

Module 9 – Medicare Prescription Drug Coverage

Section Objectives

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

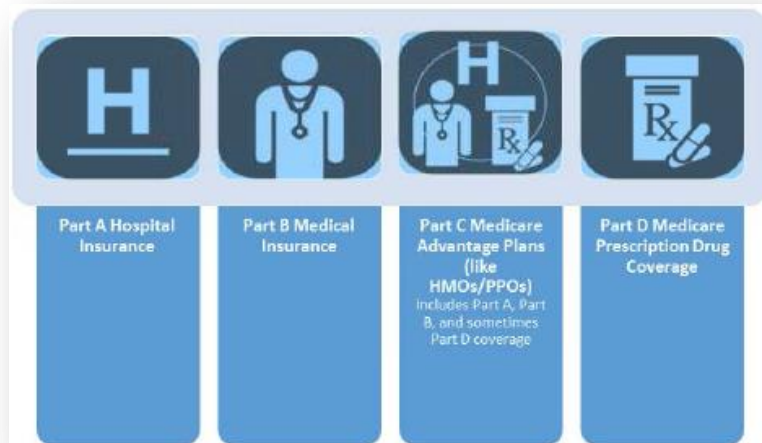
Lesson 1: The Basics

The Four Parts of Medicare

Medicare covers many types of services and you have options for how you get your Medicare coverage.

Medicare has four parts:

- **Part A (Hospital Insurance)** helps pay for inpatient hospital stays, skilled nursing facility care, home health care, and hospice care.
- **Part B (Medical Insurance)** helps cover medically-necessary services like



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

Medicare Prescription Drug Coverage

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

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

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

If you have a Medicare Advantage (MA) Plan (Part C) (like a HMO or a 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.

Part A Prescription Drug Coverage

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

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

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

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

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

Part B Prescription Drug Coverage

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

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

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

Part B Immunization Coverage

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

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

Self-administered Drugs in Hospital Outpatient Settings

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

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

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

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

Lesson 2: Medicare Part D Benefits and Costs

Part D Medicare Prescription Drug Coverage

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

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

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

2. Join an MA Plan with prescription drug coverage (MA-PD) (like an HMO or PPO) or another Medicare health plan that includes Medicare prescription drug coverage. **You'll get all your Medicare coverage (Part A and Part B), including prescription drug coverage through these plans.**

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

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

Medicare Drug Plans

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

Most plans continue to offer different benefit structures, including "tiers" of copayments (pay a set amount for all drugs on a tier) or coinsurance (pay a percentage of the cost of the drug), with different costs for different types of drugs. 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 each year.

Medicare Drug Plan Costs

Your costs for prescription drug coverage will depend on the plan you choose and some other factors, like which drugs you use, whether you go to a pharmacy in your plan's network, and whether you get Extra Help paying for your drug costs. Extra Help is discussed in more detail in Lesson 5.

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

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

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

When you are in the coverage gap, you pay no more than 40% for covered brand-name drugs, and 51% for covered generic drugs.

With every plan, once you've paid \$4,950 out-of-pocket for drug costs in 2017 (including payments from other sources, like the discount paid for by the drug company in the coverage gap), you leave the coverage gap and pay a small copayment for each drug for the rest of the year.

Standard Structure in 2017

Ms. Smith joins a prescription drug plan. Her coverage begins on January 1. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.

1. Yearly deductible	2. Copayment or coinsurance (what you pay at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first \$400 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 \$3,700.	Once Ms. Smith and her plan have spent \$3,700 for covered drugs, she's in the coverage gap. In 2017, she gets a 50% discount from the drug manufacturer on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2017, she gets an additional 10% coverage from her plan on covered brand-name drugs and 49% coverage on covered generic drugs while in the coverage gap.	Once Ms. Smith has spent \$4,950 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. Not all plans follow this design. Your drug plan costs will vary.

- **Monthly premium** – Most drug plans charge a monthly fee that differs from plan to plan. You pay this in addition to the Part B premium (if you have Part B). If you belong to a Medicare Advantage Plan that includes drug coverage (MA-PD), the monthly plan premium may include an amount for prescription drug coverage.
- **Yearly deductible (you pay up to \$400 in 2017)** – 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 \$400 in 2017. 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 (\$3,700 in 2017). In 2017, once you enter the coverage gap, you pay 40% of the plan’s cost for your covered brand-name drugs and 51% of the plan’s cost for covered generic drugs (may include a dispensing fee) until you reach the end of the coverage gap. Certain costs count toward getting out of the coverage gap, including your yearly deductible, coinsurance, and copayments, the discount you get on covered brand-name drugs in the gap, and what you pay in the gap. However, the drug plan premium, what you pay for drugs that aren’t covered, the discount for covered generic drugs in the coverage gap, and the dispensing fee don’t count toward getting you out of the coverage gap.
- **Catastrophic coverage** – Once you reach your out-of-pocket limit (\$4,950 in 2017), 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.

NOTE: If you get Extra Help, you won’t have some of these costs.

You can visit the Medicare Plan Finder at [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan) to compare the cost of plans in your area. For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP) at [shiptacenter.org/](https://www.shiptacenter.org/).

Improved Coverage in the Coverage Gap

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

Once you reach the coverage gap in 2017, you'll pay 40% of the plan's cost for covered brand-name prescription drugs. You get these savings if you buy your prescriptions at a pharmacy or order them through the mail. The discount will come off of the price that your plan has set with the pharmacy for that specific drug. In 2017, 95% of the price—what you pay plus the 50% manufacturer discount payment—will count as out-of-pocket costs, which will help you get out of the coverage gap. What the drug plan pays toward the drug cost (5% of the price) and what the drug plan pays toward the dispensing fee (55% of the fee) aren't counted toward your out-of-pocket spending.

In 2017, Medicare will pay 49% of the price for generic drugs during the coverage gap. You'll pay the remaining 51% of the price. What you pay for generic drugs during the coverage gap will decrease each year until it reaches 25% in 2020. The coverage for generic drugs works differently from the discount for brand-name drugs. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap. Visit [Medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html](https://www.medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html) for examples of what you pay for generic or brand-name drugs. If you have a Medicare drug plan that already includes coverage in the gap, you may get a discount after your plan's coverage has been applied to the price of the drug. The discount for brand-name drugs will apply to the remaining amount that you owe.

True Out-of-Pocket (TrOOP) Costs

True out-of-pocket (TrOOP) costs are the amounts you pay for covered Part D drugs that count towards your drug plan's out-of-pocket threshold of \$4,950 (for 2017). Your yearly deductible, coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan's premium. TrOOP costs determine when your catastrophic coverage begins. Your drug plan will keep track of your TrOOP costs. Each month that you buy prescriptions covered by your plan, your drug plan will mail you an Explanation of Benefits (EOB) showing your TrOOP costs to date.

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

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

What Payments Count Toward TrOOP

Payments that count toward your True out-of-pocket costs made for covered prescriptions:

- Before your drug plan begins to pay (the annual deductible, if there is one)
- After your drug plan begins to pay (copayments or coinsurance during your initial coverage period)
- During your coverage gap, if the plan has a coverage gap

Payments count toward TrOOP if they're made by any of these:

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

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

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

Source:

- Title 42: Public Health; Part 423—Voluntary Medicare Prescription Drug Benefit; Subpart C—Benefits and Beneficiary Protections ([ecfr.gov/cgi-bin/text-idx?SID=69b9803f5e5373236924daa0bc6f4c5f&mc=true&node=se42.3.423_1100&rqn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=69b9803f5e5373236924daa0bc6f4c5f&mc=true&node=se42.3.423_1100&rqn=div8)).

What Payments Don't Count Toward TrOOP

These payments **don't** count toward your True Out-of-Pocket (TrOOP) costs:

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

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

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

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

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

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

If you don't pay, you'll be disenrolled from your Medicare drug plan, even if you get your Part D coverage through a Medicare Advantage Plan or through an employer. You must pay both the extra amount (the Part B IRMAA) and your plan's premium each month to keep Medicare prescription drug coverage.

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

Source: SSA Publication No. 05-10536, "Medicare Premiums: Rules for Higher-Income Beneficiaries" at SSA.gov/pubs/EN-05-10536.pdf.

Income-Related Monthly Adjustment Amount (IRMAA)

Chart is based on your yearly income *in 2015* (for what you pay in 2017)

Filing an Individual Tax Return	Filing a Joint Tax Return	In 2017 You Pay Monthly
\$85,000 or less	\$170,000 or less	Your Plan Premium (YPP)
\$85,000–\$107,000	\$170,000–\$214,000	YPP + \$13.30*
\$107,000–\$160,000	\$214,000–\$320,000	YPP + \$34.20*
\$160,000–\$214,000	\$320,000–\$428,000	YPP + \$55.20*
Above \$214,000	Above \$428,000	YPP + \$76.20*

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

You pay only your plan premium if your yearly income in 2015 was \$85,000 or less for an individual, or \$170,000 or less for a couple.

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

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

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

Visit ssa.gov/forms/ssa-44.pdf to view and print a copy of the Medicare Income-Related Monthly Adjustment Amount – Life-Changing Event form.

Lesson 3: Medicare Part D Drug Coverage

Part D Covered Drugs

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

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

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

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

Required Coverage

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

- 1) Cancer medications
- 2) HIV/AIDS treatments
- 3) Antidepressants
- 4) Antipsychotic medications
- 5) Anticonvulsive treatments for epilepsy and other conditions
- 6) Immunosuppressants

Also, Medicare drug plans must cover all commercially available vaccines, including the shingles shot (but not vaccines covered under Part B, like the flu and pneumococcal shots), and most compounded medications (as defined in the Code of Federal Regulations' Access to covered Part D drugs, §423.120(d)), ecfr.gov/cgi-bin/textidx?SID=7805cfe316ca233ff673e2e02b0e6b74&mc=true&node=se42.3.423_1120&rgn=div8. You or your provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.

For more information visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf.

Drugs Excluded by Law Under Part D

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

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

Plans may choose to cover excluded drugs at their own cost or share the cost with you.

Visit [CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf) (42 CFR 423.100) for more information on excluded drugs.

Formulary

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

Each plan can form its tiers in different ways.

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

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

- Tier 1—Generic drugs** (the least expensive)—
 Tier 1 drugs are generic drugs and are the same as their brand-name counterparts in safety, strength, quality, the way they work, how they're taken, and the way they should be used. They use the same active ingredients as brand-name drugs. Generic drug makers must prove that their product performs the same way as the corresponding brand-name drug. They're less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the U.S. Food and Drug Administration. Today, almost half of all prescriptions in the United States are filled with generic drugs. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your prescriber.
- Tier 2—Preferred brand-name drugs**—Tier 2 drugs cost more than Tier 1 drugs.
- Tier 3—Non-preferred brand-name drug**—Tier 3 drugs cost more than Tier 2 drugs.
- Tier 4—(or Specialty Tier)**—These drugs are unique and have a high cost.

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

Formulary Changes

A formulary is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. It's also called a drug list. Medicare drug plans may only change their therapeutic categories and classes in a formulary at the beginning of each plan year, or to account for new therapeutic uses and newly approved Part D-covered drugs. A plan year is a calendar year, January through December.

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

Under Part D, no plan members should have their drug coverage discontinued or reduced for the rest of the plan year. However, this isn't the case when a drug is removed from the formulary due to a U.S. Food and Drug Administration (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.

How Plans Manage Access to Drugs

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

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

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

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

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

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

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

How Plans Manage Unsafe Use of Opioids

Medicare drug plans also monitor the safe and effective use of prescription drugs including opioids.

Opioid pain medications, like oxycodone and hydrocodone, are used to relieve pain for patients with active cancer or in hospice. Opioids can help with other types of pain in the short term, but have serious risks such as addiction, overdose, and death.

If you use high amounts of opioids from several doctors and pharmacies (and you don't have cancer and you're not in hospice), your plan may communicate with the doctor(s) who prescribed your opioid medication(s). After speaking with your doctor(s), some or no opioid medications may be found to be appropriate and medically necessary. You'll get a letter 30 days in advance before you'll be limited to some or no opioid medications. If you believe a mistake has been made, you and your prescriber have the right to request a coverage determination by contacting the plan.

In addition, plans may put in place safety alerts that could trigger when you fill a prescription at the pharmacy if your recent prescription(s) exceed a high, total amount of opioids (also referred to as a "cumulative morphine equivalent dose" (MED)). Some alerts can be overridden by the pharmacist while others may require a decision by the plan to override. If your pharmacy can't fill a prescription, the pharmacist will give you a notice explaining that you can contact the plan to request a coverage determination.

Requirement for Prescribers

CMS is using prescription drug event data to guide efforts to combat fraud and abuse and sharing the results of data analysis with Part D plan sponsors, law enforcement agencies, and pharmacy and physician licensing boards, as appropriate.

In 2019, CMS will implement key fraud and abuse provisions that will require prescribers of Part D drugs to enroll in Medicare. CMS finalized CMS-4159-F “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs” on May 23, 2014, and is delaying enforcement until 2019. This rule will require doctors and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in an approved status, or to have a valid opt-out affidavit on file with an A/B Medicare Administrative Contractor (MAC) for their prescriptions to be covered under Part D. If they haven’t enrolled or opted out, affected enrollees will get a 3-month supply of the drug prescribed with a written notice explaining that the drug will no longer be covered after that unless the prescriber meets the requirements.

NOTE: Part B MACs handle enrollment functions for doctors and other prescribers. CMS offers an enrollment file that identifies doctors and eligible professionals enrolled in Medicare in an approved or opt-out status at www.data.CMS.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx. For more information, visit CMS.gov/Outreach-and-Education/Medicare-Learning-Network-LN/MLNMattersArticles/downloads/SE1434.pdf.

If Your Prescription Changes

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

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

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

If your plan still won’t cover a specific drug you need, you can appeal. If you want to get the drug before your appeal is decided, you may have to pay out of pocket for the prescription. You may consider changing your Part D plan when permissible to one that does cover the specific prescription drug. Keep the receipt and give a copy of it to the person deciding your appeal. If you win the appeal, the plan will pay you back.

Medicare Therapy Management

Plans with Medicare prescription drug coverage must offer additional Medication Therapy Management (MTM) services to members who meet certain requirements. Members who qualify can get MTM services to help them understand how to manage their medications and use them safely.

MTM services may vary in some plans. MTM services are free and usually include a discussion with a pharmacist or health care provider to review your medications.

The pharmacist or health care provider may talk with you about:

- How well your medications are working
- Whether your medications have side effects
- If there might be interactions between the drugs you are taking
- Whether your costs can be lowered
- Other problems you are having

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

Medication Therapy Management Conditions

Your drug plan may enroll you in a medication therapy management (MTM) program if you meet all of these conditions:

- You have more than one chronic health condition (like hypertension; heart failure; diabetes; dyslipidemia; respiratory disease (like asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disorders; bone disease-arthritis (like osteoporosis, osteoarthritis, or rheumatoid arthritis); or a mental health condition (like depression, schizophrenia, bipolar disorder, or chronic and disabling disorders).
- You take several different medications.
- Your medications have a combined cost of more than \$3,919 (for 2017) per year. This dollar amount (which can change each year) is estimated based on your out-of-pocket costs and the costs your plan pays for the medications each calendar year. Your plan can help you find out if you may reach this dollar limit.

These are the requirements to qualify for additional MTM services. They're NOT requirements to join the Medicare plan itself. Even if you don't qualify for the MTM services, you may still be eligible to enroll in the plan. Lesson 4 discusses Part D eligibility requirements.

You can contact the plan directly to find out more about the plan's MTM services and what's required to get these services.

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

Lesson 4: Part D Eligibility and Enrollment

Part D Eligibility Requirements

To join a Medicare Prescription Drug Plan (PDP), you must have Medicare Part A and/or Part B. To join a Medicare Advantage Plan with prescription drug coverage (MA-PD), you must have both Medicare Part A and Part B. To join a Medicare Cost Plan with prescription drug coverage, you must have Medicare Part A and Part B, or have Medicare Part B only.

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

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

Creditable Drug Coverage

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

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

NOTE: Most Medicare Supplement Insurance (Medigap) policies that have drug coverage (were sold prior to January 1, 2006) don't meet Medicare's minimum standards (it's not creditable coverage). If you have a Medigap policy that covers drugs, you can keep your policy, but you may have to pay a penalty if you wait to join a Medicare drug plan. If you decide to join a Medicare drug plan, you'll need to tell your Medigap insurer when your coverage starts, so your insurer can remove prescription drug coverage from your Medigap policy.

Initial Enrollment Period

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

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

Some groups of people who become eligible to get Medicare will be enrolled in a Medicare drug plan by CMS (because they qualify for Extra Help) 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 Part D during your IEP if you'd like to have Medicare drug coverage. If you enroll later, you may pay a penalty.

When You Can Join or Switch Plans

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

Special Enrollment Period (SEP)

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

- If you permanently move out of your plan's service area
- If you lose your other creditable prescription drug coverage
- If you weren't properly told that your other coverage wasn't creditable, or that the other coverage was reduced so that it's no longer creditable

- If you enter, live at, or leave a long-term care facility like a nursing home
- If you qualify for Extra Help, you have a continuous SEP, and can change your Medicare drug plan once every 30 days throughout the year
- If you belong to a State Pharmaceutical Assistance Program
- If you join or switch to a plan that has a 5-star rating
- Other exceptional circumstances, like if you no longer qualify for Extra Help

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

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

5-Star Special Enrollment Period (SEP)

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

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

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

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

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

Low Performing Plan

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

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

- 1) **Drug plan customer service**—includes how well the plan handles member appeals.
- 2) **Member complaints and changes in the drug plan's performance**—includes how often Medicare found problems with the plan, and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- 3) **Member experience with the plan's drug services**—includes ratings of member satisfaction with the plan.
- 4) **Drug safety and accuracy of drug pricing**—includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way considered safer and clinically recommended for their condition.

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

Part D Late Enrollment Penalty

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

The late enrollment penalty is calculated by multiplying the 1% penalty rate times the national base beneficiary premium (\$35.63 in 2017) times the number of full, uncovered months you were eligible to join a Medicare drug plan but didn't and went without other creditable prescription drug coverage. The penalty calculation isn't based on the premium of the plan in which you are enrolled. The final amount is rounded to the nearest \$.10 and added to your monthly premium. The national base beneficiary premium may go up each year, so the penalty amount may also go up each year. You may have to pay this penalty for as long as you have a Medicare drug plan.

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

Part D Penalty Example

Ann didn't join when she was first eligible—by May 31, 2014. She doesn't have drug coverage from any other source. She joined a Medicare drug plan during the 2016 Open Enrollment Period. Her coverage will begin on January 1, 2017.

She was without creditable prescription drug coverage from July 2014–December 2016. Her penalty in 2017 is 31% (1% for each of the 31 months) of \$35.63 (the national base beneficiary premium for 2017), which is \$11.05. The monthly penalty is rounded to the nearest \$.10, so she'll be charged \$11.10 each month in addition to her plan's monthly premium in 2017.

Here's the math:

$$\begin{aligned} &.31 \text{ (30\% penalty)} \times \$35.63 \text{ (2017 base beneficiary premium)} = \$11.05 \\ &\$11.05 \text{ (rounded to the nearest } \$0.10) = \$11.05 \\ &\$11.10 = \text{Ann's monthly late enrollment penalty for 2017} \end{aligned}$$

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

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

Lesson 5: Extra Help With Part D Drugs Costs

What Is Extra Help?

Getting “Extra Help” means Medicare helps pay your Medicare prescription drug coverage monthly premium, any yearly deductible, coinsurance, and copayments. If you have limited income and resources, you may get Extra Help paying for your Medicare prescription drug costs. Extra Help is also called the Low-Income Subsidy (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 and can switch plans at any time, with the new plan going into effect the first day of the next month.

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

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

2017 Extra Help Income and Resource Limits

You may get Extra Help if you have Medicare, income below 150% of the federal poverty level (FPL), and limited resources. You may qualify for Extra Help if your income and resources are below the limits shown on the slide for 2017. 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.

- Income limits
 - Below 150% of the federal poverty level
 - \$18,090* per year for an individual, or \$24,360* per year for a married couple
 - Based on family size
 - Resources limits
 - Up to \$13,820* per year for an individual, or \$27,600* per year for a married couple
 - Doesn’t include \$1,500/person for funeral or burial expenses
 - Counts savings and investments
 - Real estate (except your home)
- *Higher amounts for Alaska and Hawaii

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

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

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

NOTE: The income and resource levels listed are for 2017 and can go up each year. Income levels are higher if you live in Alaska or Hawaii, or you or your spouse pays at least half of the living expenses of dependent family members who live with you, or if you work. Updated resource limits are usually released each fall for the next calendar year. Updated income limits are usually released each February for the same calendar year.

Qualifying for Extra Help

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

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

You can apply for Extra Help by

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

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

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

Automatic and Facilitated Enrollment

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

NOTE: For more information and a complete guide to mailings from CMS, SSA, and plans, visit [CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf).

2017 Extra Help Copayments

Extra Help Copayments	2017 Generic/Brand-name
Institutionalized (Level 3)	\$0
Receiving Home and Community-Based Services (under waiver only) (Level 3)	\$0
Up to or at 100% Federal Poverty Level (Level 2)	\$1.20/\$3.70
Full Extra Help (Level 1)	\$3.30/\$8.25
Partial Extra Help (Deductible/Cost-Sharing) (Level 4)	\$82.00/15%

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

Medicare's Limited Income Newly Eligible Transition (NET) program is designed to remove gaps in coverage for low-income individuals moving to Medicare prescription drug coverage.

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 benefits.

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

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

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

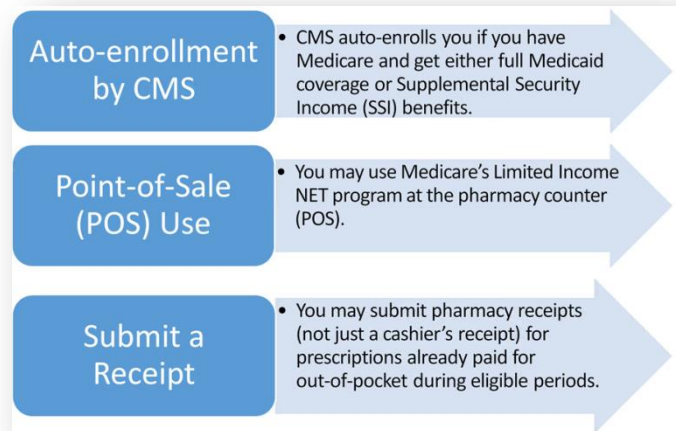
The Limited Income Newly Eligible Transition (NET) Outreach Team is run by Humana, Inc. It provides live webinar training to State Health Insurance Assistance Program counselors and pharmacy providers. To schedule a webinar or for more information, email linetoutreach@humana.com. Visit humana.com/pharmacy/pharmacists/linet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

How Do You Access Medicare's Limited Income Newly Eligible Transition (NET) Program?

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

- Get retroactive coverage up to 36 months if you have Medicare and get either full Medicaid coverage or SSI benefits (or as far back as January 1, 2006, if your Medicaid determination goes back to that point in time)

- Get up to 30 days of current coverage if you get help from your state Medicaid agency paying for your Medicare Part B premiums (in an MSP) or have applied and qualified for Extra Help
- Get immediate coverage if you show evidence of Medicaid (like a Medicaid ID card or a copy of a current Medicaid award letter with effective dates) or Extra Help eligibility to the pharmacy at POS, even if CMS's systems can't confirm your eligibility status



Reassignment Notices

In the fall, the Centers for Medicare & Medicaid Services (CMS) will reassign certain people who qualify for Extra Help into new Medicare Prescription Drug Plans to make sure they continue to pay \$0 premium for their drug coverage. CMS will reassign people who get Extra Help if their Medicare drug plan or Medicare health plan is leaving the Medicare Program as of December 31, 2016. These people will be reassigned into a new Medicare Prescription Drug Plan regardless of whether they joined their current plan on their own, or Medicare enrolled them in a plan. People affected by reassignment will get a notice on BLUE paper in the mail from CMS by early November. There are 3 versions of the notice. Two versions are for people whose plans are leaving the Medicare Program.

- CMS Product No. 11208—informs people who qualify for Extra Help and whose Medicare Prescription Drug Plan (PDP) is leaving the Medicare Program that they'll be reassigned to a new PDP if they don't join a plan on their own by December 31, 2016.
- CMS Product No. 11443—informs people who qualify for Extra Help and whose Medicare Advantage Plan is leaving the Medicare Program that they'll be enrolled in a Medicare PDP if they don't join a new plan on their own by December 31, 2016.

A third version is for people whose premiums are increasing above the regional low-income premium subsidy amount (CMS Product No. 11209). The notice tells people which plan they'll be reassigned to, explains how to stay in their current Medicare drug plan if available, and lets them know how to join a new plan. The notice also includes a list of plans in the region available for \$0 premium and their phone numbers. If people who get a notice don't tell their current plan that they want to stay or join a new plan on their own by December 31, 2016, Medicare will reassign them into a new plan with coverage effective January 1, 2017.

NOTE: Visit [CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11221-P.pdf](https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11221-P.pdf) to download the tip sheet, “Information Partners Can Use on: Reassignment” (CMS Product No. 11221-P) and [CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf) to download the “Guide to Consumer Mailings.”

Changes in Qualifying for Extra Help

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

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

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

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

Redetermination Process

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

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

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

Lesson 6: Comparing and Choosing Plans

Things to Consider Before Joining a Plan

There are several things to consider before joining a Medicare drug plan. When deciding if Medicare drug coverage is right for you, look at the type of health insurance 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 must notify you each year whether your coverage is creditable prescription drug coverage. If you haven't heard from them, call them or your benefits administrator to find out. Also, you may want to consider keeping your creditable prescription drug coverage rather than choosing a Medicare drug plan. It's important to find out how Medicare coverage affects your current health insurance plan to be sure you don't lose doctor or hospital coverage for yourself or your family members.

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

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

Steps to Choosing a Medicare Drug Plan

Step 1: Prepare

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

NOTE: For a helpful Medicare Plan Finder worksheet, visit [CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/Medicare-Plan-Finder-Worksheet.pdf](https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/Medicare-Plan-Finder-Worksheet.pdf).

Step 2: Compare Plans on Medicare Plan Finder

Visit [Medicare.gov/find-a-plan](https://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

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 these following questions:

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



Step 3: Decide and Join

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

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

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

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

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

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

What New Members Can Expect

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

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

Annual Notice of Change (ANOC)

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

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

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

Lesson 7: Coverage Determinations and Appeals

Coverage Determination Request

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

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

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

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

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

Exception Requests

An exception is a type of coverage determination. There are 2 types of exceptions: tier exceptions (like getting a tier 4 drug at the tier 3 cost) and formulary exceptions (either coverage for a drug that’s not on the plan’s formulary, or relaxed access requirements).

If you want to make an exception request, you’ll need a supporting statement from the prescriber. In general, the statement must point out the medical reason for the exception. The prescriber may give the statement verbally or in writing to the plan.

NOTE: An enrollee may request an exception for a Tier 3 drug to be covered at the Tier 2 cost-sharing level so long as there’s a drug on Tier 2 approved for treating the same condition as the Tier 3 drug.

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. For more information about tiering exceptions and approvals, visit [CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html](https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html), Chapter 18, section 30.2.1.4.

A plan may choose to extend coverage into a new plan year. If it doesn't, it must say so in writing either at the time the exception is approved, or at least 60 days before the plan year ends. If your plan doesn't extend your exception coverage, you should think about switching to a drug on the plan's formulary, asking for another exception, or changing to a plan that covers that drug during Medicare's Open Enrollment Period, which is from October 15 through December 7 each year.

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

Requesting Appeals

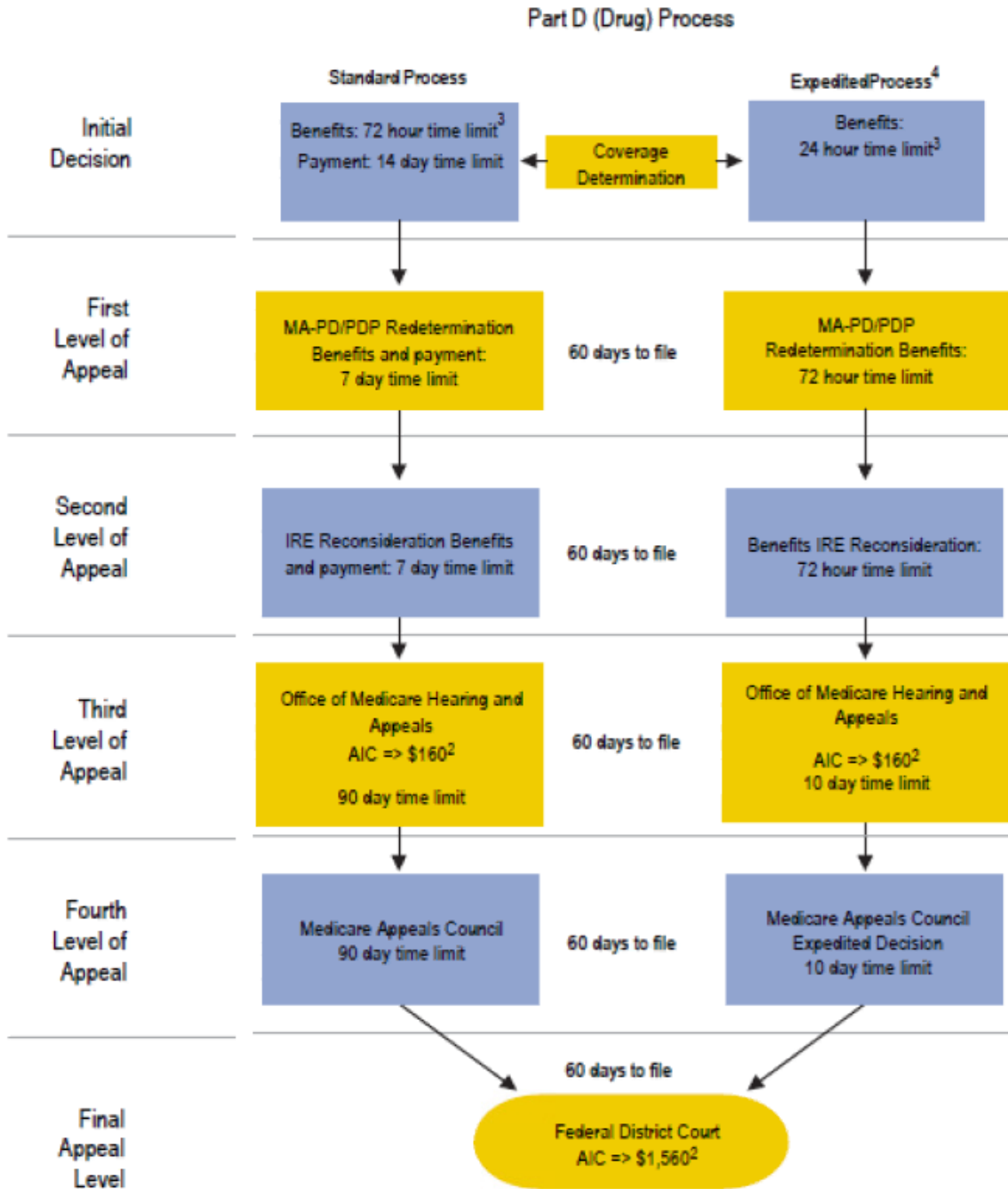
If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how you may file an appeal. Read this decision carefully, and call your plan if you have questions.

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

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

To view a chart showing the process for Medicare appeals, refer to Appendix A.

Appendix - Appeal Chart Process Part D 2017 (see Appendix B for footnotes)



1: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days. 2: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2017 AIC amounts. 3: A request for a coverage determination includes a request for a tiering exception or a formulary exception. The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement. 4: Payment requests cannot be expedited.

Appendix B: Footnotes from page 72

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

B: The Amount In Controversy requirement for all Administrative Law Judge hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2017 AIC amounts.

C: A request for a coverage determination includes a request for a tiering exception or a formulary exception. The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.

D: Payment requests cannot be expedited.

AIC = Amount in Controversy

ALJ = Administrative Law Judge

IRE = Independent Review Entity

MA-PD = Medicare Advantage Prescription Drug

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

PDP = Prescription Drug Plan


This chart reflects the CY 2017 AIC amounts.

Key Points to Remember

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

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Resources	Products
<p>Centers for Medicare & Medicaid Services (CMS)</p> <ul style="list-style-type: none"> • Call 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048. • Medicare.gov • CMS.gov <p>Social Security</p> <ul style="list-style-type: none"> • Call 1-800-772-1213. TTY: 1-800-325-0778. • socialsecurity.gov <p>State Health Insurance Assistance Programs and State Insurance Departments</p>  <ul style="list-style-type: none"> • shiptacenter.org/ <p>Limited Income NET Program (Humana)</p> <ul style="list-style-type: none"> • Call 1-877-783-1307 or 711 (TRS) • linetoutreach@humana.com 	<p>Prescription Drug Benefit Manual</p> <ul style="list-style-type: none"> • CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html <p>PD Enrollment and Disenrollment Guidance</p> <ul style="list-style-type: none"> • CMS.gov/Medicare/eligibility-and-enrollment/medicarepresdrugeligenrol/index.html <p>Medicare Premiums: Rules for Higher-Income Beneficiaries</p> <ul style="list-style-type: none"> • SSA.gov/pubs/EN-05-10536.pdf <p>2015/2016 Guide to Mailings From CMS, Social Security, and Plans</p> <ul style="list-style-type: none"> • CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf <p>National Training Program – Partner Job Aids</p> <ul style="list-style-type: none"> • CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram

Medicare Prescription Drug Coverage Resource Guide (continued)

Products (continued)	
<ol style="list-style-type: none"> 1. “Your Guide to Medicare Prescription Drug Coverage” (CMS Product No. 11109) 2. “Things to Think About When You Compare Medicare Drug Coverage” (CMS Product No. 11163) 3. “4 Ways to Help Lower Your Medicare Prescription Drug Costs” (CMS Product No. 11417) 4. “How Medicare Drug Plans Use Pharmacies, Formularies, and Common Coverage Rules” (CMS Product No. 11136) 5. “Medicare Drug Coverage Under Medicare Part A, B, & D” (CMS Product No. 11315-P) 6. “Handling Medicare Part D Complaints” (CMS Product No. 11259-P) 7. “How Retiree Coverage Works With Medicare Prescription Drug Coverage” (CMS Product No. 11403-P) 	<ol style="list-style-type: none"> 8. “LI NET for People at Pharmacy Counter” (CMS Product No. 11328-P) 9. “LI NET for People With Retroactive Medicaid & SSI Eligibility” (CMS Product No. 11401-P) 10. “How Medicare Plans Drug Coverage Work With a Medicare Advantage Plan or Medicare Cost Plan” (CMS Product No. 11135) <p>To access these products:</p> <ul style="list-style-type: none"> • View and order single copies at Medicare.gov/publications. • Order multiple copies (partners only) at Productordering.cms.hhs.gov. <i>You must register your organization.</i>

Acronyms

AIC Amount in Controversy	FDA U.S. Food and Drug Administration
ALJ Administrative Law Judge	FPL Federal Poverty Level
ANOC Annual Notice of Change	IEP Initial Enrollment Period
BPH Benign Prostatic Hyperplasia	IRE Independent Review Entity
CHIP Children's Health Insurance Program	IRMAA Income-Related Monthly Adjustment Amount
CMS Centers for Medicare & Medicaid Services	IRS Internal Revenue Service
DME Durable Medical Equipment	LPI Low Performance Icon
EOB Explanation of Benefits	MA Medicare Advantage
EOC Evidence of Coverage	
ESRD End-Stage Renal Disease	