2013 National Training Program

Module: 9

Medicare Prescription Drug Coverage

Workbook

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Module 9: Medicare Prescription Drug Coverage

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This module can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers, and the learning activities.

This training module explains Medicare prescription drug coverage.

The Centers for Medicare & Medicaid Services (CMS) developed and approved this training module. CMS is the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. Information in this module was correct as of May 2013.

To check for an updated version of this training module, visit http://cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html.

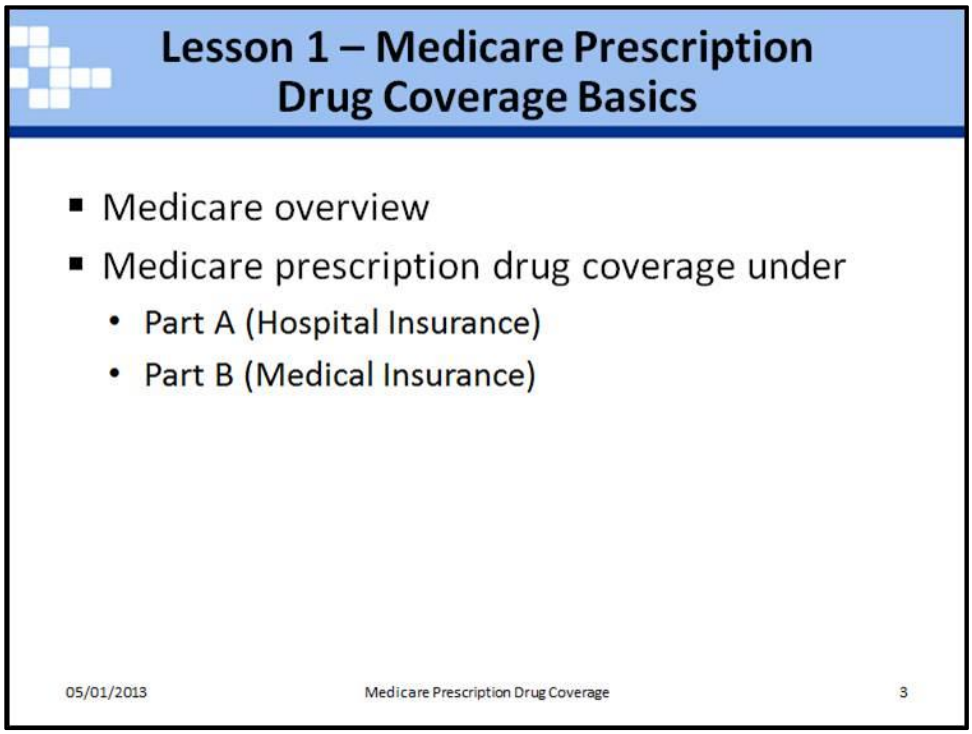
To check for updates on the new health care legislation, visit HealthCare.gov.

To view the Affordable Care Act, visit HealthCare.gov/law/full/index.html.

This set of CMS National Training Program materials isn't a legal document. Official Medicare program provisions are contained in the relevant statutes, regulations, and rulings.

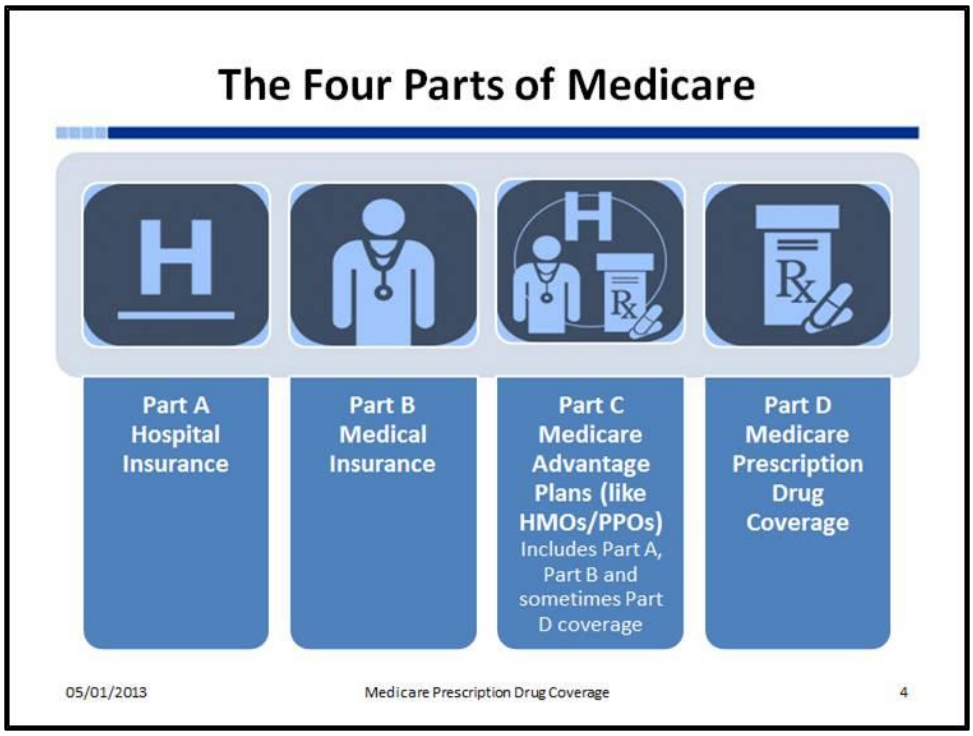
This session will help you:

- Recognize Medicare prescription drug coverage
  - Under Medicare Part A (Hospital Insurance), Part B (Medical Insurance), and Part D
- Summarize eligibility and enrollment
- Compare and choose plans
- Describe Extra Help with drug plan costs
- Review coverage determinations and appeals



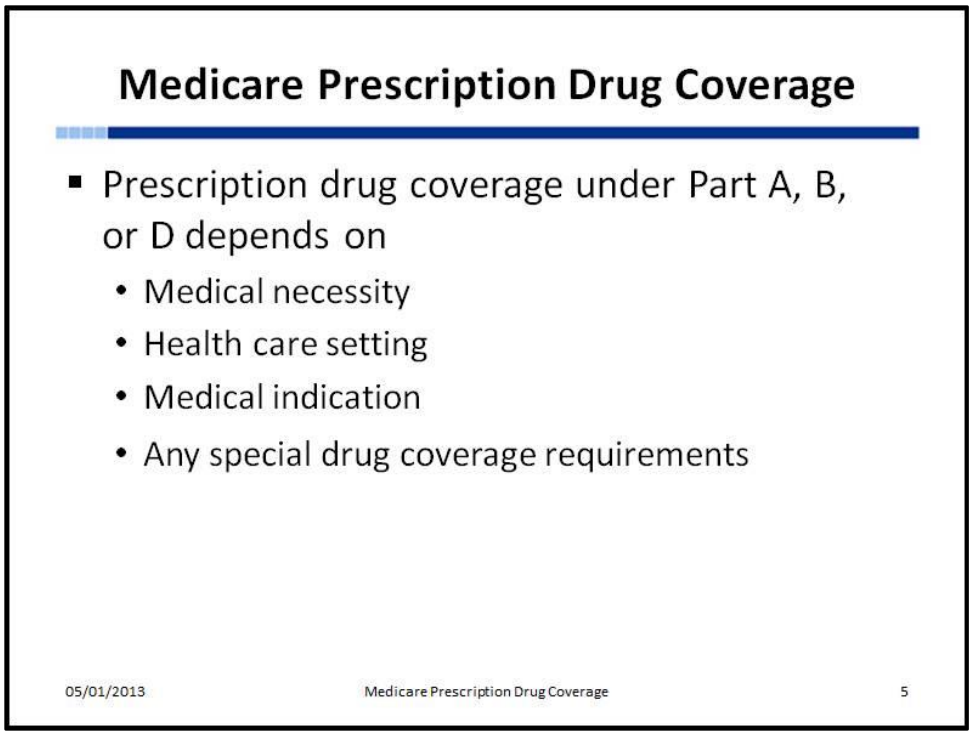
Lesson 1, *Medicare Prescription Drug Coverage Basics*, provides information on:

- Medicare overview
- Medicare prescription drug coverage under
  - Part A (Hospital Insurance)
  - Part B (Medical Insurance)



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 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 some preventive services, including screening tests and shots, diagnostic tests, some therapies, and durable medical equipment (DME) like wheelchairs and walkers.
- **Part C (Medicare Advantage)** is another way to get your Medicare benefits. It combines Parts A and B, and sometimes Part D (prescription drug coverage). Medicare Advantage (MA) plans 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 charges.
- **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.

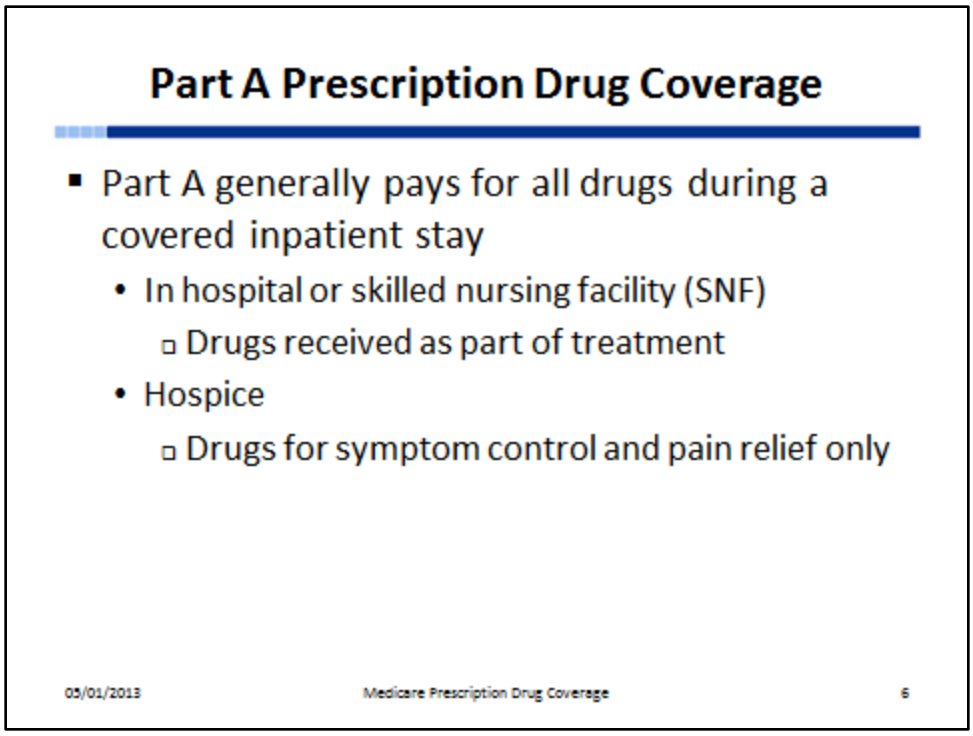


Whether prescription drugs are covered under Medicare Part A, B, or D depends on several factors, including:

- 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

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.

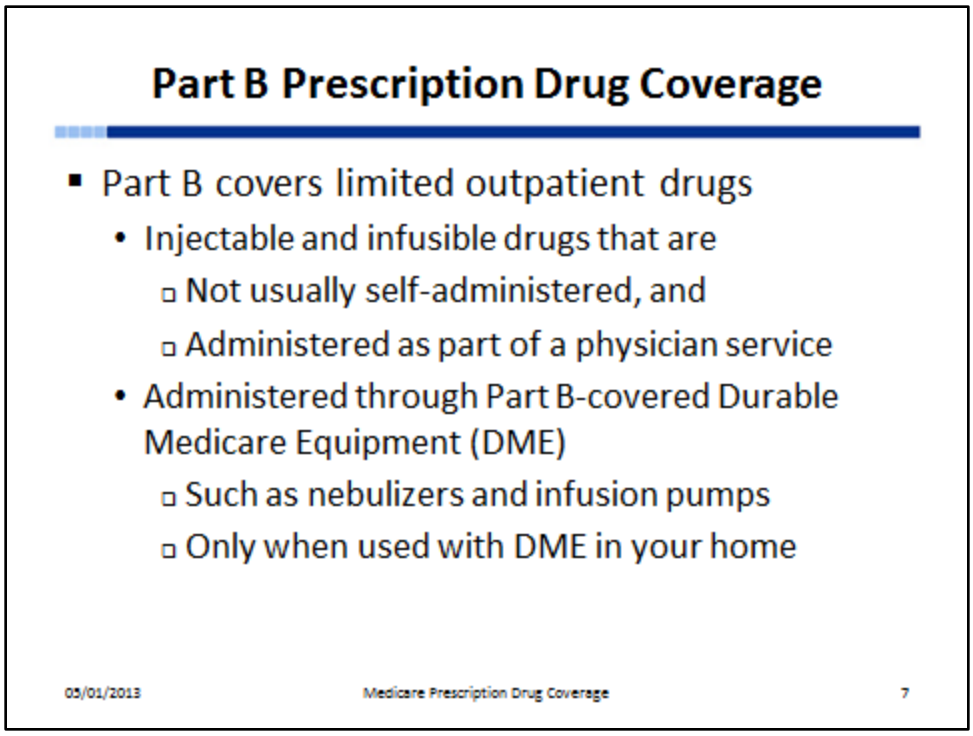
If you have a Part C Medicare Advantage (MA) plan (like an HMO or PPO) with prescription drug coverage, you get all of your Medicare-covered health care from the plan, including covered prescription drugs. Most MA plans offer prescription drug coverage.



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.

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.



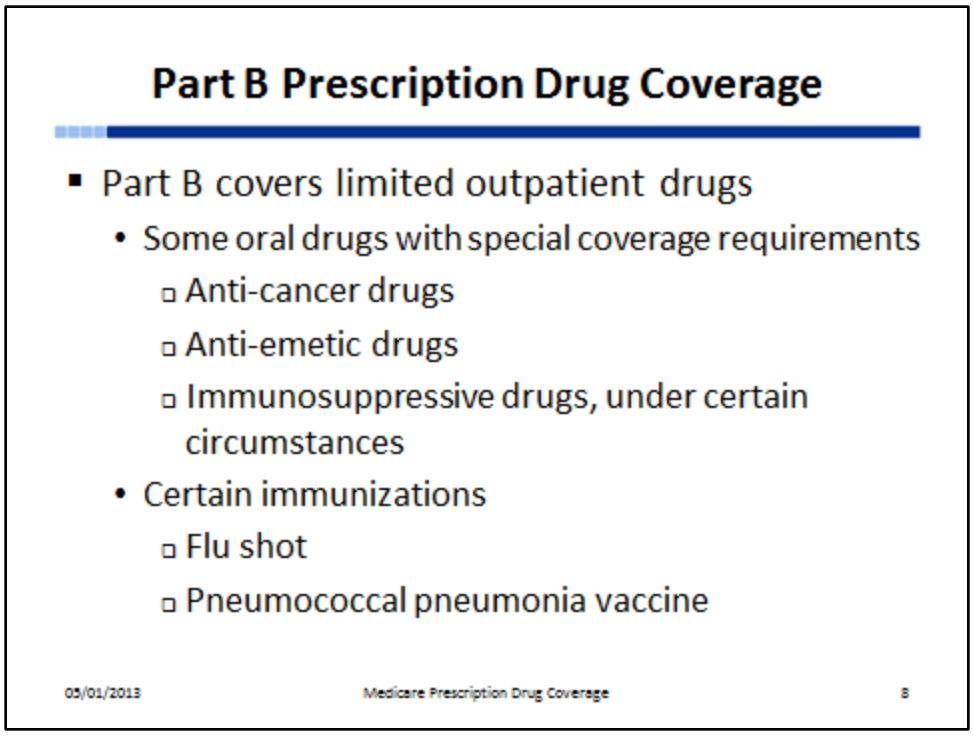
Medicare Part B gives limited prescription drug coverage. It doesn't cover most drugs you get at the pharmacy. Part B covers only a limited set of outpatient drugs, including:

- Injectable and infusible drugs that aren't usually self-administered and that are furnished and administered as part of a physician service (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 furnished and administered as part of a physician 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.

Need More Information?

For more information about DME or to find contract providers in your area, visit the Medicare Supplier Director at www.medicare.gov/supplier.

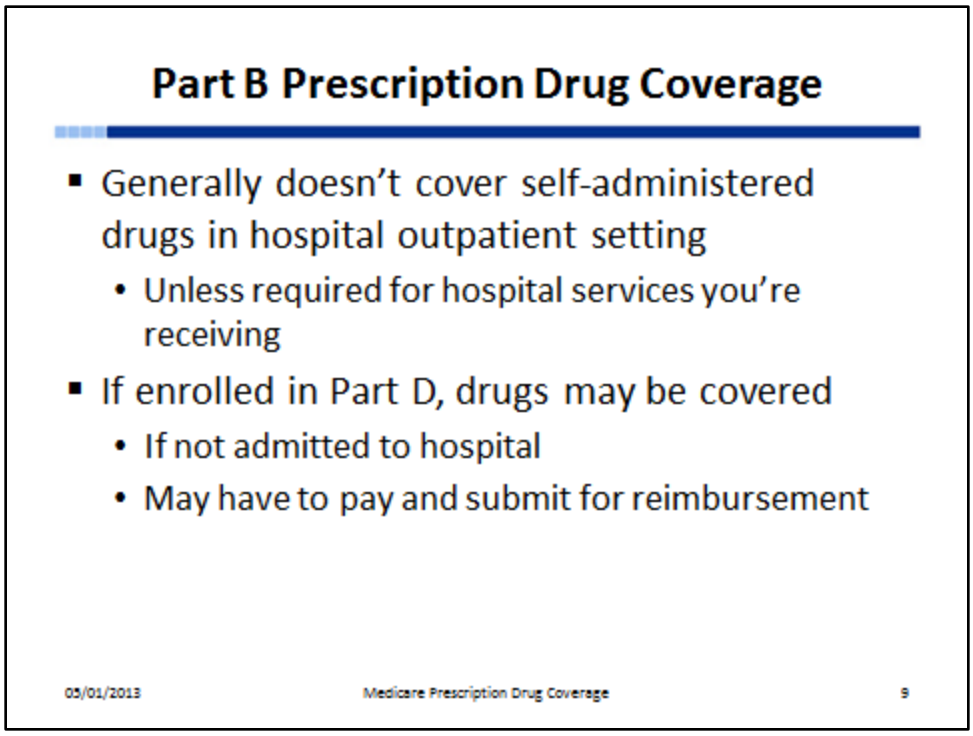
For more information about drug coverage under Medicare Parts A and B, go to http://www.cms.gov/Outreach-and-Education/Training/NationalMedicareTraining Program/Downloads/2011-Medicare-Drug-Coverage-Part-A-Part-B-and-Part-D.pdf.



Medicare Part B covers a limited set of outpatient drugs, including:

- Three categories of oral drugs with special coverage requirements: oral anti-cancer, oral anti-emetic (to treat nausea), and immunosuppressive drugs (under certain circumstances).
- 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.
- A limited number of other types of outpatient drugs. Regional differences in local Part B drug coverage policies can occur in the absence of a national coverage decision.

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



Sometimes you may need self-administered drugs (drugs you would normally take on your own) that aren't related to the services you're getting as an outpatient in a hospital setting. Generally, Medicare Part A and B don't cover self-administered drugs you get in an outpatient setting (like an emergency room, observation unit, or surgery center) unless you need these drugs for the outpatient services you're getting. For example, you may need daily blood pressure medication while in the emergency room for a sprained ankle. Medicare Parts A and 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 B while in a hospital outpatient setting, the hospital may bill you for the drug. However, if you're enrolled in a Medicare 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 only covers medically necessary prescription drugs and won't pay for over-the-counter drugs like Tylenol® or Milk-of-Magnesia®.
- 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 send the claim to your Medicare drug plan for reimbursement.

Need More Information?

Go to www.medicare.gov/publications to get the publication *How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings*, CMS Product No. 11333.

Check Your Knowledge
Lesson 1 – Medicare Prescription Drug Basics

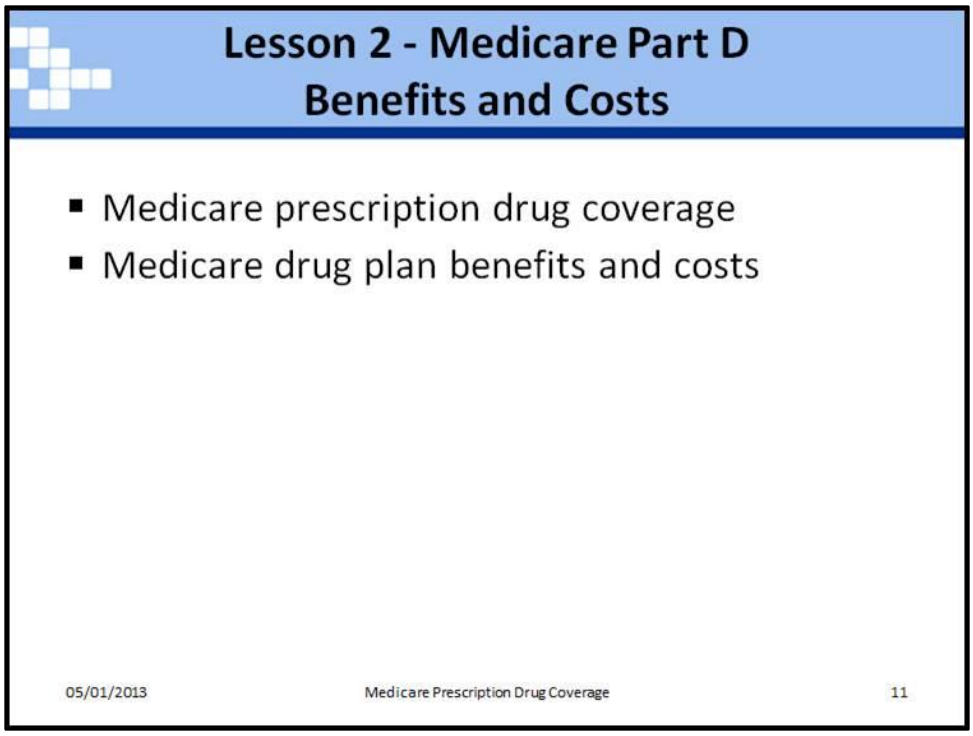
Answer the following questions:

1. Max has Original Medicare and 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? If so, which part of Medicare will cover them?

2. Which of these vaccines may NOT be covered under Medicare Part B?

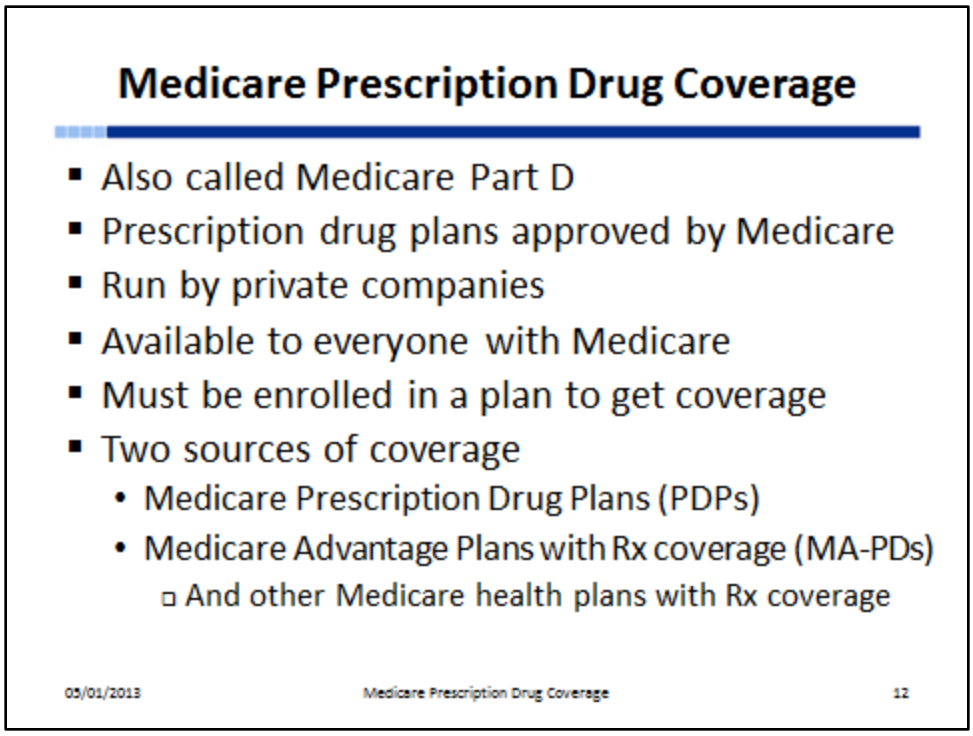
    a. Flu vaccine
    b. Shingles vaccine
    c. Hepatitis B vaccine
    d. Pneumococcal pneumonia vaccine

Refer to page 79 to check your answers.



Lesson 2, *Medicare Part D Benefits and Costs,* provides information on:

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



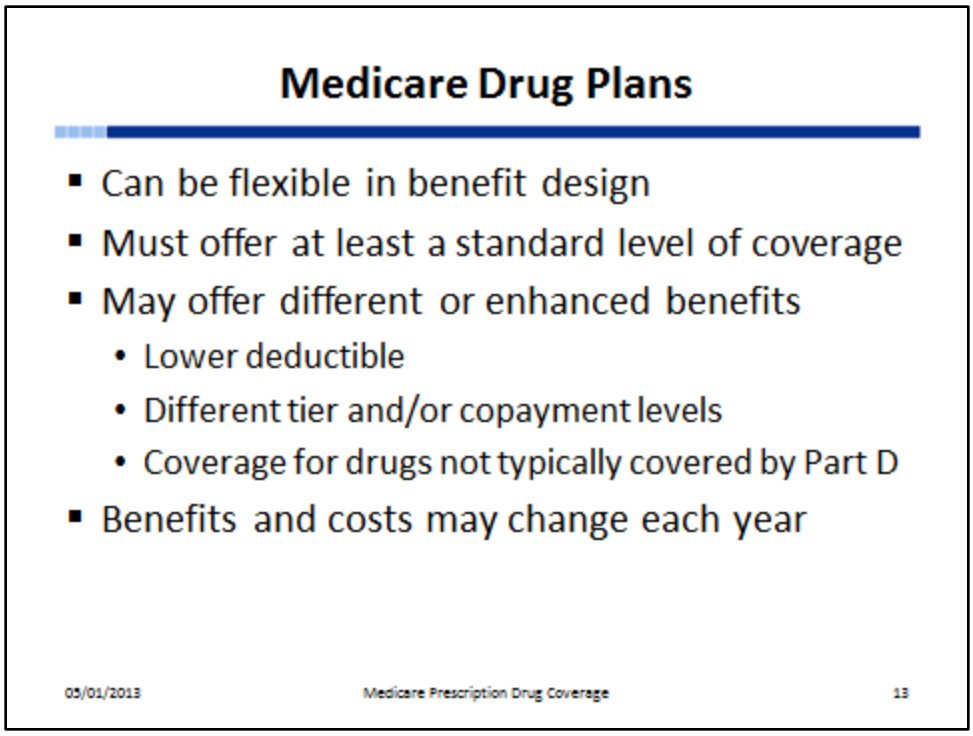
Medicare prescription drug coverage (Part D) adds to your Medicare health care coverage. It helps you pay for medically necessary brand-name and generic prescription drugs. Medicare drug plans are offered by insurance companies and other private companies approved by Medicare. All people with Medicare are eligible to enroll in a Medicare prescription drug plan. You must be enrolled in a plan to get Medicare prescription drug coverage.

You can get Medicare prescription drug coverage in two ways:

1. Medicare Prescription Drug Plans (PDPs) add coverage to Original Medicare and some other types of Medicare plans.
2. Some Medicare Advantage (MA) plans (like an HMO or PPO) and other Medicare health plans also offer Medicare prescription drug coverage.

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

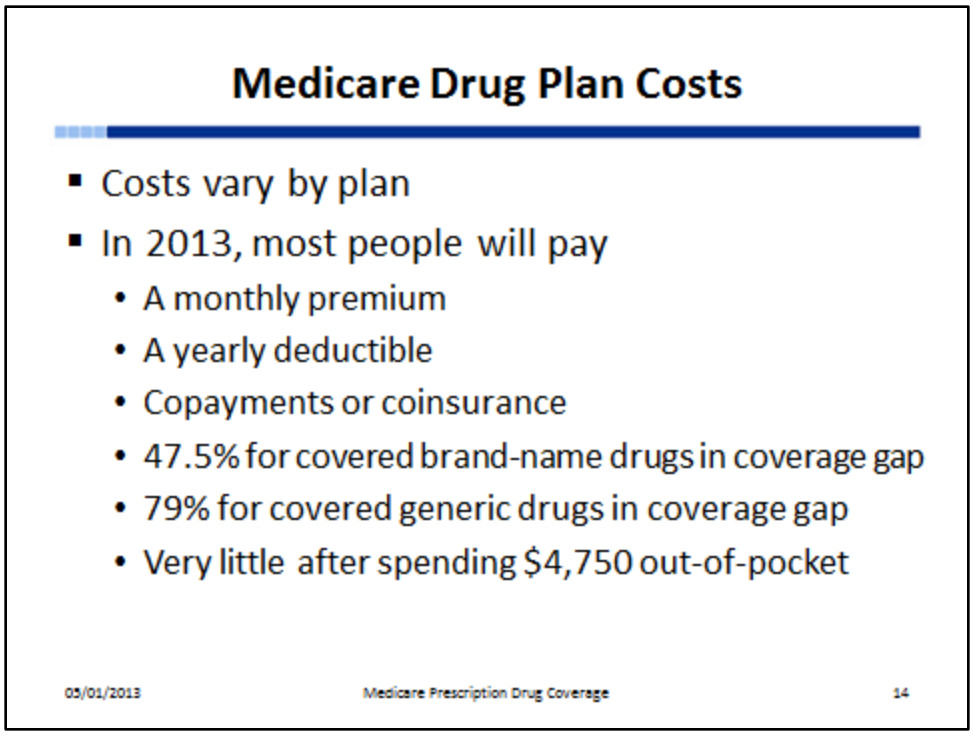
NOTE: Some Medigap policies (Medicare Supplement Insurance) offered prescription drug coverage before January 1, 2006. This is not Medicare prescription drug coverage.



Medicare drug plans may be different from each other in the 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 lower 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.



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.

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary limit on what the drug plan will cover for drugs. You enter the coverage gap after you and your drug plan have spent a certain amount for covered drugs. In 2013, once you enter the coverage gap, you pay 47.5% of the plan's cost for covered brand-name drugs and 79% of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Not everyone will enter the coverage gap.

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. However, 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 don't count toward getting you out of the coverage gap.

With every plan, once you've paid $4,750 out-of-pocket for drug costs in 2013 (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% (or a small copayment) for each drug for the rest of the year.

NOTE: Please see Appendix D for more information about the standard Medicare Part D cost and benefit structure.

Standard Structure in 2013

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2013. 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 $325 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 $2,970.	Once Ms. Smith and her plan have spent $2,970 for covered drugs, she's in the coverage gap. In 2013, she pays 47.5% of the plan's cost for her covered brand-name prescription drugs and 79% 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 $4,750 out-of-pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.

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

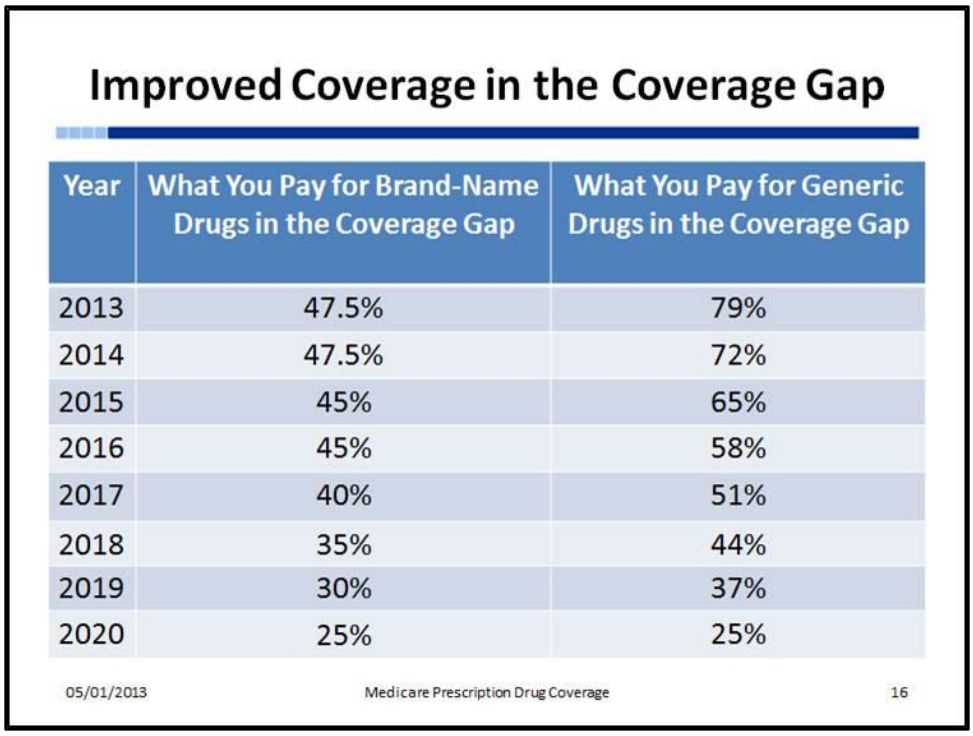
Monthly premium – Most drug plans charge a monthly fee that differs from plan to plan. You pay this in addition to the Part B premium (if you have Part B). If you belong to an MA Plan (like an HMO or PPO) that includes drug coverage, the monthly plan premium may include an amount for prescription drug coverage.

Yearly deductible (you pay up to $325 in 2013) – 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 $325 in 2013. Some drug plans don't have a deductible.

Copayments or coinsurance (you pay approximately 25%) – These are the amounts you pay for your covered prescriptions after you pay the deductible (if the plan has one). You pay your share and the drug plan pays its share for covered drugs.

Coverage gap – The coverage gap begins after you and your drug plan have spent a certain amount of money for covered drugs ($2,970 in 2013). In 2013, once you enter the coverage gap, you pay 47.5% of the plan's cost for covered brand-name drugs and 79% of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Certain costs count toward you getting out of the 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 you get on covered generic drugs in the coverage gap don't count toward getting you out of the coverage gap.

Catastrophic coverage (you pay 5%) – Once you reach your plan's 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 Brand-Name Drugs in the Coverage Gap	What You Pay for Generic Drugs in the Coverage Gap
2013	47.5%	79%
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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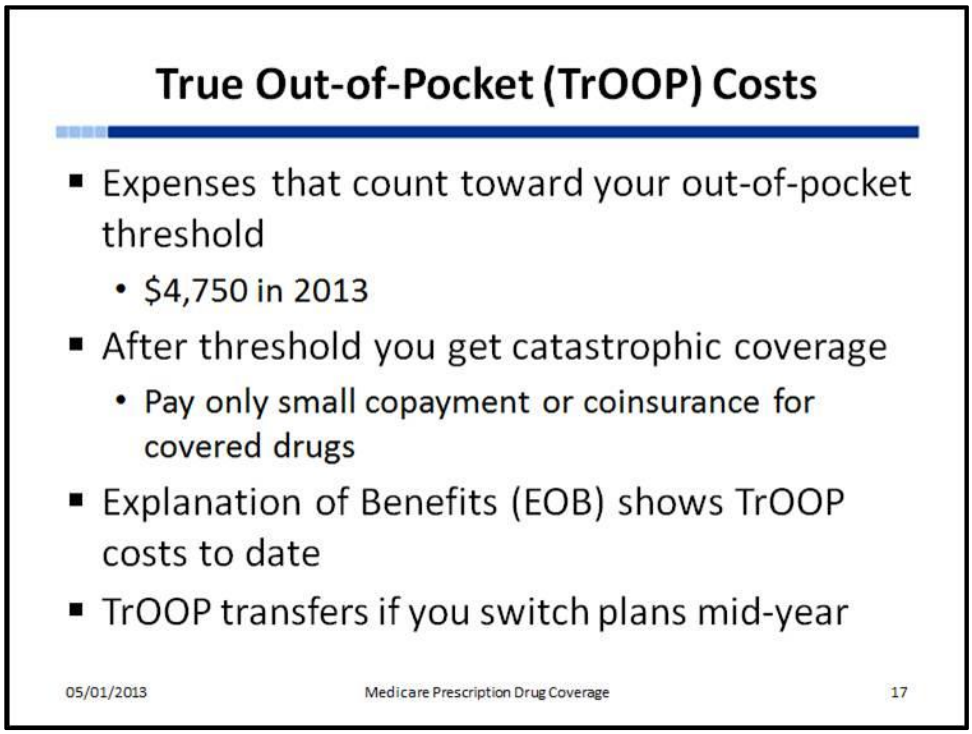
Your discount on drugs will increase each year when you're in the coverage gap until 2020, when you'll pay approximately 25% for both covered generic and brand-name drugs when in the gap.

NOTE: In 2013, you pay 47.5% of dispensing and vaccine administration fees for brand-name drugs in the coverage gap (unless you get Extra Help). Medicare drug plans pay for the remaining 52.5% of these fees. Medicare drug plans will pay an increasing amount of these fees until 2020. In 2013, you also pay 79% of the ingredient cost, sales tax, and dispensing and vaccine administration fees for generic drugs in the coverage gap.



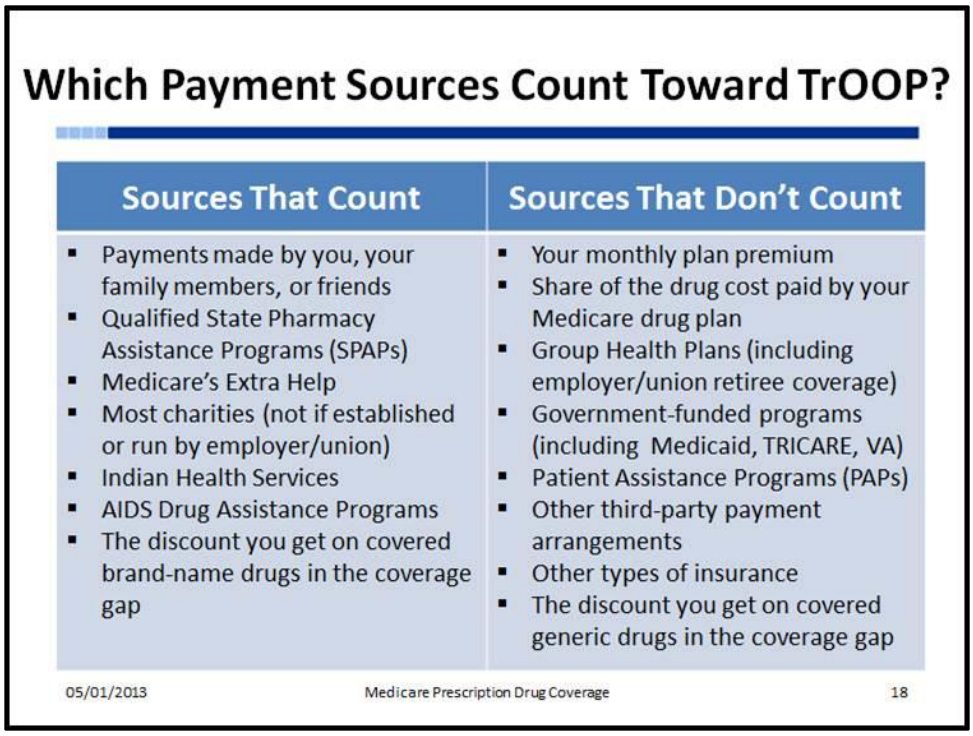
True out-of-pocket (TrOOP) costs are the expenses that count toward your Medicare drug plan out-of-pocket threshold of $4,750 (for 2013). TrOOP costs are used to figure out when catastrophic coverage begins. Your drug plan will keep track of your TrOOP costs. Each month that you buy prescriptions covered by your plan, your drug plan will mail you an Explanation of Benefits (EOB) showing your TrOOP costs to date.

In order 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. 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?

Please see *Understanding True Out-of-Pocket (TrOOP) Costs* tip sheet, CMS Product No. 11223-P, located at: http://www.cms.gov/ Outreach-and-Education/Outreach/Partnerships/downloads/11223-P.pdf.



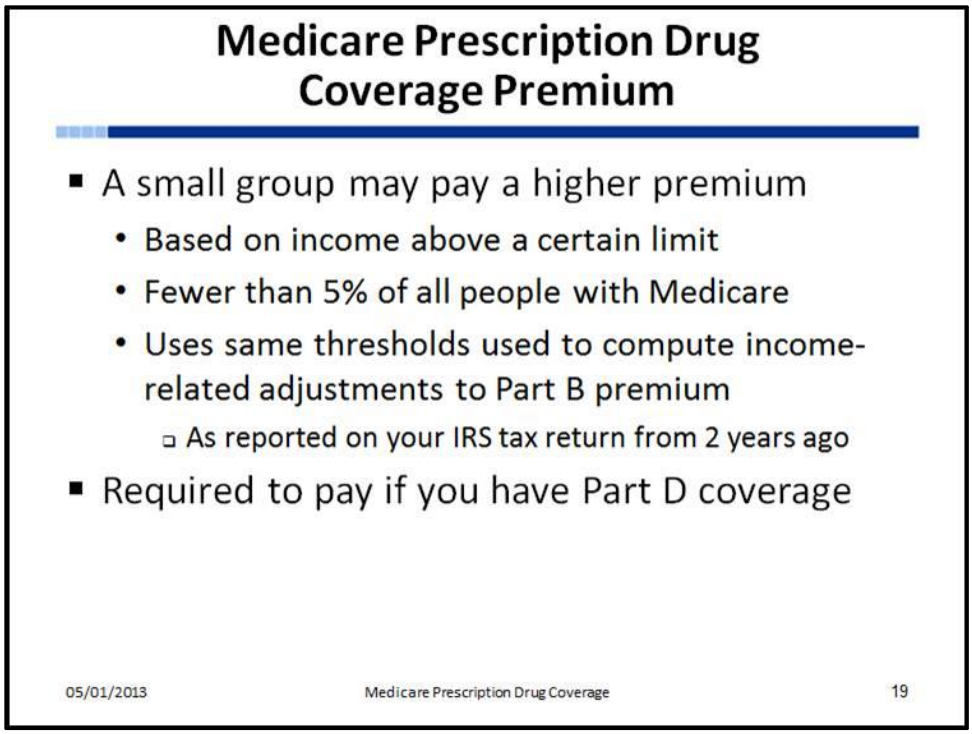
Expenses that count toward your True Out-of-Pocket (TrOOP) costs include payments for drugs that are covered by the plan and made by:

- You, your family members, or friends
- Qualified State Pharmacy Assistance Programs (SPAPs)
- Medicare's Extra Help
- Most charities, unless established, run, or controlled by a current or former employer/union
- Indian Health Services and 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:

- 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 (PAPs) 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, and over-the-counter drugs.



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

Usually, the extra amount will be taken out of your Social Security check. If you don't have enough money in your Social Security check, you'll be billed for the extra amount each month by either 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).

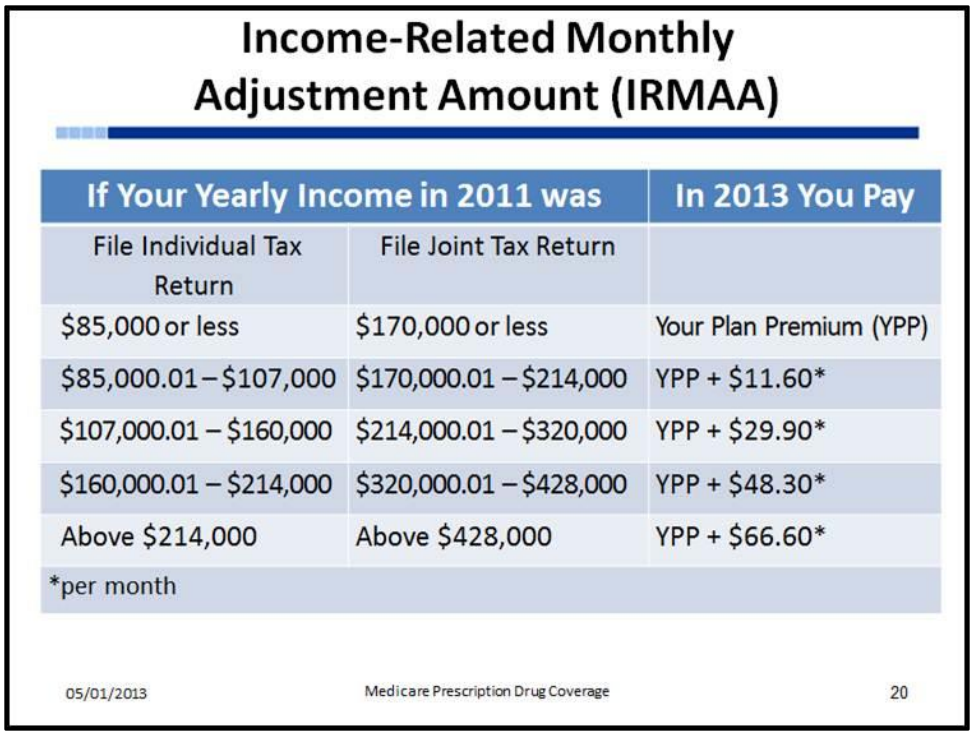
If you don't pay your entire Part D premium (including the extra amount), you may be disenrolled from your Medicare drug plan. You must pay both the extra amount and your plan's premium each month to keep Medicare prescription drug coverage.

If you have to pay an extra amount and you disagree (for example, if you have a life event that lowers your income), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Reference: Social Security Administration, SSA Publication No. 05-10536, March 2012.

Need More Information?

Visit www.socialsecurity.gov.



Income-Related Monthly Adjustment Amount (IRMAA)

If Your Yearly Income in 2011 was		In 2013 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 + $11.60*
$107,000.01 – $160,000	$214,000.01 – $320,000	YPP + $29.90*
$160,000.01 – $214,000	$320,000.01 – $428,000	YPP + $48.30*
Above $214,000	Above $428,000	YPP + $66.60*
*per month		

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You pay only your plan premium if your yearly income in 2011 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 IRS tax return 2 years ago (the most recent tax return information provided to Social Security by the IRS), you'll have to pay an extra amount for your Medicare prescription drug coverage, called the income-related monthly adjustment amount (IRMAA). You pay this extra amount in addition to your monthly Medicare drug plan premium.

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

Check Your Knowledge
Lesson 2 – Medicare Part D Benefits and Costs

Answer the following questions:

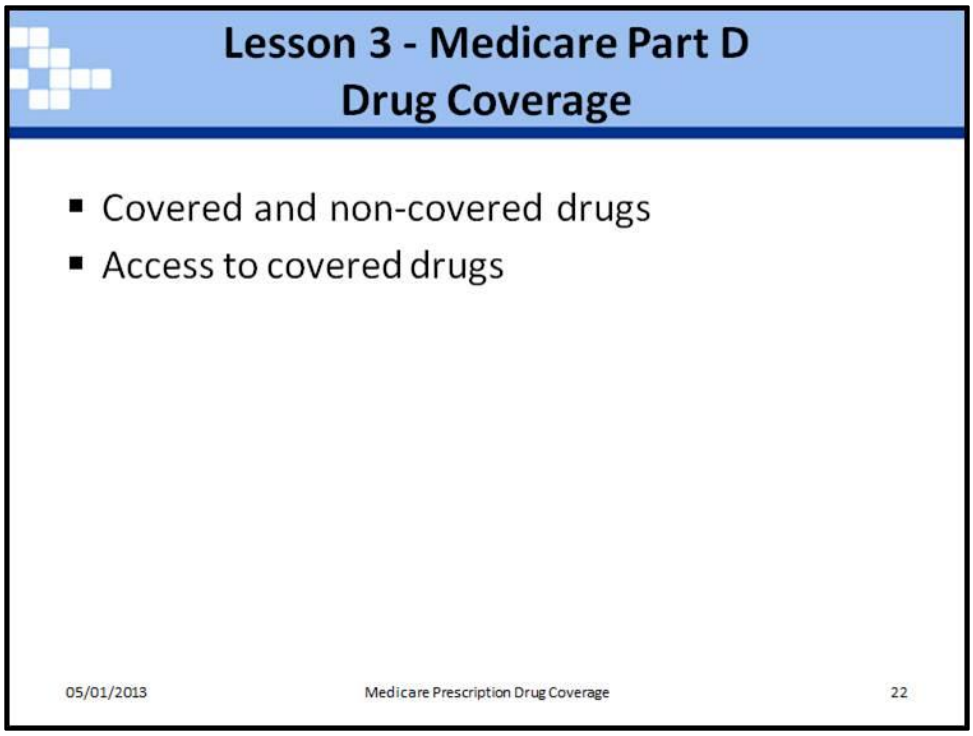
1. Which costs count toward getting out of the coverage gap? (Select all that apply.)

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

2. True or False: Medicare drug plan benefits and costs are the same from year to year.

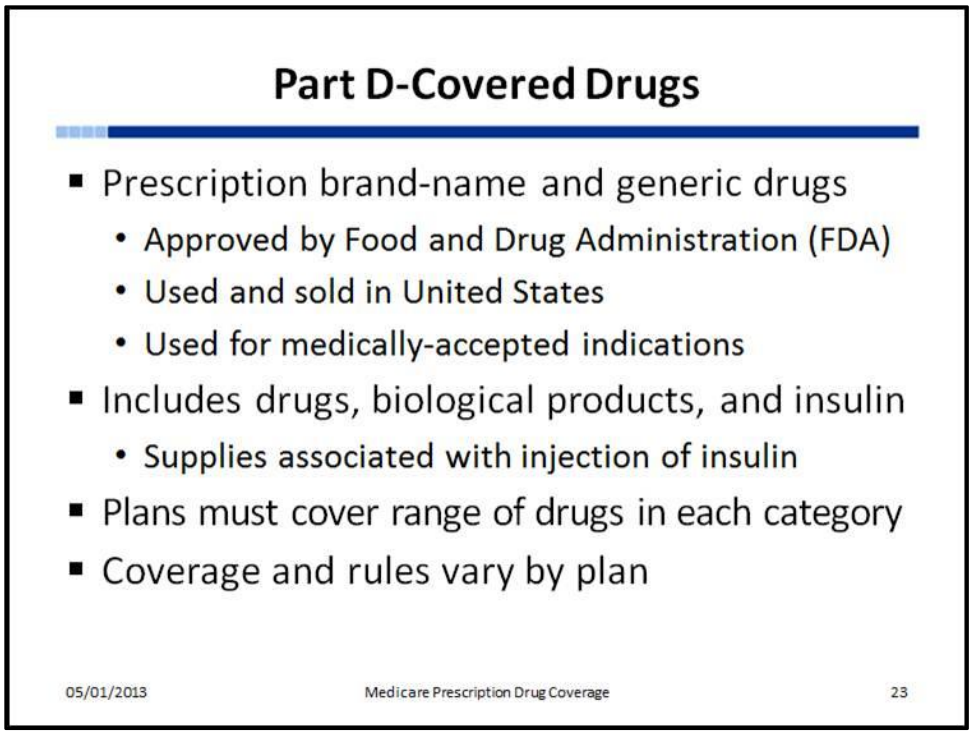
    a. True
    b. False

Refer to page 80 to check your answers.



Lesson 3, *Medicare Part D Drug Coverage,* provides information on:

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



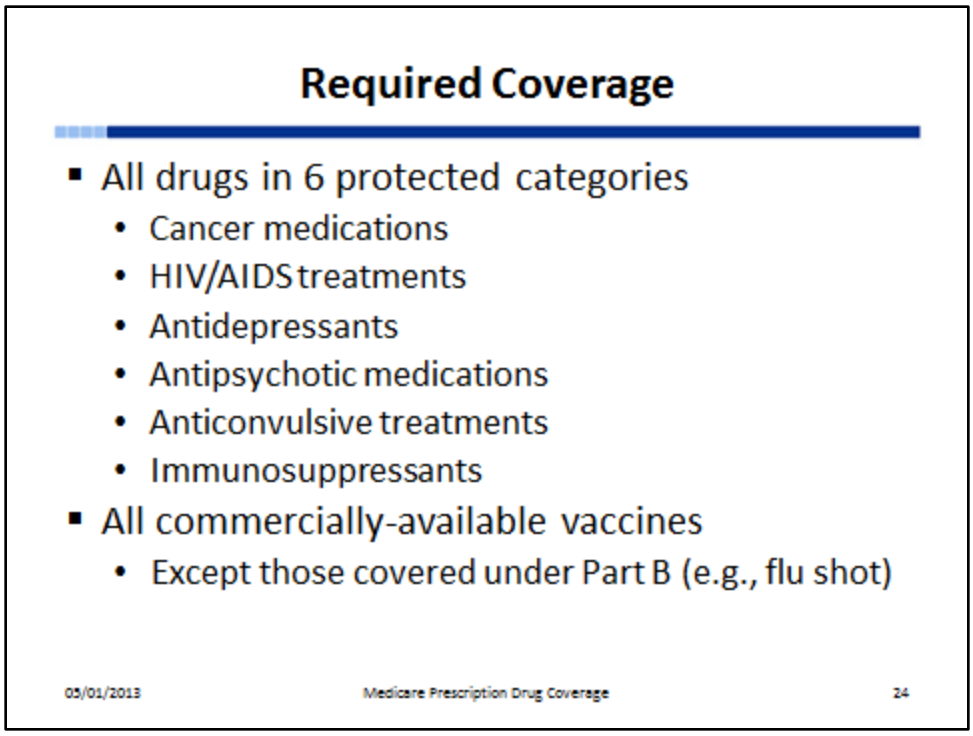
Medicare drug plans cover generic and brand-name drugs. To be covered by Medicare, a drug must be available only by prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication.

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 the most commonly prescribed categories. 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.

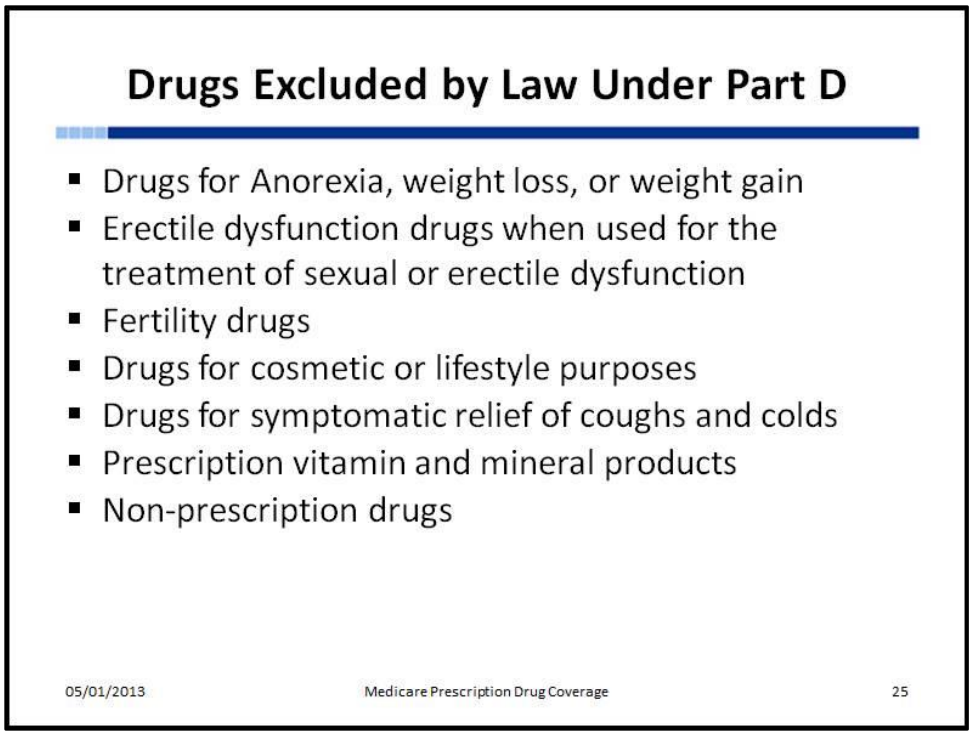
NOTE: There are older drugs that never went through FDA approval processes. As plans review their formularies and find these drugs, they are removed from the formulary.



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 vaccine (but not vaccines covered by Part B, such as the flu and pneumococcal pneumonia 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.

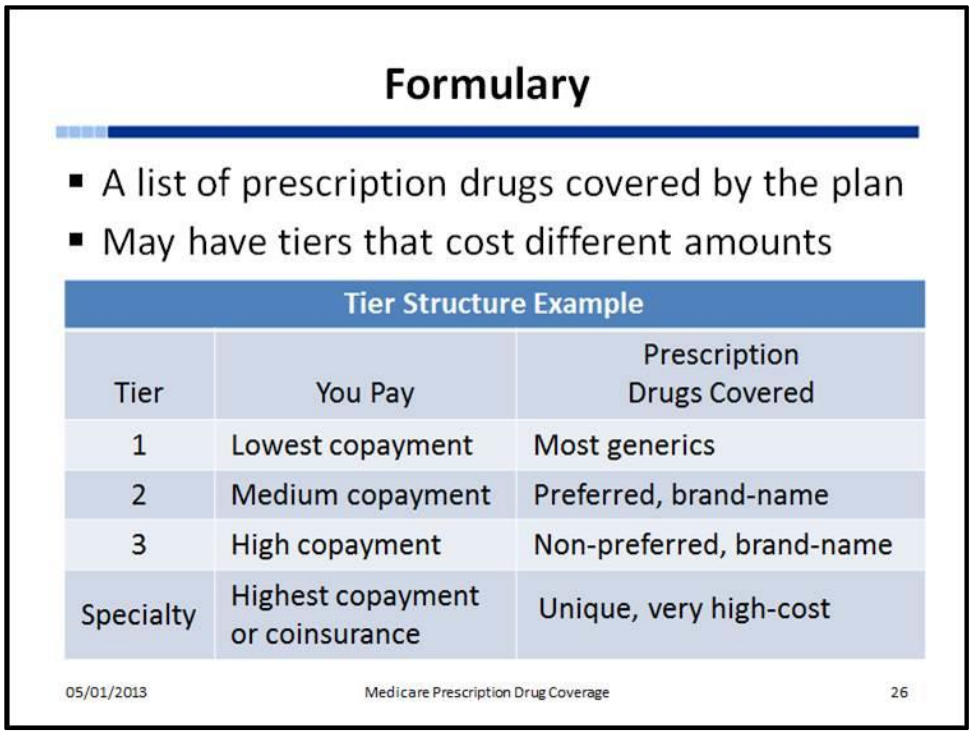


By law, Medicare doesn't cover the following drugs:

- 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 (FDA) 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.

NOTE: Barbiturates and benzodiazepines were previously excluded from coverage under Medicare Part D. As of January 1, 2013, Part D covers barbiturates (used in the treatment of epilepsy, cancer, or a chronic mental health disorder) and benzodiazepines.

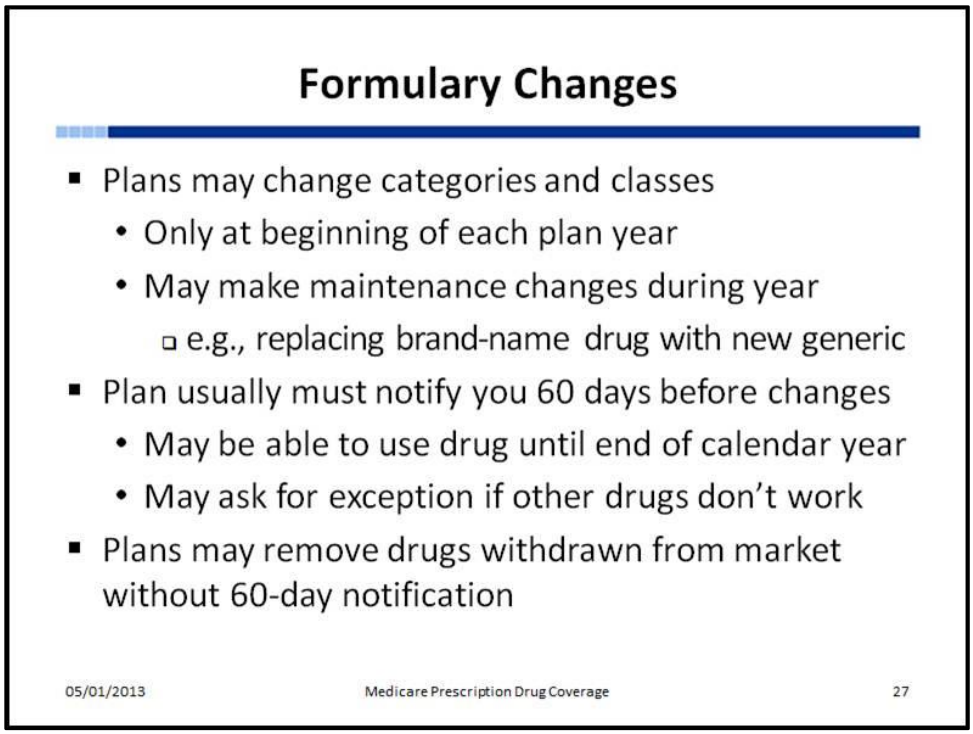


Each Medicare drug plan has a list of prescription drugs that it covers called a formulary. Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form its tiers 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 FDA 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 will cost more than Tier 1 drugs.
- **Tier 3–Non-preferred brand-name drugs** – Tier 3 drugs will cost more than Tier 2 drugs.
- **Specialty Tier** – These drugs are unique and have a high cost.

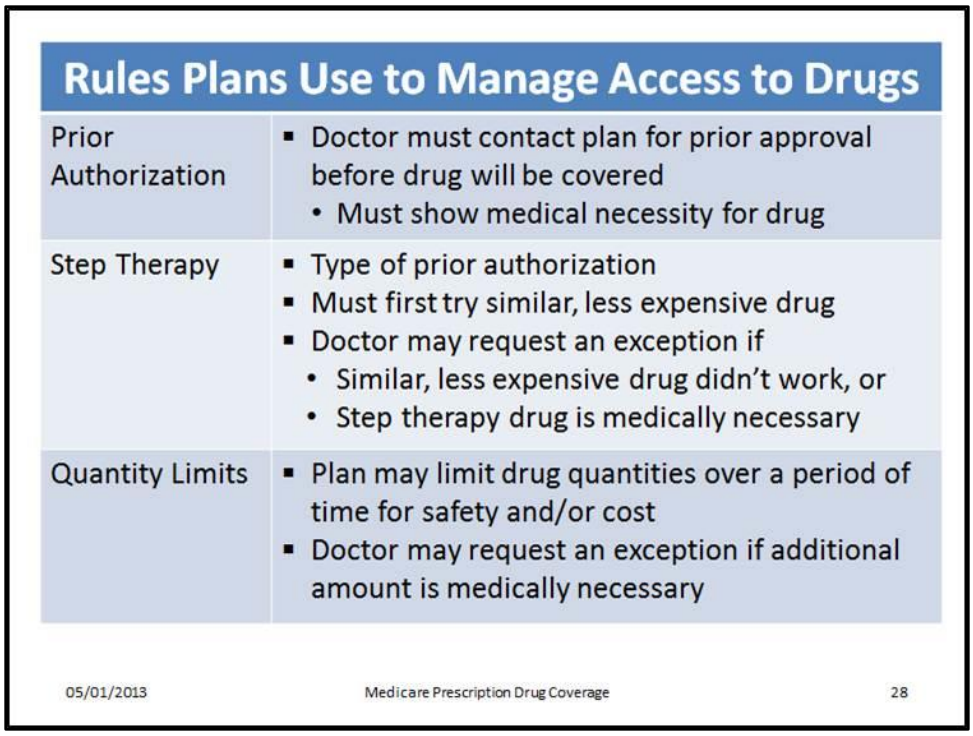
NOTE: In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can request an exception and ask your plan for a lower copayment.



Medicare drug plans may change their therapeutic categories and classes in a formulary only 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 change their formularies as a result of new information on drug safety or effectiveness. Those changes must be made according to the prescribed approval procedures and plans must give 60 days' notice to CMS, State Pharmacy Assistance Programs (SPAPs), prescribing physicians, network pharmacies, pharmacists, and people covered under the plan.

CMS has told Medicare drug plans that 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 (FDA) 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.



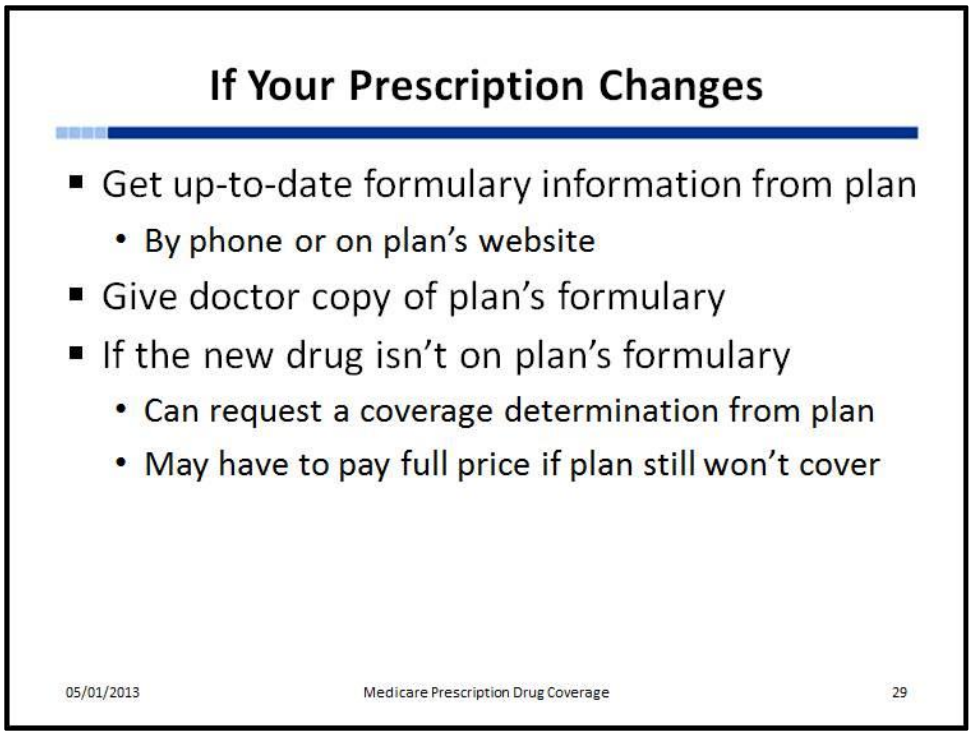
Medicare drug plans manage access to covered drugs in several ways, including prior authorization, step therapy, and quantity limits.

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 prior authorization. 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 to 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 is medically necessary to take a step-therapy drug (the drug the doctor originally prescribed), you (with your doctor's help) 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.



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 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
Lesson 3 – Medicare Part D Coverage

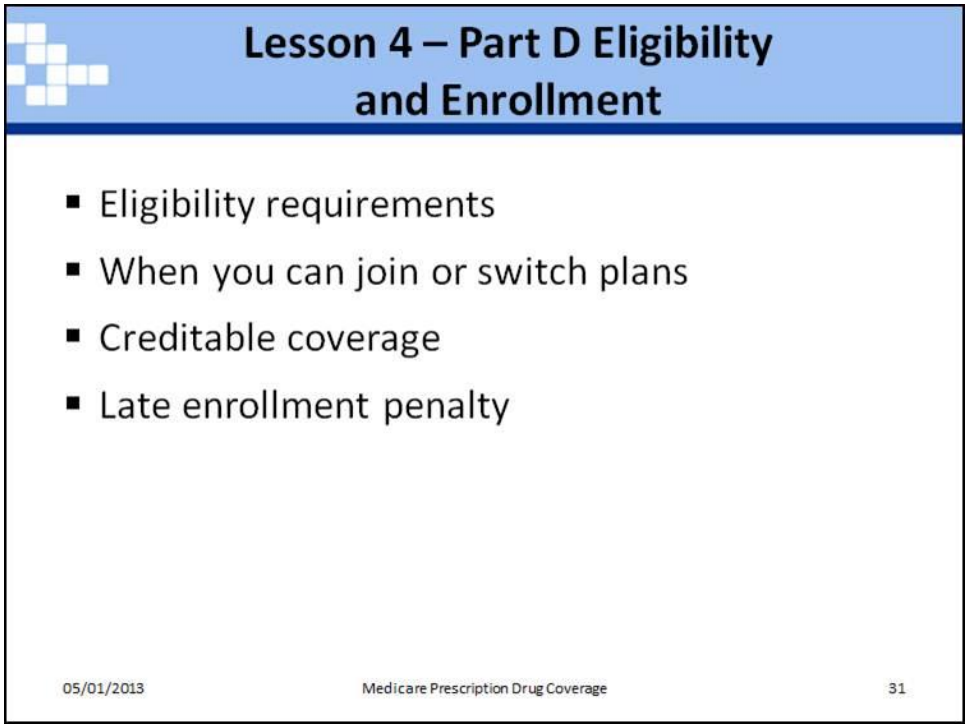
Answer the following questions:

1. Which of the following drugs are <u>NOT</u> covered by Medicare Part D?

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

2. Seema's doctor needs to prescribe a drug that her Medicare drug plan doesn't cover. Will she have to pay for the drug out-of-pocket? Why or why not?

Refer to page 81 to check your answers.



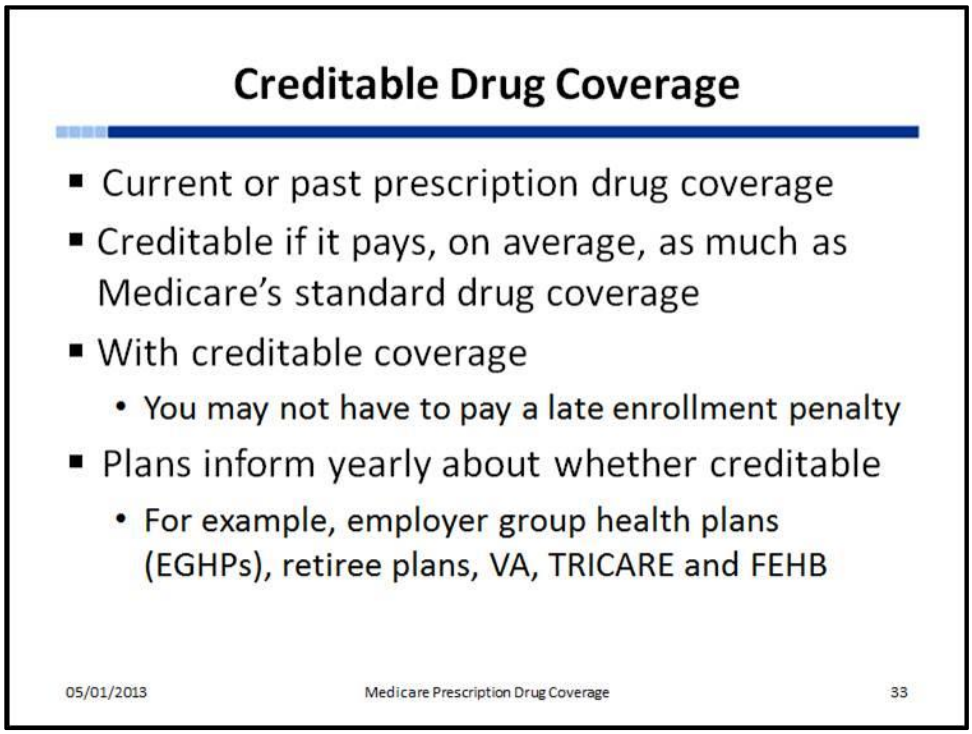
Lesson 4, *Part D Eligibility and Enrollment,* provides the following information:

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

To join a Medicare drug plan, you must have Medicare Part A and/or Part B. To join a Medicare Advantage (MA) 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 the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Commonwealth of Northern Marianas 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 coverage.

Medicare drug coverage isn't automatic. Most people must enroll in 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.

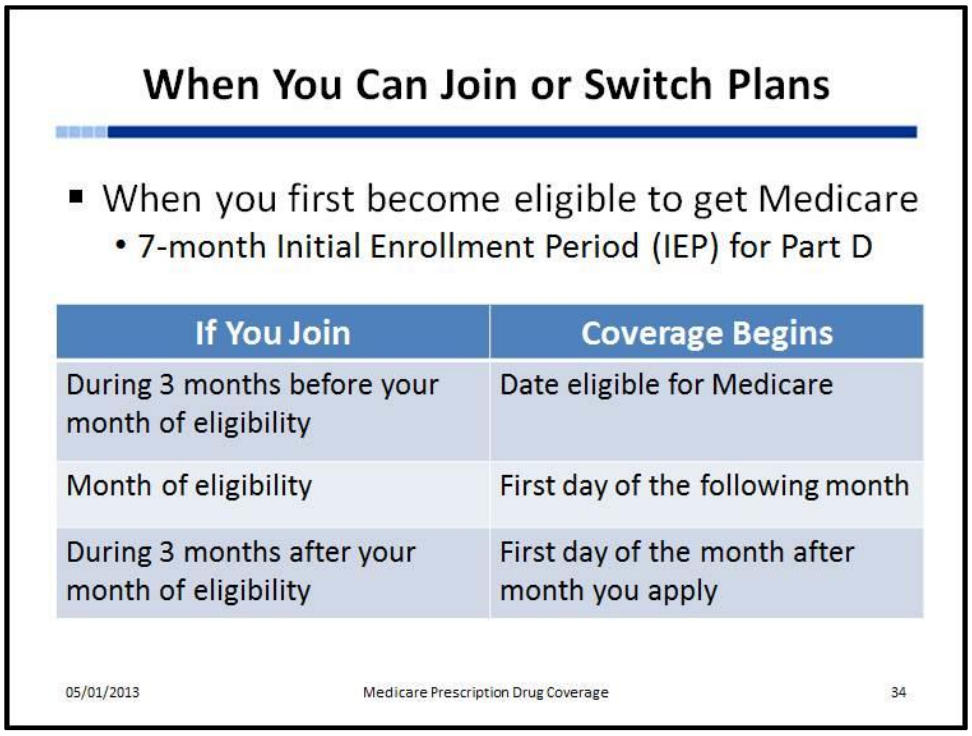


If you have other prescription drug coverage, you'll get information each year from your plan that tells you if the plan is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. We call this "creditable coverage." If you have this kind of coverage when you become 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.

Creditable prescription drug coverage could include drug coverage from a former employer or union, TRICARE, the Department of Veteran Affairs (VA), or the Indian Health Service. Your plan must tell you each year if your drug coverage is creditable coverage. Your plan may send you this information in a letter or include it in their newsletter. Keep this information, because you may need it if you join a Medicare drug plan later.

If you choose not to join a Medicare drug plan when you're first eligible and go without Part D coverage or other creditable coverage for 63 days or more, you may have to pay a higher monthly premium (penalty) for as long as you have Part D coverage, if you decide to enroll later.

NOTE: Most Medigap (Medicare Supplement Insurance) 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 you insurer can remove prescription drug coverage your Medigap policy.

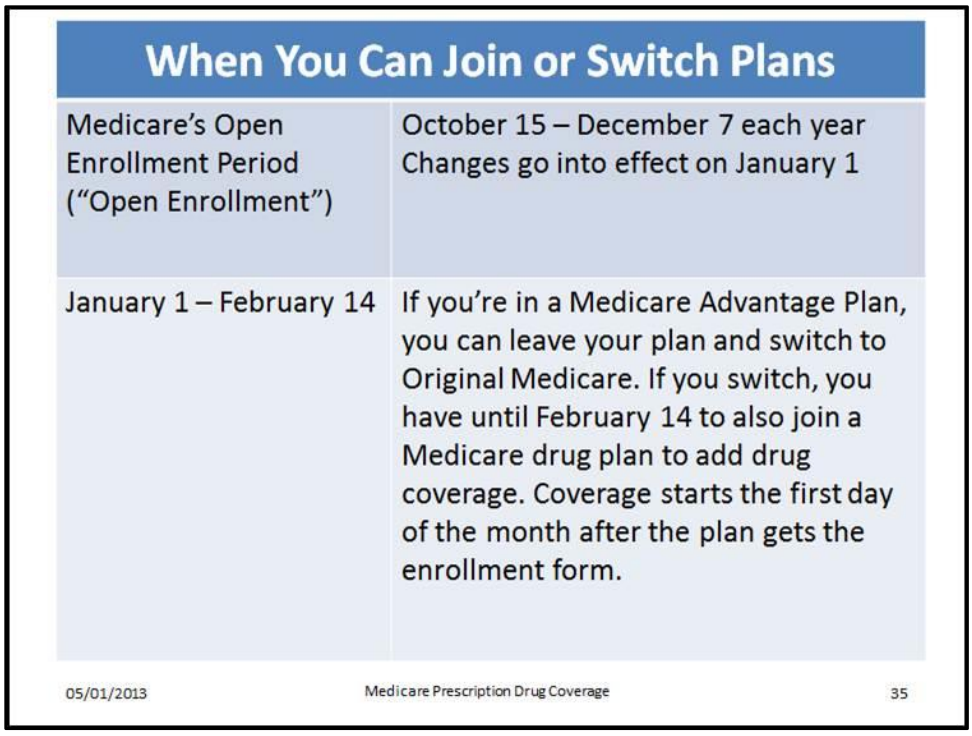


When you first become eligible to get Medicare, you have a 7-month Initial Enrollment Period (IEP) for Part D:

- You can apply 3 months before your month of Medicare eligibility. Coverage will begin on the date you become eligible for Medicare.
- If you apply during your month of eligibility, then your Medicare drug coverage begins on 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 CMS unless they join a plan on their own. We'll discuss these groups in Lesson 5.

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

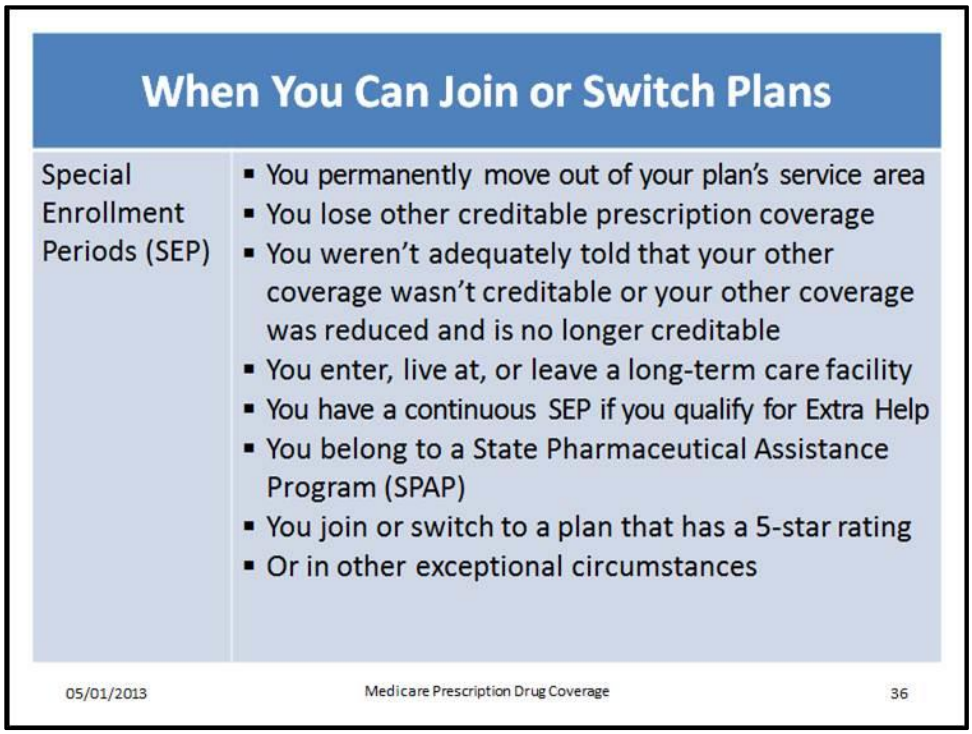


When You Can Join or Switch Plans

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.

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.

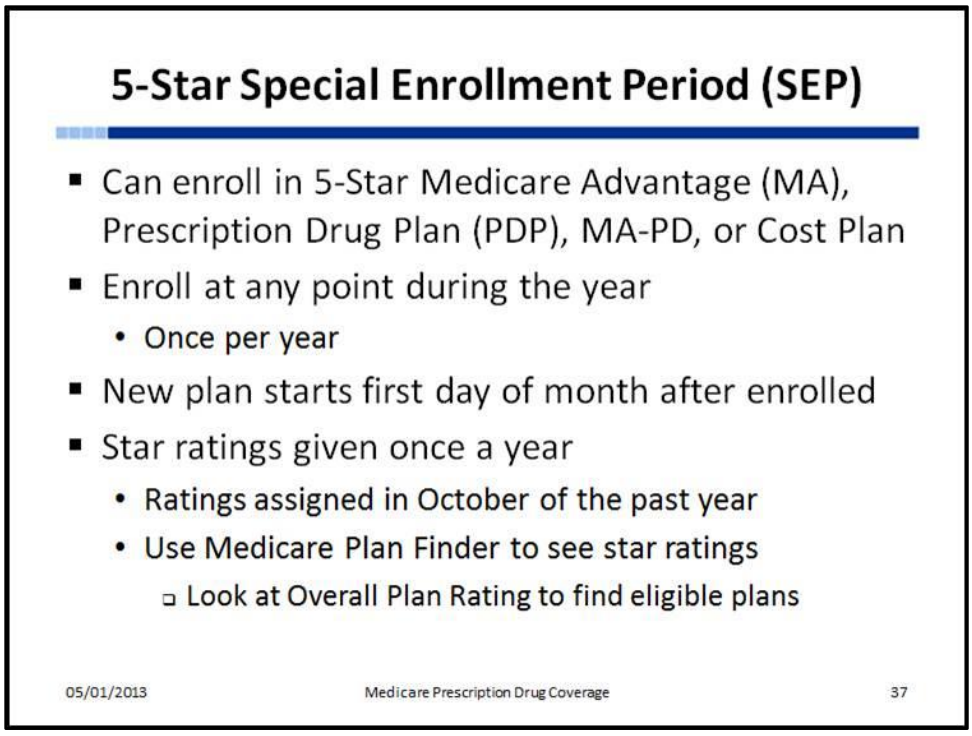
Between January 1 and February 14, you can leave a Medicare Advantage (MA) plan and switch to Original Medicare. If you make this change, you may also join a Medicare drug plan to add drug coverage. Coverage starts the first day of the month after the plan gets the enrollment form.



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 were not adequately informed that your other coverage wasn't creditable, or that your other coverage was reduced so it's no longer creditable.
- When 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.
- You belong to a State Pharmaceutical Assistance Program (SPAP).
- You join or switch to a plan that has a 5-star rating.
- Or in 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 are 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 uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from one to five 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-only (MA) plan, a 5-star Medicare Advantage plan with prescription drug coverage (MA-PD), a 5-star Medicare Prescription Drug Plan (PDP), or a 5-star Cost Plan, as long as you meet the plan's enrollment requirements (for example, living within the service area). If you're currently enrolled in a plan with a 5-star overall rating, you may use this SEP to switch to a different plan with a 5-star overall rating.

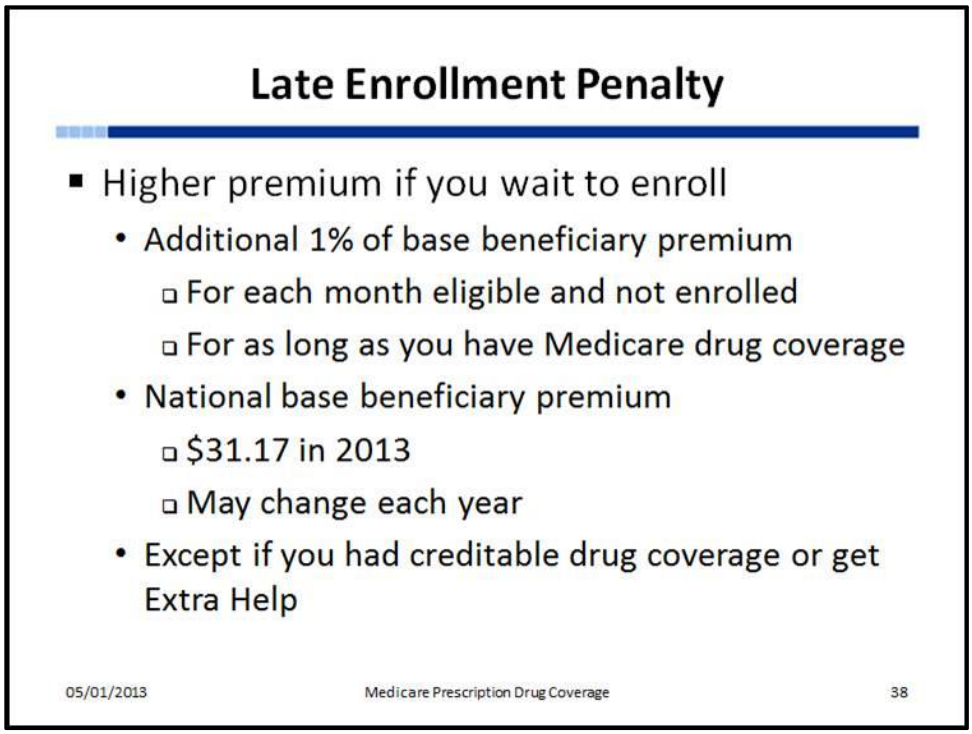
CMS also created a coordinating Special Enrollment Period (SEP) for prescription drug plans. This SEP lets people who enroll in certain types of 5-star plans without drug coverage choose a prescription drug plan, if that combination is allowed under CMS rules.

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 www.medicare.gov. 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.

For more information, please see the *5-Star Enrollment Period Job Aid* on your resource card.

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 doesn't. You'll have to wait until the next applicable enrollment period to get coverage and may have to pay a penalty.



If you choose not to join a Medicare drug plan at your first opportunity, you may have to pay a higher monthly premium (penalty) if you enroll later. The late enrollment penalty is calculated by multiplying the 1% penalty rate times the national base beneficiary premium ($31.17 in 2013) 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.

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 give proof that supports your case.

Example: Mrs. Jones didn't join when she was first eligible – by June 15, 2009. She joined a Medicare drug plan between October 15 and December 7, 2011, for an effective date of January 1, 2012. Since Mrs. Jones didn't join when she was first eligible and went without other creditable prescription drug coverage for 30 months (July 2009–December 2011), she'll be charged a monthly penalty of $9.40 in 2013 ($31.17 national base beneficiary premium x .01 penalty rate x 30 months = $9.35, rounded to nearest $.10 = $9.40). She pays this penalty each month in addition to her plan's monthly premium.

Check Your Knowledge
Lesson 4 – Part D Eligibility and Enrollment

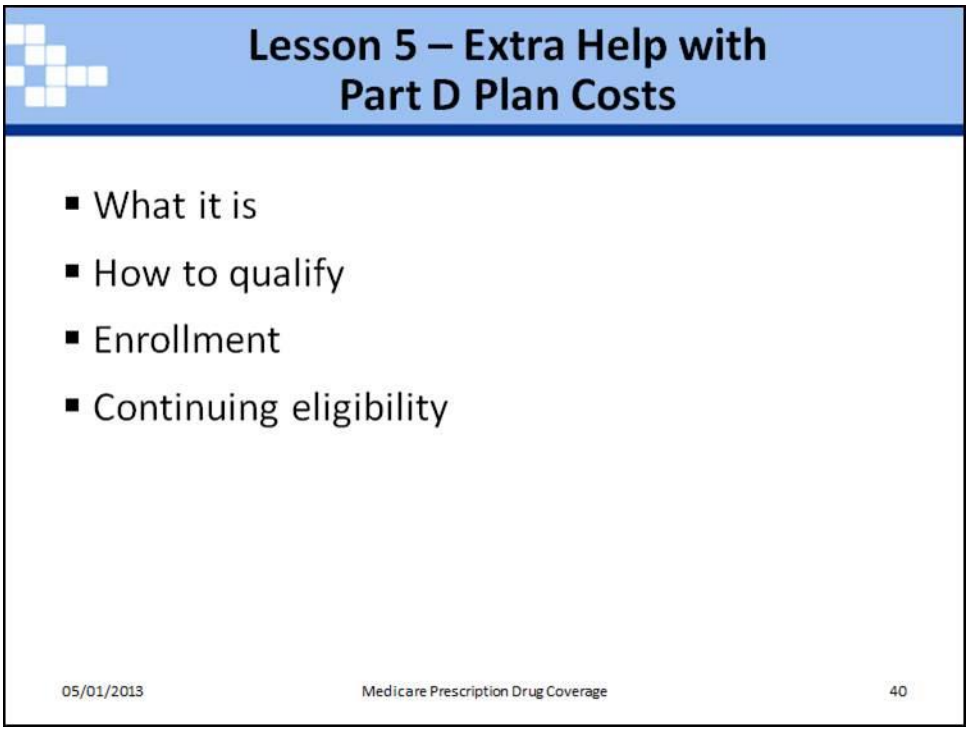
Answer the following questions:

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

    a. 3 months
    b. 5 months
    c. 7 months
    d. 12 months

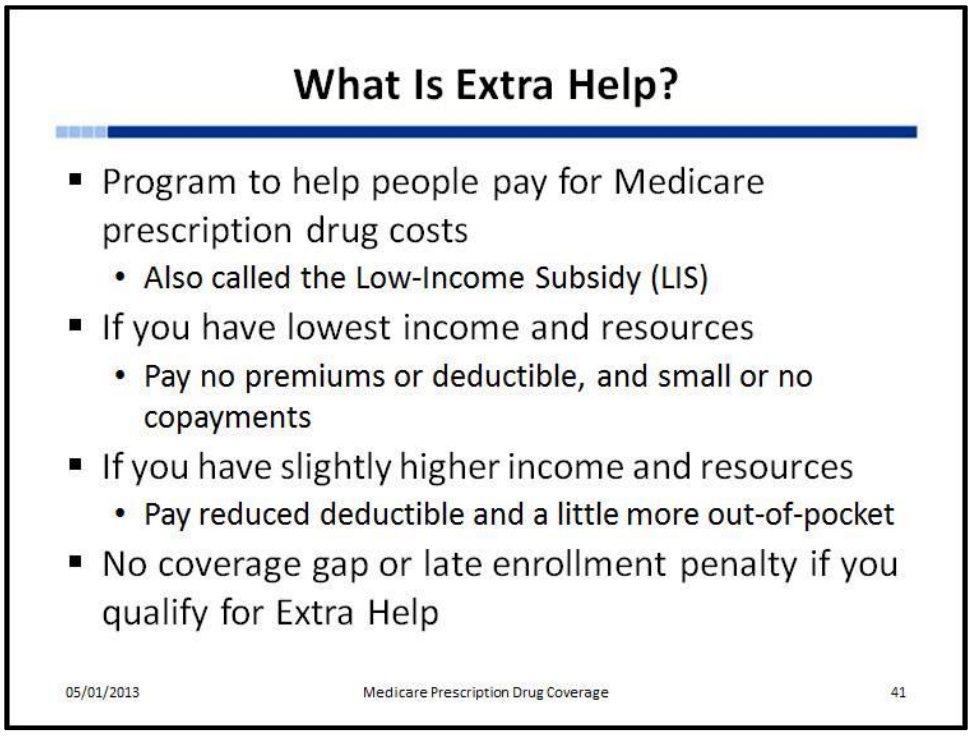
2. Xavier has a Medicare drug plan. Next month, he'll be moving from Florida to Arizona. Will he be able to switch to a different plan? Why or why not?

Refer to page 82 to check your answers.



Lesson 5, *Extra Help with Part D Drug Plan Costs,* provides the following information:

- What it is
- How to qualify
- Enrollment
- Continuing eligibility



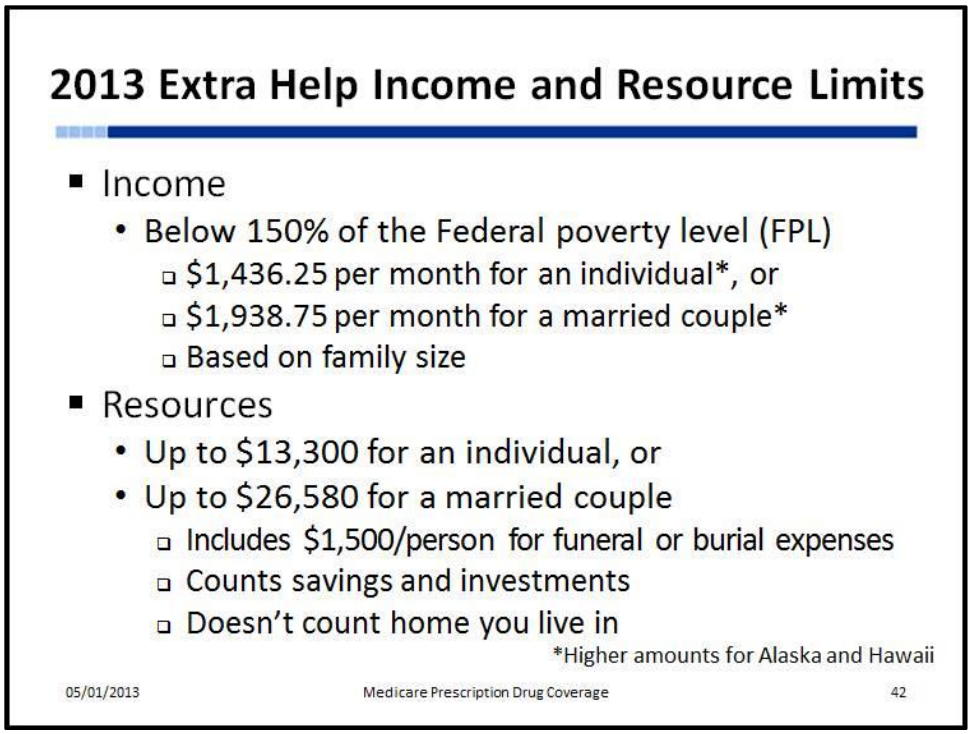
If you have limited income and resources, you may get Extra Help paying for your Medicare prescription drug costs. Extra Help is also called the Low-Income Subsidy (LIS).

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 (SEP) 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.



You may get Extra Help if you have Medicare, income below 150% of the Federal poverty level (FPL), and limited resources. You may qualify for Extra Help if your income and resources are below the above limits in 2013. These amounts may change in 2014.

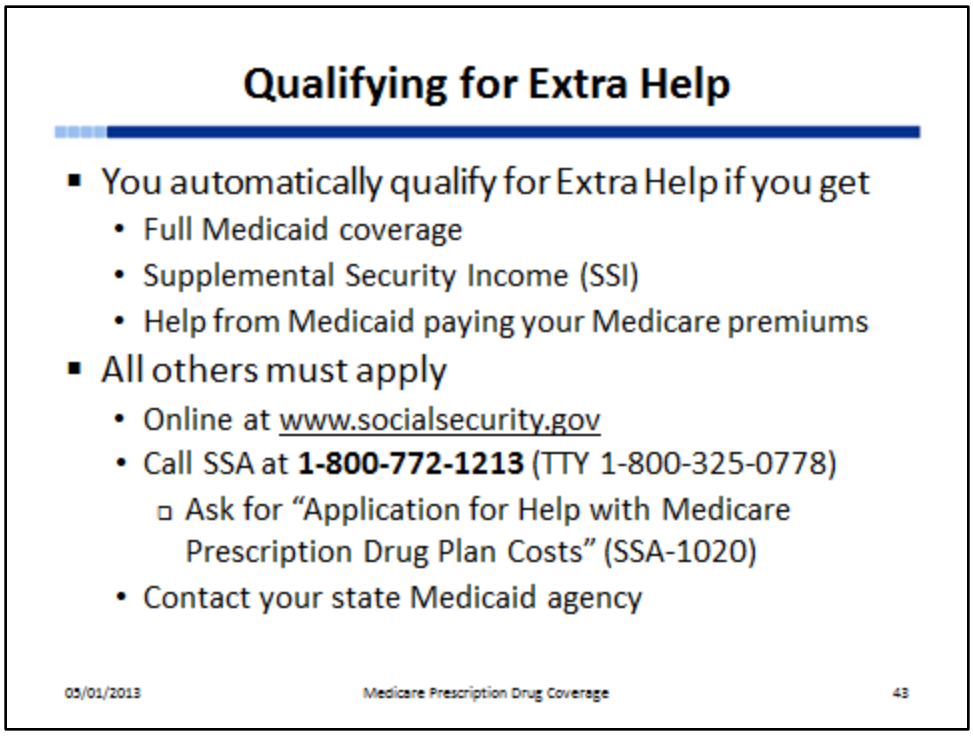
If you're married and live with your spouse, both of your incomes and resources count, even if only one of you applies for Extra Help. If you're married and don't live with your spouse when you apply, only your income and resources count. The income is compared to the FPL for a single person or a married 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), and
- 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 2013 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 usually are released each February for the same calendar year.



You automatically qualify for Extra Help (and don't need to apply) if you have Medicare and get:

- Full Medicaid coverage
- Supplemental Security Income (SSI) benefits
- Help from Medicaid paying your Medicare Part B premiums (Medicare Savings Program)

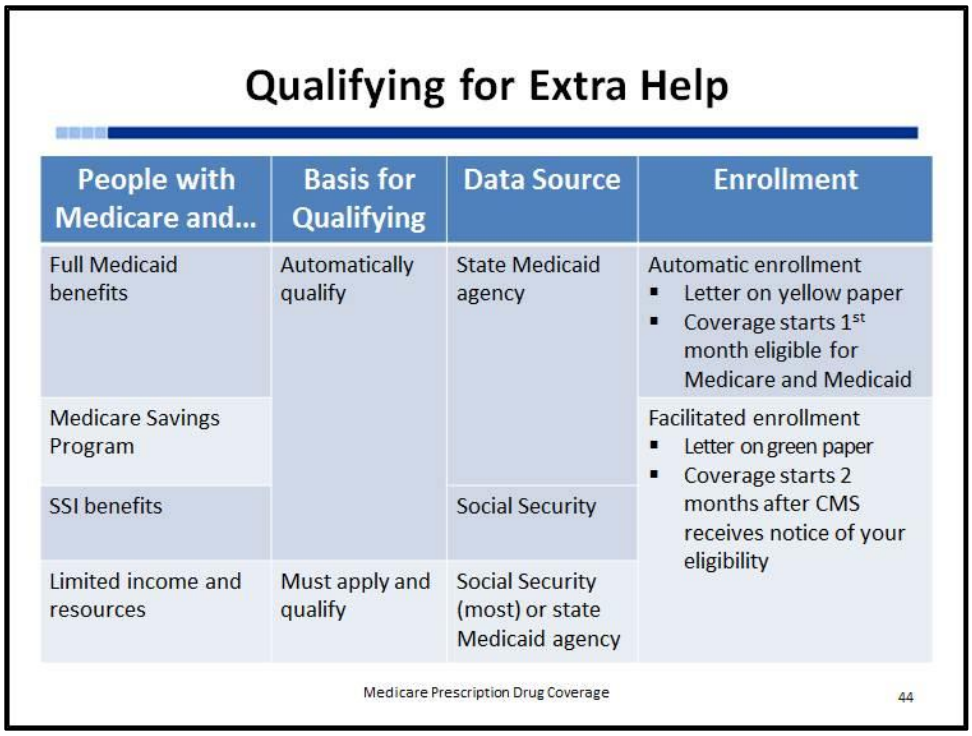
If you don't meet one of the above conditions, you may still qualify for Extra Help, but you'll have to apply for it. If you think you qualify but aren't sure, you should still apply. You can apply for Extra Help at any time, and if you're denied, you can reapply if your circumstances change. Eligibility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

You can apply for Extra Help by:

- Completing a paper application you can get by calling Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778)
- Applying online at www.socialsecurity.gov
- Applying through your state Medicaid agency
- Working with an organization, such as a State Health Insurance Assistance Program (SHIP)

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, Social Security will transmit the data from your application to your state Medicaid agency to initiate an application for Medicare Savings Programs (MSP), which can help you pay for your Medicare premiums.



Qualifying for Extra Help

People with Medicare and…	Basis for Qualifying	Data Source	Enrollment
Full Medicaid benefits	Automatically qualify	State Medicaid agency	Automatic enrollment ▪ Letter on yellow paper ▪ Coverage starts 1st month eligible for Medicare and Medicaid
Medicare Savings Program			Facilitated enrollment ▪ Letter on green paper ▪ Coverage starts 2 months after CMS receives notice of your eligibility
SSI benefits		Social Security	
Limited income and resources	Must apply and qualify	Social Security (most) or state Medicaid agency	

Medicare Prescription Drug Coverage 44

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 to identify people who have Medicare and are entitled to Supplemental Security Income (SSI) but not Medicaid, or who have applied and qualified for Extra Help.

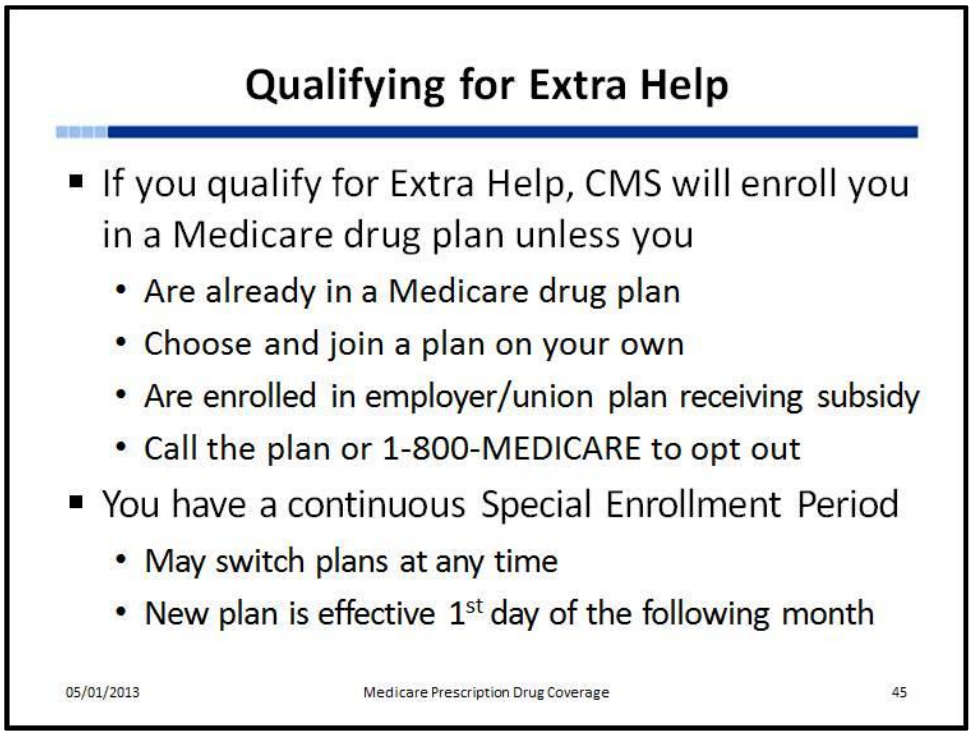
When you first qualify for Extra Help, CMS will enroll you in a Medicare drug plan if you don't join a plan on your own to be sure you have coverage. This applies whether you qualify automatically or whether you apply and qualify for Extra Help.

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 will 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 facilitated into a Medicare drug plan. The facilitated enrollment goes into effect two 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.

NOTE: Please see Appendix F for a list of letters sent to people with Medicare about Extra Help.



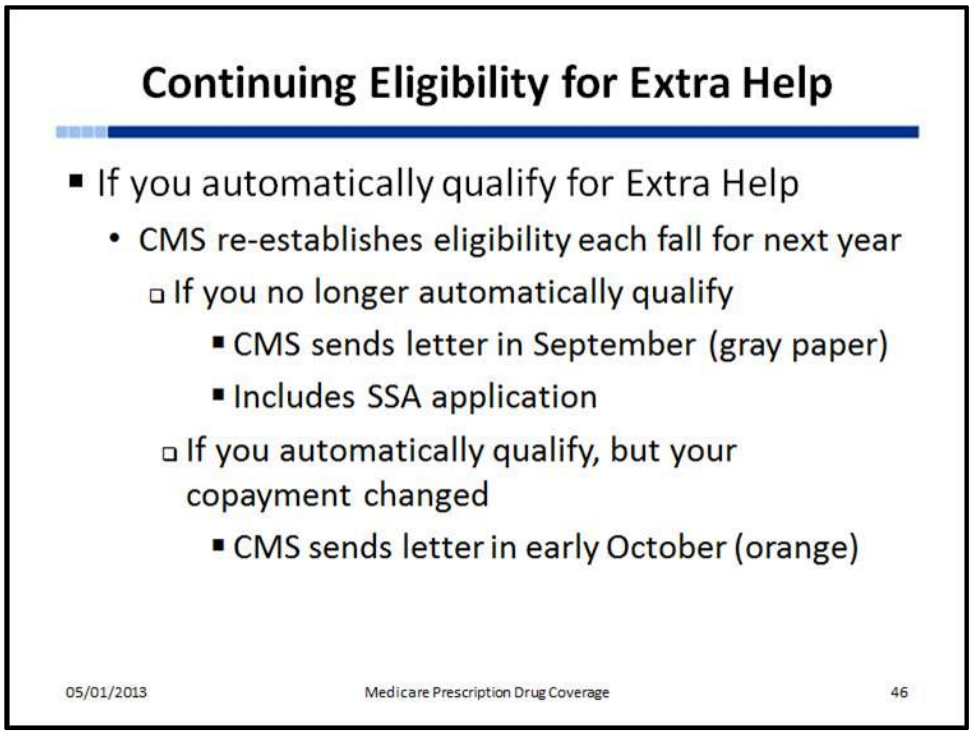
When you first qualify for Extra Help, CMS will enroll you in a Medicare drug plan to be sure you have coverage. CMS will do this whether you qualify automatically, or apply and qualify for Extra Help. CMS will enroll you into a plan unless:

- You're already in a Medicare drug plan
- You choose and join a plan on your own
- You're enrolled in an employer or union plan that gets the employer subsidy (sometimes called the retiree drug subsidy or RDS)
- You call 1-800-MEDICARE (1-800-633-4227) or the plan CMS assigned you to and ask to opt out of Medicare drug coverage

If you don't want to be in any Medicare drug plan, you can call 1-800-MEDICARE (1-800-633-4227) or the plan in which CMS enrolled you and ask to opt out of Medicare drug coverage. TTY users should call 1-877-469-2048. However, Medicaid won't pay for your drugs that Medicare would have covered.

You have a continuous Special Enrollment Period (SEP) and can switch plans at any time, with the new plan going into effect the first day of the following month.

NOTE: Please see Appendix F for a list of letters sent to people with Medicare about Extra Help.



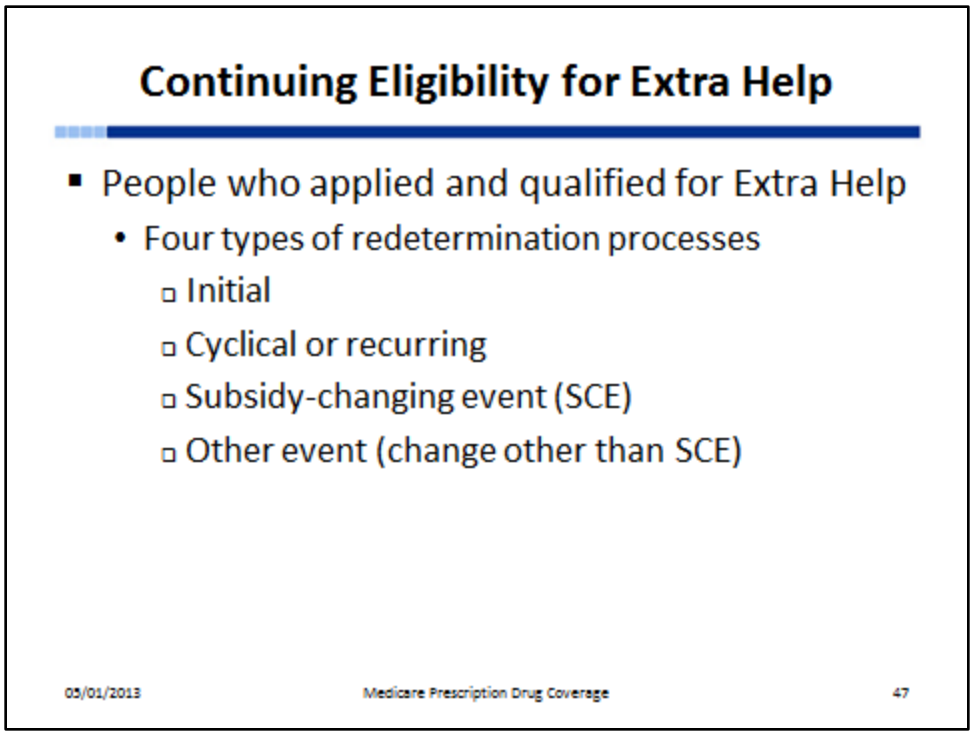
Every August, CMS reestablishes Extra Help eligibility for the next calendar year if you automatically qualify. Your Extra Help continues or changes depending on whether you're still eligible for full Medicaid coverage, get help from Medicaid paying Medicare premiums, or get Supplemental Security Income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

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 Supplemental Security Income 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.

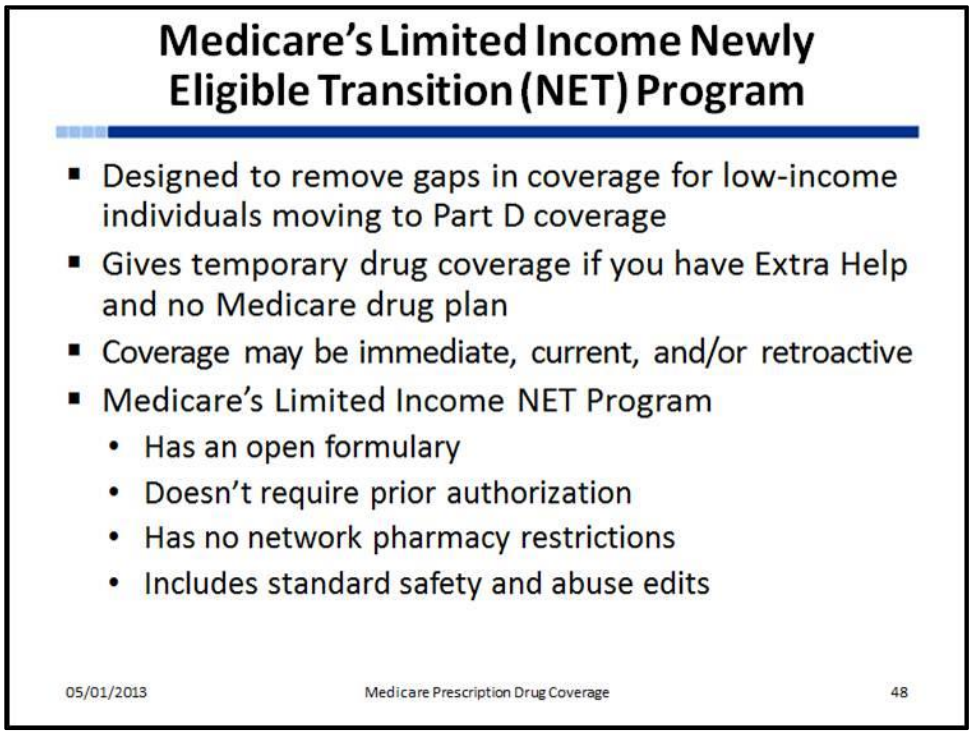
When people who no longer automatically qualify regain their eligibility for full Medicaid coverage, a Medicare Savings Program, or SSI, CMS mails them a new letter informing them that they now automatically qualify for Extra Help.

NOTE: Please see Appendix F for a list of the letters sent to people with Medicare regarding Extra Help.



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

- Initial redeterminations – To redetermine eligibility, the Social Security Administration (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 their eligibility for Extra Help may be ended, 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 re-determination form in the mail in September. They must respond to the form within 30 days of receiving it, even if nothing has changed. If they don't complete and return the form, 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, and/or the death of a spouse. They're required to report these events to SSA and fill out a special SCE redetermination form or they may lose their eligibility for Extra Help.
- 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 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 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:

- Have a valid Health Insurance Claim Number (HICN), which is on your Medicare Card;
- Be eligible for Part D;
- Not be enrolled in a Part D plan;
- Not be enrolled in a retiree drug subsidy (RDS) plan;
- Not be enrolled in a Part C plan which doesn't allow associated enrollment in a Part D plan;
- Have not opted out of auto-enrollment; and
- Have a permanent address in the 48 adjoining United States or D.C. – that is, not including Alaska or Hawaii.

Medicare's Limited Income NET program has an open formulary (Part D-covered drugs), doesn't require prior authorization, includes standard safety and abuse edits, and has no network pharmacy restrictions. However, CMS can't require a pharmacy to use this program.

Check Your Knowledge
Lesson 5 – Extra Help With Part D Plan Costs

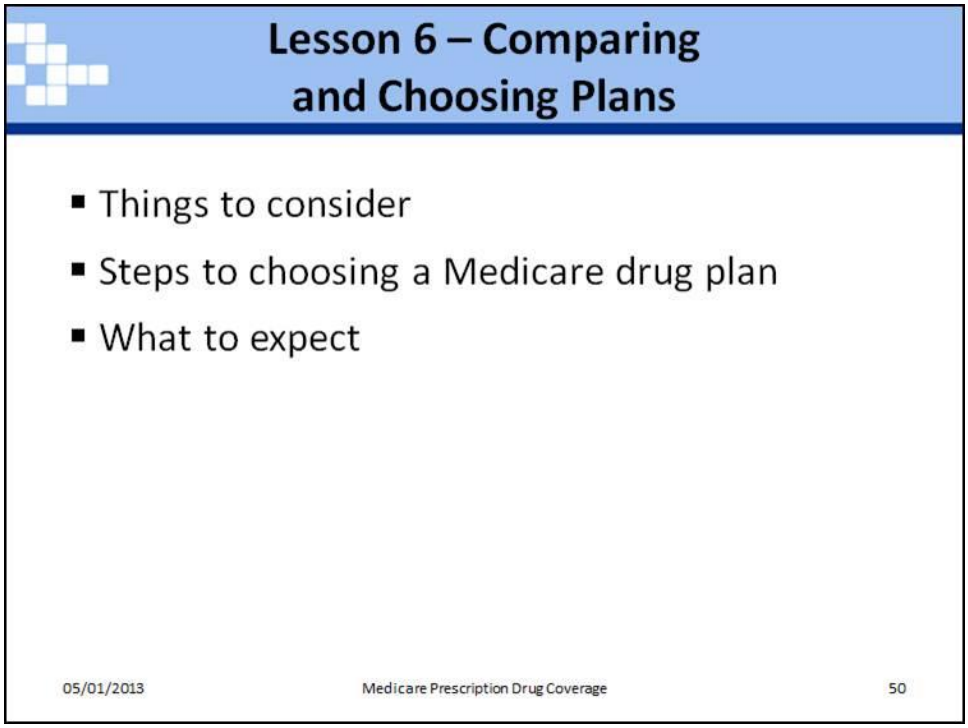
Answer the following questions:

1. 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? Why or why not?

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

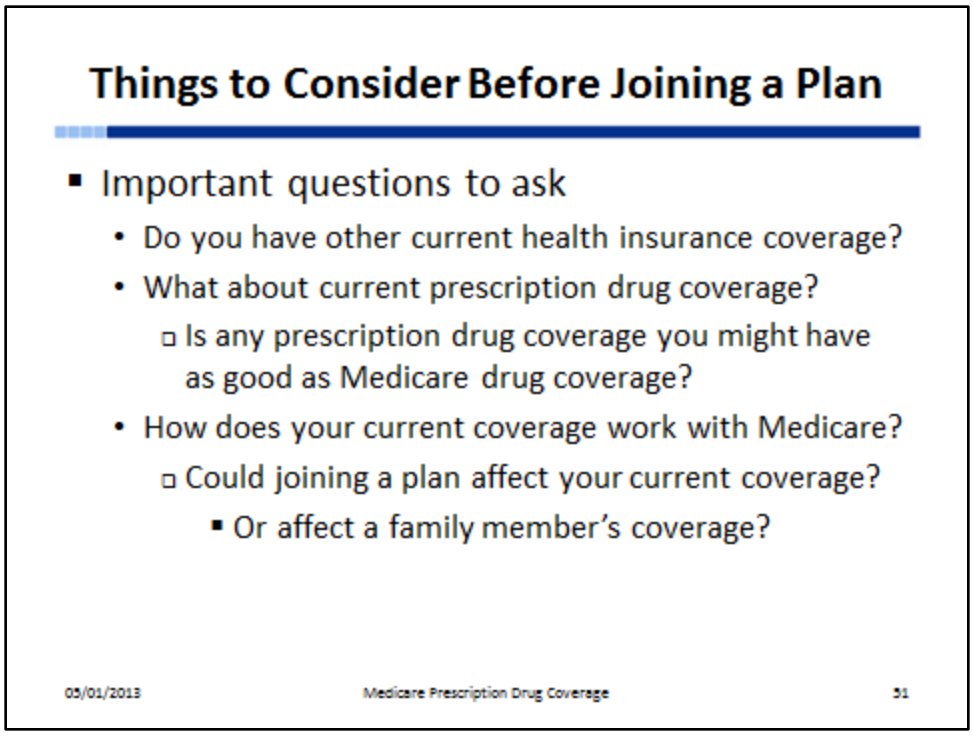
    a. By completing a paper application from Social Security
    b. By contacting your state's Medicaid agency
    c. By contacting your State Health Insurance Assistance Program (SHIP)
    d. By applying online at www.socialsecurity.gov
    e. All of the above

Refer to page 83 to check your answers.



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

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



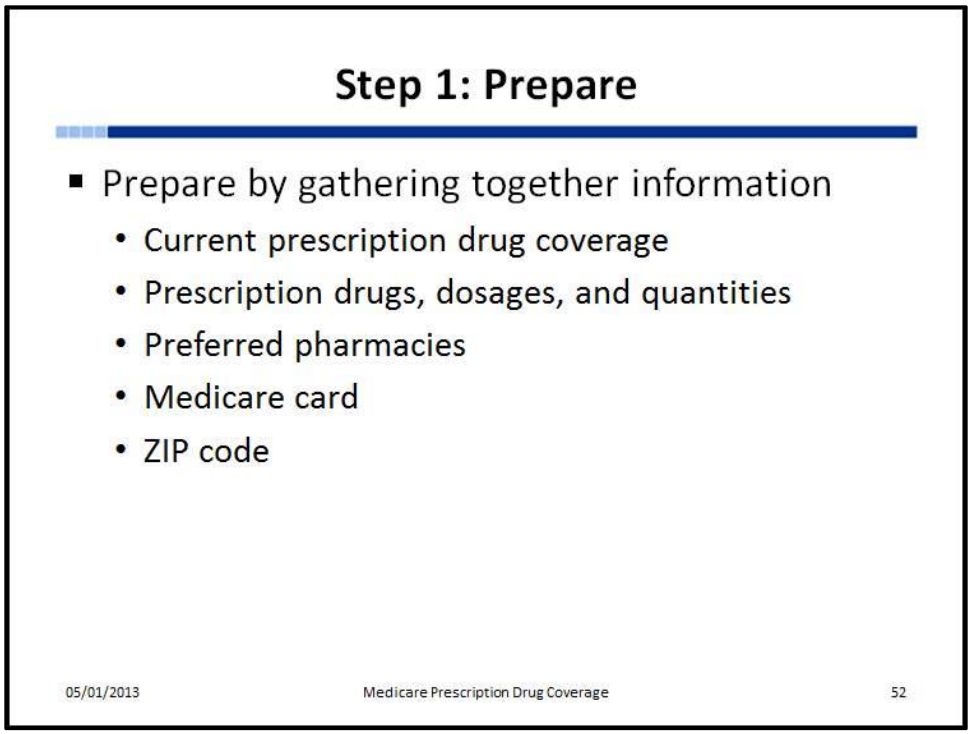
There are several things to consider when joining a Medicare drug plan. The most important consideration in deciding if Medicare drug coverage is right for you is to look at the type of health insurance coverage you have currently and how that affects your choices.

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.

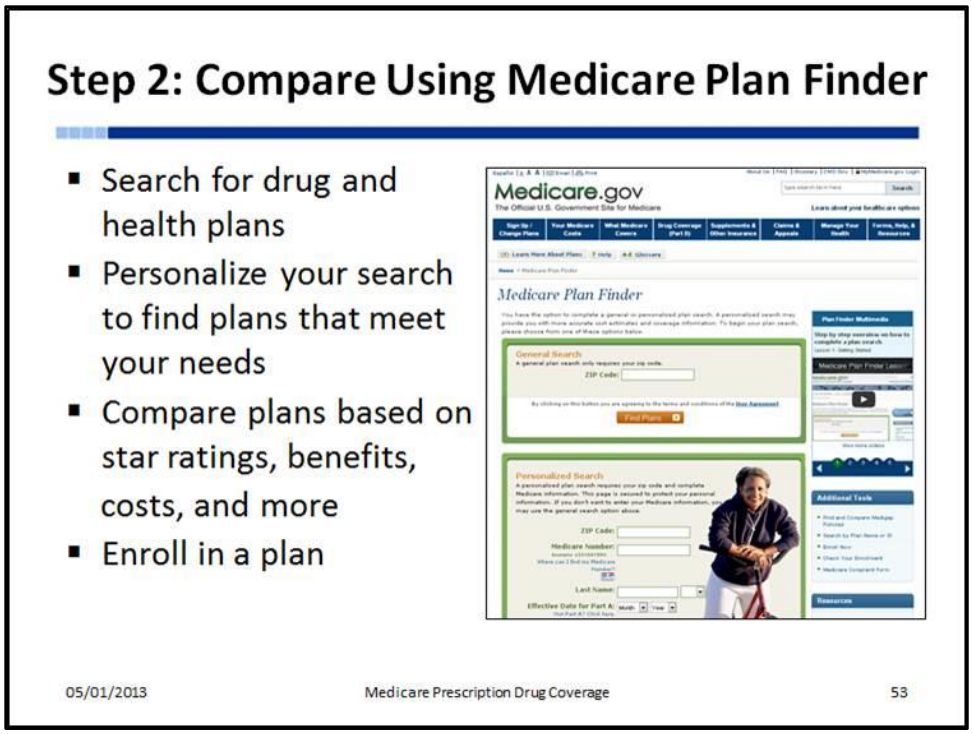
If you have employer or union coverage, call your benefits administrator before you make any changes or sign up for any other coverage. If you drop your employer or union coverage, you may not be able to get it back. Also, you may not be able to drop your employer or union drug coverage without also 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 about how different types of current coverage work with Medicare prescription drug coverage by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-469-2048.



Step 1: Before choosing a Medicare drug plan, you may want to gather together some information about yourself. 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.



Step 2: Visit www.medicare.gov/find-a-plan and use the Medicare Plan Finder to:

- 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 is 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 more information about using the Medicare Plan Finder, please see the plan finder job aids and videos in NTP Training Library at: http://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library.html.

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, www.medicare.gov. You can also call Medicare to enroll at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

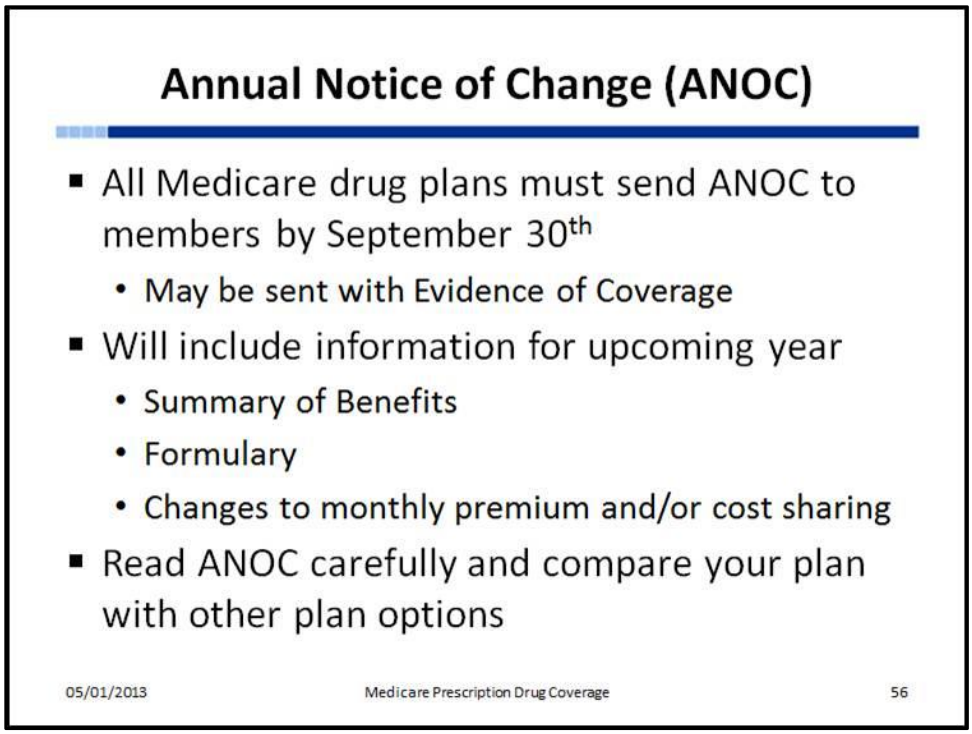
It's a good idea to keep a copy of your application, confirmation number, any other papers you sign, and letters or materials you get.

You can find these steps, and worksheets to help with this process in *Your Guide to Medicare Prescription Drug Coverage,* CMS publication number 11109.

NOTE: There are a small number of plans that may have more limited enrollment options, including some Special Needs Plans (SNPs), Cost Plans, and consistently poor performing plans that have received less than a 3-star rating for three 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.

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.



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 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 Evidence of Coverage with the ANOC.

Check Your Knowledge
Lesson 6 – Comparing and Choosing Plans

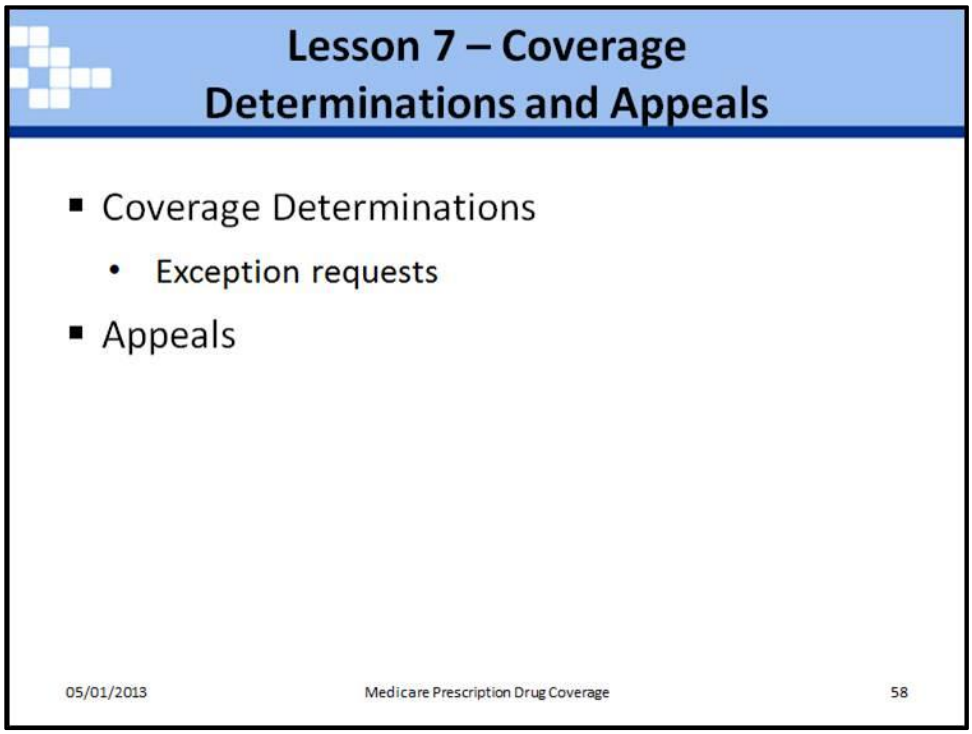
Answer the following questions:

1. Carl recently joined a Medicare drug plan and got materials from the plan in the mail. What should have been included in the materials?

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

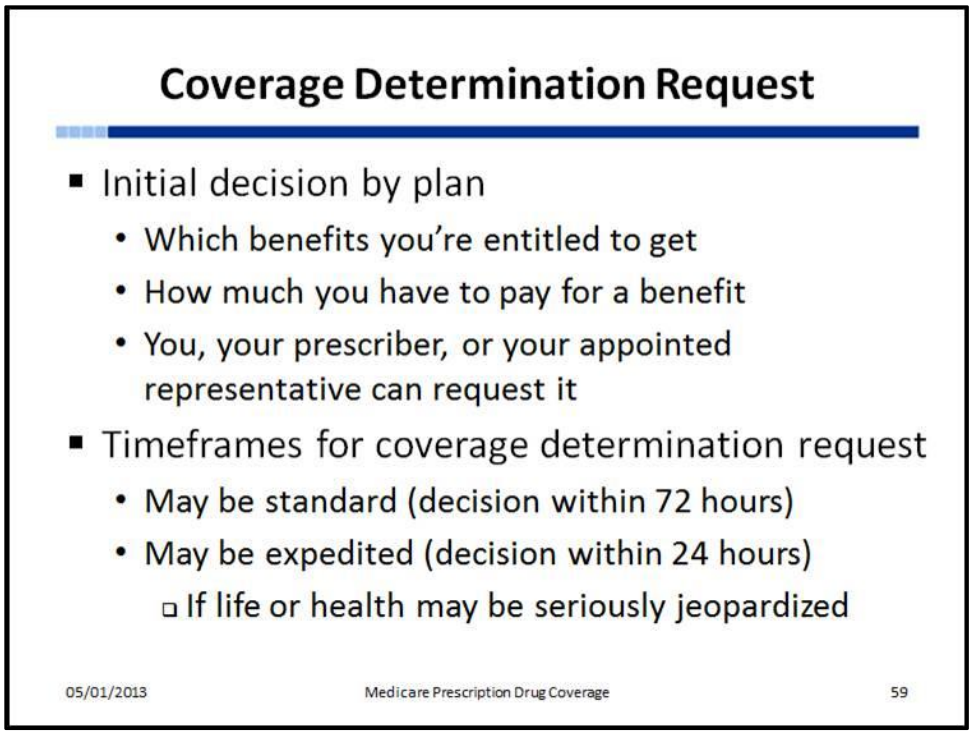
   a. Using the Medicare Plan Finder
   b. Calling 1-800-MEDICARE
   c. Through the Social Security website
   d. Calling the plan

Refer to page 84 to check your answers.



Lesson 7, *Coverage Determinations and Appeals,* provides the following information:

- Coverage Determinations
  - Exceptions
- Appeals



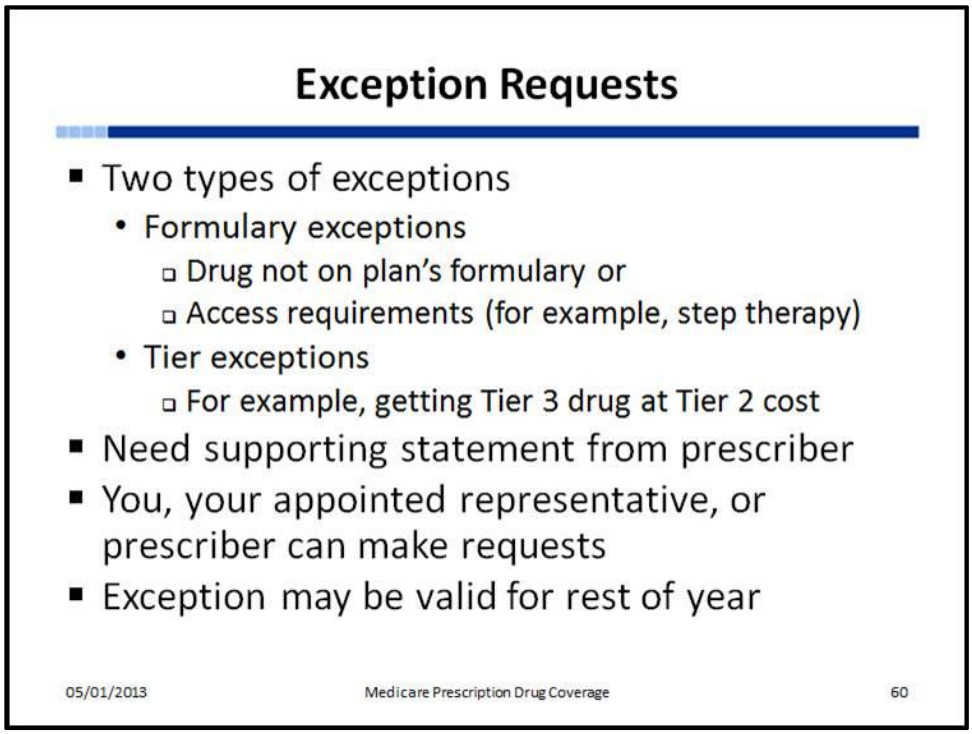
A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your prescription drug benefits. This includes whether a certain drug is covered, whether you have met all the requirements for getting a requested drug, and how much you must pay for a drug. You or 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 them a letter. If you write to the plan, you can write a letter or use the "Model Coverage Determination Request" form found at: http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms.html.

There are two types of coverage determinations: standard or 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 getting 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, the time clock starts when the plan gets your doctor's supporting statement.

If a plan fails to meet these timeframes, 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 their contact information at www.medicarepartdappeals.com.



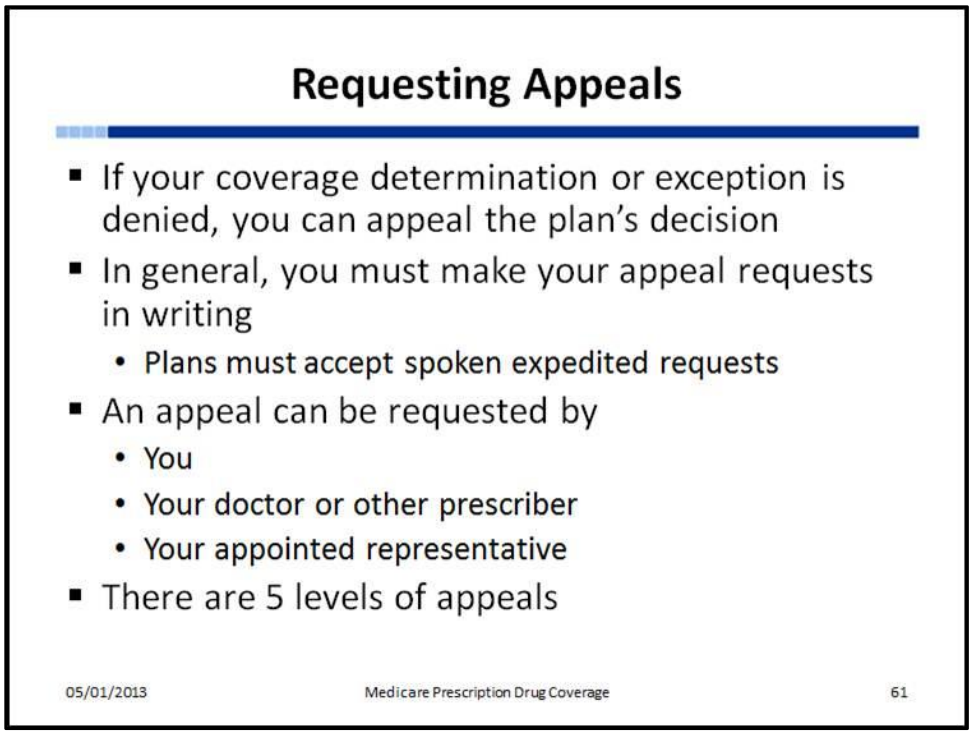
An exception is a type of coverage determination. There are two types of exceptions: tier exceptions (such as getting a Tier 3 drug at the Tier 2 cost) and formulary exceptions (either coverage for a drug not on the plan's formulary, or relaxed access requirements).

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 (also known as Open Enrollment), 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 http://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.



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.

NOTE: Please see Appendix H for more information about the five levels of appeal.

Check Your Knowledge
Lesson 7 – Coverage Determinations and Appeals

Answer the following questions:

1. Who can request a coverage determination for a certain drug? (Select all that apply.)

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

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

Refer to page 85 to check your answers.

Medicare Prescription Drug Coverage Resource Guide

Resources

www.medicare.gov
1-800-MEDICARE (1-800-633-4227)
(TTY users should call 1-877-466-2048)

Prescription Drug Benefit Manual
http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html

PDP Enrollment and Disenrollment Guidance
http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/index.html

Local State Health Insurance Programs
www.medicare.gov/contacts

Centers for Medicare & Medicaid Services
www.cms.gov

Social Security
1-800-772-1213
www.socialsecurity.gov

Medicare's Limited Income NET Program
1-800-783-1307 or 1-877-801-0369 (TTY)
e-mail : MedicareLINET@cms.hhs.gov

Affordable Care Act
www.healthcare.gov/law/full/index.html

RxAssist
A directory of Patient Assistance Programs (PAPs)
www.rxassist.org

Medicare Part D Appeals
www.medicarepartdappeals.com

Determining the Part B income-related premium
SSA publication 10161 available at
http://www.socialsecurity.gov/pubs/10536.pdf

Medicare Products

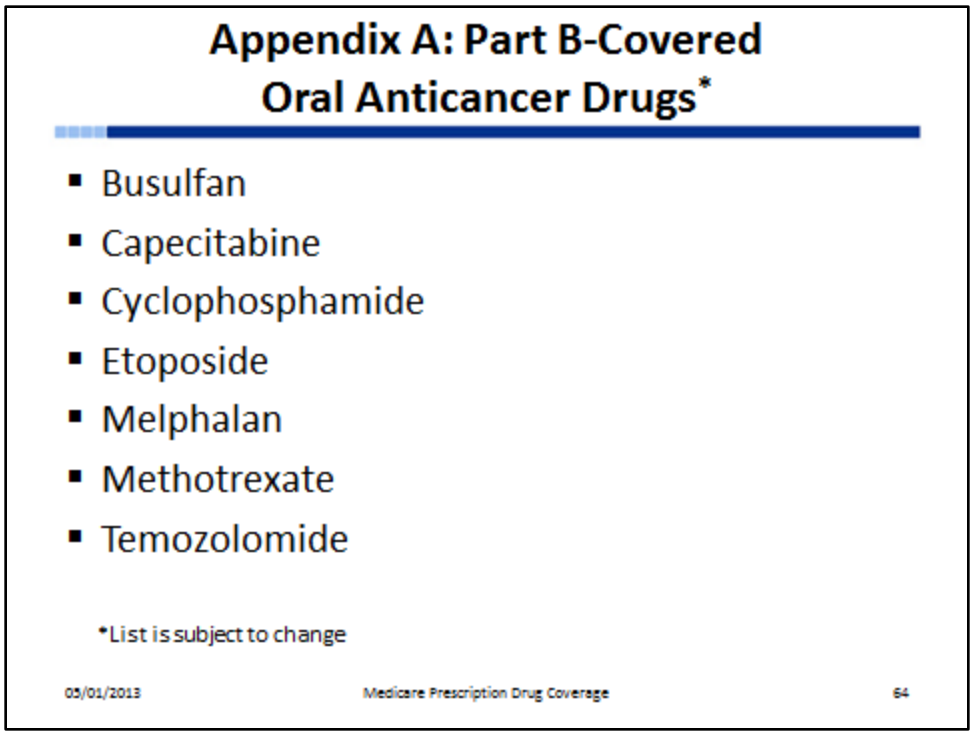
Medicare & You Handbook
CMS (Product No. 10050)

Your Guide to Medicare Prescription Drug Coverage
(CMS Product No. 11109)

Your Medicare Benefits
(CMS Product No. 10116)

To get these products:
View and order single copies:
www.medicare.gov

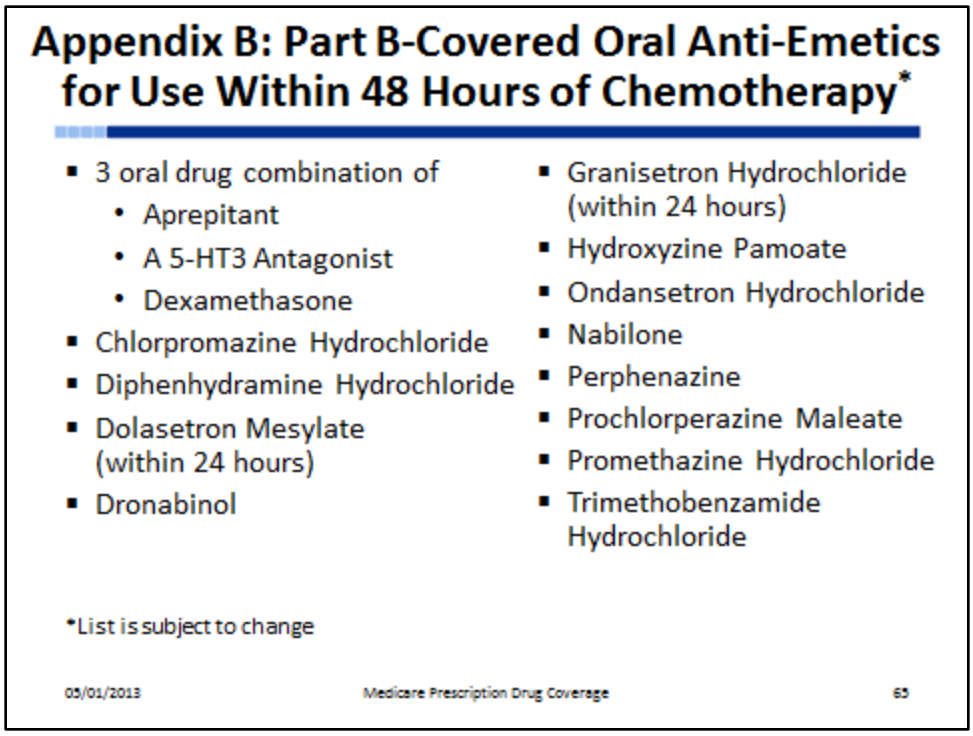
Order multiple copies (partners only):
productordering.cms.hhs.gov
(You must register your organization)



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

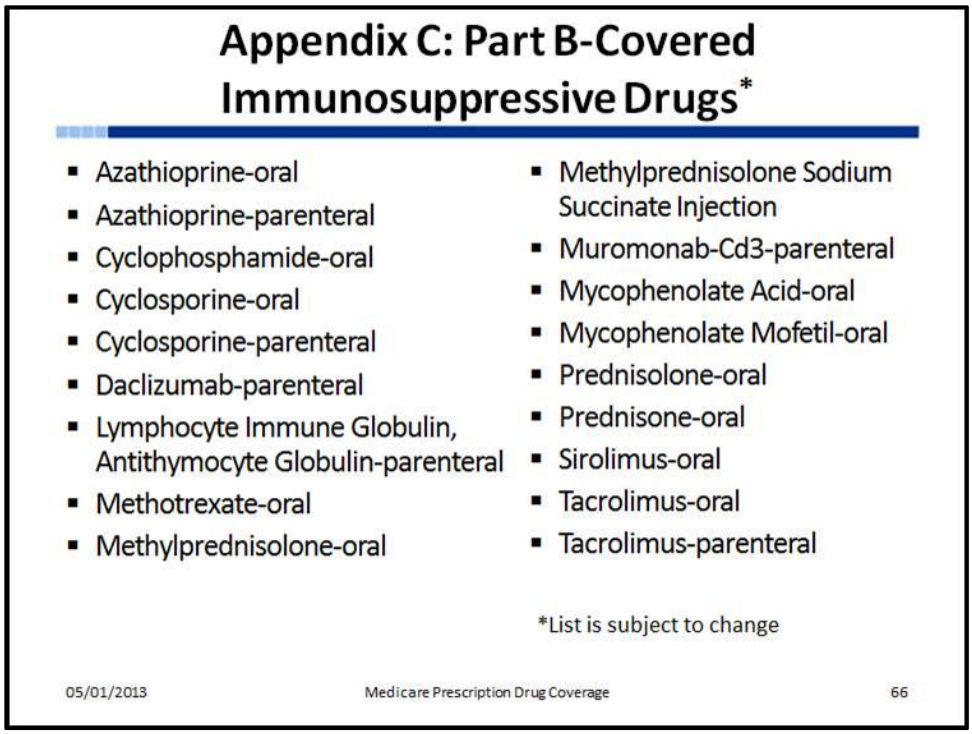
- Busulfan
- Capecitabine
- Cyclophosphamide
- Etoposide
- Melphalan
- Methotrexate
- Temozolomide

NOTE: This list is subject to change.



The following lists the oral anti-emetic (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



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 FDA. 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 which aren't directly related to rejection.

Appendix D: 2013 Standard Drug Benefit

Benefit Parameters	2013	2014
Deductible	$325	$310
Initial Coverage Limit	$2,970.00	$2,850.00
Out-of-Pocket Threshold	$4,750.00	$4,550.00
Total Covered Drug Spending at OOP Threshold	$6,954.52	$6,690.77
Minimum Cost-Sharing in Catastrophic Coverage	$2.65/$6.60	$2.55/$6.35
Extra Help Copayments	**2013**	**2014**
Institutionalized	$0	$0
Receiving Home and Community-Based Services	$0	$0
Up to or at 100% Federal Poverty Level (FPL)	$1.15/$3.50	$1.20/$3.60
Full Extra Help	$2.65/$6.60	$2.55/$6.35
Partial Extra Help (Deductible/Cost-Sharing)	$66/15%	$63/15%

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

If you have Medicare and…	Your monthly premium	Your yearly deductible	Your cost per Rx at the pharmacy (until $4,750*)	Your cost per Rx at the pharmacy (after $4,750*)
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 $11,490 (single) $15,510 (married)	$0	$0	Generic and certain preferred drugs: no more than $1.15 Brand-name drugs: no more than $3.50	$0
Full Medicaid coverage and have a yearly income above $11,490 (single) $15,510 (married)	$0	$0	Generic and certain preferred drugs: no more than $2.65 Brand-name drugs: no more than $6.60	$0
Help from Medicaid paying your Medicare Part B premiums	$0	$0	Generic and certain preferred drugs: no more than $2.65 Brand-name drugs: no more than $6.60	$0
Supplemental Security Income (SSI)	$0	$0	Generic and certain preferred drugs: no more than $2.65 Brand-name drugs: no more than $6.60	$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 $4,750 per year.

The cost sharing, income levels, and resources listed are for 2013 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.

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

If you have Medicare and…	Your monthly premium	Your yearly deductible	Your cost per prescription at the pharmacy (until $4,750*)	Your cost per prescription at the pharmacy (after $4,750*)
A yearly income below $15,511.50 (single) $20,938.50 (married) with resources of no more than $8,580 (single) $13,620 (married)	$0	$0	Generic and certain preferred drugs: no more than $2.65 Brand-name drugs: no more than $6.60	$0
A yearly income below $15,511.50 (single) $20,938.50 (married) with resources between $8,580 and $13,330 (single) $13,620 and $26,580 (married)	$0	$66	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than $2.65 Brand-name drugs: no more than $6.60
A yearly income between $15,511.50 and $16,086 (single) $20,938.50 and $21,714 (married) with resources up to $13,330 (single) $26,580 (married)	25%	$66	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than $2.65 Brand-name drugs: no more than $6.60
A yearly income between $15,638 and $16,660.50 (single) $21,182 and $22,489.50 (married) with resources up to $13,330 (single) $26,580 (married)	50%	$66	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than $2.65 Brand-name drugs: no more than $6.60
A yearly income between $16,660.50 and $17,235 (single) $21,938.50 and $23,265 (married) with resources up to $13,330 (single) $26,580 (married)	75%	$66	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than $2.65 Brand-name drugs: no more than $6.60

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 $4,750 per year.

The cost sharing, income levels, and resources listed are for 2013 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.

Appendix F: Guide to Consumer Mailings
Mid-May – Late September

This chart was being updated at print time. An electronic version of the update is available at www.cms.hhs.gov/LimitedIncomeandResources/Downloads/2013Mailings.pdf

Guide to consumer mailings from CMS, Social Security, & plans in 2012/2013

(All notices available online are hyperlinked, but note that current year versions for many notices aren't posted until fall.)

Mail date	Sender	Mailing/color	Main message	Consumer action
Mid-May	Social Security	Social Security LIS and MSP Outreach Notice (SSA Pub. Forms L447 & L448)	Informs people who may be eligible for Medicare Savings Programs (MSPs) about MSPs and the Extra Help available for Medicare prescription drug coverage.	• If you think you qualify for Extra Help, you should apply. • Apply for Extra Help through Social Security.
Early September	Social Security	Social Security Notice to Review Eligibility for Extra Help (SSA Form No. 1026)	Informs people selected for review that they should see if they continue to qualify for Extra Help. Includes an "Income and Resources Summary" sheet.	If you get this notice, you must return the enclosed form in the enclosed postage-paid envelope within 30 days or your Extra Help may end.
September	Plans	Plan Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) Model ANOC	By September 30, people will get a notice from their current plan outlining 2013 formulary, benefit design, and/or premium changes.	Review changes to decide whether the plan will continue to meet your needs in 2013.
September	Plans	Plan LIS Rider Model LIS Rider	By September 30, all people who qualify for Extra Help will get an LIS rider from their plan telling them how much help they'll get in 2013 towards their Part D premium, deductible, and copayments.	Keep this with your plan's "Evidence of Coverage" (EOC), so you can refer to it if you have questions about your costs.
September	Employer /union plans	Notice of Creditable Coverage	By September 30, employer/union and other group health plans must tell all Medicare-eligible enrollees whether or not their drug coverage is creditable.	Keep the notice.
September	CMS	Loss of Deemed Status Notice (Product No. 11198) (GREY Notice)	Informs people that they no longer automatically qualify for Extra Help as of January 1, 2013.	Apply for Extra Help through Social Security (application and postage-paid envelope enclosed) or a State Medical Assistance (Medicaid) office.
Late September	CMS	"Medicare & You" 2013 Handbook	Mailed to all Medicare households each fall. Includes a summary of Medicare benefits, rights, and protections; lists of available health and drug plans; and answers to frequently asked questions about Medicare.	Keep the handbook as a reference guide. You can also download a copy online at www.medicare.gov.

Appendix F: Guide to Consumer Mailings
October – Early November

Mail date	Sender	Mailing/color	Main message	Consumer action
October	Plans	Plan Marketing Materials	On October 1, plans begin sending marketing materials for 2013.	Use this information to compare options for 2013.
October	Plans	Plan Non-Renewal Notice	By October 2, people whose 2012 plan is leaving the Medicare program in 2013 will get notices from plans.	You must look for a new plan for coverage in 2013.
October	CMS	Change in Extra Help Co-payment Notice (Product No. 11199) (ORANGE Notice)	Informs people that they still automatically qualify for Extra Help, but their copayment levels will change starting January 1, 2013.	• Keep the notice. • No action, unless you believe an error has occurred.
Late October	CMS	October Notice to Individuals Enrolled in Plans with Fewer Than Three Stars for Three or More Consecutive Years (Product No. 11627)	Informs people that they're enrolled in a plan that has been identified as a consistent poor performer and encourages them to explore other plan options in their area.	• Visit www.medicare.gov/find-a-plan find and compare plans in your area. • You can change plans during the Open Enrollment Period (October 15–December 7). Call 1-800-MEDICARE to change plans outside of this period.
Late October	CMS	Reassignment Notice – Plan Termination (Product No. 11208) (BLUE Notice)	Informs people that their current Medicare drug plan is leaving the Medicare Program and they'll be reassigned to a new Medicare drug plan effective January 1, 2013, unless they join a new plan on their own by December 31, 2012.	• Keep the notice. • Compare plans to see which plan meets your needs. • Change plans, if you choose, in early December. • For more information call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.
		Reassignment Notice – Premium Increase (Product No. 11209) (BLUE Notice)	Informs auto-enrollees that because their current Medicare drug plan premium is increasing above the regional LIS premium subsidy amount, they'll be reassigned to a new Medicare drug plan effective January 1, 2013, unless they join a new plan on their own by December 31, 2012.	
Late October/ Early November	CMS	MA Reassignment Notice (Product No. 11443) (BLUE Notice)	Informs people who get Extra Help and whose current Medicare Advantage (MA) plan is leaving the Medicare Program that they'll be re-assigned to a Medicare drug plan effective January 1, 2013, if they don't join a new MA or PDP plan on their own by December 31, 2012.	• Keep the notice. • Compare plans to see which plan meets your needs. • Change plans, if you choose, in early December. • For more information call 1-800-MEDICARE (1-800-633-4227).TTY users should call 1-877-486-2048; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.

Appendix F: Guide to Consumer Mailings
Early November - December

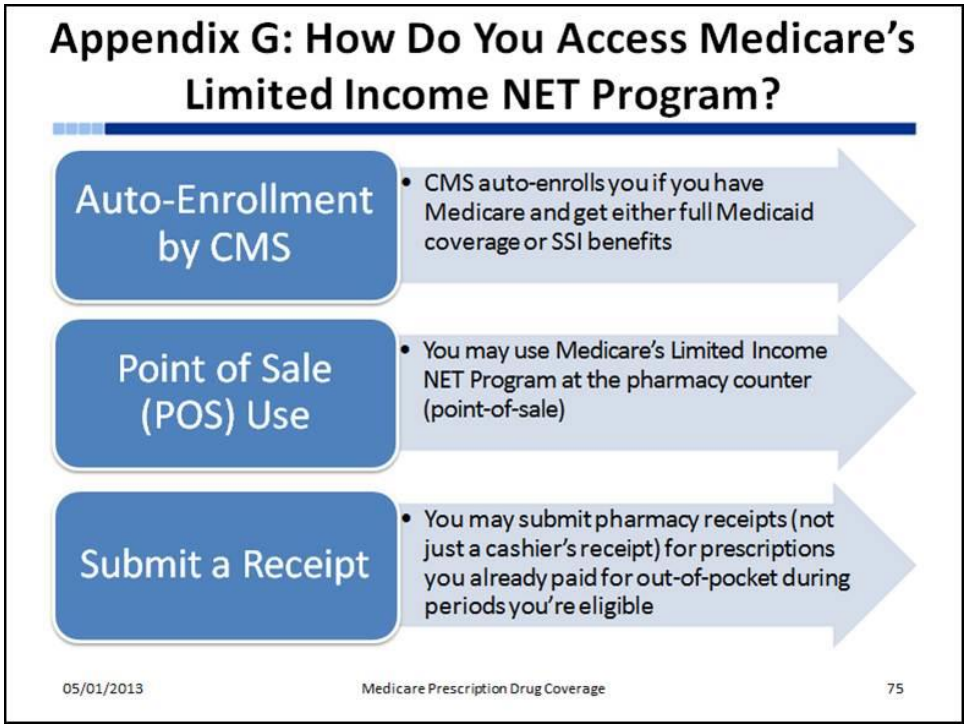
Mail date	Sender	Mailing/color	Main message	Consumer action
Early November	CMS	LIS Choosers Notice (Product No. 11267) (TAN Notice)	Informs people who get Extra Help and chose a Medicare dug plan on their own that their plan's premium is changing, and they'll have to pay a portion of their plan's premium in 2013 unless they join a new $0 premium plan.	• Keep the notice. • You may want to look for a new plan for coverage for 2013 with a premium below the regional low income subsidy benchmark. (Notice includes list of local plans with no premium liability.) • Change plans in early Dec. if you choose.
November	CMS	CMS Non-Renewal Reminder Notice (Product No. 11433 & Product No.11438)	Reminds people who don't get Extra Help and whose plan is leaving the Medicare Program that they need to choose a new plan for 2013.	You must look for a new plan for coverage in 2013.
November	Social Security	Social Security Part B & Part D Income-Related Adjustment Amount Notice	Tells higher-income consumers about income-related Part B and Part D premium adjustments. Includes the information in the December BRI notices (see below).	Keep the notice.
November	Social Security	Social Security LIS Redetermination Decision Notice Begins	Social Security begins mailing notices letting people know whether they still qualify for Extra Help in the coming year.	• Keep the notice • If you believe the decision is incorrect, you have the right to appeal it. The notice explains how to appeal. • If you have questions, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
Late November	Social Security	Social Security LIS and MSP Outreach Notice (Form SSA-L441)	Informs people who may be eligible for Qualified Disabled Working Individual (QDWI) about the Medicare Savings Programs and the Extra Help available for Medicare prescription drug coverage.	• If you think you qualify for Extra Help, you should apply. • For more information about the Extra Help or if you want to apply, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
December	Social Security	Social Security Benefit Rate Change (BRI) Notice	Tells people about benefit payment changes for the coming year due to cost of living increases, variations in the premiums that are withheld, etc.	Keep the notice.

Appendix F: Guide to Consumer Mailings
December – Daily Ongoing

Mail date	Sender	Mailing/color	Main message	Consumer action
December	CMS	Reassign Formulary Notice (Product No. 11475 & Product No. 11496) (BLUE Notice)	Informs people who get Extra Help and were affected by reassignment which of the Part D drugs they took in 2012 will be covered in their new 2013 Medicare drug plan.	• Consider whether this plan is right for you, or whether another plan might cover more of your drugs. • Compare this Medicare drug plan with others in your area. • For more information call 1-800-MEDICARE (1-800-633-4227).TTY users should call 1-877-486-2048; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.
January	CMS	CMS Non-Renewal Action Notice (Product No. 11452)	Reminds people who don't get Extra Help and whose Medicare plan left the Medicare Program that they need to join a new Medicare drug plan if they want Medicare drug coverage for 2013.	You must join a Medicare drug plan by February 28 if you want Medicare drug coverage for 2013.
Daily - ongoing	CMS	Deemed Status Notice (Product No. 11166) (PURPLE Notice beginning in Sept/Oct)	Informs people that they'll automatically get Extra Help, including people 1) with Medicare and Medicaid, 2) in Medicare Savings Program, and 3) who receive Supplemental Security Income (SSI) benefits.	• Keep the notice. • No need to apply to get the Extra Help. • Compare Medicare prescription drug plans with others to meet your needs. • For more information call 1-800-MEDICARE (1-800-633-4227).TTY users should call 1-877-486-2048; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.
Daily - ongoing	CMS	Auto-Enrollment Notice (Product No. 11154) (YELLOW Notice)	Sent to people who automatically qualify for Extra Help because they qualify for Medicare & Medicaid and currently get their benefits through Original Medicare. These people will be automatically enrolled in a drug plan unless they decline coverage or enroll in a plan themselves.	• Keep the notice. • No need to apply to get the Extra Help. • If you don't join a plan, Medicare will enroll you in one. • Compare Medicare prescription drug plans with others to meet your needs. • For more information call 1-800-MEDICARE (1-800-633-4227).TTY users should call 1-877-486-2048; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.

Appendix F: Guide to Consumer Mailings
Daily Ongoing

Mail date	Sender	Mailing/color	Main message	Consumer action
Daily - ongoing	CMS	Auto-Enrollment - Retroactive Notice (Product No. 11429) (YELLOW Notice)	Sent to people who automatically qualify for Extra Help with a retroactive effective date because they either 1) qualify for Medicare & Medicaid or 2) get Supplemental Security Income (SSI). These people will be automatically enrolled in a drug plan unless they decline coverage or enroll in a plan themselves.	• Keep the notice. • No need to apply to get the Extra Help. • If you don't join a plan, Medicare will enroll you in one. • Compare Medicare prescription drug plans with others to meet your needs. • For more information call 1-800-MEDICARE (1-800-633-4227).TTY users should call 1-877-486-2048; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.
Daily - ongoing	CMS	Facilitated Enrollment Notice (Product No. 11186 & Product No. 11191) (GREEN Notice)	Informs people who either 1) belong to a Medicare Savings Program or 2) get Supplemental Security Income (SSI), or 3) applied and qualified for Extra Help that they will be automatically enrolled in a drug plan unless they decline coverage or enroll in a plan themselves.	• Keep the notice. • If you don't join a plan, Medicare will enroll you in one. • Compare Medicare prescription drug plans with others to meet your needs. • For more information call 1-800-MEDICARE (1-800-633-4227).TTY users should call 1-877-486-2048; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.
Daily - ongoing	CMS	FBDE RDS Notice (Product No. 11334)	Informs people with Medicare & Medicaid who already have qualifying creditable drug coverage through an employer or union that they automatically qualify for Extra Help, and can join a Medicare drug plan if they want to at no cost to them.	Contact your employer or union plan to learn how joining a Medicare drug plan may affect your current coverage.
Daily - ongoing	Social Security	Initial IRMAA Determination Notice	Sent to people with Medicare Part B and/or Part D when Social Security determines whether any IRMAA amounts apply. Notice includes information about Social Security's determination and appeal rights.	Keep the notice.

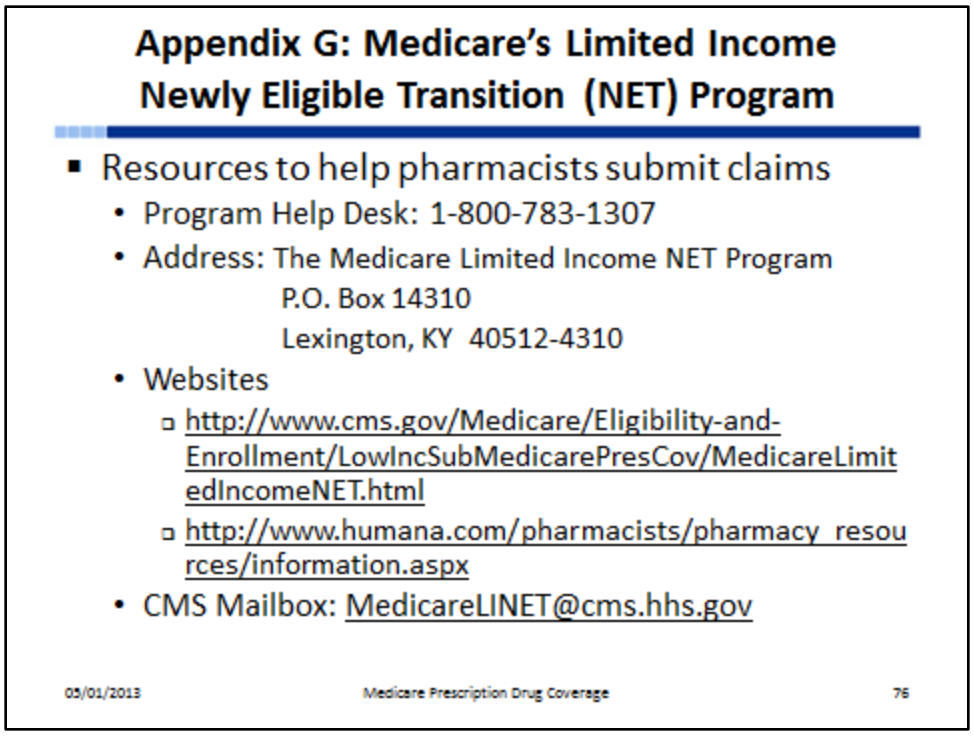


There are three ways you can access Medicare's Limited Income Newly Eligible Transition (NET) program:

- **Auto-enrollment by CMS.** CMS auto-enrolls you in this program if you have Medicare and get either full Medicaid coverage or 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) 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 (point-of-sale).
- **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. See Appendix G for the mailing address.

If you use Medicare's Limited Income NET program by point of sale (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 a Medicare Savings Program) or have applied and were eligible for Extra Help.
- Get immediate coverage if you show evidence of Medicaid or Extra Help eligibility to the pharmacy at point-of-sale (POS), even if CMS' systems can't confirm your eligibility status.



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

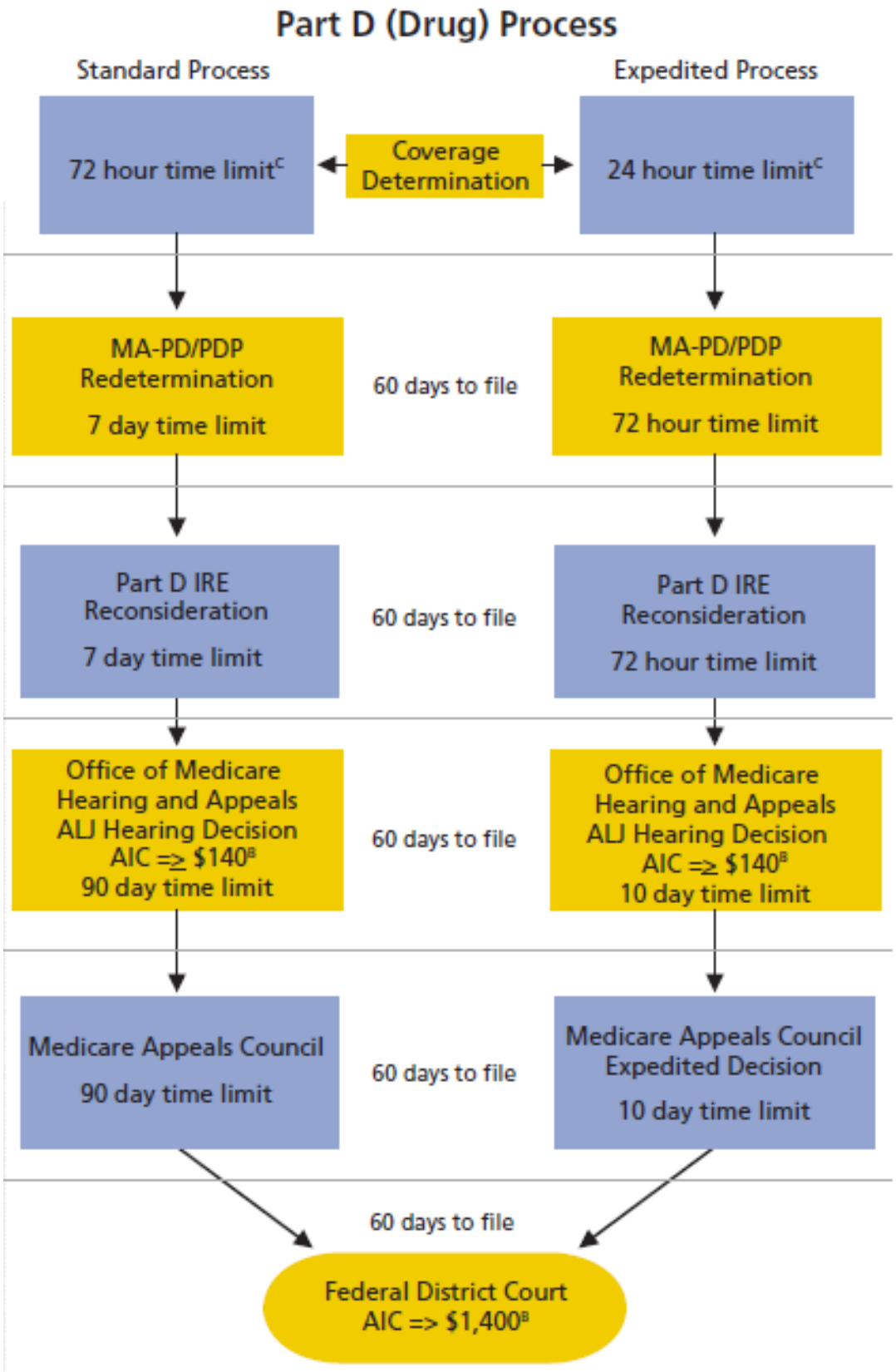
People with Medicare can submit receipts for claims they paid out-of-pocket to:

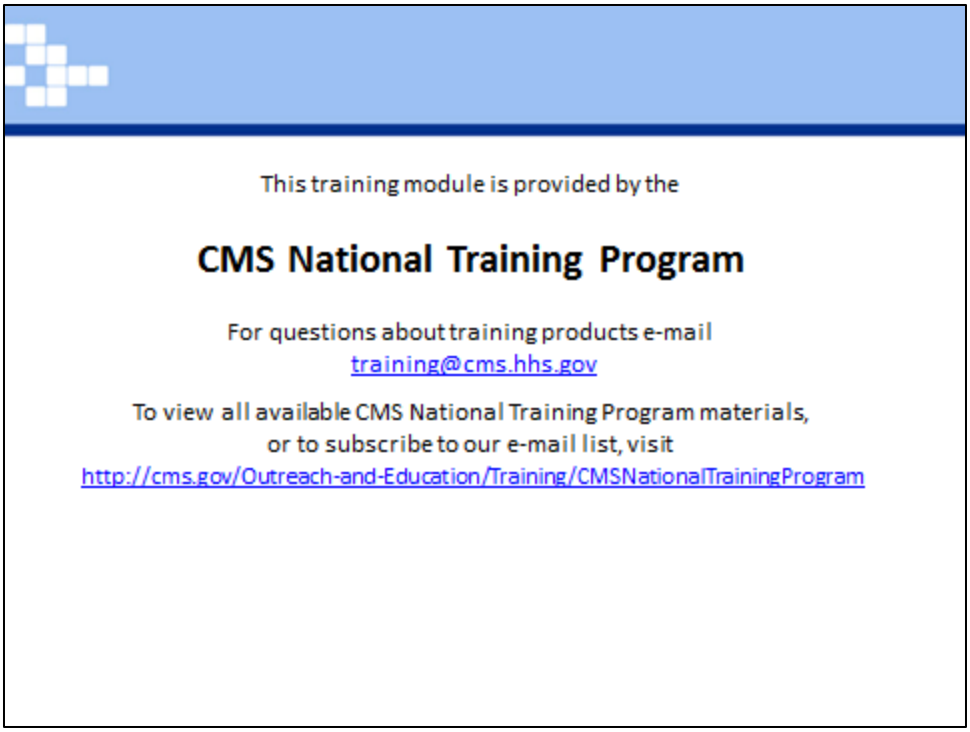
- The Medicare Limited Income NET Program
  P.O. Box 14310
  Lexington, KY 40512-4310

Pharmacists who need help using Medicare's Limited Income NET program can contact:

- Program Help Desk
  - 1-800-783-1307
- Websites
  - CMS
    - http://www.cms.gov/Medicare/Eligibility-and-Enrollment
  - Humana
    - http://www.humana.com/pharmacists/pharmacy_resources/information.aspx
  - CMS Mailbox
    - MedicareLINET@cms.hhs.gov

Appendix H: Levels of Appeal





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Check Your Knowledge
Lesson 1 – Medicare Prescription Drug Basics
(from p. 10)

Answer the following questions:

1. Max has Original Medicare and 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? If so, which part of Medicare will cover them?

   ANSWER: Yes, Medicare Part A will pay for the prescription drugs Max got during his inpatient stay at a skilled nursing facility (SNF) if they are medically necessary. Medicare Part A payments made to hospitals and SNFs generally cover all drugs provided during an inpatient stay. (p. 6)

2. Which of these vaccines may <u>NOT</u> be covered under Medicare Part B?

   a. Flu vaccine
   b. Shingles vaccine
   c. Hepatitis B vaccine
   d. Pneumococcal pneumonia vaccine

   ANSWER: The answer is b. 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. (p. 7, 8)

Check Your Knowledge
Lesson 2 – Medicare Part D Benefits and Costs
(from p. 21)

Answer the following questions:

1. Which costs count toward getting out of the coverage gap? (Select all that apply.)

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

    ANSWER: c, d, and e. 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 do not count toward getting you out of the coverage gap, including the drug plan premium, what you pay for drugs that are not covered, and the discount you get on covered generic drugs in the coverage gap. (p. 14)

2. True or False: Medicare drug plan benefits and costs are the same from year to year.

    ANSWER: False. Medicare drug plan benefits and costs may change each year. (p. 13)

Check Your Knowledge
Lesson 3 – Medicare Part D Coverage
(from p. 30)

Answer the following questions:

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

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

ANSWER: d. Prescription vitamin and mineral products are not covered by Medicare Part D (except prenatal vitamins and fluoride preparations). However, Medicare drug plans may choose to cover excluded drugs at their own cost or share the cost with you. (p. 25)

2. Seema's doctor needs to prescribe a drug that her Medicare drug plan doesn't cover. Will she have to pay for the drug out-of-pocket? Why or why not?

    ANSWER: Not necessarily. If her doctor needs to prescribe a drug isn't on her Medicare drug plan's formulary and she doesn't have any other health insurance that covers outpatient prescription drugs, Seema or her doctor can ask the plan for an exception. If her plan still won't cover the specific drug she needs, she can appeal. (p. 29)

Check Your Knowledge
Lesson 4 – Part D Eligibility and Enrollment
(from p. 39)

Answer the following questions:

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

    a. 3 months
    b. 5 months
    c. 7 months
    d. 12 months

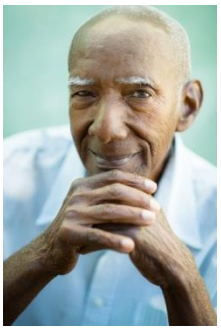
    ANSWER: c. 7 months. When Marissa first becomes eligible for Medicare, she'll have a 7-month Initial Enrollment Period (IEP) for Medicare Part D. (p. 34)

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

    ANSWER: Yes. Even though Medicare's Open Enrollment Period is from October 15 to December 7, you can make changes to your Medicare prescription drug coverage when certain events happen in your life, such as if you permanently move out of your plan's service area or you lose other creditable insurance coverage. These chances to make changes are called Special Enrollment Period (SEPs). (p. 36)

Check Your Knowledge
Lesson 5 – Extra Help With Part D Plan Costs
(from p. 49)

Answer the following questions:



1. 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? Why or why not?

   ANSWER: Yes. If you qualify for Extra Help you will have a continuous Special Enrollment Period (SEP) and can switch plans at any time with the new plan going into effect the first day of the following month. (p. 41)

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

   a. By completing a paper application from Social Security
   b. By contacting you state's Medicaid agency
   c. By contacting your State Health Insurance Assistance Program (SHIP)
   d. By applying online at www.socialsecurity.gov
   e. All of the above

   ANSWER: e. All of the above. (p. 43)

Check Your Knowledge
Lesson 6 – Comparing and Choosing Plans
(from p. 57)

Answer the following questions:

1. Carl recently joined a Medicare drug plan and got materials from the plan in the mail. What should have been included in the materials?

ANSWER: 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. (p. 55)

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

    a. Using the Medicare Plan Finder
    b. Calling 1-800-MEDICARE
    c. Through the Social Security website
    d. Calling the plan

    ANSWER: c. You cannot join a Part D plan through the Social Security 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, www.medicare.gov. You can also call Medicare to enroll at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (p. 54)

Check Your Knowledge
Lesson 7 – Coverage Determinations and Appeals
(from p. 62)

Answer the following questions:

1. Who can request a coverage determination for a certain drug? (Select all that apply.)

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

    ANSWER: a, b, and d. You, your prescriber, or your appointed representative can request a coverage determination by calling your plan or writing a letter. (p. 59)

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

    ANSWER: 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. (p. 60)

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
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
FDA	Food and Drug Administration
FEHB	Federal Employees Health Benefits Program
FPL	Federal Poverty Level
HICN	Health Insurance Claim Number
HIV	Human Immunodeficiency Virus
HSAs	Health Savings Accounts
HMO	Health Maintenance Organization
IEP	Initial Enrollment Period
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
LIS	Low-income Subsidy
MA	Medicare Advantage
MA-PD	Medicare Advantage Plans with Prescription Coverage
MSP	Medicare Savings Program
NET	Newly Eligible Transition
NTP	National Training Program
PAP	Patient Assistance Programs
PDP	Prescription Drug Plan
POS	Point-of-Sale
PPO	Preferred Provider Organization
RDS	Retiree Drug Subsidy
RRB	Railroad Retirement Board
SCE	Subsidy-Changing Event
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SNF	Skilled Nursing Facility
SNPs	Special Needs Plans
SPAP	State Pharmacy Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TrOOP	True-Out-of-Pocket
TTY	Teletypewriter
VA	Veterans Affairs

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Inside back cover

Website: cms.gov/www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram
E-mail training@cms.hhs.gov

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244