you first have Medicare and get either full Medicaid coverage or SSI benefits, or during the last uncovered month—whichever is later.

- **Point-of-Sale (POS) Use.** If you get Extra Help, you may use Medicare's Limited Income NET program at the pharmacy counter (POS). Pharmacy participation is voluntary.
- **Submit a receipt.** You may submit pharmacy receipts (not just a cashier's receipt) for prescriptions already paid for out of pocket during eligible periods to the Medicare Limited Income NET Program, P.O. Box 14310, Lexington, KY 40512-4310.



If you use Medicare's Limited Income NET program by POS (at the pharmacy counter) or by submitting a pharmacy receipt, you may

- Get retroactive coverage up to 36 months if you have Medicare and get either full Medicaid coverage or SSI benefits (or as far back as January 1, 2006, if your Medicaid determination goes back to that point in time)
- Get up to 30 days of current coverage if you get help from your state Medicaid agency paying for your Medicare Part B premiums (in an MSP) or have applied and qualified for Extra Help
- Get immediate coverage if you show evidence of Medicaid (like a Medicaid ID card or a copy of a current Medicaid award letter with effective dates) or Extra Help eligibility to the pharmacy at POS, even if CMS's systems can't confirm your eligibility status

## Lesson 6: Comparing and Choosing Plans

### *Things to Consider Before Joining a Plan*

There are several things to consider before joining a Medicare drug plan. The most important consideration in deciding if Medicare drug coverage is right for you is to look at the type of health insurance coverage you have currently and how that affects your choices.

If you have prescription drug coverage, you need to find out whether it's creditable prescription drug coverage. Your current insurer or plan provider is required to notify you each year whether your coverage is creditable prescription drug coverage. If you haven't heard from them, call them or your benefits administrator to find out. Also, you may want to consider keeping your creditable prescription drug coverage rather than choosing a Medicare drug plan. It's important to find out how Medicare coverage affects your current health insurance plan to be sure you don't lose doctor or hospital coverage for yourself or your family members.

If you have employer or union coverage, call your benefits administrator before you make any changes, or sign up for any other coverage. If you drop your employer or union coverage, you may not be able to get it back. Also, you may not be able to drop your employer or union drug coverage without also dropping your employer or union health (doctor and hospital) coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependents.

You can get information on how different types of current coverage work with Medicare prescription drug coverage by visiting [Medicare.gov/](http://Medicare.gov/) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### *Steps to Choosing a Medicare Drug Plan*

#### *Step 1: Prepare*

Before choosing a Medicare drug plan, you may want to get your information together. You need information about any prescription drug coverage you may currently have, as well as a list of the prescription drugs and doses you currently take. You'll also need the names of any pharmacies you prefer to use, your Medicare card, and your ZIP code. Finally, gather any notices you get from Medicare, Social Security, or your current Medicare drug plan about changes to your plan.

**NOTE:** For a helpful Medicare Plan Finder worksheet, see [CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2014-Medicare-Plan-Finder-Worksheet.pdf](http://CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2014-Medicare-Plan-Finder-Worksheet.pdf).

## Step 2: Compare Plans on Medicare Plan Finder

Visit [Medicare.gov/find-a-plan/questions/home.aspx](http://Medicare.gov/find-a-plan/questions/home.aspx)

and use the Medicare Plan Finder:

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on quality ratings, benefits covered, costs, and more

You should compare Medicare drug plans based on what's most important to your situation and your drug needs. You may want to ask yourself the following questions:

- Which plan(s) covers the prescriptions I take?
- Which plan(s) gives me the best overall price on all of my prescriptions?
- What's the monthly premium, yearly deductible, and the coinsurance or copayment(s)?
- Which plan(s) allows me to use the pharmacy I want or get prescriptions through the mail?
- Which plan(s) gives me coverage in multiple states, if I need it?
- What star ratings did the plan(s) get?
- Can my coverage start when I want it to?
- Is it likely that I'll need protection against unexpected drug costs in the future?



## Step 3: Decide and Join

After you pick a plan that meets your needs, call the company offering it, and ask how to join. You may be able to join online, by phone, or by paper application. You'll have to give the number on your Medicare card when you join.

You can join with the plan directly. All plans must offer paper enrollment applications. Also, plans may let you enroll through their website or over the phone. Most plans also participate and offer enrollment through Medicare's website, [Medicare.gov/find-a-plan/questions/home.aspx](http://Medicare.gov/find-a-plan/questions/home.aspx). You can also call Medicare to enroll at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Plans must process applications in a timely manner, and after you apply, the plan must notify you that it has accepted or denied your application.

It's a good idea to keep a copy of your application, confirmation number, any other papers you sign, and letters or materials you get.

You can find these steps, and worksheets to help with this process in "Your Guide to Medicare Prescription Drug Coverage," CMS Product No. 11109, which you can find at [Medicare.gov/Pubs/pdf/11109.pdf](http://Medicare.gov/Pubs/pdf/11109.pdf).

**NOTE:** There are a small number of plans that may have more limited enrollment options, including some Special Needs Plans, Cost Plans, and consistently poor performing plans that have received less than a 3-star rating for 3 consecutive years. In these cases, you may not be able to enroll online. You can still call the plan directly to enroll.

### *What New Members Can Expect*

When you join a plan, or when Medicare enrolls you in a plan, the plan will send you an enrollment letter and membership materials, including an identification card and customer service information with a toll-free phone number and website address.

Plans will also have a transition process in place for you if you're new to the plan and taking a drug that isn't on the plan's formulary. The plan must let you get a 30-day temporary supply of the prescription (a 90-day supply if you're a resident of a long-term care facility). This gives you time to work with your prescribing doctor to find a different drug that's on the plan's formulary. If an acceptable alternative drug isn't available, you or your doctor can request an exception from the plan, and you can appeal denied requests.

### *Annual Notice of Change (ANOC)*

Each year, Medicare drug plans are required to send an Annual Notice of Change (ANOC) to all plan members. The letter must be sent by September 30, along with a summary of benefits and a copy of the formulary for the upcoming year.

You should read the ANOC carefully. The letter will explain any changes to your current plan, including changes to the monthly premium and changes to cost-sharing information like copayments or coinsurance.

Plans must send an Evidence of Coverage (EOC) to all members no later than January 31 each year. It gives details about the plan's service area, benefits, and formulary; how to get information, benefits, and Extra Help; and how to file an appeal. The plan may choose to send the EOC with the ANOC.

## **Lesson 7: Coverage Determinations and Appeals**

### *Coverage Determination Request*

A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about a prescription drug benefit that you request. This includes whether a certain drug is covered, whether you have met all the requirements for getting a requested drug, and how much you must pay for a drug. You or your prescriber must contact your plan to ask for a coverage determination.

You, your prescriber, or your appointed representative can ask for a coverage determination by calling your plan or writing a letter. If you write to the plan, you can write a letter or use the “Model Coverage Determination Request” form found at [CMS.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev/forms.html](https://www.cms.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev/forms.html) .

There are 2 types of coverage determinations: standard and expedited. Your request will be faster (expedited) if the plan determines, or if your doctor tells the plan that your life or health may be seriously jeopardized by waiting for a standard request.

A plan must give you its coverage determination decision as quickly as your health condition requires. After receiving your request, the plan must give you its decision no later than 72 hours for a standard determination, or 24 hours for an expedited determination. If your coverage determination request involves an exception (see next slide), the time clock starts when the plan gets your doctor’s supporting statement.

If a plan fails to meet these time frames, it must automatically forward the request and case file to the Independent Review Entity (IRE) for review, and the request will skip over the first level of appeal (redetermination by the plan). The IRE is MAXIMUS. You can find its contact information at [MedicarePartDAppeals.com](https://www.MedicarePartDAppeals.com).

### *Exception Requests*

An exception is a type of coverage determination. There are 2 types of exceptions: tier exceptions (like getting a tier 4 drug at the tier 3 cost) and formulary exceptions (either coverage for a drug that’s not on the plan’s formulary, or relaxed access requirements). If you want to make an exception request, you’ll need a supporting statement from the prescriber. In general, the statement must point out the medical reason for the exception. The prescriber may give the statement verbally or in writing to the plan.

If your exception request is approved, the exception is valid for refills for the remainder of the plan year, so long as you remain enrolled in the plan, your doctor continues to prescribe the drug, and the drug remains safe for treating your condition. A plan may choose to extend coverage into a new plan year. If it doesn’t, it must say so in writing either at the time the exception is approved, or at least 60 days before the plan year ends. If your plan doesn’t extend your exception coverage, you should think about switching to a drug on the plan’s formulary, asking for another exception, or changing to a plan that covers that drug during Medicare’s Open Enrollment Period, which is from October 15 through December 7 each year.

**NOTE:** If you want to choose a representative to help you with a coverage determination or appeal, you and the person you want to help you must fill out the Appointment of Representative form (Form CMS-1696). You can get a copy of the form at [CMS.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html](https://www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html). You can also appoint a representative with a letter signed and dated by you and the person helping you, but the letter must have the same information that’s asked for on the Appointment of Representative form. You must send the form or letter in with your coverage determination or appeal request.

### *Requesting Appeals*

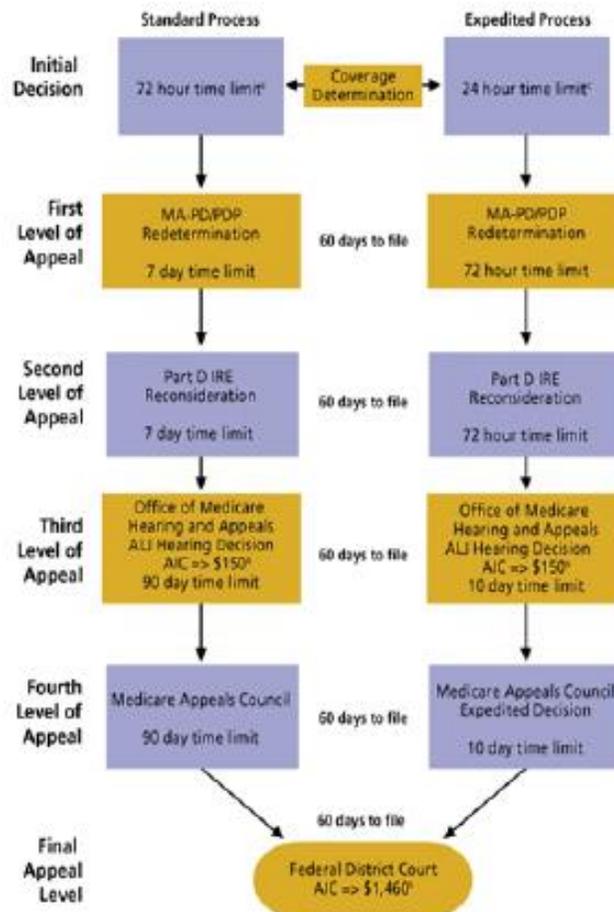
If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how you may file an appeal. Read this decision carefully, and call your plan if you have questions.

In general, you must make your appeal requests in writing. However, plans must accept oral (spoken) expedited redetermination requests. In addition, plans may choose to accept verbal standard redetermination requests. Check your plan materials or contact your plan to see if you can make spoken standard redetermination requests.

You or your appointed representative may ask for any level of appeal. Your doctor or other prescriber can ask for an expedited redetermination on your behalf.

To view a chart showing the process for Medicare appeals, visit [CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2015-Medicare-Parts-A-B-C-and-D-Appeals-Process-Chart.pdf](https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2015-Medicare-Parts-A-B-C-and-D-Appeals-Process-Chart.pdf).

# Appendix A: Part D Appeals Flow Chart



### *Appendix B: Appeals Flow Chart Foot Note*

**a:** Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days

**b:** The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index.

**c:** A request for a coverage determination includes a request for a tiering exception or a formulary exception.

**AIC** = Amount in Controversy

**ALJ** = Administrative Law Judge

**MA-PD** = Medicare Advantage Prescription Drug

**MAC** = Medicare Administrative Contractor or Medicare Appeals Council

**MMA** = Medicare Prescription Drug, Improvement & Modernization Act of 2003

A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, the Prescription Drug Plan (PDP) or the enrollee's physician.

The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication time frame begins when the plan sponsor gets the physician's supporting statement.

**IRE** = Independent Review Entity

**QIC** = Qualified Independent Contractor

This chart reflects the **CY 2015 AIC** amounts.

### **Key Points to Remember**

- ✓ Medicare Part D provides your Medicare prescription drug coverage
- ✓ You must take action to join a plan
- ✓ A delay in joining may result in a late enrollment penalty
- ✓ You have choices in how you get your coverage
- ✓ Extra Help is available to people with low income and resources

# Medicare Prescription Drug Coverage Resource Guide

## Resources

**Websites:**  
Centers for Medicare & Medicaid Services (CMS) [CMS.gov](http://CMS.gov)  
RxAssist - A directory of Patient Assistance Programs [rxassist.org](http://rxassist.org)  
Medicare Part D Appeals [MedicarePartDAppeals.com](http://MedicarePartDAppeals.com)

**Contacts:**  
[Medicare.gov](http://Medicare.gov)  
1-800-MEDICARE (1-800-633-4227)  
1-877-486-2048 (TTY)

Social Security  
1-800-772-1213  
[socialsecurity.gov](http://socialsecurity.gov)

Local State Health Insurance Programs [Medicare.gov/contacts](http://Medicare.gov/contacts)

Limited Income NET Program (HUMANA)  
1-800-783-1307 or 711 (TRS)  
Email: [linetoutreach@humana.com](mailto:linetoutreach@humana.com)

**Manuals/Guidance**  
"Prescription Drug Benefit Manual"  
[CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcontrol/partdmanuals.html](http://CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcontrol/partdmanuals.html)

"PDP Enrollment and Disenrollment Guidance"  
[CMS.gov/Medicare/eligibility-and-enrollment/medicarepresdrugeligenrol/index.html](http://CMS.gov/Medicare/eligibility-and-enrollment/medicarepresdrugeligenrol/index.html)

## Medicare Products

**Manuals/Guidance (continued)**  
"Medicare Premiums: Rules For Higher-Income Beneficiaries"  
[SSA.gov/pubs/EN-05-10536.pdf](http://SSA.gov/pubs/EN-05-10536.pdf)

"2014/2015 Guide to Mailings from CMS, Social Security, and Plans"  
[CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/2014Mailings.pdf](http://CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/2014Mailings.pdf)

**National Training Program – Partner Job Aids**  
Visit the Training Library at [CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram](http://CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram)

**CMS Publications**  
"Your Guide to Medicare Prescription Drug Coverage" (CMS Product No. 11109)  
"Things to Think About When You Compare Medicare Drug Coverage" (CMS Product No. 11163)  
"4 Ways to Help Lower Your Medicare Prescription Drug Costs" (CMS Product No. 11417)  
"How Medicare Drug Plans Use Pharmacies, Formularies, and Common Coverage Rules" (CMS Product No. 11136)  
To view or order these products: Single copies - [Medicare.gov/Publications](http://Medicare.gov/Publications); Multiple copies (partners only) [productorder.inh.cms.hhs.gov](http://productorder.inh.cms.hhs.gov)

**CMS Partner Tip Sheets** — [CMS.gov/publications-for-partners.html](http://CMS.gov/publications-for-partners.html)

**Partner Tip Sheets (continued)**  
"Medicare Drug Coverage Under Medicare Part A, B, & D" (CMS Product No. 11315-P)  
"Handling Medicare Part D Complaints" (CMS Product No. 11259-P)  
"How Retiree Coverage Works With Medicare Prescription Drug Coverage" (CMS Product No. 11403-P)  
"Correcting Subsidy Status or Level Based on Best Evidence" (CMS Product No. 11325-P)  
"Information Partners Can Use On: Closing the Coverage Gap" (CMS Product No. 11495-P)  
"Information Pharmacists Can Use On: Closing the Coverage Gap" (CMS Product No. 11522-P)  
"LI NET for People at Pharmacy Counter" (CMS Product No. 11328-P)  
"LI NET for People With Retroactive Medicaid & SSI Eligibility" (CMS Product No. 11401-P)  
"How Medicare Plans Drug Coverage Work With a Medicare Advantage Plan or Medicare Cost Plan" (CMS Product No. 11135)

## Acronyms

ANOC	Annual Notice of Change
BPH	Benign Prostatic Hyperplasia
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DME	Durable Medical Equipment
EOB	Explanation of Benefits
EOC	Evidence of Coverage
ESRD	End-Stage Renal Disease
FDA	U.S. Food and Drug Administration
FPL	Federal Poverty Level
IEP	Initial Enrollment Period
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
LPI	Low Performance Icon
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MA-PD	Medicare Advantage Plans With Prescription Coverage
MSP	Medicare Savings Program
NET	Newly Eligible Transition
NTP	National Training Program
PDP	Prescription Drug Plan
POS	Point-of-Sale
RRB	Railroad Retirement Board
SCE	Subsidy-Changing Event
SEP	Special Enrollment Period
SNF	Skilled Nursing Facility
SSA	Social Security
SSI	Supplemental Security Income
TrOOP	True Out-of-Pocket
TTY	Teletypewriter