Medicare Prescription Drug Coverage
SHIBA and WA Version
Updated August 2018
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Session Objectives

This session should help you

- Differentiate Medicare Part A, Part B, and Part D drug coverage
- Summarize Part D eligibility and enrollment requirements
- Compare and choose drug plans
- Describe Extra Help with drug plan costs
- Explain coverage determinations and the appeals process
Lesson 1—The Basics

- The 4 parts of Medicare
- Prescription drug coverage under
  - Medicare Part A (Hospital Insurance)
  - Medicare Part B (Medical Insurance)
The 4 Parts of Medicare

Throughout this training, these icons are used to identify the part of Medicare being discussed.

Original Medicare
- Part A: Hospital Insurance
- Part B: Medical Insurance

Medicare Advantage
- Part C
- Part A + Part B

Medicare Prescription Drug Coverage
- Part D: Medicare prescription drug coverage

(Usually)
Prescription drug coverage under Original Medicare Part A, Part B, or Part D depends on

- Medical necessity
- Health care setting
- Medical indication (why you need it, like for cancer)
- Any special drug coverage requirements
  - Such as immunosuppressive drugs following a transplant
Part A Prescription Drug Coverage

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

- Part B covers limited outpatient drugs
  - Most injectable and infusible drugs given as part of a doctor’s service
  - Drugs and biologicals
    - Used for the treatment of End-Stage Renal Disease
  - Drugs used at home with some types of Part B covered durable medical equipment
    - Such as nebulizers and infusion pumps
  - Some oral drugs with special coverage requirements like
    - Certain oral anti-cancer and antiemetic drugs
    - Immunosuppressive drugs, under certain circumstances
Part B Immunization Coverage

- Part B covers certain immunizations as part of Medicare-covered preventive services
  - Flu shot
  - Pneumococcal shot (to prevent pneumonia)
  - Hepatitis B shot
- Part B may cover certain vaccines after exposure to a disease or after an injury
  - Tetanus shot
Self-administered Drugs in Hospital Outpatient Settings

- Part B doesn’t cover self-administered drugs in a hospital outpatient setting
  - Unless needed for hospital services
- If enrolled in Part D, drugs may be covered
  - If not admitted to hospital
  - May have to pay and submit for reimbursement
Check Your Knowledge—Question 1

Which part of Medicare pays for drugs used in hospice care for symptom control and pain relief only?

a. Part A
b. Part B
c. Part D
d. None of the above
Medicare Part D doesn’t cover the cost of the flu shot, a preventive service immunization.

a. True
b. False
Lesson 2—Medicare Part D Benefits and Costs

- Medicare prescription drug coverage
- Medicare drug plan benefits and costs
Part D Medicare Prescription Drug Coverage

- Medicare drug plans
  - Approved by Medicare
  - Run by private companies
  - Available to everyone with Medicare

- In most cases, you must join a plan to get coverage

- There are **2 ways** to get coverage
  - Medicare Prescription Drug Plans
  - Medicare Health Plans with prescription drug coverage
Part D Medicare Prescription Drug Plans

- Can be flexible in benefit design
- Must offer at least a standard level of coverage
- Vary in costs and drugs covered
  - Different tier and/or copayment/coinsurance levels
  - Enhanced ("extra") coverage for drugs not typically covered by Part D
- Benefits and costs may change each year
Medicare Drug Plan Costs

- Costs vary by plan
- In 2019, most people will pay
  - A monthly premium
  - A yearly deductible (if applicable)
  - Copayments or coinsurance
  - 25% for covered brand-name drugs in the coverage gap
  - 37% for covered generic drugs in the coverage gap
  - Very little after spending $5,100 out of pocket
Ms. Smith joins a prescription drug plan. Her coverage begins on January 1. She doesn’t get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ms. Smith pays the first $415 of her drug costs before her plan starts to pay its share.</td>
<td>Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches $3,820.</td>
<td>Once Ms. Smith and her plan have spent $3,820 for covered drugs, she’s in the coverage gap. In 2019, she gets a 70% discount from the drug manufacturer on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2019, she gets an additional 5% coverage from her plan on covered brand-name drugs and 63% coverage on covered generic drugs while in the coverage gap.</td>
<td>Once Ms. Smith has spent $5,100 out-of-pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.</td>
</tr>
</tbody>
</table>
## Improved Coverage in the Coverage Gap

<table>
<thead>
<tr>
<th>Year</th>
<th>What You Pay for Covered Brand-Name Drugs in the Coverage Gap</th>
<th>What You Pay for Covered Generic Drugs in the Coverage Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>35%</td>
<td>44%</td>
</tr>
<tr>
<td>2019</td>
<td>25%</td>
<td>37%</td>
</tr>
<tr>
<td>2020</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>
True Out-of-Pocket (TrOOP) Costs

- Expenses that count toward your out-of-pocket threshold ($5,100 in 2019)
- After threshold you get catastrophic coverage
  - You pay only small copayment or coinsurance for covered drugs
- Explanation of Benefits (EOB) shows TrOOP costs to date
- TrOOP transfers if you switch plans mid-year
What Payments Count Toward TrOOP?

**Payments made by**

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

- Most charities (unless they’re established, run, or controlled by the person’s current or former employer or union or by a drug manufacturer’s Patient Assistance Program operating outside Part D)
- Drug manufacturer discounts on brand name/generic drugs under the Medicare Coverage Gap Program
- AIDS Drug Assistance Programs (ADAPs)
What Payments Don’t Count Toward TrOOP?

- The amount paid by a Medicare drug plan
- The monthly drug plan premium
- Drugs purchased outside the U.S. and its territories
- Drugs not covered by the plan
- Drugs excluded from the definition of Part D drug, even in cases where the plan chooses to cover them as a supplemental benefit (like drugs for hair growth)
- Payments made by, or reimbursed to you by
  - Group health or retiree coverage
  - Government-funded programs
  - Other third-party groups
  - Patient Assistance Programs operating outside the Part D benefit
  - Other types of insurance
- Over-the-counter drugs or most vitamins (even if they’re required by the plan as part of step therapy)
Part D Monthly Premium and Income-Related Monthly Adjustment Amounts (IRMAA)

- Based on income above a certain limit
  - Fewer than 5% pay a higher premium
  - Uses same thresholds used to compute IRMAA for the Part B premium
  - Income as reported on your IRS tax return from 2 years ago

- Required to pay if you have Part D coverage
  - Failure to pay will result in disenrollment
### Income-Related Monthly Adjustment Amount (IRMAA)

Chart is based on your yearly income *in 2016* (for what you pay in 2018)

<table>
<thead>
<tr>
<th>Filing an Individual Tax Return</th>
<th>Filing a Joint Tax Return</th>
<th>File Married &amp; Separate Tax Return</th>
<th>In 2018 You Pay Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
<td>$85,000 or less</td>
<td>Your Plan Premium (YPP)</td>
</tr>
<tr>
<td>Above $85,000 Up to $107,000</td>
<td>Above $170,000 Up to $214,000</td>
<td>Not applicable</td>
<td>YPP + $13.00*</td>
</tr>
<tr>
<td>Above $107,000 Up to $133,500</td>
<td>Above $214,000 Up to $267,000</td>
<td>Not applicable</td>
<td>YPP + $33.60*</td>
</tr>
<tr>
<td>Above $133,500 Up to $160,000</td>
<td>Above $267,000 Up to $320,000</td>
<td>Not applicable</td>
<td>YPP + $54.20*</td>
</tr>
<tr>
<td>Above $160,000</td>
<td>Above $320,000</td>
<td>Above $85,000</td>
<td>YPP + $74.80*</td>
</tr>
</tbody>
</table>

*IRMAA is adjusted each year, as it’s calculated from the annual beneficiary base premium.*
Check Your Knowledge—Question 3

Which of the following counts toward your True out-of-pocket (TrOOP) costs?

a. The amount paid by you for your drugs covered under the plan

b. Your monthly drug plan premium

c. Over-the-counter drugs and most vitamins

d. The amount paid by your Medicare drug plan
A small group of people will pay a higher monthly drug plan premium based on their income (as reported on their Internal Revenue Service tax return from 2 years ago).

a. True
b. False
Lesson 3—Medicare Part D Drug Coverage

- Covered and non-covered drugs
- Access to covered drugs
Part D Covered Drugs

- Prescription brand-name and generic drugs
  - Approved by the U.S. Food and Drug Administration
  - Used and sold in United States
  - Used for medically-accepted indications

- Includes drugs, biological products, and insulin
  - And supplies associated with injection of insulin

- Plans must cover a range of drugs in each category

- Coverage and rules vary by plan
Required Coverage

- All drugs in 6 protected categories
  - Cancer medications
  - HIV/AIDS treatments
  - Antidepressants
  - Antipsychotic medications
  - Anticonvulsive treatments
  - Immunosuppressants

- All commercially available vaccines
  - Except those covered under Part B (e.g., flu shot)
Drugs Excluded by Law Under Part D

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

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

### Tier Structure Example

<table>
<thead>
<tr>
<th>Tier</th>
<th>You Pay</th>
<th>Prescription Drugs Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lowest copayment</td>
<td>Most generics</td>
</tr>
<tr>
<td>2</td>
<td>Medium copayment</td>
<td>Preferred, brand name</td>
</tr>
<tr>
<td>3</td>
<td>High copayment</td>
<td>Non-preferred, brand name</td>
</tr>
<tr>
<td>4 or Specialty</td>
<td>Highest copayment or coinsurance</td>
<td>Unique, very high cost</td>
</tr>
</tbody>
</table>
Formulary Changes

- Plans may only change categories and classes at the beginning of each plan year
  - May make maintenance changes during year
    - Such as replacing brand-name drug with new generic
  - May make price changes during year

- Plans usually notify you 60 days before changes
  - You may be able to continue to have your drug covered until end of calendar year
    - You may ask for exception if other drugs don’t work

- Plans may remove drugs withdrawn from the market by the FDA or the manufacturer without a 60-day notification
# How Plans Manage Access to Drugs

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Authorization</strong></td>
<td>Doctor must contact plan for prior approval and show medical necessity before drug will be covered</td>
</tr>
</tbody>
</table>
| **Step Therapy**   | Must first try similar, less expensive drug  
                      Doctor may request an exception if  
                      • Similar, less expensive drug didn’t work, or  
                      • Step therapy drug is medically necessary |
| **Quantity Limits** | 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 |
If Your Prescription Changes

- Get up-to-date formulary information from your plan’s
  - Website
  - Customer service center
- Give your doctor a copy of plan’s formulary if it isn’t prescribed electronically
- If the new drug isn’t on the plan’s formulary
  - You can request an exemption from the plan
  - You may have to pay full price if plan still won’t cover
  - You may consider changing your Part D plan when permissible to one that does cover
Check Your Knowledge—Question 5

Part D covers syringes and needles for the injection of insulin.

a. True  
b. False
Lesson 4—Part D Eligibility and Enrollment

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

- You must have Medicare Part A and/or Part B to join a Medicare Prescription Drug Plan
- You must have Medicare Part A and Part B to join a Medicare Advantage Plan with drug coverage
- You must live in the plan’s service area
  - You can’t be incarcerated
  - You can’t be unlawfully present in the U.S.
  - You can’t live outside the United States
- You must join a plan to get drug coverage (in most cases)
Creditable Drug Coverage

- Current or past prescription drug coverage
  - For example, employer group health plans, retiree plans, Veterans Affairs, TRICARE, the Indian Health Service, and the Federal Employee Health Benefits Program

- Creditable if it pays, on average, as much as Medicare’s standard drug coverage

- Plans inform yearly about whether creditable

- With creditable coverage you may not have to pay a late enrollment penalty
**Initial Enrollment Period (IEP)**

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

<table>
<thead>
<tr>
<th>If You Join</th>
<th>Coverage Begins</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the 3 months before you turn 65</td>
<td>Date eligible for Medicare</td>
</tr>
<tr>
<td>During the month you turn 65</td>
<td>First day of the following month</td>
</tr>
<tr>
<td>During the 3 months after you turn 65</td>
<td>First day of the month after month you apply</td>
</tr>
</tbody>
</table>
When You Can Join or Switch Plans

- Medicare’s Open Enrollment Period is October 15–December 7 each year, coverage starts January 1.

- If you don’t have Medicare Part A coverage, and enroll in Part B during the General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan or a Medicare Advantage plan from April 1–June 30.
  - Coverage for B, D and/or C will start July 1.
When You Can Join or Switch Plans continued

- **NEW in 2019! Medicare Advantage Open Enrollment Period**
  - January 1 – March 31 each year
  - Replaces Medicare Advantage Disenrollment Period

- **One-time option to change:**
  - MAPD to MAPD
  - MAPD to Original Medicare and a Part D plan
  - Original Medicare and a Part D plan to MAPD
  - MA Only plan to MA Only plan
  - MA Only plan to Original Medicare
  - Original Medicare to MA Only plan
Continuous SEP for people with Extra Help is changing in 2019!

• No longer every month
• Change plans once per calendar quarter in first 3 quarters of the year
• To change plans in 4th quarter, would use Annual Open Enrollment Period
• Will provide more detailed information once it is available
Other Special Enrollment Periods (SEP)

- Life events that allow an SEP include
  - You permanently move out of your plan’s service area
  - You lose other creditable prescription coverage
  - You weren’t properly told that your other coverage wasn’t creditable, or your other coverage was reduced and is no longer creditable
  - You enter, live at, or leave a long-term care facility
  - You belong to a State Pharmaceutical Assistance Program
  - You join or switch to a plan that has a 5-star rating
  - Other exceptional circumstances
5-Star Special Enrollment Period (SEP)

- Use Medicare Plan Finder tool at Medicare.gov to see quality and performance ratings.
- Star ratings are given once a year in October for the past year.
- Use 5-star SEP to switch to any 5-star plan one time:
  - December 8–November 30 of following year
  - Coverage starts first day of month after enrolled.
- Be careful not to switch from a Medicare Advantage (MA) Plan with drug coverage to an MA Plan with no Part D coverage.
Part D Late Enrollment Penalty

- Higher premium if you wait to enroll
  - Exceptions if you have
    - Creditable coverage
    - Extra Help
- Pay penalty for as long as you have coverage
  - 1% of base beneficiary premium ($35.02 in 2018)
    - For each full month eligible and not enrolled
  - Amount changes every year
Life events that allow a Special Enrollment Period (SEP) don’t include

a. You permanently move out of your plan’s service area

b. You weren’t properly told that your other coverage wasn’t creditable, or your other coverage was reduced and is no longer creditable

c. You lose other creditable prescription coverage

d. You begin hospice care
Lesson 5—Extra Help With Part D Drug Costs

- What’s Extra Help?
- 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

- For people with limited income and resources
  - Lowest income and resources
    - Pay no premiums or deductible and small or no copayments
  - Slightly higher income and resources
    - Pay a reduced deductible and a little more out of pocket

- No coverage gap or late enrollment penalty if you qualify
2018* Extra Help
Income and Resource Limits

- **Income limits**
  - Below 150% of the federal poverty level
    - $18,456 per year for an individual, or $24,936 per year for a married couple
  - Based on family size

- **Resources limits**
  - Up to $14,100 for an individual, or $28,150 for a married couple
    - Doesn’t include $1,500/person for funeral or burial expenses
    - Counts savings and investments
    - Real estate (except your home)

*2019 Limits not yet available
Qualifying for Extra Help

You automatically qualify for Extra Help if you get

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

All others must apply

- Online at ssa.gov/medicare/prescriptionhelp/
- Call Social Security (SSA) at 1-800-772-1213
- TTY: 1-800-325-0778
  - Ask for “Application for Help With Medicare Prescription Drug Plan Costs” (SSA-1020)
- Contact your state Medicaid agency
### 2019 Extra Help Copayments

<table>
<thead>
<tr>
<th>Extra Help Copayments</th>
<th>2018 Generic/Brand-name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized (Level 3)</td>
<td>$0</td>
</tr>
<tr>
<td>Receiving Home and Community-Based Services (under waiver only) (Level 3)</td>
<td>$0</td>
</tr>
<tr>
<td>Up to or at 100% Federal Poverty Level (Level 2)</td>
<td>$1.25/$3.80</td>
</tr>
<tr>
<td>Full Extra Help (Level 1)</td>
<td>$3.40/$8.50</td>
</tr>
<tr>
<td>Partial Extra Help (Deductible/Cost-Sharing) (Level 4)</td>
<td>$85.00/15%</td>
</tr>
</tbody>
</table>
Medicare’s Limited Income Newly Eligible Transition (NET) Program

- Designed to remove gaps in coverage for low-income individuals moving to Part D coverage
- Gives temporary drug coverage if you have Extra Help and no Medicare drug plan
- Coverage may be immediate, current, and/or retroactive
- Medicare’s Limited Income NET Program
  - Has an open formulary
  - Doesn’t require prior authorization
  - Has no network pharmacy restrictions
- Run by Humana- Pharmacy can call Help Desk 1-800-783-1307
Reassignment Notices

- People reassigned notified by CMS early November (BLUE paper)
  - People whose plans are leaving the Medicare Program
  - People whose premiums are increasing

See *Guide to consumer mailings from CMS, Social Security, & plans in 2018/2019*

Changes in Qualifying for Extra Help

Medicare reestabilishes eligibility each fall for next year

- If you no longer automatically qualify
  - Medicare sends “Loss-of-Deemed-Status” notice in September (GRAY paper)
    - Includes Social Security application to reapply
- If your status changes and you again automatically qualify
  - Medicare sends “Deemed Status” notice (PURPLE paper)
- If you automatically qualify, but your copayment changed
  - Medicare sends “Change in Extra Help Co-payment” notice in early October (ORANGE paper)
You automatically qualify for Extra Help if you get

a. Help from Medicaid paying your Part B premium (Medicare Savings Program)

b. Full Medicaid coverage

c. Supplemental Security Income

d. All of the above
Lesson 6—Comparing and Choosing Plans

- 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?
  - Is any prescription drug coverage you might have as good as (creditable) Medicare drug coverage?
  - How does your current coverage work with Medicare?
  - Could joining a plan affect your current coverage or family member’s coverage?
Steps to Choosing a Medicare Drug Plan

1. Prepare
2. Compare plans on the Medicare Plan Finder
3. Decide and enroll
Step 1: Prepare

Prepare by getting your information together

- Current prescription drug coverage
- Prescription drugs, dosages, and quantities
- Preferred pharmacies
- Medicare card
- ZIP code
Step 2: Compare Plans on Medicare Plan Finder

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on star ratings, benefits, costs, and more
Step 3: Decide and Join

- Decide which plan is best for you and enroll
  - Online enrollment
    - Medicare.gov/find-a-plan
    - Plan’s website
  - Enroll by phone
    - Call 1-800-MEDICARE (1-800-633-4227)
    - TTY: 1-877-486-2048
    - Call the plan
  - Mail or fax paper application to plan
What New Members Can Expect

- Your plan will send you
  - An enrollment letter
  - Membership materials, including card
  - Customer service contact information

- If your current drug isn’t covered by plan
  - You can get a transition supply (generally 30 days)
  - Work with prescriber to find a drug that’s covered
  - Request an exception if no acceptable alternative drug is on the list
All Medicare drug plans must send an ANOC to members by September 30
  • May be sent with Evidence of Coverage (EOC)
Will include information for upcoming year
  • Summary of Benefits
  • Formulary
  • Changes to monthly premium and/or cost sharing
Read ANOC carefully and compare your plan with other plan options
Lesson 7—Coverage Determinations and Appeals

- Coverage determinations
- Exception requests
- Appeals
Coverage Determination Request

- Initial decision by plan
  - Which benefits you’re entitled to get
  - How much you have to pay for a benefit
  - You, your prescriber, or your appointed representative can request it

- Time frames for coverage determination request
  - May be standard (decision within 72 hours)
  - May be expedited (decision within 24 hours) if life or health may be seriously jeopardized
Exception Requests

- Two types of exceptions
  - Formulary exceptions
    - Drug not on plan’s formulary, or
    - Access requirements (for example, step therapy)
  - Tier exceptions
    - For example, getting a tier 4 drug at tier 3 cost
- Need supporting statement from prescriber
  - You, your prescriber, or your appointed representative can request it
- Exception may be valid for rest of year
Requesting Appeals

- If your coverage determination or exception is denied, you can appeal the plan’s decision.
- Request must generally be in writing.
  - Plans must accept oral (spoken) expedited requests.
  - You, your prescriber, or your appointed representative can request it.
- There are 5 levels of appeals.
  - Read notices carefully to find next steps and time limits.
Key Points to Remember

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

<table>
<thead>
<tr>
<th>Resources</th>
<th>Products</th>
</tr>
</thead>
</table>
| **Centers for Medicare & Medicaid Services (CMS)**  
- Call 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048.  
- [Medicare.gov](https://www.medicare.gov)  
- [CMS.gov](https://www.cms.gov) | **Prescription Drug Benefit Manual**  
- [CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html](https://www.cms.gov/Medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html) |
| **Social Security**  
- Call 1-800-772-1213. TTY: 1-800-325-0778.  
- [ssa.gov](https://www.ssa.gov) | **PD Enrollment and Disenrollment Guidance**  
| **State Health Insurance Assistance Programs and State Insurance Departments** | **Medicare Premiums: Rules for Higher-Income Beneficiaries**  
- [ssacenter.org/](https://www.shiptacenter.org/) |  
| **Limited Income NET Program (Humana)**  
- Call 1-877-783-1307 or 711 (TRS)  
| **National Training Program – Partner Job Aids**  
## Medicare Prescription Drug Coverage Resource Guide (continued)

<table>
<thead>
<tr>
<th>Products (continued)</th>
<th>1. “Your Guide to Medicare Prescription Drug Coverage” (CMS Product No. 11109)</th>
<th>8. “LI NET for People at Pharmacy Counter” (CMS Product No. 11328-P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. “Medicare Drug Coverage Under Medicare Part A, B, &amp; D” (CMS Product No. 11315-P)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. “Handling Medicare Part D Complaints” (CMS Product No. 11259-P)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. “How Retiree Coverage Works With Medicare Prescription Drug Coverage” (CMS Product No. 11403-P)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To access these products:

- View and order single copies at [Medicare.gov/publications](http://Medicare.gov/publications).
- Order multiple copies (partners only) at [Productordering.cms.hhs.gov](http://Productordering.cms.hhs.gov). You must register your organization.
Acronyms

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

**MAC** Medicare Administrative Contractor
**MA-PD** Medicare Advantage Plans With Prescription Coverage
**MSP** Medicare Savings Program
**MTM** Medication Therapy Management
**NET** Newly Eligible Transition
**NTP** National Training Program
**PDP** Prescription Drug Plan
**POS** Point-of-Sale

**RRB** Railroad Retirement Board
**SCE** Subsidy-Changing Event
**SEP** Special Enrollment Period
**SNF** Skilled Nursing Facility
**SSA** Social Security
**SSI** Supplemental Security Income
**TrOOP** True Out-of-Pocket
**TTY** Teletypewriter
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