



This training module explains Medicare prescription drug coverage.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The information in this module was correct as of April 2012.

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

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

To check for an updated version of this training module, visit

<http://www.cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/Training-Library.html>

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Session Objectives

This session will help you to

- Understand Medicare prescription drug coverage
 - Under Medicare Part A
 - Under Medicare Part B
 - Under Medicare Part D
- Summarize eligibility and enrollment
- Compare and choose plans
- Describe Extra Help with drug plan costs
- Review coverage determinations and appeals

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Lessons

1. Medicare Prescription Drug Coverage Basics
 - Part A Drug Coverage
 - Part B Drug Coverage
2. Medicare Part D
3. Part D Eligibility and Enrollment
4. Extra Help with Part D Plan Costs
5. Comparing and Choosing Part D Plans
6. Coverage Determinations and Appeals

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Medicare Prescription Drug Coverage is divided into six lessons:

1. Medicare Prescription Drug Coverage Basics
 - Part A Drug Coverage
 - Part B Drug Coverage
2. Medicare Part D
3. Part D Eligibility and Enrollment
4. Extra Help with Part D Plan Costs
5. Comparing and Choosing Part D Plans
6. Coverage Determinations and Appeals



Lesson 1 – Medicare Prescription Drug Coverage Basics

- Medicare Overview
- Medicare Prescription Drug Coverage Under
 - Part A
 - Part B

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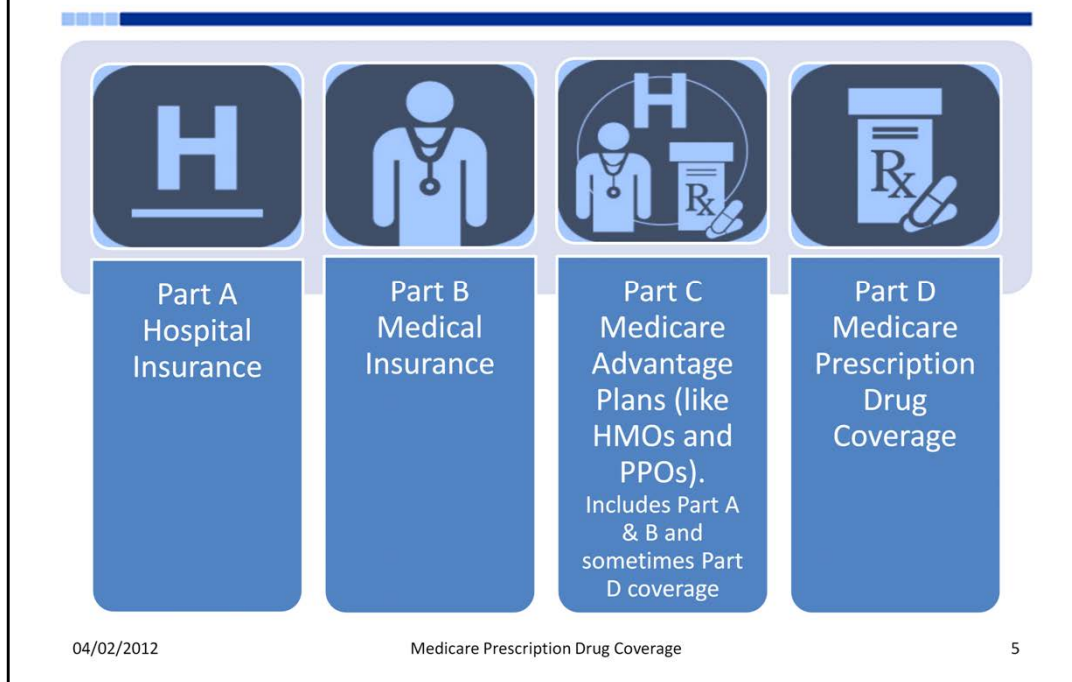
Medicare Prescription Drug Coverage

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

- Medicare overview
- Medicare prescription drug coverage under
 - Part A
 - Part B

Four Parts of Medicare



Medicare covers many types of services, and you have options for how you can 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 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 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.
- **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

- Medicare Parts A, B and D cover prescription drugs
 - Drugs must be medically necessary
- Coverage by Parts A, B, or D depends on
 - Health care setting
 - Medical indication
 - Need for special coverage requirements

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

- The health care setting (e.g., home, hospital (as inpatient or outpatient), surgery center or institution) where the health care is provided,
- The medical indication or reason why you need medication (e.g., cancer),
- Any special coverage requirements, such as those for immunosuppressive drugs.

This information applies if you are in 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 (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 Medicare Advantage Plans offer prescription drug coverage.

Part A Prescription Drug Coverage

- Part A generally pays for all drugs
 - During a covered inpatient stay
 - In hospital or skilled nursing facility (SNF)
 - Drugs received as part of treatment
 - Hospice
 - Drugs for symptom control and pain relief only

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You may receive 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 provided during an inpatient stay.

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 is not covered by Part A.

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.

Part B Prescription Drug Coverage

- Part B covers limited outpatient drugs
 - Injectable and infusible drugs that are
 - Not usually self-administered, and
 - Administered as part of a physician service
 - Administered through Part B-covered Durable Medicare Equipment (DME)
 - Some other types of drugs with special coverage requirements
 - Certain vaccines (e.g., flu shot)

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Medicare Part B covers a limited set of outpatient drugs:

- Injectable and infusible drugs that are not usually self-administered and that are furnished and administered as part of a physician service (e.g., an injectable drug used to treat anemia that is administered at the same time as chemotherapy). However, if an injection is usually self-administered (e.g., Imitrex® for migraines) or is not furnished and administered as part of a physician service, it is not covered by Part B.
- 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.

For more information, please view the publication *How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings*, CMS publication number 11333.

For more information on local and national Medicare Part B coverage determinations, please visit the web-based Medicare National Coverage Determination Manual at

http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

Part B Prescription Drug Coverage

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

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Sometimes you may need “self-administered drugs” (drugs you would normally take on your own) while in a hospital outpatient setting. Part B generally doesn't pay for self-administered drugs unless they are required for the hospital outpatient services you're getting. If you get self-administered drugs that aren't covered by Medicare Part B while in a hospital outpatient setting, the hospital may bill you for the drug. However, if you are enrolled in a Medicare prescription drug plan (Part D), these drugs may be covered.

- Generally, your Medicare drug plan only covers prescription drugs and won't pay for over-the-counter drugs you get, 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 up front and out-of-pocket for these drugs and submit the claim to your Medicare drug plan for reimbursement

For more information, please view the publication *How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings*, CMS publication number 11333.

Part B Prescription Drug Coverage

- Covers drugs administered through Part B-covered Durable Medical Equipment (DME)
 - Such as nebulizers and infusion pumps
 - Only when used with DME in your home
- Supplier must be accredited DME provider
 - In some areas must be contract provider

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Medicare Part B only covers drugs administered through a Part B-covered item in your home (e.g., when used in conjunction with covered durable medical equipment (DME), 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 area, so ask the supplier if they are accredited. You can also visit the Medicare Supplier Directory at www.medicare.gov for more information.

Part B Prescription Drug Coverage

- Covers oral drugs with special coverage requirements
 - Anti-cancer drugs (see Appendix A)
 - Anti-emetic drugs (see Appendix B)
 - Immunosuppressive drugs, under certain circumstances (Appendix C)

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Medicare Part B covers three categories of oral drugs with special coverage requirements: oral anti-cancer, oral anti-emetic, and under certain circumstances immunosuppressive drugs.

Please see Appendices A, B, and C for a list of the covered drugs.

NOTE: For long-term care facilities that do not qualify as a patient's home, we recommend that providers prescribing the above categories of drugs include in the written order both the diagnosis and indication for the drug, as well as a statement of status such as "Nursing Home Part B."

Exercise

Medicare Part A pays for all of your prescription drugs while you are receiving Part A-covered hospice care.

1. True
2. False

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Medicare Part A pays for all of your prescription drugs while you are receiving Part A-covered hospice care.

1. True
2. False

Answer: 2. False

Medicare Part A only pays for drugs you get for symptom control or pain relief while receiving Part A-covered hospice care.

Exercise

Medicare Part B covers certain vaccines, including the influenza (“flu”) and pneumococcal pneumonia vaccines.

1. True
2. False

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Medicare Part B covers certain vaccines, including the influenza (“flu”) and pneumococcal pneumonia vaccines.

1. True
2. False

Answer: 1. True



Lesson 2 - Medicare Part D

- Medicare Prescription Drug Coverage
- Medicare Drug Plan Costs and Benefits
- Covered and Non-Covered Drugs
- Access to Covered Drugs

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Lesson 2, *Medicare Part D*, provides information on

- Medicare prescription drug coverage
- Medicare drug plan costs and benefits
- Covered and non-covered drugs
- Access to covered drugs

Medicare Prescription Drug Coverage

- Also called Medicare Part D
- Prescription drug plans approved by Medicare
- Run by private companies
- Available to everyone with Medicare
- Must be enrolled in a plan to get coverage
- Two sources of coverage
 - Medicare Prescription Drug Plans (PDPs)
 - Medicare Advantage Plans with Rx coverage (MA-PDs)
 - And other Medicare health plans with Rx coverage

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Medicare Prescription Drug Plans are approved by Medicare and run by private companies. 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.

There are two sources of Medicare prescription drug coverage:

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

The term “Medicare drug plan” is used throughout this presentation to mean both Medicare Prescription Drug Plans and Medicare Advantage or other Medicare plans with prescription drug coverage.

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

Medicare Drug Plans

- Can be flexible in benefit design
- Must offer at least standard level of coverage
- May offer different or enhanced benefits
- Benefits and costs may change each year

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Plans can be flexible in their benefit design, as long as what they offer is at least as good as the standard level of coverage established by CMS.

Most plans continue to offer different benefit structures, including tiers, copayments, and/or lower deductibles. Enhanced plans can even offer coverage for generic and/or brand-name medications in the coverage gap and may also pay for non-Part D-covered medications.

Plan benefits and costs may change each year.

Medicare Drug Plan Costs

- Costs vary by plan
- In 2012, most people will pay
 - A monthly premium
 - A yearly deductible
 - Copayments or coinsurance
 - 50% for covered brand name drugs in coverage gap
 - 86% for generic drugs in coverage gap
 - Very little after spending \$4,700 out-of-pocket

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Your prescription drug costs will vary depending on the plan. Most people will pay a monthly premium for Medicare prescription drug coverage. You will also pay a share of the cost of your prescriptions, including a deductible, copayments, and/or coinsurance. All Medicare drug plans have to provide at least a standard level of coverage, set by Medicare. However, some plans might offer more coverage and additional drugs, generally for a higher monthly premium.

In 2012, you will get a 50% discount on brand name drugs and a 14% discount on generic drugs while in the coverage gap. In 2013, you will get a 52.5% discount on brand name drugs and a 21% discount on generic drugs while in the coverage gap. By 2020, you will get a 75% discount both for covered generic and brand-name drugs when in the gap.

With every plan, once you have paid \$4,700 out of pocket (this includes payments from other sources, including the 50% discount paid for by the plan in the coverage gap) for drugs costs in 2012, you will pay 5% (or a small copayment) for each drug for the rest of the year.

People with limited income and resources may be able to get Extra Help paying for their Medicare drug plan costs.

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

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
2012	50%	86%
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%

Note: Dispensing fees are not discounted.

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In addition to the 50% discount on covered brand-name prescription drugs, there will be increasing savings for you in the coverage gap each year until 2020. The dispensing fees charged by the pharmacy are not discounted.

Standard Structure in 2012

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2012. 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	3. Coverage Gap	4. Catastrophic Coverage
→	→	→	
Ms. Smith pays the first \$320 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus deductible) reaches \$2,930.	Once Ms. Smith and her plan have spent \$2,930 for covered drugs, she is in the coverage gap. In 2012, she gets a 50% discount on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2012, she also gets 14% coverage on covered generic drugs while in the coverage gap.	Once Ms. Smith has spent \$4,700 out-of-pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each drug until the end of the year.

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This is an example showing what you would pay each year in a defined standard Medicare drug plan. Very few plans actually follow this design. Your drug plan costs will vary.

Monthly premium—Varies by plan. You still pay the Part B premium if you have Part B. In a Medicare Health Plan (like an HMO, or a Medicare Cost Plan) with drug coverage, the plan premium may include Rx drug coverage.

Yearly deductible (you pay \$320 in 2012)—What you pay for prescriptions before your plan begins to pay. Some drug plans don't have a deductible.

Copayments or coinsurance (you pay 25%)—Your share at the pharmacy for your covered prescriptions after the deductible. The drug plan pays its share.

Coverage gap (you pay 100%)—Most plans have a coverage gap, which begins after you and your drug plan have spent a certain amount of money for covered drugs (\$2,930 in 2012). In 2012, you will continue to get a 50% discount on brand-name drugs that counts toward your out-of-pocket spending, and helps you get out of the coverage gap.

Catastrophic coverage (you pay 5%)—Once you reach your plan's out-of-pocket limit, you get "catastrophic coverage" and you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

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

Reference: Page 14 of *Your Guide to Medicare Prescription Drug Coverage* (CMS Product No. 11109).

Which Payment Sources Count Toward TrOOP?

Sources That Count	Sources That Don't Count
<ul style="list-style-type: none"> • Your payments • Payments by family members or other individuals • Most state pharmacy assistance programs (SPAPs) • Extra Help • Charities (not if established/controlled by employer/union) • Indian Health Services • AIDS drug assistance programs • Payments by manufacturers under coverage gap discount program 	<ul style="list-style-type: none"> • Payments made by your Medicare drug plan • Group Health Plans (including employer and union retiree coverage) • Government-funded programs (including TRICARE and VA) • Manufacturer Patient Assistance Programs (PAPs) • Other third-party payment arrangements

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Part D out-of-pocket costs are sometimes referred to as “true out-of-pocket” costs, or TrOOP. Payments that count toward TrOOP include payments for drugs on the plan’s formulary made by

- You, your family members, or other individuals
- Most State Pharmacy Assistance Programs (SPAPs)
- Extra Help
- Charities, unless established, run, or controlled by a current or former employer or union
- Indian Health Services and AIDS Drug Assistance Programs
- Pharmaceutical manufacturers under the coverage gap manufacturer discount program

The following payments don’t count as true out-of-pocket costs:

- Payments made by your Medicare drug plan
- Group health plans, including employer or union retiree coverage (and personal Health Savings Accounts (HSAs) when structured as a group health plan)
- Government-funded programs, including TRICARE or VA
- Manufacturer-sponsored Patient Assistance Programs (PAPs) that provide free or significantly reduced-priced products. You can still take advantage of these programs, but the amount of this in-kind assistance will not count toward TrOOP. PAPs may charge a small copayment when providing this in-kind assistance, and this amount may count toward TrOOP. You will need to submit a paper claim to your Medicare drug plan, along with documentation of the copayment. A list of PAPs is available at

www.rxassist.org.

- Other third-party payment arrangements

Medicare Prescription Drug Coverage Premium

- A small group may pay a higher premium
 - Based on income
 - Fewer than 5% of all people with Medicare
 - Uses same thresholds used to compute income-related adjustments to Part B premium
 - As reported on your IRS tax return from 2 years ago
- Required to pay if have Part D coverage

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A small group—affecting fewer 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 determine 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 premium adjustment amount (IRMAA).

Usually, the extra amount will be deducted from your Social Security check. If you don't have enough money in your Social Security check, you will be billed for the extra amount each month by either CMS or the Railroad Retirement Board (RRB). This means that you will pay your plan each month for your monthly premium and pay CMS or RRB each month for your IRMAA amount. (The Part D-IRMAA amount is paid directly to the government and not the plan.) This also applies if you have Part D coverage through your employer (but not through retiree drug subsidy or other creditable coverage).

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

Reference: Social Security Administration, SSA Publication No. 05-10536 December 2011

See Section 3308 of the Affordable Care Act.

Income-Related Monthly Adjustment Amount (IRMAA)

If Your Yearly Income in 2010 was		In 2012 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 + \$48.10*
Above \$214,000	Above \$428,000	YPP + \$66.40*
*per month		

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You pay only your plan premium if your yearly income in 2010 was \$85,000 or less for an individual or \$170,000 or less for a couple.

You pay your plan premium plus an extra amount, based on your yearly income, if your yearly income in 2010 was higher than \$85,000 for an individual or \$170,000 for a couple.

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

Part D-Covered Drugs

- Prescription brand-name and generic drugs
 - Approved by Food and Drug Administration (FDA)
 - Used and sold in United States
 - Used for medically-accepted indications
- Includes drugs, biological products, and insulin
 - Supplies associated with injection or inhalation

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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.

Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze are also covered. Supplies associated with the inhalation of insulin may also be covered by Medicare drug plans.

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.

Required Coverage

- “All or substantially all” drugs in 6 categories
 - Cancer medications
 - HIV/AIDS treatments
 - Antidepressants
 - Antipsychotic medications
 - Anticonvulsive treatments
 - Immunosuppressants
- All commercially-available vaccines
 - Except those covered under Part B (e.g., flu shot)

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Medicare drug plans must cover “all or substantially all” drugs in 6 categories to treat certain conditions:

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

Medicare drug plans must cover all commercially available vaccines, including the shingles vaccine (but not vaccines such as the flu and pneumococcal pneumonia shots that are covered under Part B).

You or your provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.

NOTE: Please see Appendices A - C for a list of oral anti-cancer drugs, oral anti-emetics prescribed for use within 48 hours of chemotherapy, and immunosuppressive drugs.

Drugs Excluded By Law Under Part D

- Anorexia, weight loss or weight gain drugs
- Barbiturates and benzodiazepines*
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- 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

**To be covered in 2013*

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

- Anorexia, weight loss or weight gain drugs
- Barbiturates and benzodiazepines (will be covered starting in 2013)
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration
- 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.

Access to Covered Drugs

- Plans must cover range of drugs in each category
- Coverage and rules vary by plan
- Plans can manage access to drug coverage through
 - Formularies (list of covered drugs)
 - Prior authorization (doctor requests before service)
 - Step therapy (type of prior authorization)
 - Quantity limits (limits quantity over period of time)

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Plans must cover a range of drugs in the most commonly prescribed categories and classes. This helps make sure that people with different medical conditions can get the prescription drugs they need. The prescription drug list might 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 can ask for an exception.

Coverage and rules vary by plan, which can affect what you pay.

Some of the methods (rules) that plans use to manage your access to drug coverage include the following:

- Formularies (list of covered drugs)
- Prior authorization (doctor requests before prescribing)
- Step therapy (type of prior authorization)
- Quantity limits (limits quantity of prescription over a period of time)

Formulary

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

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

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Each Medicare drug plan has a list of prescription drugs that it covers called a formulary. Plans cover both generic and brand-name prescription drugs.

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 is an example of how a plan might form its tiers:

- **Tier 1–Generic drugs** (the least expensive) - The Food and Drug Administration (FDA) says 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 to the FDA 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 U.S. 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 file an exception and ask your plan for a lower copayment.

Rules Plans Use to Manage Access to Drugs

Prior Authorization	<ul style="list-style-type: none"> ▪ Doctor must contact plan for prior approval <ul style="list-style-type: none"> • Before prescription will be covered • Must show medical necessity for drug ▪ Process for requests may vary by plan
Step Therapy	<ul style="list-style-type: none"> ▪ Type of prior authorization ▪ You 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

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Some Medicare drug plans may have rules that require prior authorization. Prior authorization means that before the plan will cover a prescription, your doctor must first contact the plan. Your doctor has to show there is a medically necessary reason why you must use that particular drug for it to be covered. Plans do this to be sure these drugs are used correctly and only when medically necessary.

You can request the plan's prior authorization requirements in order to understand what you will need to do to access a drug or provide this information to your doctors. Prior authorization requirements are also available on Medicare drug plans' websites.

Step therapy is a type of prior authorization. With step therapy, in most cases you must first try less expensive drugs that have been proven effective for most people with a specific medical condition. For example, some plans may require you to try a generic drug (if available), then a less expensive brand-name drug on their drug list before they will cover a more expensive brand-name drug.

However, if you have 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 originally prescribed step therapy drug will be covered.

For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time. If you require more, then your doctor may need to contact the plan to request an exception if he/she believes the additional amount is medically necessary. If the request is approved, the amount prescribed by your doctor will be covered.

Formulary Changes

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

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Medicare drug plans may not change their therapeutic categories and classes in a formulary other than at the beginning of each plan year, except 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 modifying formularies as a result of new information on drug safety or effectiveness. Those changes must be made according to the prescribed approval procedures and following 60-days notice to CMS, State Pharmacy Assistance Programs (SPAPs), prescribing physicians, network pharmacies, pharmacists, and affected members.

CMS has issued guidance to Medicare drug plans indicating that no plan members should be subject to a discontinuation or reduction in coverage of drugs they are currently using for the remainder of the plan year. However, this is not true in the case of drugs removed from the formulary due to Food and Drug Administration (FDA) or the manufacturer's withdrawal of the drug from the market. Medicare drug plans are not required to obtain CMS approval or give 60-days notice when removing formulary drugs that have been withdrawn from the market by either the FDA or a manufacturer.

If Your Prescription Changes

- Get up-to-date information from plan
 - By phone or on plan's website
- Give doctor copy of plan's formulary
- If the new drug is not on plan's formulary
 - Can request a coverage determination from plan
 - May have to pay full price if plan still won't cover drug

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Medicare Prescription Drug Coverage

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If your doctor needs to change your prescription or prescribe a new drug, you should give your doctor a copy of the formulary for your Medicare drug plan. This list and the prices for drugs can change. You can get current information by calling the plan, or looking on the plan's website to find the most up-to-date drug list and prices.

If your doctor needs to prescribe a drug that isn't on your Medicare drug plan's formulary and you don't have any other health insurance that covers outpatient prescription drugs, he or she can request a coverage determination from the plan. If your network pharmacy can't fill a prescription as written, the pharmacist will give or show you a notice that explains how to contact your Medicare drug plan so you can make your request. We'll talk more about coverage determinations in Lesson 6.

If your plan still won't cover a specific drug, you may have to pay full price for the prescription.

Your plan may change its formulary, benefits, and costs each January. If you're in a Medicare drug plan, review the Evidence of Coverage (EOC) and Annual Notice of Change (ANOC) your plan sends you each fall. The EOC gives you details about what the plan covers, how much you pay, and more. The ANOC includes any changes in coverage, costs, or service area that will be effective in January. If you don't get these important documents, contact your plan.

Exercise

Medicare drug plans manage access to drug coverage in all of the following ways, except:

1. Formularies
2. Coverage gap
3. Prior authorization
4. Step therapy
5. Quantity limits

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Medicare Prescription Drug Coverage

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Medicare drug plans manage access to drug coverage in all of the following ways, except

1. Formularies
2. Coverage gap
3. Prior authorization
4. Step therapy
5. Quantity limits

Answer: 2. Coverage gap. The coverage gap is part of the standard Part D benefit structure. The other options listed are ways plans can manage access to drug coverage.

Exercise

How much will you pay for covered drugs during the coverage gap in 2012?

1. 50% for brand-name drugs and 50% for generic drugs
2. 86% for brand-name drugs and 50% for generic drugs
3. 50% for brand-name drugs and 86% for generic drugs

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How much will you pay for covered drugs during the coverage gap in 2012?

1. 50% for brand-name drugs and 50% for generic drugs
2. 86% for brand-name drugs and 50% for generic drugs
3. 50% for brand-name drugs and 86% for generic drugs

Answer: 3. 50% for brand-name drugs and 86% for generic drugs.



Lesson 3 – Part D Eligibility and Enrollment

- Eligibility Requirements
- When to Join or Switch Plans
- Creditable Coverage
- Late Enrollment Penalty

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Medicare Prescription Drug Coverage

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Lesson 3, *Part D Eligibility and Enrollment*, provides the following information

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

Part D Eligibility Requirements

- To be eligible to join a Prescription Drug Plan
 - You must have Medicare Part A **or** Part B
- To be eligible to join a MA Plan with drug coverage
 - You must have Part A **and** Part B
- You must live in plan's service area
 - You cannot be incarcerated
 - You cannot live outside the United States
- You **must** be enrolled in a plan to get drug coverage

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Medicare Prescription Drug Coverage

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Anyone who has Medicare Part A and/or Part B, and lives in the plan's service area is eligible to join a Medicare drug plan. To get prescription drug coverage through a Medicare Advantage plan, generally you must have both Part A and Part B.

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 U.S. and its territories, or are incarcerated, you are not eligible to enroll in a plan and therefore cannot get coverage.

Medicare prescription drug coverage is not automatic. You 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.

You can only be a member of one Medicare drug plan at a time.

When You Can Join or Switch Plans

- When you become newly entitled to Medicare
 - 7-month Initial Enrollment Period (IEP) for Part D

If You Join	Coverage Begins
3 months before your month of eligibility	Date eligible for Medicare
Month of eligibility	First of the following month
3 months after your month of eligibility	First of the month after month you apply

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Medicare Prescription Drug Coverage

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When you become entitled to 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.
- You can apply during your month of eligibility, in which case your Medicare drug coverage will begin on the first of the following month.
- Or you can apply during the 3 months after your month of eligibility, with coverage beginning the first of the month after the month you apply.

Some groups of people who become entitled to Medicare will be enrolled in a Medicare drug plan by CMS unless they join a plan on their own. We will discuss these groups in Lesson 4.

When You Can Join or Switch Plans	
Medicare's Open Enrollment Period ("Open Enrollment")	October 15 – December 7 each year Changes are effective January 1
January 1 – February 14	Between 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 to Original Medicare during this period, you will have until February 14 to also join a Medicare drug plan to add drug coverage. Coverage begins the first of the month after the plan gets the enrollment form.

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You can join, switch, or drop a Medicare drug plan during Medicare's Open Enrollment Period (also known as Open Enrollment), October 15 – December 7 each year. The changes are effective January 1 of the following year, as long as the plan gets your request for enrollment by December 7.

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

See Section 3204 of the Affordable Care Act.

When You Can Join or Switch Plans

Special Enrollment Periods (SEP)

- You permanently move out of your plan's service area
- You lose other creditable prescription coverage
- You weren't adequately informed your other coverage was not creditable or was reduced and is no longer creditable
- You enter, live in or leave a long-term care facility
- You have a continuous SEP if you qualify for Extra Help
- You belong to a State Pharmaceutical Assistance Program (SPAP)
- Or in other exceptional circumstances

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In certain situations, you may get a Special Enrollment Period (SEP):

- 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 was not creditable, or that the coverage was reduced so that it is no longer creditable.
- When you enter, reside in, 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).
- Or in other exceptional circumstances, such as if you no longer qualify for Extra Help.

5-Star Special Enrollment Period (SEP)

- Can enroll in 5-Star Medicare Advantage (MA), Prescription Drug Plan (PDP), or MA-PD
- Enroll at any point during the year
 - Once per year
- New plan starts first of month after enrolled
- Plan ratings granted on calendar basis
 - Ratings assigned in October of the preceding year
 - Use Medicare Plan Finder to view plan ratings
 - Look at Overall Plan Rating to identify eligible plans

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You can use this SEP to enroll in a 5-star Medicare Advantage-only plan, a 5-star Medicare Advantage plan with prescription drug coverage, or a 5-star Medicare Prescription Drug Plan at any time during the year, provided you meet the plan's enrollment requirements (e.g., living within the service area, etc.).

If you are currently enrolled in a plan with a 5-star overall rating, you may use this SEP to switch to a different plan with a 5-star overall rating.

- CMS also created a coordinating SEP for prescription drug plans to allow people who enroll in certain types of 5-star plans without drug coverage to select a prescription drug plan, if this combination is permitted under CMS rules.

You may use the 5-star SEP 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 plan year and you are limited to making changes only during other applicable enrollment periods.

Your enrollment effective date will be the first day of the month following the month in which the plan receives your enrollment request.

Star ratings are granted on a calendar year basis, and are assigned in October of the preceding year. The plan won't actually have the rating until January 1, but will be assigned the rating in the October prior to that January 1.

To find plan rating information, visit the Medicare Plan Finder at www.medicare.gov. Look for the "Overall Plan Rating" to identify plans that are eligible for use with this SEP.

NOTE: You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that doesn't. You will have to wait until the next applicable enrollment period to get drug coverage and you may have to pay a late enrollment penalty.

Creditable Drug Coverage

- Current or prior prescription drug coverage
- Creditable if it meets or exceeds Medicare's minimum standards
- With creditable coverage
 - May not have to pay a late enrollment penalty
- Plans inform yearly about whether creditable
 - For example, employer group health plans (EGHPs), retiree plans, VA, TRICARE and FEHB

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If you have other prescription drug coverage, you will get information each year from your plan that tells you if the plan meets Medicare's minimum standards. This is referred to as "creditable coverage." The plan will also notify you if your coverage changes and no longer meets Medicare's minimum standards.

If you have other drug coverage that meets Medicare's minimum standards, you may 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.

Some examples of coverage that meets Medicare's minimum standards include

- Some group health plans
- Employer or union retiree drug coverage
- VA coverage, military coverage including TRICARE, and the Federal Employees Health Benefits Program (FEHB) are all currently considered creditable coverage.

Most Medigap (Medicare Supplement Insurance) policies do not provide drug coverage that meets Medicare's minimum standards. If you have a Medigap policy that covers drugs, you can keep your policy, but 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 will need to tell your Medigap insurer when your coverage starts, so the prescription drug coverage can be removed from your Medigap policy.

Late Enrollment Penalty

- Higher premium if you wait to enroll
 - Additional 1% of base beneficiary premium
 - For each month eligible and not enrolled
 - For as long as you have Medicare drug coverage
 - Except if you had creditable drug coverage
 - National base beneficiary premium
 - \$31.08 in 2012
 - Can change each year

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Medicare Prescription Drug Coverage

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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 decide to enroll later.

The penalty is added to the premium payment amount. It is calculated by multiplying 1% of the national base beneficiary premium by the number of months you were eligible but not enrolled in a plan and did not have creditable drug coverage. The penalty calculation is not based on the premium of the plan you are enrolled in. The base beneficiary premium (\$31.08 in 2012) is a national number and can change each year.

If you have another source of drug coverage (e.g., through a former employer), you may choose to stay in that plan and not enroll in a Medicare drug plan. If your other coverage is at least as good as Medicare prescription drug coverage, called “creditable” coverage, you will not have to pay a higher premium if you later join a Medicare drug plan. You also will not have to pay a higher premium if you get Extra Help paying for your prescription drugs.

If you don't agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You will need to fill out a reconsideration request form (that your plan will send you), and you will have the chance to provide proof that supports your case, such as information about previous creditable prescription drug coverage.

Example: Mr. Smith did not enroll in a Medicare drug plan by May 31, 2011, the end of his IEP. He did not have creditable prescription drug coverage and first enrolled in a Medicare drug plan in December 2011, during open enrollment. His penalty is 7% because he had 7 months without creditable coverage, starting with the first month he would have been covered if he had joined a plan by May 31. CMS counts June through December of 2011 (7 months). Since the national base beneficiary premium in 2012 is \$31.08, the penalty would be \$2.20 per month. ($\$31.08 \times .07 = \2.17 , rounded to the nearest 10 cents = \$2.20). In general, the penalty will be added to his premium payment, and assessed for as long as he has Medicare drug coverage. It is recalculated each year that the national base beneficiary premium changes.

Exercise

To be eligible to join a stand-alone Medicare Prescription Drug Plan (PDP), you must have:

1. Medicare Part A
2. Medicare Part B
3. Medicare Part A **or** Part B
4. Medicare Part A **and** Part B

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To be eligible to join a stand-alone Medicare Prescription Drug Plan (PDP), you must have

1. Medicare Part A
2. Medicare Part B
3. Medicare Part A or Part B
4. Medicare Part A and Part B

Answer: 3. Medicare Part A or Part B.

Exercise

You may use the 5-Star Special Enrollment Period (SEP) to enroll in any 5-Star MA, MA-PD, or PDP.

1. True
2. False

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Medicare Prescription Drug Coverage

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You may use the 5-Star Special Enrollment Period (SEP) to enroll in any 5-Star MA, MA-PD, or PDP.

1. True
2. False

Answer: 1. True



Lesson 4 – Extra Help with Part D Plan Costs

- What it is
- How to Qualify
- Enrollment
- Continuing Eligibility

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Medicare Prescription Drug Coverage

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Lesson 4, *Extra Help with Part D Drug Plan Costs*, provides the following information:

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

What is Extra Help?

- Program to help people pay for Medicare prescription drug costs
 - Also called the Low-Income Subsidy (LIS)
- If you have lowest income and resources
 - Pay no premiums or deductible, and small or no copayments
- If you have slightly higher income and resources
 - Pay reduced deductible and a little more out-of-pocket
- No coverage gap if you qualify for Extra Help

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Medicare Prescription Drug Coverage

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If you have limited income and resources, you may get Extra Help paying for your Medicare prescription drug costs. Extra Help is sometimes referred to as the low-income subsidy (LIS).

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

If you qualify for Extra Help, you will not have a coverage gap or late enrollment penalty. You will also have a continuous Special Enrollment Period (SEP) and can switch plans at any time, with the new plan effective the first of the following month.

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

NOTE: Residents of U.S. territories are not eligible for Extra Help. Each of the territories provides help for its 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 provided elsewhere in the United States.

Qualifying for Extra Help

- You automatically qualify for Extra Help if you
 - Have full Medicaid coverage
 - Receive Supplemental Security Income (SSI)
 - Get help from Medicaid paying your Medicare premiums
- All others must apply
 - Online at www.socialsecurity.gov
 - Call SSA at **1-800-772-1213** (TTY 1-800-325-0778)
 - Ask for “Application for Help with Medicare Prescription Drug Plan Costs” (SSA-1020)
 - Contact your state Medicaid agency

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

- Have full Medicaid coverage (including prescription drug coverage)
- Get Supplemental Security Income (SSI) benefits
- Get help from your state Medicaid program paying your Medicare Part B premiums (Medicare Savings Program)

If you don't meet one of the above conditions, you must apply for Extra Help. 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 are 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
- Applying through the Social Security website 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 your application can be filed by a personal representative with the authority to act on your behalf, such as 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.

2012 Income and Resource Limits

■ Income

- Below 150% of the Federal poverty level (FPL)
 - \$1,396.25 per month for an individual*, or
 - \$1,891.25 per month for a married couple*
 - Based on family size

■ Resources

- Up to \$13,070 for an individual, or
- Up to \$26,120 for a married couple
 - Includes \$1,500/person for funeral or burial expenses
 - Counts savings and investments
 - Does not count home you live in

*Higher amounts for Alaska and Hawaii

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Medicare Prescription Drug Coverage

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Extra Help is available if you have Medicare, income below 150% of the Federal poverty level, and limited resources. You may qualify for Extra Help if your income and resources are below the above limits in 2012. These amounts may change in 2013.

Medicare counts the income of you and your spouse (living in the same household), regardless of whether or not your spouse is applying for Extra Help. The income is compared to the Federal poverty level for a single person or a married person, as appropriate. This takes into consideration whether you and/or your spouse has dependent relatives who live with you and who rely on you for at least half of their support. A grandparent raising grandchildren may qualify, but the same person might not have qualified as an individual living alone.

Resources are counted for you and a spouse (living in the same household). Only two types of resources are considered:

- Liquid resources (i.e., savings accounts, stocks, bonds, and other assets that can be cashed 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 are not considered resources for the purposes of qualifying for Extra Help.

NOTE: These amounts may change each calendar year. Updated resource limits are typically released each fall for the following calendar year. Updated income limits are usually released each January or February for the same calendar year. Please see Appendix E for more information about the different levels of Extra Help, including the income and resource requirements and benefits for each level of

Extra Help.

Medicare and Full Medicaid

- You are auto-enrolled in a plan unless you
 - Are already in a Medicare drug plan
 - Choose and join a plan on your own
 - Are enrolled in employer/union plan receiving subsidy
 - Call the plan or 1-800-MEDICARE to opt out
- You are covered 1st month you are covered by
 - Medicaid and are entitled to Medicare
- Will get auto-enrollment letter (yellow paper)
- You have a continuous Special Enrollment Period

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Medicare Prescription Drug Coverage

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When people who have full Medicaid benefits, including drug coverage, become entitled to Medicare, Medicaid no longer pays for their Medicare-covered drugs. CMS uses state Medicaid data to identify people with Medicare who have full Medicaid benefits. These individuals are sometimes called full-benefit dual eligibles, and they automatically qualify for Extra Help.

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

New auto-enrollments are identified and processed every month. Plans are randomly chosen from those with premiums at or below the regional low-income premium subsidy amount. CMS chooses plans with premiums at or below that amount so that you will pay no premium if you're qualified for full Extra Help. If you're qualified for partial Extra Help, you will pay a reduced or no premium. People who are already in a Medicare Advantage Plan will be enrolled in the same plan with prescription drug coverage (MA-PD), if offered by the MA organization.

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 effective the first day you have both Medicare and Medicaid. You will get a yellow auto-enrollment notice with the name of the plan assigned to you.

If you don't wish to be in any Medicare drug plan, you can call 1-800-MEDICARE (1-800-633-4227) or the plan in which CMS auto-enrolled you and ask to opt out of Medicare drug coverage. TTY users should call 1-877-469-2048. However, Medicaid will not 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 effective the first of the following month.

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

Others Qualified for Extra Help

- You are facilitated into a plan unless you
 - Are already in a Medicare drug plan
 - Choose and join a plan on your own
 - Are enrolled in employer/union plan receiving subsidy
 - Call the plan or 1-800-MEDICARE to opt out
- Coverage is effective 2 months after CMS notifies
- Will get facilitated enrollment letter (green paper)
- You have a continuous Special Enrollment Period

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Other people who qualify for Extra Help are facilitated into a Medicare drug plan. This is very similar to the auto enrollment process for people who automatically qualify for Extra Help. The difference is the timing of enrollment. Facilitated enrollment is effective two months after CMS receives notice of your eligibility, whereas auto enrollment is effective the first month of eligibility to both Medicare and Medicaid.

CMS uses data submitted by state Medicaid agencies to identify whether you get help from your state Medicaid program paying your Medicare Part B premiums (in a Medicare Savings Program). CMS uses data submitted by Social Security to identify whether you have Medicare and are entitled to Supplemental Security Income (SSI) but not Medicaid, or applied and qualified for Extra Help.

CMS will facilitate you into a plan unless

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

You will receive a facilitated enrollment letter on green paper, in one of two versions—full or partial Extra Help. Both versions of the letter include a list of the plans in your area that are at or below the regional low-income premium subsidy amount, so you can look for other plans that meet your needs.

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

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

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

- Designed to eliminate gaps in coverage for low-income individuals transitioning to Part D coverage
- Provides temporary drug coverage if you have Extra Help and no Medicare drug plan
- Coverage may be immediate, current, and/or retroactive
- Medicare's Limited Income NET Program
 - Has an open formulary
 - Requires no prior authorization
 - Has no network pharmacy restrictions
 - Includes standard safety and abuse edits

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Medicare's Limited Income Newly Eligible Transition Program (Medicare's Limited Income NET Program) is designed to eliminate gaps in coverage for low-income individuals transitioning to Medicare Part D drug coverage. It has been operated by a single contractor, Humana, Inc. on behalf of CMS since January 1, 2010.

Enrollment in Medicare's Limited Income NET Program is temporary and ends prior to the prospective enrollment into a Medicare drug plan. If you're eligible for Extra Help, you will be prospectively enrolled, on a random basis, into a Medicare drug plan with a premium amount at or below the low-income premium subsidy amount.

The Program provides point-of-sale coverage if you receive Extra Help and do not yet have a Medicare drug plan. It also provides retroactive coverage if you have full Medicaid coverage or get Supplemental Security Income (SSI) benefits.

Also, you must

- Have a valid Health Insurance Claim Number (HICN) which is on your Medicare Card;
- Be Part D eligible;
- Not be enrolled in a Part D plan;
- Not be enrolled in an retiree drug subsidy (RDS) plan;
- Not be enrolled in a Part C plan that does not allow concomitant enrollment in a Part D plan;
- Have not opted out of auto-enrollment; and
- Have a permanent address in the fifty States or DC.

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

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

Auto-Enrollment by CMS

- CMS auto-enrolls you if you have Medicare and get either full Medicaid coverage or SSI benefits

Point of Sale (POS) Use

- 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 periods you're eligible

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Medicare Prescription Drug Coverage

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There are three ways you can access Medicare's Limited Income 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 are 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 begins when you first have Medicare and get either full Medicaid coverage or SSI benefits, or the last uncovered month whichever is later.
- **Point-of-Sale (POS) Use.** If you receive Extra Help, you may use Medicare's Limited Income NET Program at the 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.

If you access Medicare's Limited Income NET Program through point of sale (at the pharmacy counter) or by submitting a pharmacy receipt, you may:

- Receive retroactive coverage up to 36 months if you have Medicare and get either full Medicaid coverage or SSI benefits (or as far back as 1/1/2006 if Medicaid determination goes back to that point in time).
- Receive 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 qualified for Extra Help.
- Have immediate coverage if you show evidence of Medicaid or Extra Help eligibility to the pharmacy at point of sale (POS), but your eligibility status cannot be confirmed in CMS' systems.

NOTE: Please see Appendix G for helpful resources about Medicare's Limited Income NET Program.

Re-establishing Eligibility for People Who Automatically Qualify

- CMS re-establishes eligibility each fall for next calendar year
 - If you no longer automatically qualify
 - CMS sends letter in September (gray paper)
 - Includes SSA application
 - If you automatically qualify, but your copayment changed
 - CMS sends letter in early October (orange paper)

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Medicare Prescription Drug Coverage

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Every August, CMS re-establishes Extra Help eligibility for the following calendar year for people who 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 are effective the next January.

People who were automatically eligible in a year continue to qualify for Extra Help through December of that year. If they become no longer eligible, their automatic status ends on December 31 on that year. People who no longer automatically qualify for Extra Help receive a letter from Medicare on gray paper with an Extra Help application from SSA.

Other people may continue to automatically qualify for Extra Help, but their copayment levels may have changed. The change in copayment level could have resulted from a change in one of the following categories to another: they are institutionalized with Medicare and Medicaid, they have Medicare and full Medicaid coverage, they get help from Medicaid paying Medicare premiums (belong to a Medicare Savings Program), or they get Supplemental Security Income benefits but not Medicaid. These people will receive a letter from CMS on orange paper notifying them of the change in their copayment level for the following year.

If people who no longer automatically qualify regain their eligibility for full Medicaid coverage, a Medicare Savings Program, or SSI, CMS will mail 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.

Continuing Eligibility for Extra Help

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

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

- Initial redeterminations - To redetermine eligibility, SSA selects a group of people who are eligible for Extra Help and who may have experienced a change in circumstances which could impact their eligibility for Extra Help. These people receive a redetermination form in the mail in September. The form must be completed and returned within 30 days, even if nothing has changed, or their eligibility for Extra Help may be terminated, effective January 1 of the following 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 receive a redetermination form in the mail in September. They must respond to the form within 30 days of receipt, even if nothing has changed. If they do not complete and return the form, SSA may terminate their eligibility for Extra Help, effective January 1 of the following year.
- Subsidy-changing event (SCE) - People with Extra Help may experience subsidy-changing events (SCE), including marriage, divorce, separation, annulment, and the death of a spouse. They are required to report these events to SSA and complete a special SCE redetermination form or their eligibility for Extra Help may be terminated.
- Other events - Eligibility for Extra Help may also be redetermined by SSA based on other changes, aside from subsidy-changing events (SCE).

Exercise

To be eligible for Extra Help, you must have limited resources and income below:

1. 125% FPL
2. 150% FPL
3. 175% FPL
4. 200% FPL

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To be eligible for Extra Help, you must have limited resources and income below

1. 125% of the Federal Poverty Level
2. 150% of the Federal Poverty Level
3. 175% of the Federal Poverty Level
4. 200% of the Federal Poverty Level

Answer: 2

150% of the Federal Poverty Level. Additionally, you must have resources of less than \$13,070 for an individual or \$26,120 for a married couple.

Exercise

If you receive Extra Help, you have a continuous Special Enrollment Period (SEP).

1. True
2. False

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People receiving Extra Help have a continuous Special Enrollment Period (SEP).

1. True
2. False

Answer: 1. True



Lesson 5 – Comparing and Choosing Plans

- Things to Consider
- Steps to Choosing a Medicare Drug Plan
- What to Expect

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Lesson 5, *Comparing and Choosing Plans*, provides the following information:

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

Things to Consider Before Joining a Plan

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

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

If you currently have prescription drug coverage, you will receive information each year from your plan telling you whether or not the coverage is considered creditable coverage. If you did not receive that information, you should call the benefits administrator for your plan. It is 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. You also 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 dependants.

Information on how different types of current coverage work with Medicare prescription drug coverage is available on www.medicare.gov and by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-469-2048

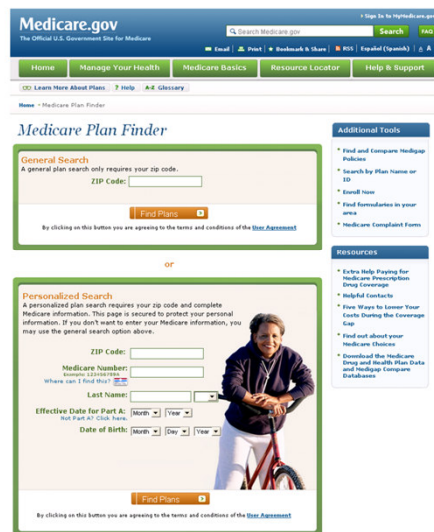
Step 1: Collect Information

- Collect information
 - Current prescription drug coverage
 - Prescription drugs, dosages, and quantities
 - Preferred pharmacy
 - Medicare card
 - ZIP code

Step 1: Collect information about your current prescription drug coverage and needs. Include information about any prescription drug coverage you may currently have, as well as a list of the prescription drugs you currently take, the dosages, and how often you take them. You'll also need your zip code, Medicare card, and the names of any pharmacies you prefer to use.

Step 2: Use the Medicare Plan Finder

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



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Step 2: Use the Medicare Plan Finder (www.medicare.gov/find-a-plan):

- 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

NOTE: For more information about using the Medicare Plan Finder, please see the plan finder Job Aids on your NMTP Resource Card or visit NMTP Training Library located at:

<http://www.cms.gov/NationalMedicareTrainingProgram/TL/list.asp>

Step 3: Decide and Enroll

- Decide which plan is best for you and enroll
 - Mail or fax paper application to plan
 - Online
 - www.medicare.gov
 - Plan's website
 - Telephone
 - 1-800-MEDICARE (TTY 1-877-486-2048)
 - The plan

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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 by telephone, by paper application, or online. You will have to provide the number on your Medicare card when you join.

You can join with the plan directly. All plans must offer paper enrollment applications. In addition, plans have the option to offer enrollment through their website or over the telephone. Most plans also participate and offer enrollment through Medicare's website at 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 is a good idea to keep a copy of your application, confirmation number, any other papers you sign, and letters or materials you receive.

NOTE: These steps, and worksheets to help with this process, are available in *Your Guide to Medicare Prescription Drug Coverage*, CMS publication number 11109.

What New Members Can Expect

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

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If you join a plan, or are enrolled in a plan by CMS, you will 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.

Plans will also have a transition process in place for you if you are new to the plan and taking a non-formulary drug. The plan will provide a 30-day temporary supply of the prescription (a 90-day supply if you are a resident of a long-term care facility). This gives you time to work with your prescribing physician to find a different drug that is 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 denied requests can be appealed.

Annual Notice of Change (ANOC)

- All Medicare drug plans must send to members by September 30th
 - May arrive with Evidence of Coverage
- Will include information for upcoming year
 - Summary of Benefits
 - Formulary
 - Changes
 - New premium
 - Copayments/coinsurance

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

You should read the Annual Notice of Change carefully. The letter will explain any changes to your current plan, including changes to the monthly premium and 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 provides 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.

Exercise

Joining a Medicare drug plan may affect your current health and/or prescription drug coverage.

1. True
2. False

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Joining a Medicare drug plan may affect your current coverage.

1. True
2. False

Answer: 1. True

Exercise

You can use the Medicare Plan Finder to do all of the following, except:

1. Search for health/drug plans
2. Compare plans
3. Enroll in a plan
4. File a plan complaint

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Plan Finder gives you details on all of the following topics except

1. Search for health/drug plans
2. Compare plans
3. Enroll in a plan
4. File a plan complaint

Answer: 4. File a plan complaint



Lesson 6 – Coverage Determinations and Appeals

- Coverage Determinations
- Exceptions
- Appeals

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Lesson 6, *Coverage Determinations and Appeals*, provides the following information:

- Coverage Determinations
- Exceptions
- Appeals

Coverage Determination Request

- Initial decision by plan
 - Which benefits you are entitled to receive
 - How much you are required to pay for a benefit
 - Can be requested by you, your prescriber, or your appointed representative
- Timeframes for coverage determination request
 - May be standard (decision within 72 hours)
 - May be expedited (decision within 24 hours)
 - If life or health is seriously jeopardized

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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're required to pay for a drug. You or your prescriber must contact your plan to ask for a coverage determination, including an exception.

You, your prescriber, or your appointed representative can request 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. You can get a copy of this form at: <http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms.html>

Coverage determinations can be standard or expedited. The request will be expedited if the plan determines, or if your doctor tells the plan, that your life or health will be seriously jeopardized by waiting for a standard request.

A plan must notify you of its coverage determination decision as quickly as your health condition requires, but no later than 72 hours (standard) or 24 hours (expedited) after receiving your request. If a coverage determination request involves an exception, the time clock starts when the plan receives the 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. Their contact information is available at www.medicarepartdappeals.com.

Part D Exception Requests

- Two types of exceptions
 - Tier exceptions
 - e.g., getting Tier 2 drug at Tier 1 cost
 - Formulary exceptions
 - Drug not on plan's formulary or
 - Access requirements (e.g., step therapy)
- Requests can be made by you, your appointed representative, or prescriber
- Requires supporting statement from doctor
- Exception may be valid for remainder of year

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An exception is a type of coverage determination. There are two types of exceptions—tier exceptions (e.g., getting a Tier 2 drug at the Tier 1 cost), and formulary exceptions that either allow coverage for a drug not on the plan's formulary, or relaxed access requirements.

Exception requests require a supporting statement from the prescriber. In general, the statement must indicate the medical reason for the exception. The prescriber may submit the statement orally or in writing.

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.

A plan may choose to extend coverage into a new plan year. If it does not, it must provide you with written notice either at the time the exception is approved, or at least 60 days before the plan year ends. If coverage isn't extended, you should consider switching to a drug on the plan's formulary, requesting another exception, or changing plans during Medicare's Open Enrollment Period (also known as Open Enrollment), which is from October 15 – December 7 each year.

NOTE: If you want to appoint a representative to help you with a coverage determination or appeal, you and the person you want to help you must complete 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. Your letter must include the same information that is requested on the Appointment of Representative form. The form or letter must be sent with your coverage determination or appeal request.

Requesting Appeals

- If your coverage determination or exception is denied, you can appeal the plan's decision
- In general, appeal requests must be written
 - Plans must accept expedited requests orally
- An appeal can be requested by
 - You
 - Your doctor
 - Your appointed representative
- There are 5 levels of appeals

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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 to file an appeal. You should read this decision carefully, and call your plan if you have questions.

In general, appeal requests must be made in writing. However, plans must accept expedited redetermination requests that are submitted orally as well. In addition, plans may choose to accept standard redetermination requests orally. You should consult your plan materials or contact your plans to determine if standard redetermination requests can be submitted orally.

You, or your appointed representative, may request any level of appeal. Your doctor can request an expedited redetermination on your behalf.

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

Exercise

If an exception request is approved, it is usually valid for refills for as long as you are enrolled in the plan.

1. True
2. False

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If an exception request is approved, it is usually valid for refills for as long as you are enrolled in the plan.

1. True
2. False

Answer: 2. False. An exception request is typically valid for the remainder of the plan year (so long as the member remains enrolled in the plan, the physician continues to prescribe the drug, and the drug remains safe for treating the person's condition).

Exercise

If a coverage determination request involves an exception, the clock starts when the plan receives the physician's supporting statement.

1. True
2. False

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If a coverage determination request involves an exception, the clock starts when the plan receives the physician's supporting statement.

1. True
2. False

Answer: 1. True

Medicare Prescription Drug Coverage Resource Guide

Resources	Medicare Products	
<p>www.medicare.gov 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-466-2048)</p> <p>Prescription Drug Benefit Manual www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp</p> <p>PDP Enrollment and Disenrollment Guidance http://www.cms.gov/MedicarePresDrugEligEnrol/01_Overview.asp</p> <p>Local State Health Insurance Programs www.medicare.gov/contacts</p> <p>Centers for Medicare & Medicaid Services www.cms.gov</p> <p>Social Security 1-800-772-1213 www.socialsecurity.gov</p> <p>LI NET Program 1-800-783-1307 1-877-801-0369 (TTY) e-mail : MedicareLINET@cms.hhs.gov</p> <p>Affordable Care Act www.healthcare.gov/law/full/index.htm</p>	<p>RxAssist www.rxassist.org</p> <p>Medicare Part D Appeals www.medicarepartdappeals.com</p> <p>Determining the Part B income-related premium – SSA publication 10161 available at http://www.socialsecurity.gov/pubs/10536.pdf.</p> <p>Information about drugs covered under Parts B & D www.cms.gov/PrescriptionDrugCovContra/</p>	<p>Medicare & You Handbook CMS (Product No. 10050)</p> <p>Your Guide to Medicare Prescription Drug Coverage (CMS Product no. 11109)</p> <p>Your Medicare Benefits (CMS Product No. 10116)</p> <p>Understanding True Out-of-Pocket (TrOOP) Costs (CMS Product No. 11223)</p> <p>To access these products: View and order single copies: www.medicare.gov</p> <p>Order multiple copies (partners only): productordering.cms.hhs.gov (You must register your organization.)</p>

Appendix A: Part B Covered Oral Anticancer Drugs*

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

*List is subject to change

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The oral anti-cancer drugs covered by Part B include, but are not limited to

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

NOTE: This list is subject to change.

Appendix B: Part B Covered Oral Anti-Emetics for Use Within 48 Hours of Chemotherapy*

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

*List is subject to change

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The following lists the oral anti-emetic (anti-nausea) drugs covered under Part B. This is not an exhaustive list and it is possible for the list of drugs to change over time.

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

Appendix C: Part B Covered Immunosuppressive Drugs*

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ Azathioprine-oral ▪ Azathioprine-parenteral ▪ Cyclophosphamide-Oral ▪ Cyclosporine-Oral ▪ Cyclosporine-Parenteral ▪ Daclizumab-Parenteral ▪ Lymphocyte Immune Globulin, ▪ Antithymocyte Globulin-Parenteral ▪ Methotrexate-Oral ▪ Methylprednisolone-Oral | <ul style="list-style-type: none"> ▪ Methylprednisolone Sodium Succinate Injection ▪ Muromonab-Cd3-Parenteral ▪ Mycophenolate Acid-Oral ▪ Mycophenolate Mofetil-Oral ▪ Prednisolone-Oral ▪ Prednisone-Oral ▪ Sirolimus-Oral ▪ Tacrolimus-Oral ▪ Tacrolimus-Parenteral |
|--|--|

*List is subject to change

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This list includes some immunosuppressive drugs covered by Medicare Part B and 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: These drugs may be covered when furnished to an individual who receives 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 conjunction with immunosuppressive drugs as part of a therapeutic regime. Antibiotics, hypertensives, and other drugs not directly related to rejection are not covered.

Appendix D: 2012 Standard Drug Benefit

Benefit Parameters	2011	2012
Deductible	\$310	\$320
Initial Coverage Limit	\$2,840.00	\$2,930.00
Out-of-Pocket Threshold	\$4,550.00	\$4,700.00
Total Covered Drug Spending at OOP Threshold	\$6,483.72	\$6,730.39
Minimum Cost-Sharing in Catastrophic Coverage	\$2.50/\$6.30	\$2.60/\$6.50
Extra Help Copayments	2011	2012
Institutionalized	\$0	\$0
Receiving Home and Community-Based Services (under waiver only)	---	\$0
Up to or at 100% Federal Poverty Level (FPL)	\$1.10/\$3.30	\$1.10/\$3.30
Full Extra Help	\$2.50/\$6.30	\$2.60/\$6.50
Partial Extra Help (Deductible/Cost-Sharing)	\$63/15%	\$65/15%

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

If you have Medicare and...	Your monthly premium	Your yearly deductible	Your cost per prescription at the pharmacy (until \$4,700**)	Your cost per prescription at the pharmacy (after \$4,700**)
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 \$11,170 (single) \$15,130 (married)	\$0	\$0	Generic and certain preferred drugs: no more than \$1.10 Brand-name drugs: no more than \$3.30	\$0
Full Medicaid coverage and have a yearly income above \$11,170 (single) \$15,130 (married)	\$0	\$0	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50	\$0
Help from Medicaid paying your Medicare Part B premiums	\$0	\$0	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50	\$0
Supplemental Security Income (SSI)	\$0	\$0	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50	\$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 you 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 \$4,700 per year. The cost sharing, income levels, and resources listed are for 2012 and can increase each year. Income levels are higher if you live in Alaska or Hawaii, or you or your spouse pays at least half of the living expenses of dependent family members who live with you, or you work.

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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 you 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 \$4,700 per year.

The cost sharing, income levels, and resources listed are for 2012 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 \$4,700**)	Your cost per prescription at the pharmacy (after \$4,700**)
A yearly income below \$15,079.50 (single) \$20,425.50 (married) with resources of no more than \$8,440 (single) \$13,410 (married)	\$0	\$0	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50	\$0
A yearly income below \$15,079.50 (single) \$20,425.50 (married) with resources between \$8,440 and \$13,070 (single) \$13,410 and \$26,120 (married)	\$0	\$65	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50
A yearly income between \$15,079.50 and \$15,638 (single) \$20,425.50 and \$21,182 (married) with resources up to \$13,070 (single) \$26,120 (married)	25%	\$65	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50
A yearly income between \$15,638 and \$16,196.50 (single) \$21,182 and \$21,938.50 (married) with resources up to \$13,070 (single) \$26,120 (married)	50%	\$65	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50
A yearly income between \$16,196.50 and \$16,755 (single) \$21,938.50 and \$22,695 (married) with resources up to \$13,070 (single) \$26,120 (married)	75%	\$65	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50

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 you 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 \$4,700 per year.

The cost sharing, income levels, and resources listed are for 2012 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



Guide to Consumer Mailings from CMS, Social Security and Plans in 2011/2012

(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.	<ul style="list-style-type: none"> If you think you qualify for Extra Help, you should apply. Apply for Extra Help through Social Security.
Mid-May	CMS	LIS Choosers Reminders Notice (Product No. 11465) (TAN Notice)	Reminds people who get Extra Help and chose a drug plan on their own with a premium liability that other drug plans are available for \$0 premium as long as they qualify for Extra Help.	If you're thinking about switching plans, make sure the plan covers the prescriptions you take and includes the pharmacies you use.
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 2012 formulary, benefit design, and/or premium changes.	Review changes to decide whether the plan will continue to meet your needs in 2012.
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 2012 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, 2012.	Apply for Extra Help through Social Security (application and postage-paid envelope enclosed) or a State Medical Assistance (Medicaid) office.

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Appendix F: Guide to Consumer Mailings

Mail Date	Sender	Mailing/Color	Main Message	Consumer Action
Late September	CMS	"Medicare & You" 2012 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 .
October	Plans	Plan Marketing Materials	On October 1, plans begin sending marketing materials for 2012.	Use this information to compare options for 2012.
October	Plans	Plan Non-Renewal Notice	By October 2, people whose 2011 plan is leaving the Medicare program in 2012 will get notices from plans.	You must look for a new plan for coverage in 2012.
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 co-payment levels will change starting January 1, 2012.	<ul style="list-style-type: none"> Keep the notice. No action, unless you believe an error has occurred.
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 will be reassigned to a new Medicare drug plan effective January 1, 2012, unless they join a new plan on their own by December 31, 2011.	<ul style="list-style-type: none"> 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 will be reassigned to a new Medicare drug plan effective January 1, 2012, unless they join a new plan on their own by December 31, 2011.	
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 will be re-assigned to a Medicare drug plan effective January 1, 2012 if they don't join a new MA or PDP plan on their own by December 31, 2011.	<ul style="list-style-type: none"> 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.

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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 drug 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 2012 unless they join a new \$0 premium plan.	<ul style="list-style-type: none"> Keep the notice. You may want to look for a new plan for coverage for 2012 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 2012.	You must look for a new plan for coverage in 2012.
November	Social Security	Social Security Part B & Part D Income-Related Premium Adjustment 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.	<ul style="list-style-type: none"> 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 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.	<ul style="list-style-type: none"> 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 1-800-325-0778).
December	Social Security	Social Security Benefit Rate Change (BR) 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.
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 2011 will be covered in their new 2012 Medicare drug plan.	<ul style="list-style-type: none"> 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; check "Medicare & You"; visit www.medicare.gov; or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.

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Appendix F: Guide to Consumer Mailings

Mail Date	Sender	Mailing/Color	Main Message	Consumer Action
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 2012.	You must join a Medicare drug plan by February 29 if you want Medicare drug coverage for 2012.
Daily - ongoing	CMS	Deemed Status Notice (Product No. 11166) (PURPLE Notice beginning in Sept/Oct)	Informs people that they will 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.	<ul style="list-style-type: none"> 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; 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.	<ul style="list-style-type: none"> 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; 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 - 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.	<ul style="list-style-type: none"> 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; check "Medicare & You"; visit www.medicare.gov; or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.

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Appendix F: Guide to Consumer Mailings

Mail Date	Sender	Mailing/ Color	Main Message	Consumer Action
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.	<ul style="list-style-type: none"> 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; 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.

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

■ Resources

- Program Help Desk: 1-800-783-1307
- Address: The Medicare Limited Income NET Program
P.O. Box 14310
Lexington, KY 40512-4310
- Websites
 - http://www.cms.hhs.gov/LowIncSubMedicarePresCov/03_MedicareLimitedIncomeNET.asp
 - http://www.humana.com/pharmacists/resources/li_net.asp
- CMS Mailbox: MedicareLINET@cms.hhs.gov

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Medicare's Limited Income NET Program is administered by Humana.

Program Help Desk

- 1-800-783-1307

Address for Beneficiaries Who Need to Submit Receipts for Claims Paid Out-of-Pocket

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

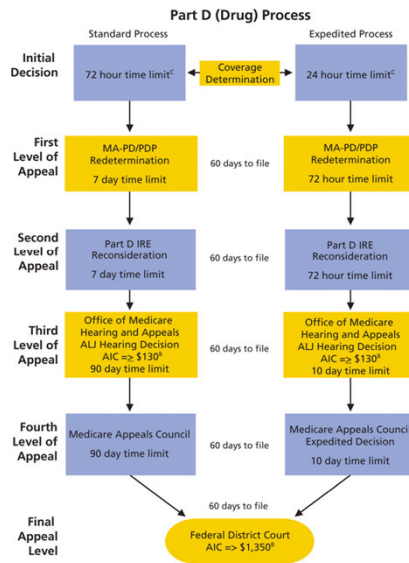
Websites

- CMS
 - http://www.cms.hhs.gov/LowIncSubMedicarePresCov/03_MedicareLimitedIncomeNET.asp
- Humana
 - http://www.humana.com/pharmacists/resources/li_net.asp

Mailbox

- MedicareLINET@cms.hhs.gov

Appendix H: Levels of Appeal



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