

Centers for Medicare & Medicaid Services
National Training Program
Instructor Information Sheet

Module 9 - Medicare Part D — Prescription Drug Coverage

Module Description

The lessons in this module, “Medicare Part D — Prescription Drug Coverage,” explain the Medicare Prescription Drug Coverage program.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers who are familiar with the Medicare program, and would like to have prepared information for their presentations.

Objectives

- Differentiate Part D, Part A, and Part B 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

Target Audience

This module is designed for presentation to trainers and other information givers.

Time Considerations

The module consists of 77 PowerPoint slides with corresponding speaker’s notes, and questions to help engage the audience and check knowledge before moving forward with the next lesson. It can be presented in 90 minutes. Allow approximately 20 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities. It has a resource guide and National Training Program contact slide to reference. The Appendices in the back (slides 78-87) provide additional resources and are a useful reference tool.

Course Materials

Most materials are self-contained within the module. YouTube links provided in the Extra Help section are included in the slide, but if you don’t have the Internet, you should download the video to your laptop as a precaution. Each lesson includes two Check Your Knowledge questions that give participants the opportunity to apply the module concepts in a real-world setting.

- **Vides: New Twist in the law**
Show Chubby Checker video - new “twist” in the law that makes it easier to qualify for Extra Help with Medicare prescription drug costs.
[youtube.com/watch?feature=player_embedded&v=zI2jp2p40ie](https://www.youtube.com/watch?feature=player_embedded&v=zI2jp2p40ie)

Module 9: Medicare Part D — Prescription Drug Coverage

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2014 National Training Program

Module 9

**Medicare Part D —
Prescription Drug
Coverage**

Module 9 explains Medicare Prescription Drug Coverage under Parts A, B, and D.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace. The information in this module was correct as of May 2014.

To check for an updated version of this training module, visit [cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html).

This set of CMS National Training Program materials isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Session Objectives

This session will help you

- 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

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Medicare Prescription Drug Coverage

This session will help you

- 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 — Drug Coverage Basics

- The four parts of Medicare
- Prescription drug coverage under
 - Medicare Part A (Hospital Insurance)
 - Medicare Part B (Medical Insurance)

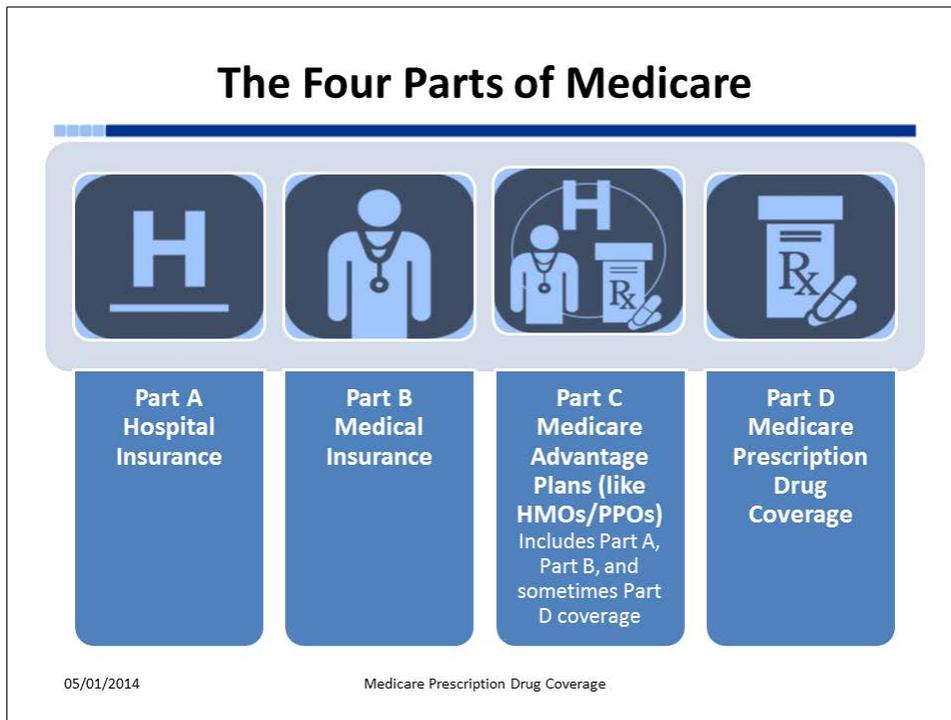
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Medicare Prescription Drug Coverage

Lesson 1, “Drug Coverage Basics,” provides basic information on the following:

- The four parts of Medicare
- Prescription drug coverage under
 - Medicare Part A (Hospital Insurance)
 - Medicare Part B (Medical Insurance)

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)** is another way to get your Medicare benefits. It combines Part A and B, and sometimes Part D (Medicare prescription drug coverage). Medicare Advantage 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

- Prescription drug coverage under Part A, Part B, or Part D depends on
 - Medical necessity
 - Health care setting
 - Medical indication (such as for cancer)
 - Any special drug coverage requirements
 - Such as immunosuppressive drugs following a transplant
- This information applies if you have Original Medicare

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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, cancer).
- Any special coverage requirements, such as 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.

Need more information?

For useful resources about drug coverage under Medicare Parts A and B, please see the Medicare Prescription Drug Coverage Resource Guide on page 76.



Part A Prescription Drug Coverage

- Part A generally pays for all drugs during a covered inpatient stay
 - Received as part of treatment in a hospital or skilled nursing facility
- Drugs used in hospice care for symptom control and pain relief only

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Medicare 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 receive 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 cover drugs covered under the Medicare Part A per diem payment to the hospice.

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

Part B Prescription Drug Coverage

- Part B covers limited outpatient drugs
 - Injectable and infusible drugs given as part of a doctor's service
 - Drugs used at home with some types of Part B–covered durable medical equipment
 - Such as nebulizers and infusion pumps
 - Some oral drugs with special coverage requirements
 - Anti-cancer and antiemetic drugs
 - Immunosuppressive drugs, under certain circumstances

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Medicare Prescription Drug Coverage

Medicare Part B gives limited prescription drug coverage. It doesn't cover most drugs you get at the pharmacy. Part B covers only the following limited set of outpatient drugs:

- 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 is administered at the same time as chemotherapy). However, if an injection is usually self-administered (such as Imitrex® for migraines) or isn't given as part of a doctor's service, it isn't covered by Part B.
- 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 is a participating DME provider in the Medicare Part B program. 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/supplier.
- Three categories of oral drugs with special coverage requirements: oral anti-cancer, oral antiemetic (to treat nausea), and immunosuppressive drugs (under certain circumstances).

Need more information?

For the lists of oral drugs with special coverage requirements, please see Appendices A, B, and C.



Part B Immunization Coverage

- Part B covers certain immunizations as part of Medicare-covered preventive services
 - Flu shot
 - Pneumococcal shot (to prevent pneumonia)
 - Hepatitis B shot
 - Tetanus shot

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Medicare Prescription Drug Coverage

Medicare Part B covers certain immunizations:

- Influenza virus vaccine (flu shot), pneumococcal shot (to prevent certain types of pneumonia), Hepatitis B shot (for individuals at high or intermediate risk), and other vaccines (such as 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 other vaccines (like the shingles vaccine) needed to prevent illness.
- 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.

Self-Administered Drugs in Hospital Outpatient Settings

- Part B doesn't cover self-administered drugs in a hospital outpatient setting
 - Unless needed for hospital services
- If enrolled in Part D, drugs may be covered
 - If not admitted to hospital
 - May have to pay and submit for reimbursement

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Medicare Prescription Drug Coverage

There may be a need for self-administered drugs (drugs you would normally take on your own) in hospital outpatient settings, such as 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 have 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.

Need more information?

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).



Check Your Knowledge—Question 1



Max has a Part D plan. He recently got prescription drugs during a Medicare-covered stay at a skilled nursing facility. Will Medicare pay for his prescription drugs? Which part of Medicare?

- a. No
- b. Yes, Part A
- c. Yes, Part B
- d. Yes, Part D



Refer to page 88 to check your answers.

Check Your Knowledge—Question 2



Which of these vaccines is NOT covered under Medicare Part B?

- a. Flu shot
- b. Shingles shot
- c. Hepatitis B shot
- d. Pneumococcal shot (to prevent pneumonia)



Refer to page 88 to check your answers.

Lesson 2 — Medicare Part D Benefits and Costs

- Medicare prescription drug coverage
- Medicare drug plan benefits and costs

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Medicare Prescription Drug Coverage

Lesson 2, “Medicare Part D Benefits and Costs,” provides information on Medicare prescription drug coverage, benefits, and costs under Part D.

Part D Medicare Prescription Drug Coverage

- Medicare drug plans
 - Approved by Medicare
 - Run by private companies
 - Available to everyone with Medicare
- You must join a plan to get coverage
- There are two ways to get coverage
 - Medicare Prescription Drug Plans
 - Medicare Health Plans with prescription drug coverage

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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 is not automatic).

There are two 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 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 Medicare Supplement Insurance (Medigap) policies offered prescription drug coverage before January 1, 2006. This isn't Medicare prescription drug coverage.

Medicare Drug Plans

- Can be flexible in benefit design
- Must offer at least a standard level of coverage
- Vary in cost and drugs covered
 - Deductible
 - Different tier and/or copayment levels
 - Coverage for drugs not typically covered by Part D
- Benefits and costs may change each year

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Medicare Prescription Drug Coverage

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

- Costs vary by plan
- In 2014, most people will pay
 - A monthly premium
 - A yearly deductible
 - Copayments or coinsurance
 - 47.5 percent for covered brand-name drugs in coverage gap
 - 72 percent for covered generic drugs in coverage gap
 - Very little after spending \$4,550 out of pocket

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Medicare Prescription Drug Coverage

Your costs for prescription drug coverage will depend on the plan you choose and some other factors, such as 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, 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.

With every plan, once you've paid \$4,550 out of pocket for drug costs in 2014 (including payments from other sources, such as the discount paid for by the drug company in the coverage gap) you leave the coverage gap and pay 5 percent (or a small copayment) for each drug for the rest of the year.

Need more information?

Please see Appendix D for the standard Medicare Part D cost and benefit structure.



Standard Structure in 2014			
Ms. Smith joins a prescription drug plan. Her coverage begins on January 1, 2014. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions.			
Monthly Premium – Ms. Smith 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 \$310 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 \$2,850.	Once Ms. Smith and her plan have spent \$2,850 for covered drugs, she's in the coverage gap. In 2014, she pays 47.5% of the plan's cost for her covered brand-name prescription drugs and 72 percent 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 \$4,550 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.
05/01/2014		Medicare Prescription Drug Coverage	

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 \$310 in 2014)** – 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 \$310 in 2014. Some drug plans don't have a deductible.
- **Copayments or coinsurance (you pay approximately 25 percent)** – 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 (\$2,850 in 2014). In 2014, once you enter the coverage gap, you pay 47.5 percent of the plan's cost for your covered brand-name drugs and 72 percent 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 percent)** – Once you reach your out of pocket limit, 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
2014	47.5%	72%
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

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Medicare Prescription Drug Coverage

Your coverage gap discount on drugs will increase each year until 2020, when you'll pay approximately 25 percent for all covered drugs in the gap.

In 2014, you pay 47.5 percent of dispensing and vaccine administration fees for brand-name drugs in the coverage gap (unless you get Extra Help). Medicare drug plans together with a manufacturer's 50 percent discount pay for the remaining 52.5 percent of the costs. Medicare drug plans will pay an increasing amount of these costs until 2020. In 2014, you also pay 72 percent of the ingredient cost, sales tax, and dispensing and vaccine administration fees for generic drugs in the coverage gap.

Need more information?

Visit [cms.gov/outreach-and-education/outreach/partnerships/publications-for-partners.html](https://www.cms.gov/outreach-and-education/outreach/partnerships/publications-for-partners.html) to download the publication, "Information Partners can use on: Closing the Coverage Gap" (CMS 11522-P), and "Information Pharmacists can use on Closing the Coverage Gap" (CMS 11495-P).



True Out-of-Pocket (TrOOP) Costs

- Expenses that count toward your out of pocket threshold (\$4,550 in 2014)
- After threshold you get catastrophic coverage
 - You pay only small copayment or coinsurance for covered drugs
- Explanation of Benefits (EOB) shows TrOOP costs to date
- TrOOP transfers if you switch plans mid-year

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Medicare Prescription Drug Coverage

True out-of-pocket (TrOOP) costs are the expenses that count toward your Medicare drug plan out of pocket threshold of \$4,550 (for 2014). 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.

Need more information?

Visit [cms.gov/outreach-and-education/outreach/partnerships/publications-for-partners.html](https://www.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 That Count	Payments That Don't Count
<ul style="list-style-type: none"> ▪ Payments made by you, your family members, or friends ▪ Qualified State Pharmacy Assistance Programs ▪ Medicare's Extra Help ▪ Most charities (not if established or run by employer/union) ▪ Indian Health Service ▪ AIDS Drug Assistance Programs ▪ The discount you get on covered brand-name drugs in the coverage gap 	<ul style="list-style-type: none"> ▪ Your monthly plan premium ▪ Share of the drug cost paid by your Medicare drug plan ▪ Group Health Plans (including employer/union retiree coverage) ▪ Government-funded programs (including Medicaid, TRICARE, VA) ▪ Patient Assistance Programs ▪ Other third-party payment arrangements ▪ Other types of insurance ▪ The discount you get on covered generic drugs in the coverage gap

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Medicare Prescription Drug Coverage

Expenses that **count** toward your True Out-of-Pocket (TrOOP) costs include payments for drugs that are covered by the plan and made by the following:

- You, your family members, or friends
- Qualified State Pharmacy Assistance Programs
- Medicare's Extra Help
- Most charities, unless established, run, or controlled by a current or former employer/union
- Indian Health Service
- AIDS Drug Assistance Programs
- Drug manufacturers under the Medicare coverage gap discount program (for example, the discount you get on covered brand-name drugs in the coverage gap)

Expenses that **don't** count toward your TrOOP costs include payments made by the following:

- Your Medicare drug plan (for example, the share of the cost of the drug paid by your plan).
- Group health plans, including employer or union retiree coverage (and personal Health Savings Accounts when structured as a group health plan).
- Government-funded programs, including Medicaid, TRICARE, or Veterans Affairs (VA).
- Patient Assistance Programs that give free or significantly reduced-price drugs may charge a small copayment and this amount may count toward TrOOP. You'll need to submit a claim to your drug plan, along with documentation of the copayment.
- Other third-party payment arrangements or insurance.
- The discount you get on covered generic drugs in the coverage gap.

NOTE: The following payments don't count toward TrOOP: monthly plan premium, drugs not covered by the plan, drugs excluded from Part D, over-the-counter drugs, and drugs purchased outside the United States and its territories.

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

- Based on income above a certain limit
 - Fewer than 5 percent pay a higher premium
 - Uses same thresholds used to compute IRMAA for the Part B premium
 - Income as reported on your IRS tax return from 2 years ago
- Required to pay if you have Part D coverage
 - Failure to pay may result in disenrollment

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Medicare Prescription Drug Coverage

A small group—less than 5 percent of all people with Medicare—may pay a higher monthly premium based on their income (as reported on your IRS tax return from 2 years ago). If your income is above a certain limit, you will pay an extra amount in addition to your plan premium. Social Security (SSA) 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 SSA check, you'll be billed for the extra amount each month by either the Centers for Medicare & Medicaid Services (CMS) or the Railroad Retirement Board (RRB). This means that you'll pay your plan each month for your monthly premium and pay CMS 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 your entire Part D premium (including the extra amount), you may be disenrolled from your Medicare drug plan. You must pay both the extra amount 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 SSA at 1-800-772-1213. TTY users should call 1-800-325-0778.

SOURCE: SSA Publication No. 05-10536, "Medicare Premiums: Rules for Higher-Income Beneficiaries."



Need more information?

For more information, visit [socialsecurity.gov](https://www.socialsecurity.gov).

Income-Related Monthly Adjustment Amount (IRMAA)

If Your Yearly Income in 2012 was		In 2014 You Pay
File Individual Tax Return	File Joint Tax Return	
\$85,000 or less	\$170,000 or less	Your Plan Premium (YPP)
\$85,000.01 – \$107,000	\$170,000.01 – \$214,000	YPP + \$12.10*
\$107,000.01 – \$160,000	\$214,000.01 – \$320,000	YPP + \$31.10*
\$160,000.01 – \$214,000	\$320,000.01 – \$428,000	YPP + \$50.20*
Above \$214,000	Above \$428,000	YPP + \$69.30*

*per month.

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

05/01/2014

Medicare Prescription Drug Coverage

You pay only your plan premium if your yearly income in 2012 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 [SSA] 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 SSA considers, contact SSA 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

Check Your Knowledge—Question 3



Which costs don't count toward getting out of the coverage gap?

- a. Drug plan premium
- b. Discount on covered generic drugs
- c. Discount on covered brand-name drugs
- d. Copayments or coinsurance
- e. Yearly deductible



Refer to page 88 to check your answers.

Check Your Knowledge—Question 4



Medicare drug plan benefits and costs are the same from year to year.

- a. True
- b. False



Refer to page 88 to check your answers.

Lesson 3 — Medicare Part D Drug Coverage

- Covered and non-covered drugs
- Access to covered drugs

05/01/2014

Medicare Prescription Drug Coverage

Lesson 3, “Medicare Part D Drug Coverage,” provides information on the following:

- Covered and non-covered drugs
- Access to covered drugs

Part D – Covered Drugs

- Prescription brand-name and generic drugs
 - Approved by the Food and Drug Administration
 - Used and sold in United States
 - Used for medically accepted indications
- Include drugs, biological products, and insulin
 - And supplies associated with injection of insulin
- Plans must cover range of drugs in each category
- Coverage and rules vary by plan

05/01/2014

Medicare Prescription Drug Coverage

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 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, such as syringes, needles, alcohol swabs, and gauze.

To make sure people with different medical conditions can get the prescriptions they need, drug lists for each plan must include a range of drugs in each prescribed category. All Medicare drug plans generally must cover at least two 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.

A plan's prescription drug list may not include your specific drug. However, 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. Exceptions are discussed in more detail on slide 71.

Required Coverage

- All drugs in six protected categories
 - Cancer medications
 - HIV/AIDS treatments
 - Antidepressants
 - Antipsychotic medications
 - Anticonvulsive treatments
 - Immunosuppressants
- All commercially-available vaccines
 - Except those covered under Part B (e.g., flu shot)

05/01/2014

Medicare Prescription Drug Coverage

Medicare drug plans must cover all drugs in six 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, such as 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.

Drugs Excluded by Law Under Part D

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Non-prescription drugs

05/01/2014

Medicare Prescription Drug Coverage

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

- Drugs for anorexia, weight loss, or weight gain.
- 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 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.

Barbiturate Coverage Under Part D

NEW!

- Prior to 2013, barbiturates and benzodiazepines were excluded from coverage under Part D
- In 2013, Part D–covered benzodiazepines and those barbiturates used for the treatment of epilepsy, cancer, or chronic mental health disorders
- Effective January 1, 2014, barbiturates are covered under Part D for any medically accepted indication

05/01/2014

Medicare Prescription Drug Coverage

Barbiturates and benzodiazepines were previously excluded from coverage under Medicare Part D. In 2013, Part D–covered benzodiazepines and those barbiturates used for the treatment of epilepsy, cancer, or chronic mental health disorders. As of January 1, 2014, the Affordable Care Act removed restrictions related to treatment. Part D now covers barbiturates for any medically accepted indication and will no longer be limited to use in the treatment of epilepsy, cancer, or a chronic mental health disorder.

Formulary

- A list of prescription drugs covered by the plan
- May have tiers that cost different amounts

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

05/01/2014

Medicare Prescription Drug Coverage

Each Medicare drug plan has a formulary, 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) – A generic drug is the same as its brand-name counterpart in safety, strength, quality, the way it works, how it's taken, and the way it should be used. Generic drugs 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. Generic drugs are less expensive because of market competition. Generic drugs are thoroughly tested and must be Food and Drug Administration approved. 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 drugs** – Tier 3 drugs cost more than Tier 2 drugs.
- **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 (see slide 71) and ask your plan for a lower copayment.

Formulary Changes

- Plans may only change categories and classes at beginning of each plan year
 - May make maintenance changes during year
 - Such as replacing brand-name drug with new generic
- Plan usually must notify you 60 days before changes
 - You may be able to use drug until end of calendar year
 - May ask for exception if other drugs don't work
- Plans may remove drugs withdrawn from market without 60-day notification

05/01/2014

Medicare Prescription Drug Coverage

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, such as 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 the Centers for Medicare & Medicaid Services (CMS), State Pharmacy Assistance Programs, prescribing physicians, network pharmacies, pharmacists, and people covered under the plan.

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 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.

Rules Plans Use to Manage Access to Drugs

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

05/01/2014

Medicare Prescription Drug Coverage

Medicare drug plans manage access to covered drugs in several ways 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.

Strategy to Combat Part D Fraud and Abuse

NEW!

- Key provisions in the CY 2015 final rule
 - For policy and technical changes to the Medicare Advantage (MA) and Prescription Drug Program
 - Requires prescribers of Part D Drugs to enroll in Medicare
 - Permit revocation of Medicare enrollment for abusive prescribing practices and patterns
 - Allow Part D sponsors ability to request/collect information directly from pharmacy benefit managers
 - Require MA Plans and Part D sponsors to report and return identified Medicare overpayments

05/01/2014

Medicare Prescription Drug Coverage

The Centers for Medicare & Medicaid Services (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. **Key fraud and abuse provisions in the CY 2015 policy & technical changes to the Medicare Advantage (MA) and prescription drug program final rule include the following:**

- **Requiring prescribers of Part D Drugs to enroll in Medicare.** This would help CMS ensure that Part D drugs are only prescribed by qualified individuals.
- **Permitting revocation of Medicare Enrollment for abusive prescribing practices and patterns.** This would help protect beneficiaries and the Medicare Trust Fund from fraud, waste, and abuse.
- **Providing direct access to Part D sponsors' downstream entities.** This would streamline CMS's and its anti-fraud contractors' investigative processes. Currently, it can take a long time for CMS's contractors, who are often assisting law enforcement, to obtain important documents (like invoices and prescriptions) directly from pharmacies, because they must work through the Part D plan sponsor to obtain this information. This proposal is designed to provide more timely access to records, including for investigations of Part D fraud and abuse, and responds to recommendations from the U.S. Department of Health and Human Services Office of Inspector General.
- **Improving payment accuracy.** The proposed regulation also would implement the Affordable Care Act requirement that MA Plans and Part D sponsors report and return identified Medicare overpayments.

If Your Prescription Changes

- Get up-to-date formulary information from your plan's
 - Website
 - Customer service center
- Give doctor copy of plan's formulary
- If the new drug isn't on plan's formulary
 - Can request a coverage determination from plan
 - May have to pay full price if plan still won't cover

05/01/2014

Medicare Prescription Drug Coverage

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.

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.

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

Check Your Knowledge—Question 5



Which of the following drugs are NOT covered by Medicare Part D?

- a. Prescription vitamin and mineral products
- b. Insulin
- c. Cancer medications
- d. Barbiturates and benzodiazepines



Refer to page 89 to check your answers.

Check Your Knowledge—Question 6



For prescription brand-name and generic drugs to be covered by a Medicare drug plan, they must be

- a. Approved by the Food and Drug Administration
- b. Used and sold in the United States
- c. Used for medically-accepted indications
- d. All the above



Refer to page 89 to check your answers.

Lesson 4 — Part D Eligibility and Enrollment

- Eligibility requirements
- When you can join or switch plans
- Creditable coverage
- Late enrollment penalty

05/01/2014

Medicare Prescription Drug Coverage

Lesson 4, “Part D Eligibility and Enrollment,” provides information on the following:

- Eligibility requirements
- When you can join or switch plans
- Creditable coverage
- Late enrollment penalty

Part D Eligibility Requirements

- You must have Medicare Part A and/or Part B
 - To join a Prescription Drug Plan
- You must have Medicare Part A and Part B
 - To join a Medicare Advantage Plan with drug coverage
- You must live in plan's service area
 - You can't be incarcerated
 - You can't live outside the United States
- You must join a plan to get drug coverage

05/01/2014

Medicare Prescription Drug Coverage

To join a Medicare 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, and you must live in a plan's service area 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, or if you're incarcerated, you're not eligible to enroll in a plan, and therefore, can't get Part D coverage.

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, most must take action to get it. If you qualify for Extra Help to pay for your prescription drugs, Medicare will enroll you in a Medicare Prescription 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

- Current or past prescription drug coverage
 - For example, employer group health plans, retiree plans, Veterans Affairs, TRICARE, the Indian Health Service, and the Federal Employee Health Benefits Program
- Creditable if it pays, on average, as much as Medicare's standard drug coverage
- Plans inform yearly about whether creditable
- With creditable coverage you may not have to pay a late enrollment penalty

05/01/2014

Medicare Prescription 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 Medicare Supplement Insurance (Medigap) policies don't give drug coverage that meets Medicare's minimum standards. 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 (IEP)

- When you first become eligible to get Medicare
 - 7-month IEP for Part D

If You Join	Coverage Begins
During the 3 months <u>before</u> you turn 65	Date eligible for Medicare
During the month you turn 65	First day of the following month
During the 3 months <u>after</u> you turn 65	First day of the month after month you apply

05/01/2014

Medicare Prescription Drug Coverage

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

- You can apply 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.
- Or 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 the Centers for Medicare & Medicaid Services 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.

When You Can Join or Switch Plans

Medicare's Open Enrollment Period ("Open Enrollment")	October 15 – December 7 each year Changes go 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.

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Medicare Prescription Drug Coverage

You can join, switch, or drop a Medicare drug plan during Medicare's Open Enrollment Period (also known as Open Enrollment), which is from October 15 through December 7 each year. The changes go into effect on January 1 of the following year, as long as the plan gets your request for enrollment by December 7.

Between January 1 and February 14, you can leave a Medicare Advantage Plan and switch to Original Medicare. If you make this change, you may 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.

Special Enrollment Period (SEP)

Life events that allow a SEP

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

05/01/2014

Medicare Prescription Drug Coverage

You can make changes to your Medicare prescription drug coverage when certain events happen in your life, such as if you move out of your plan's service area or if you lose other insurance coverage. 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, such as if you no longer qualify for Extra Help

NOTE: You may be eligible for a Medicare Part B SEP if you're over age 65 and you (or your spouse) are still working and have health insurance through active employment. 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. 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.

Medicare.gov Online Enrollment Center Special Enrollment Period Selection

By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

<input type="checkbox"/> I am new to Medicare.	<input type="checkbox"/> I recently moved outside of the service area for my current plan. I moved on --Month-- --Day-- --Year--
<input type="checkbox"/> In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan* for the first time (*Medicare Advantage plan with prescription drug coverage)	<input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
<input type="checkbox"/> My plan is ending its contract with Medicare.	<input type="checkbox"/> I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or rehabilitation hospital). I moved or will move into or out of a Long Term Care Facility on --Month-- --Day-- --Year--
<input type="checkbox"/> I recently "left" a Programs of All-inclusive Care for the Elderly program. I left a PACE program on --Month-- --Day-- --Year--	<input type="checkbox"/> I am losing coverage I had from an employer. I left, will leave, lost or will lose my employer coverage on --Month-- --Day-- --Year--
<input type="checkbox"/> I belong to a pharmacy assistance program provided by my state, or I am losing or recently lost participation in such a program.	<input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on --Month-- --Day-- --Year--
<input type="checkbox"/> I recently involuntarily lost my creditable drug coverage. I lost my creditable drug coverage on --Month-- --Day-- --Year--	<input type="checkbox"/> In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.

05/01/2014

Medicare Prescription Drug Coverage

Special Enrollment Period (SEP) options will display for you if you enroll through the Medicare Plan Finder online enrollment center on medicare.gov. This screen shot doesn't include all the SEP options that are listed. 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)

- Use Medicare Plan Finder tool at medicare.gov to see quality and performance ratings
- Star ratings given once a year, assigned in October of the past year
- Use 5-star SEP to switch to any 5-star plan one time
 - December 8 - November 30 of following year
 - Coverage starts first day of month after enrolled
 - Be careful not to switch from Part D coverage to **no** Part D

Kaiser Permanente Medicare Plus Std w/Part D (AB) (Cost) (H2150-009-0) 						
Estimated Annual Drug Costs:[?]	Monthly Premium: [?]	Deductibles [?] and Drug Copay [?] / Coinsurance:[?]	Health Benefits: [?]	Drug Coverage [?], Drug Restrictions[?] and Other Programs:	Estimated Annual Health and Drug Costs: [?]	Overall Star Rating:[?]
Retail Annual: \$25.20 Rest of 2014: \$23.10*	\$15.00 Drug: \$2.10 Health: \$12.90	Annual Drug Deductible: \$0 Health Plan Deductible: \$0 Drug Copay/	Doctor Choice: Plan Doctors Only Out of Pocket Spending Limit: \$4,400 Medicare Prescription Drug Coverage	All Your Drugs on Formulary: N/A Drug Restrictions: N/A No Additional Gap	\$2,420	 This plan got Medicare's highest rating (5 stars)

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from 1 star 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.

The Centers for Medicare & Medicaid Services (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.

Plans are assigned their star rating once per year, in October. However, the plan won’t actually get this rating until the following January 1. To find star rating information, visit the Medicare Plan Finder at medicare.gov/find-a-plan. Look for the Overall Plan Rating to identify 5-star plans that you can change to during this SEP. The “Medicare & You” handbook doesn’t have the full, updated ratings for this SEP.

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.

Need more information?

For more information, please see the “5-Star Enrollment Period Job Aid” at cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/downloads/2013-5-star-enrollment-period-job-aid.pdf.



Part D Late Enrollment Penalty

- Higher premium if you wait to enroll
 - Exceptions are creditable coverage, or
 - Get Extra Help
- Pay penalty for as long as you have coverage
 - 1 percent of base beneficiary premium (\$32.42 in 2014)
 - For each full month eligible and not enrolled
 - Amount changes every year

05/01/2014

Medicare Prescription Drug Coverage

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. The late enrollment penalty is calculated by multiplying the 1 percent penalty rate times the national base beneficiary premium (\$32.42 in 2014) 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 is not based on the premium of the plan you are enrolled in. 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.

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 that in Lesson 5, starting on slide 48.

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

- Mrs. Martin was first eligible June 2011
 - 30 months without coverage Jul 2011–Dec 2013
 - 2011, Jan-Feb-Mar-Jun-Jul-Aug-Sep-Oct-Nov-Dec
 - 2012, Jan-Feb-Mar-Jun-Jul-Aug-Sep-Oct-Nov-Dec
 - 2013, Jan-Feb-Mar-Jun-Jul-Aug-Sep-Oct-Nov-Dec
- Here's the math
 - $.30$ (30 percent penalty) \times **\$32.42** (2014 base beneficiary premium) = **\$9.73**
 - **\$9.73** (rounded to the nearest \$0.10) = **\$9.70**
 - **\$9.70 = Mrs. Martin's monthly late enrollment penalty for 2014 (added to monthly premium)**

05/01/2014

Medicare Prescription Drug Coverage

Mrs. Martin didn't join when she was first eligible for Medicare—by June 2011. She doesn't have prescription drug coverage from any other source. She joined a Medicare drug plan during the 2013 Open Enrollment Period, and her coverage began on January 1, 2014.

Since Mrs. Martin was without creditable prescription drug coverage from July 2011–December 2013, her penalty in 2014 is 30 percent (1 percent for each month without coverage) multiplied by \$32.42 (the national base beneficiary premium for 2014), which is \$9.73. The monthly penalty is rounded to the nearest \$.10, so she'll be charged \$9.70 each month in addition to her plan's monthly premium in 2014.

Here's the math:

$.30$ (30 percent penalty) \times **\$32.42** (2014 base beneficiary premium) = **\$9.73**

\$9.73 (rounded to the nearest \$0.10) = **\$9.70**

\$9.70 = Mrs. Martin's monthly late enrollment penalty for 2014

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 penalty is re-computed each year. If she becomes eligible for Extra Help, she would no longer have to pay the penalty.

Check Your Knowledge—Question 7



Marisa just became eligible for Medicare. How long is her Initial Enrollment Period for Medicare Part D?

- a. 3 months
- b. 5 months
- c. 7 months
- d. 9 months



Refer to page 89 to check your answers.

Check Your Knowledge—Question 8



Xavier has a Medicare drug plan. He'll be moving from Florida to Arizona. Will he be able to switch to a different plan? Why or why not?

- a. Yes
- b. No



Refer to page 89 to check your answers.

Lesson 5 — Extra Help With Part D Drug Costs

- What it is
- How to qualify
- Enrollment
- Continuing eligibility
- New twist in the law

Lesson 5, “Extra Help with Part D Drug Costs,” provides information on the following:

- What it is
- How to qualify (income and resource limits)
- Enrollment
- Continuing eligibility
- Show Chubby Checker video—new “twist” in the law that makes it easier to qualify for Extra Help with Medicare prescription drug costs [youtube.com/watch?feature=player_embedded&v=zI2jp2p40ie](https://www.youtube.com/watch?feature=player_embedded&v=zI2jp2p40ie).

What Is Extra Help?

- Program to help people pay for Medicare prescription drug costs
 - Also called the Low-Income Subsidy
- For people with limited income and resources
 - Lowest income and resources
 - Pay no premiums or deductible and small or no copayments
 - Slightly higher income and resources
 - Pay a reduced deductible and a little more out of pocket
- No coverage gap or late enrollment penalty if you qualify
- Continuous Special Enrollment Period

05/01/2014

Medicare Prescription Drug Coverage

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.

Please see Appendix E for more information about the different levels of Extra Help, including the benefits and eligibility requirements for each level.

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.

2014 Extra Help Income and Resource Limits

- Income limits
 - Below 150 percent of the federal poverty level
 - \$1,458.75* per month for an individual
 - \$1,966.25* per month for married couple
 - Based on family size
- Resources limits
 - Up to \$13,440* for an individual, or
 - Up to \$26,860* 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 AK & HI

05/01/2014

Medicare Prescription Drug Coverage

You may get Extra Help if you have Medicare, income below 150 percent of the federal poverty level (FPL), and limited resources. You may qualify for Extra Help if your income and resources are below the above limits in 2014. If you're married and live with your spouse, both of your incomes and 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 two types of resources are used to see if you're eligible for Extra Help:

- Liquid resources (such as 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 such as 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 2014 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 if you get
 - Full Medicaid coverage
 - Supplemental Security Income
 - Help from Medicaid paying your Part B premium (Medicare Savings Program)
- All others must apply
 - Online at socialsecurity.gov
 - Call Social Security (SSA) at **1-800-772-1213** (TTY 1-800-325-0778)
 - Ask for “Application for Help With Medicare Prescription Drug Plan Costs” (SSA-1020)
 - Contact your state Medicaid agency

05/01/2014

Medicare Prescription Drug Coverage

You automatically qualify for Extra Help (and don't need to apply) if you have Medicare and get full Medicaid coverage, Supplemental Security Income 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 (SSA) or your state Medicaid agency.

You can apply for Extra Help by

- Completing a paper application you can get by calling SSA at 1-800-772-1213 (TTY users should call 1-800-325-0778)
- Applying online at socialsecurity.gov
- Applying through your state Medicaid agency
- Working with a local organization, such as 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 (such as with Power of Attorney) or you can ask someone else to help you apply.

If you apply for Extra Help, SSA 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	Automatic enrollment in Part D drug plan (unless already in a drug plan) <ul style="list-style-type: none"> ▪ Letter on YELLOW paper ▪ Coverage starts 1st month eligible for Medicare and Medicaid ▪ Continuous Special Enrollment Period (SEP)
Medicare Savings Program			Facilitated enrollment in Part D drug plan <ul style="list-style-type: none"> ▪ Letter on GREEN paper ▪ Coverage starts 2 months after CMS receives notice of your eligibility ▪ Continuous SEP
Supplemental Security Income benefits	Must apply and qualify	Social Security (SSA)	
Limited income and resources <small>05/01/2014</small>		SSA (most) or state Medicaid agency <small>Medicare Prescription Drug Coverage</small>	

The Centers for Medicare & Medicaid Services (CMS) uses state Medicaid data to identify people with Medicare who have full Medicaid benefits and people who get help from their state Medicaid program paying their Medicare premiums (in a Medicare Savings Program). CMS uses data from Social Security (SSA) to identify people who have Medicare and are entitled to Supplemental Security Income but not Medicaid, or who have applied and qualified for Extra Help.

When you first qualify for Extra Help, CMS will enroll you in a Medicare drug plan if you don't join a plan on your own to be sure you have coverage. This applies whether you qualify automatically or whether you apply and qualify for Extra Help.

Each month, CMS identifies and processes new automatic and facilitated enrollments. CMS chooses plans randomly from those with premiums at or below the regional low-income premium subsidy amount so that you won't pay a premium if you qualify for full Extra Help. If you qualify for partial Extra Help, you'll pay a reduced or no premium.

If you have Medicare and full Medicaid benefits and don't choose and join a Medicare drug plan on your own, CMS will automatically enroll you in a plan that goes into effect the first day you have both Medicare and Medicaid. You'll get a yellow auto-enrollment notice with the name of the plan you're assigned to.

Other people who qualify for Extra Help will be assisted into a Medicare drug plan. The facilitated enrollment goes into effect 2 months after CMS gets notice that you're eligible. You'll get a facilitated enrollment letter on green paper, in one of two versions: full or partial Extra Help.

Need more information?

For more information and a complete guide to mailings from CMS, SSA, and plans, go to [cms.gov/medicare/prescription-drug-coverage/limitedincomeandresources/downloads/2013mailings.pdf](https://www.cms.gov/medicare/prescription-drug-coverage/limitedincomeandresources/downloads/2013mailings.pdf).



Reassignment Notices

- People reassigned notified by CMS early November (BLUE paper)
 - Three versions of notice
 - People whose plans are leaving Medicare program
 - CMS product No. 11208 (MA-PD)
 - CMS product No. 11443 (MA)
 - People whose premiums are increasing
 - CMS product No. 11209

05/01/2014

Medicare Prescription Drug Coverage

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, 2014. 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 three 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, 2014.
- 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, 2014.

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, 2014, Medicare will reassign them into a new plan with coverage effective January 1, 2015.

Need more information?

Visit [cms.gov/outreach-and-education/outreach/partnerships/publications-for-partners.html](https://www.cms.gov/outreach-and-education/outreach/partnerships/publications-for-partners.html) to download the tip sheet, "Information Partners can use on: Reassignment" (CMS Product No. 11221-P and Spanish 11221-PS).



Changes in Qualifying for Extra Help

- Centers for Medicare & Medicaid Services (CMS) reestablishes eligibility each fall for next year
 - If you no longer automatically qualify
 - CMS sends “Loss-of-Deemed Status” notice in September (GRAY paper)
 - Includes Social Security application to reapply
 - If your status changes and again automatically qualify
 - CMS sends “Deemed Status” notice (PURPLE paper)
 - If you automatically qualify, but your copayment changed
 - CMS sends “Change in Extra Help Co-payment” notice in early October (ORANGE paper)

05/01/2014

Medicare Prescription Drug Coverage

Every August, the Centers for Medicare & Medicaid Services (CMS) 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, CMS 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 CMS on orange paper telling you about the change in your copayment level for the next year.

Need more information?

Visit [cms.gov/outreach-and-education/outreach/partnerships/publications-for-partners.html](https://www.cms.gov/outreach-and-education/outreach/partnerships/publications-for-partners.html) to download the tip sheet “Changes in Qualifying for Extra Help” (CMS Product No. 11232-P).



Redetermination Process

- People who applied and qualified for Extra Help
 - Four types of redetermination processes
 - Initial
 - Cyclical or recurring
 - Subsidy-changing event (SCE)
 - Other event (change other than SCE)

05/01/2014

Medicare Prescription Drug Coverage

There are four 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, such as 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 subsidy-changing events, such as a recent decrease in income due to a cut in work hours.

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

- Designed to remove gaps in coverage for low-income individuals moving to Part D coverage
- Gives temporary drug coverage if you have Extra Help and no Medicare drug plan
- Coverage may be immediate, current, and/or retroactive
- Medicare's Limited Income NET Program
 - Has an open formulary
 - Doesn't require prior authorization
 - Has no network pharmacy restrictions
 - Includes standard safety and abuse edits

05/01/2014

Medicare Prescription Drug Coverage

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.

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
- Have not opted out of auto-enrollment
- Have a permanent address in the 50 states or DC

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

Limited Income Newly Eligible Transition (NET) Group Training

NEW!

- Continuing Education credit webinars
 - Limited to 200 participants per session
 - Multiple sessions may be scheduled
- To schedule a live webinar for your group
 - Email LINETOutreach@humana.com
- For more information visit humana.com/linet

05/01/2014

Medicare Prescription Drug Coverage

The Limited Income Newly Eligible Transition (NET) Outreach Team is run by Humana, Inc. It is now providing live webinar training to State Health Insurance Assistance Program counselors and pharmacy providers. This is a great opportunity to learn more about the Limited Income NET program and obtain continuing education credits. You can schedule your group session throughout the year based on need. Sessions are limited to 200 participants, and multiple sessions may be scheduled.

Need more information?

To schedule a webinar or for more information, email linetoutreach@humana.com.

Visit humana.com/linet for more information and supporting documents like the Limited Income NET brochure and 4 Steps for Pharmacists.

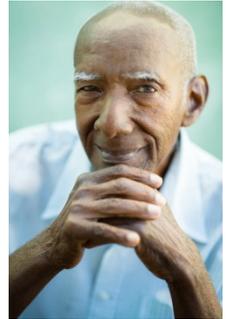


Check Your Knowledge—Question 9



Donald has Medicare and qualifies for Extra Help. He would like to switch to a new Medicare drug plan, but it is not currently in Medicare's Open Enrollment Period. Is he able to switch?

- a. Yes
- b. No



Refer to page 90 to check your answers.

Check Your Knowledge—Question 10



If you want to apply for Extra Help, how can you do it?

- a. Complete a paper application from Social Security
- b. Contact your state's Medicaid agency
- c. Contact your State Health Insurance Assistance Program (SHIP)
- d. Apply online at [socialsecurity.gov](https://www.socialsecurity.gov)
- e. All of the above



Refer to page 90 to check your answers.

Lesson 6 — Comparing and Choosing Plans

- Things to consider
- Steps to choosing a Medicare drug plan
- What to expect

05/01/2014

Medicare Prescription Drug Coverage

Lesson 6, “Comparing and Choosing Plans,” provides the following information:

- Things to consider
- Steps to choosing a Medicare drug plan
- What to expect

Things to Consider Before Joining a Plan

- Important questions to ask
 - Do you have other current health insurance coverage?
 - Is any prescription drug coverage you might have as good as Medicare drug coverage?
 - How does your current coverage work with Medicare?
 - Could joining a plan affect your current coverage or family member's coverage?

05/01/2014

Medicare Prescription Drug Coverage

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.

Need more information?

You can get information on how different types of current coverage work with Medicare prescription drug coverage by visiting medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-469-2048.



Step 1: Prepare

- Prepare by getting your information together
 - Current prescription drug coverage
 - Prescription drugs, dosages, and quantities
 - Preferred pharmacies
 - Medicare card
 - ZIP code

05/01/2014

Medicare Prescription Drug Coverage

Step 1: 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.

Need more information?

For a helpful Medicare Plan Finder worksheet, see [cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/downloads/2013-medicare-plan-finder-worksheet.pdf](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/downloads/2013-medicare-plan-finder-worksheet.pdf).



Step 2: Compare Plans on Medicare Plan Finder

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on star ratings, benefits, costs, and more
- Enroll in a plan

05/01/2014

Medicare Prescription Drug Coverage

Step 2: Visit [medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan) 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
- Enroll in a plan

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?

Need more information?

For Medicare Plan Finder General Tips, see [cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/downloads/2013-medicare-plan-finder-tip-sheet.pdf](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/downloads/2013-medicare-plan-finder-tip-sheet.pdf).



Step 3: Decide and Join

- Decide which plan is best for you and enroll
 - Online enrollment
 - [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)
 - Plan's website
 - Enroll by phone
 - 1-800-MEDICARE (1-800-633-4227)
 - TTY users should call 1-877-486-2048
 - Call plan
 - Mail or fax paper application to plan

05/01/2014

Medicare Prescription Drug Coverage

Step 3: 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](https://www.medicare.gov/find-a-plan). 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.

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 a row. In these cases, you may not be able to enroll online. You can still call the plan directly to enroll.

Need more information?

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/Publications/Pubs/pdf/11109.pdf](https://www.medicare.gov/Publications/Pubs/pdf/11109.pdf).



What New Members Can Expect

- Your plan will send you
 - An enrollment letter
 - Membership materials, including card
 - Customer service contact information
- If your current drug isn't covered by plan
 - You can get a transition supply (generally 30 days)
 - Work with prescriber to find a drug that's covered
 - Request exception if no acceptable alternative drug is on the list

05/01/2014

Medicare Prescription Drug Coverage

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 physician to find a different drug that's on the plan's formulary. If an acceptable alternative drug is not available, you or your physician can request an exception from the plan, and you can appeal denied requests.

Annual Notice of Change (ANOC)

- All Medicare drug plans must send ANOC to members by September 30
 - May be sent with Evidence of Coverage
- Will include information for upcoming year
 - Summary of Benefits
 - Formulary
 - Changes to monthly premium and/or cost sharing
- Read ANOC carefully and compare your plan with other plan options

05/01/2014

Medicare Prescription Drug Coverage

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 such as 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.

Check Your Knowledge—Question 11



Carl recently joined a Medicare drug plan and got materials from the plan in the mail. What materials should he receive from the plan in the mail?

- a. Enrollment letter
- b. Plan ID card
- c. Customer service toll-free numbers
- d. Plan's website
- e. All of the above



Refer to page 90 to check your answers.

Check Your Knowledge—Question 12



Amy wants to join a Medicare drug plan and knows there are several ways she can enroll. Which of the following is NOT an option?

- a. Enroll online using the Medicare Plan Finder
- b. Call 1-800-MEDICARE
- c. Enroll online at [socialsecurity.gov](https://www.socialsecurity.gov)
- d. Call the plan



Refer to page 91 to check your answers.

Lesson 7 — Coverage Determinations and Appeals

- Coverage determinations and exception requests
- Appeals

05/01/2014

Medicare Prescription Drug Coverage

Lesson 7, “Coverage Determinations and Appeals,” provides information on Medicare coverage determinations, exception requests, and appeals.

Coverage Determination Request

- Initial decision by plan
 - Which benefits you're entitled to get
 - How much you have to pay for a benefit
 - You, your prescriber, or your appointed representative can request it
- Time frames for coverage determination request
 - May be standard (decision within 72 hours)
 - May be expedited (decision within 24 hours) if life or health may be seriously jeopardized

05/01/2014

Medicare Prescription Drug Coverage

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 two types of coverage determinations: standard and expedited. Your request will be sped up (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 for review, and the request will skip over the first level of appeal (redetermination by the plan). The Independent Review Entity is MAXIMUS. You can find its contact information at [medicarepartdappeals.com](https://www.medicarepartdappeals.com).

Exception Requests

- Two types of exceptions
 - Formulary exceptions
 - Drug not on plan's formulary or
 - Access requirements (for example, step therapy)
 - Tier exceptions
 - For example, getting Tier 3 drug at Tier 2 cost
- Need supporting statement from prescriber
- You, your appointed representative, or prescriber can make requests
- Exception may be valid for rest of year

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Medicare Prescription Drug Coverage

An exception is a type of coverage determination. There are two types of exceptions: tier exceptions (such as getting a Tier 3 drug at the Tier 2 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.

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/cmsforms/downloads/cms1696.pdf](https://www.cms.gov/cmsforms/downloads/cms1696.pdf). 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 your coverage determination or exception is denied, you can appeal the plan's decision
- In general, you must make your appeal requests in writing
 - Plans must accept spoken expedited requests
- An appeal can be requested by
 - You
 - Your doctor or other prescriber
 - Your appointed representative
- There are five levels of appeals

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Medicare Prescription Drug Coverage

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 spoken expedited redetermination requests. In addition, plans may choose to accept verbal standard redetermination requests. Check your plan materials or contact your plans 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.



Need more information?

Please see Appendix J for more information about the five levels of appeal.

Check Your Knowledge—Question 13



Who can't request a coverage determination for a certain drug?

- a. You
- b. Your prescriber
- c. Your pharmacist
- d. Your appointed representative



Refer to page 91 to check your answers.

Check Your Knowledge—Question 14



Mitchell's doctor wants to prescribe a drug that's not included on his Medicare drug plan's formulary. His doctor submits an exception request to the plan and it is approved. How long is the exception valid?

- a. For the remainder of the month
- b. Until the next refill
- c. For the remainder of the plan year
- d. None of the above



Refer to page 91 to check your answers.

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

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Medicare Prescription Drug Coverage

- 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

<p>Websites: Centers for Medicare & Medicaid Services (CMS) cms.gov RxAssist - A directory of Patient Assistance Programs rxassist.org Medicare Part D Appeals medicarepartdappeals.com Contacts: medicare.gov 1-800-MEDICARE (1-800-633-4227) 1-877-466-2048 (TTY) Social Security 1-800-772-1213 socialsecurity.gov Local State Health Insurance Programs medicare.gov/contacts Limited Income NET Program (HUMANA) 1-800-783-1307 or 711 (TRS) Email: linetoutreach@humana.com</p>	<p>Manuals/Guidance (continued) "Medicare Premiums: Rules For Higher-Income Beneficiaries" ssa.gov/pubs/en-05-10536.pdf "2013/2014 Guide to Mailings from CMS, Social Security, and Plans" cms.gov/medicare/prescription-coverage/limitedincomeandresources/downloads/2013mailings.pdf National Training Program – Partner Job Aids Visit the Training Library at 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; Multiple copies (partners only) productordering.cms.hhs.gov CMS Partner Tip Sheets — cms.gov/outreach-and-education/outreach/partnerships/publications-for-partners.html view Publications for Partners</p>	<p>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)</p>
<p>"PDP Enrollment and Disenrollment Guidance" cms.gov/medicare/eligibility-and-enrollment/medicarepresdrugeligenrol/index.html 05/01/2014</p>	<p style="text-align: center;">Medicare Prescription Drug Coverage</p>	

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Appendix A: Part B—Covered Oral Anticancer Drugs*

- Busulfan
- Capecitabine
- Cyclophosphamide
- Etoposide
- Melphalan
- Methotrexate
- Temozolomide

*List is subject to change

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Medicare Prescription Drug Coverage

The oral anti-cancer drugs covered by Part B include, but aren't limited to the following:

- Busulfan
- Capecitabine
- Cyclophosphamide
- Etoposide
- Melphalan
- Methotrexate
- Temozolomide

NOTE: This list is subject to change.

Appendix B: Part B—Covered Oral Antiemetics for Use Within 48 Hours of Chemotherapy*

- 3 oral drug combination of
 - Aprepitant
 - A 5-HT3 Antagonist
 - Dexamethasone
- Chlorpromazine Hydrochloride
- Diphenhydramine Hydrochloride
- Dolasetron Mesylate (within 24 hours)
- Dronabinol
- Granisetron Hydrochloride
- Hydroxyzine Pamoate
- Ondansetron Hydrochloride
- Nabilone
- Perphenazine
- Prochlorperazine Maleate
- Promethazine Hydrochloride
- Trimethobenzamide Hydrochloride

*List is subject to change

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Medicare Prescription Drug Coverage

The following lists the oral antiemetic (anti-nausea) drugs that Medicare Part B covers. This isn't a complete list and it's possible that the list of drugs will change over time.

- 3 oral drug combination of
 - Aprepitant
 - A 5-HT3 Antagonist
 - Dexamethasone
- Chlorpromazine Hydrochloride
- Diphenhydramine Hydrochloride
- Dolasetron Mesylate (within 24 hours)
- Dronabinol
- Granisetron Hydrochloride (within 24 hours)
- Hydroxyzine Pamoate
- Ondansetron Hydrochloride
- Nabilone
- Perphenazine
- Prochlorperazine Maleate
- Promethazine Hydrochloride
- Trimethobenzamide Hydrochloride

Appendix C: Part B–Covered Immunosuppressive Drugs*

- Azathioprine-oral
- Azathioprine-parenteral
- Cyclophosphamide-oral
- Cyclosporine-oral
- Cyclosporine-parenteral
- Daclizumab-parenteral
- Lymphocyte Immune Globulin, Antithymocyte Globulin-parenteral
- Methotrexate-oral
- Methylprednisolone-oral
- Methylprednisolone Sodium Succinate Injection
- Muromonab-Cd3-parenteral
- Mycophenolate Acid-oral
- Mycophenolate Mofetil-oral
- Prednisolone-oral
- Prednisone-oral
- Sirolimus-oral
- Tacrolimus-oral
- Tacrolimus-parenteral

*List is subject to change

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Medicare Prescription Drug Coverage

This list includes some immunosuppressive drugs Medicare Part B covers. This list is subject to change.

- Azathioprine-oral
- Azathioprine-parenteral
- Cyclophosphamide-oral
- Cyclosporine-oral
- Cyclosporine-parenteral
- Daclizumab-parenteral
- Lymphocyte Immune Globulin, Antithymocyte Globulin-parenteral
- Methotrexate-oral
- Methylprednisolone-oral
- Methylprednisolone Sodium Succinate Injection
- Muromonab-Cd3-parenteral
- Mycophenolate Acid-oral
- Mycophenolate Mofetil-oral
- Prednisolone-oral
- Prednisone-oral
- Sirolimus-oral
- Tacrolimus-oral
- Tacrolimus-parenteral

NOTE: Part B may cover these drugs when given to a person with Medicare who gets a covered organ transplant. Covered drugs include those immunosuppressive drugs that have been specifically labeled as such and approved for marketing by the Food and Drug Administration. Also included are prescription drugs, such as prednisone, that are used in combination with immunosuppressive drugs as part of a therapeutic regime. Part B doesn't cover antibiotics, hypertensives, and other drugs that aren't directly related to rejection.

Appendix D: 2014 Standard Drug Benefit

Benefit Parameters	2014	2015
Deductible	\$310	\$320
Initial Coverage Limit	\$2,850	\$2,960
Out of Pocket (OOP) Threshold	\$4,550	\$4,700
Total Covered Drug Spending at OOP Threshold	\$6,690.77	\$7,061.76
Minimum Cost-Sharing in Catastrophic Coverage	\$2.55/\$6.35	\$2.65/\$6.60
Extra Help Copayments		
Institutionalized	\$0	\$0
Receiving Home and Community-Based Services	\$0	\$0
Up to or at 100% Federal Poverty Level (FPL)	\$1.20/\$3.60	\$1.20/\$3.60
Full Extra Help – up to 135% FPL	\$2.55/\$6.35	\$2.60/\$6.60
Partial Extra Help (Deductible/Cost-Sharing)	\$63/15%	\$66/15%

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Medicare Prescription Drug Coverage

Appendix E: 2014 Medicare Drug Plan Costs If You Automatically Qualify for Extra Help

If you have Medicare and...	Your monthly premium	Your yearly deductible	Your cost per prescription at the pharmacy (until \$4,550)	Your cost per prescription at the pharmacy (after \$4,550*)
Full Medicaid coverage for each full month you live in an institution, like a nursing home	\$0	\$0	\$0	\$0
Full Medicaid coverage and have a yearly income at or below 100% FPL \$11,670 (single) \$15,730 (married)	\$0	\$0	Up to \$1.20 Generic/preferred drugs: \$3.60 Brand-name drugs:	\$0
Full Medicaid coverage and have a yearly income above 100% FPL \$11,670 (single) \$15,730 (married)	\$0	\$0	Up to \$2.55 Generic/preferred drugs: \$6.35 Brand-name drugs:	\$0
Help from Medicaid paying your Medicare Part B premiums (Medicare Savings Program Participant, QMB-only, SLMB only or QI)	\$0	\$0	Up to \$2.55 Generic/preferred drugs: \$6.35 Brand-name drugs:	\$0
Supplemental Security Income	\$0	\$0	Up to \$2.55 Generic/preferred drugs: \$6.35 Brand-name drugs:	\$0

Note: There are plans you can join and pay no premium. There are other plans where you will have to pay part of the premium even when you automatically qualify for Extra Help. Tell your plan you qualify for Extra Help and ask how much you will pay for your monthly premium. Your cost per prescription generally decreases once the amount you pay and Medicare pays as the Extra Help reach \$4,550 per year. The cost sharing, income levels, and resources listed are for 2014 and can increase 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 you work.
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*Your cost per prescription generally decreases once the amount you pay and Medicare pays as the Extra Help reaches \$4,550 per year.

The cost-sharing, income levels, and resources listed are for 2014 and can increase 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 you work. Resource limits may be higher in some states.

NOTE: There are plans you can join and pay no premium. There are other plans where you will have to pay part of the premium even when you automatically qualify for Extra Help. Tell your plan you qualify for Extra Help and ask how much you will pay for your monthly premium.

Appendix F: Medicare Drug Plan Costs If You Apply and Qualify for Extra Help

If you have Medicare with a yearly income and resources of ...		Your monthly premium	Your yearly deductible	Your cost per prescription at the pharmacy (until \$4,550)	Your cost per prescription at the pharmacy (after \$4,550*)
Single Income below \$15,754.50 Resources up to \$8,660	Married Income below \$21,235.50 Resources up to \$13,750	\$0	\$0	Up to \$2.55 Generic/preferred \$6.35 Brand-name drugs:	\$0
Single Income below \$15,754.50 Resources between \$8,660—\$13,440	Married Income below \$21,235.50 Resources between \$13,750—\$26,860	\$0	\$63	up to 15% of the cost of each prescription	Up to \$2.55 Generic/preferred \$6.35 Brand-name drugs:
Single Income: (135%-140% FPL) \$15,754.50 —\$16,338 Resources up to \$13,440	Married Income: (135%-140% FPL) \$21,235.50—\$22,022 Resources up to \$26,860	25%	\$63	up to 15% of the cost of each prescription	Up to \$2.55 Generic/preferred \$6.35 Brand-name drugs:
Single Income: (140%-145% FPL) \$16,338—\$16,921.50 Resources up to \$13,440	Married Income: (140%-145% FPL) \$22,022—\$22,808.50 Resources up to \$26,860	50%	\$63	up to 15% of the cost of each prescription	Up to \$2.55 Generic/preferred \$6.35 Brand-name drugs:
Single Income: (145%-150% FPL) \$16,921.50—\$17,505 Resources up to \$13,440	Married Income: (145%-150% FPL) \$22,808.50—\$23,595 Resources up to \$26,860	75%	\$63	up to 15% of the cost of each prescription	Up to \$2.55 Generic/preferred \$6.35 Brand-name drugs:

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*Your cost per prescription generally decreases once the amount you pay and Medicare pays as the Extra Help reaches \$4,550 per year.

The cost sharing, income levels, and resources listed are for 2014 and can increase 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 you work. Resource limits may be higher in some states.

NOTE: There are plans you can join and pay no premium. There are other plans where you will have to pay part of the premium. Tell your plan you qualify for Extra Help and ask how much you will pay for your monthly premium.

Appendix G: Medicare Plan Finder Step 1 of 4: Enter Your Information

How do you get your Medicare coverage?

- Original Medicare [?]
- Medicare Health Plan (such as an HMO, PPO, or Private-Fee-for-Service plan) [?]
- I don't have any Medicare coverage yet
- I don't know what coverage I have

Do you get help from Medicare or your state to pay your Medicare prescription drug costs?

- I get help from Medicaid [?]
- I get Supplemental Security Income [?]
- I belong to a Medicare Savings Program (MSP) [?]
- I applied for and got Extra Help through Social Security
 - I pay \$2.55 - \$6.35 for covered drugs [?]
 - I pay 15% coinsurance for covered drugs [?]
 - I pay the following percentage for my monthly prescription drug plan premium:
 - 0% 25% 50% 75% I don't know
- I don't get any Extra Help [?]
- I don't know

[Go Back](#) [Continue to Plan Results](#)

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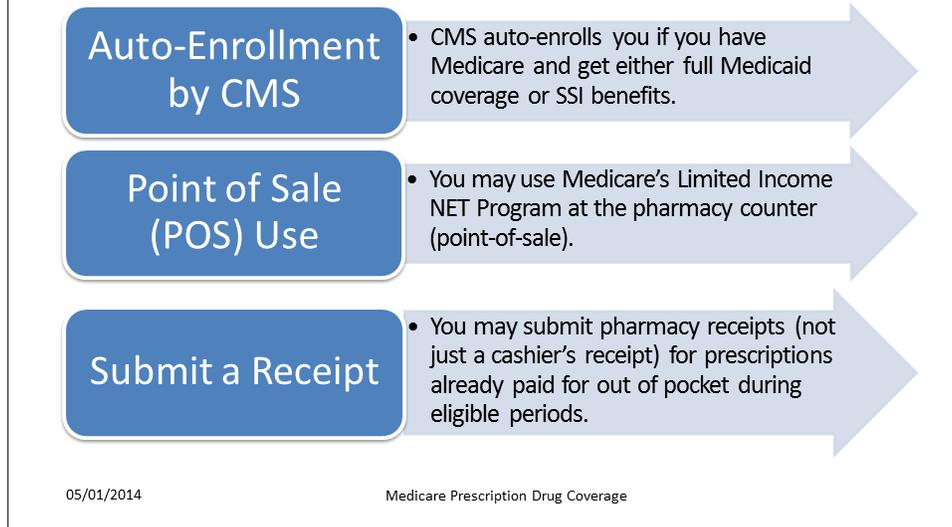
Callouts:

- Green box: See Appendix E Automatically Qualify for Extra Help (points to Medicaid and SSI options)
- Orange box: See Appendix E Automatically Qualify for Extra Help (points to MSP option)
- Blue box: See Appendix F Applied and Qualified for Extra Help (points to Social Security Extra Help options)

Appendices E and F will help you determine whether an individual qualifies for Extra Help based on his/her income and resources. Step 1 of the Medicare Plan Finder tool will ask if you get help from Medicare or your state to pay your Medicare prescription drug costs to display the drug costs accurately in your plan results.

The questions are asked in a manner that most people with Medicare can understand. For example, most people with Medicare know whether they get help from Medicaid or if they are receiving Supplemental Security Income, etc. Also, when a person receives his/her low-income subsidy notice, it states what percentage he or she is expected to pay for his or her premium. You can refer to the specific appendices to see how these scenarios line up with income and resources.

Appendix H: How Do You Access Medicare's Limited Income NET Program?



There are three 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 (such as 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

Appendix I: Medicare's Limited Income Newly Eligible Transition (NET) Program

- Resources to help pharmacists submit claims
 - Help Desk: 1-800-783-1307 (TTY: 1-877-801-0369)
 - Address: The Medicare Limited Income NET Program
P.O. Box 14310
Lexington, KY 40512-4310
 - Websites
 - [CMS.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET.html](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET.html)
 - [Humana.com/pharmacists/pharmacy_resources/information.aspx](https://www.humana.com/pharmacists/pharmacy_resources/information.aspx)
 - CMS Mailbox: MedicareLINET@cms.hhs.gov

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Medicare Prescription Drug Coverage

Humana manages Medicare's Limited Income Newly Eligible Transition (NET) program.

People with Medicare can submit receipts for claims they paid out of pocket to the following address:

The Medicare Limited Income NET Program
P.O. Box 14310
Lexington, KY 40512-4310

Pharmacists who need help using Medicare's Limited Income NET program can contact the Program Help Desk at 1-800-783-1307 (TTY users should call 1-877-801-0369).

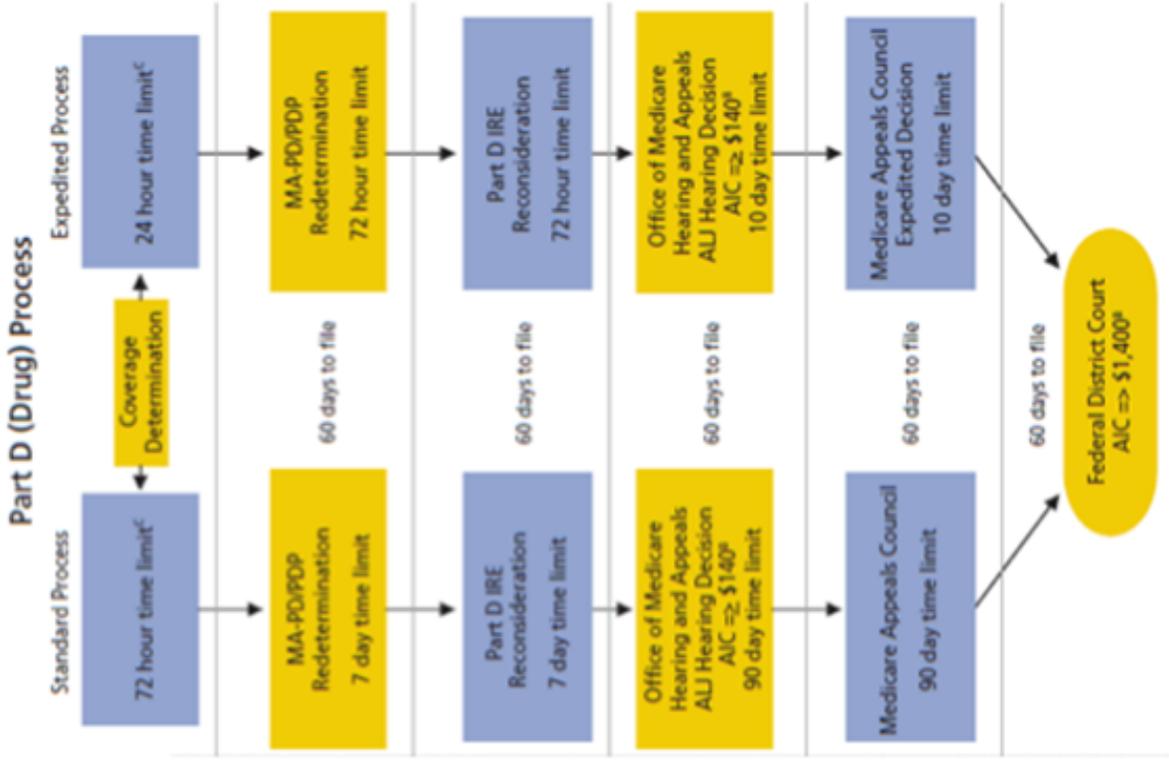
- Websites
 - The Centers for Medicare & Medicaid Services (CMS) [cms.gov/medicare/eligibility-and-enrollment/lowincsubmedicareprescov/medicarelimitedincomenet.html](https://www.cms.gov/medicare/eligibility-and-enrollment/lowincsubmedicareprescov/medicarelimitedincomenet.html)
 - Humana [humana.com/pharmacists/pharmacy_resources/information.aspx](https://www.humana.com/pharmacists/pharmacy_resources/information.aspx)
- CMS Mailbox
 - medicarelinet@cms.hhs.gov

Appendix J: Levels of Appeal

B-The Amount In Controversy (AIC) for all Administrative Law Judge (ALJ) hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index.

The chart reflects the CY 2011 AIC amounts.

C- A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, 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 receives the physician's supporting statement.



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Medicare Prescription Drug Coverage

Check Your Knowledge Answer Key



Question 1 (page 10)

Max has a Part D plan. He recently got prescription drugs during a Medicare-covered stay at a skilled nursing facility (SNF). Will Medicare pay for his prescription drugs? Which part of Medicare?

Answer: b

b. Yes, Medicare Part A will pay for the prescription drugs Max got during his inpatient stay at an SNF if they are medically necessary. Medicare Part A payments made to hospitals and SNFs generally cover all drugs provided during an inpatient stay (see slide 6).

Question 2 (page 11)

Which of these vaccines is NOT covered under Medicare Part B?

Answer: b

b. Shingles shot. Part B covers certain immunizations, including the influenza virus vaccine (flu shot), pneumococcal pneumonia vaccine, Hepatitis B vaccine (for individuals at high or intermediate risk), and other vaccines (such as tetanus) 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 other vaccines (like the shingles vaccine) needed to prevent illness (see slide 8).

Question 3 (page 22)

Which costs don't count toward getting out of the coverage gap?

Answer: b

b. Discount on covered generic drugs. Certain costs count toward you getting out of the coverage gap, including your yearly deductible, coinsurance, and copayments, the discount you get on covered brand-name drugs in the coverage gap, and what you pay in the coverage gap. Other costs don't count toward getting you out of the coverage gap, including the drug plan premium, what you pay for drugs that aren't covered, and the discount you get on covered generic drugs in the coverage gap (see slides 18 and 19).

Question 4 (page 23)

Medicare drug plan benefits and costs are the same from year to year.

Answer: b

b. False. Medicare drug plan benefits and costs may change each year (see slide 14).

Question 5 (page 34)

Which of the following drugs are NOT covered by Medicare Part D?

Answer: a

a. Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations) are not covered by Medicare Part D. However, Medicare drug plans may choose to cover excluded drugs at their own cost or share the cost with you (see slide 27).

Question 6 (page 35)

For prescription brand-name and generic drugs to be covered by a Medicare drug plan, they must be

Answer: d

- a. Approved by the Food and Drug Administration (FDA)
- b. Used and sold in the United States
- c. Used for medically-accepted indications
- d. All the above

d. All the above. 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 FDA, used and sold in the United States, and used for a medically accepted indication.

Question 7 (page 46)

Marisa just became eligible for Medicare. How long is her Initial Enrollment Period (IEP) for Medicare Part D?

Answer: c

c. 7 months. When Marisa first becomes eligible for Medicare, she'll have a 7-month IEP for Medicare Part D (see slide 39). It starts 3 months before the month she turns 65, and ends 3 months after the month she turns 65.

Question 8 (page 47)

Xavier has a Medicare drug plan. He'll be moving from Florida to Arizona. Will he be able to switch to a different plan? Why or why not?

Answer: a

a. Yes. Even though Medicare's Open Enrollment Period is from October 15 through December 7, he can make changes to his Medicare prescription drug coverage if and when certain events happen in his life, such as if he permanently moves out of his plan's service area or he loses other creditable insurance coverage. These chances to make changes are called Special Enrollment Periods (see slide 41).

Question 9 (page 58)

Donald has Medicare and qualifies for Extra Help. He would like to switch to a new Medicare drug plan, but it is not currently Medicare's Open Enrollment Period. Is he able to switch?

Answer: a

a. Yes. If you qualify for Extra Help, you will 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 following month (see slide 49).

Question 10 (page 59)

If you want to apply for Extra Help, how can you do it?

Answer: e

- a. Complete a paper application from Social Security (SSA)
- b. Contact your state's Medicaid agency
- c. Contact your State Health Insurance Assistance Program (SHIP)
- d. Apply online at [socialsecurity.gov](https://www.socialsecurity.gov)
- e. All of the above

e. All of the above (see slide 51).

Question 11 (page 67)

Carl recently joined a Medicare drug plan and got materials from the plan in the mail. What materials should he receive from the plan in the mail?

Answer: e

- a. Enrollment letter
- b. Plan ID card
- c. Customer service toll-free numbers
- d. Plan's website address
- e. All of the above

e. All of the above. If you join a plan, you'll receive an enrollment letter and membership materials from the plan. The materials will contain an identification card and customer service information, including a toll-free phone number and website address (see slide 65).

Question 12 (page 68)

Amy wants to join a Medicare drug plan and knows there are several ways she can enroll. Which of the following is NOT an option?

Answer: c

c. Enroll online at [socialsecurity.gov](https://www.socialsecurity.gov). You cannot join a Part D plan through the SSA website. 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. 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 at [medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan). You can also call Medicare to enroll at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (see slide 64).

Question 13 (page 73)

Who can't request a coverage determination for a certain drug?

Answer: c

c. Your pharmacist. You, your prescriber, or your appointed representative can request a coverage determination by calling your plan or writing a letter (see slide 70).

Question 14 (page 74)

Mitchell's doctor wants to prescribe a drug that's not included on his Medicare drug plan's formulary. His doctor submits an exception request to the plan and it is approved. How long is the exception valid?

Answer: c

c. For the remainder of the plan year. If an 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 (see slide 71).

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
FDA	Food and Drug Administration
FPL	Federal Poverty Level
IEP	Initial Enrollment Period
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
MA	Medicare Advantage
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

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Website: [cms.gov/outreach-and-education/training/cmsnationaltrainingprogram](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram)

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