

## Chapter Five

# Medicare Part D (Prescription Drug Coverage)

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# Chapter Five: Medicare Part D

## Medicare Part D

Medicare Part D provides prescription drug coverage. Benefits are provided by many different private drug plans that contract with Medicare. People who get their Medicare health benefits through original Medicare can get Medicare Part D through a stand-alone Prescription Drug Plan, referred to as a PDP. California has 25 of these plans available in 2018. Those who get their health benefits through a Medicare Advantage plan can get their prescription drug benefit as part of that managed care plan. Medicare Advantage plans that include Part D coverage are referred to as MA-PDs. Their availability varies by county.

### Enrollment

All Medicare recipients are eligible for the program. Dual eligible recipients (those with both Medi-Cal and Medicare coverage) are automatically enrolled in the program. All others who receive the Low Income Subsidy (“Extra Help”), including individuals in Medicare Savings Programs, have enrollment facilitated into a Part D plan.

Most participants in Medicare Part D can only switch Part D plans during the annual open enrollment period, from October 15 to December 7. There are some exceptions, such as when a person is new to Medicare, or moves out of state, or loses an alternative source of prescription drug coverage. Dual eligibles and other people who get the Low Income Subsidy or “Extra Help,” however, can switch plans any time during the year. Individuals living in institutions such as nursing homes also can change plans at any time.

### Late Enrollment Policy

Beneficiaries who do not enroll in Part D when they first become eligible potentially face increased monthly premiums if they sign up later. The late enrollment penalty, which is based on the national average premium, is \$.35 in 2018 for each uncovered month. The penalty is permanent and continues for as long as the person has Part D coverage. The penalty does not apply to people with other drug coverage that is at least as good as Part D coverage. This is called “creditable coverage.” Employers, unions, the Veterans Administration and others operating those plans are required to send notices to their members with Medicare and tell them whether the drug coverage in their plan is at least as good as Part D coverage. People who do not sign up for Part D because of other coverage should keep those notices to prove that the penalty does not apply to them. The penalty is waived for people who qualify for the Low Income Subsidy.

**NOTE:** *People with incomes above \$85,000 for an individual or \$170,000 for a couple will be required to pay a monthly surcharge to their Part D premium called the Income-Related Monthly Adjustment Amount, (IRMAA).*

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## Part D Costs

Medicare beneficiaries have a number of out-of-pocket costs associated with Part D. People with low incomes are subsidized for many of these out-of-pocket costs. Premium amounts vary widely depending on the plan: the cheapest monthly PDP premium in California in 2018 is \$19.70, and the most expensive is \$169.80. Without a subsidy, beneficiaries also may need to make significant payments. Beneficiaries with higher incomes who pay a higher Part B premium will also pay a higher Part D premium; this affects those with incomes of at least \$85,000 for an individual, and \$170,000 for a couple.

Plans are permitted to impose a deductible of up to \$405. Once the deductible is met, beneficiaries must still pay co-payments for each medication they receive. Plans typically have up to five co-payment tiers. Co-payment amounts can also vary depending on whether a beneficiary uses a preferred or non-preferred pharmacy or uses a mail order option.

Most Part D plans also have a coverage gap, referred to by many as the “donut hole.” Once a beneficiary’s drug costs reach about \$3,750 in 2018 (this amount may vary depending on the plan), the beneficiary is in the “donut hole.” Although in the past the beneficiary paid all costs while in the “donut hole,” health care reform laws have changed this. While in the “donut hole,” the cost-sharing for 2018 is 35% of covered brand name drugs, and 44% of generics. Once these out-of-pocket costs exceed \$5,000, Part D catastrophic coverage begins and co-pay liability is significantly reduced. Enrollees must continue to pay premiums even when they are in the donut hole.

The donut hole will be eliminated in 2019.

Beneficiaries needing a drug on a non-preferred tier can file a “tiering exception” if they can show that a similar drug is available on a lower cost tier, but that the lower-priced drug will not work as effectively for them. They can then get the lower co-payment. Tiering exceptions are not available if the needed drug is on a “specialty tier.”

*The Plan Finder at [www.medicare.gov](http://www.medicare.gov) is the best tool available to help individuals decide on a Part D plan. The Plan Finder shows whether a plan covers particular drugs and if any restrictions apply. It also estimates total costs based on a combination of premiums, deductibles and co-payments for the drugs the individual lists, allowing for comparisons among plans.*

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## Low Income Subsidy

A Low Income Subsidy program for Part D (also called “Extra Help”) provides subsidies automatically for beneficiaries who are dual eligibles receiving Medi-Cal benefits (including Medicare Savings Program enrollees). People who do not receive Medi-Cal benefits but who have incomes at or below 150% of the poverty level also can receive the Low Income Subsidy, but they must apply. For 2018, the threshold for 150% of the poverty level is \$18,450 in annual income for an individual and \$24,930 for a couple (including \$20/mo. income disregard); asset value may not exceed \$1,340 and \$2,150, respectively.

They can apply through the Social Security Administration. Individuals are divided into categories based on their income and asset levels. Those who apply based on income will pay either no premium or a reduced premium. They will pay no deductible or a low deductible. They will have lower co-pays and they will not face the donut hole.

Dual eligible beneficiaries receive prescription drugs with no cost for premiums, no deductibles and no donut hole. Co-pays for each prescription filled range from \$1.25 to \$8.35, depending upon their income, and whether the drug is generic or brand name. Dual-eligible residents of nursing homes have no co-pays and have additional protections.

Most dual eligibles receiving home and community-based services in the community also are eligible for zero co-pays. Only certain Part D plans, those with monthly premiums below a “benchmark” amount, are available to people receiving the full Low Income Subsidy with zero premium. They can choose to enroll in plans with higher premiums, but they must pay the difference between the benchmark amount and the monthly premium. Plan premiums change every year, and the “benchmark” amount also changes. This means that every year some dual eligibles have to face the choice of either changing plans or having to pay some premium. For 2018, the benchmark amount in California is \$35.51. Five California PDP plans are below the benchmark.

Problems also can arise for Medi-Cal recipients who start to qualify for Medicare on the basis of age or disability. Once they qualify for Medicare, most of their Medi-Cal prescription drug coverage stops immediately and they must get their drug coverage through Medicare Part D. For these new dual eligible beneficiaries, the transition of prescription drug coverage from Medi-Cal to Medicare Part D can be hard. The “Limited Income Newly Eligible Transition Program” (LI-NET), currently contracted to Humana, functions as a safety net during the transition.

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## Medication Choice

Every Part D plan has its own formulary, a list of drugs that the plan covers. A plan formulary can also contain restrictions, such as requirements that one drug be tried before another can be approved, or limits on the number of doses of a medication. Part D plans tend to be more restrictive than Medi-Cal in covering various medications. Though not every drug is covered, plans are required to have at least two drugs within each pharmaceutical category. If a patient needs medication not covered by the plan, she or her doctor may file for an “exception.” Plans are required to make exception decisions within 24 or 72 hours of receipt of a supporting statement by the prescriber, depending on medical urgency. Five subsequent levels of appeal are available if beneficiaries are unsatisfied with the result of their initial appeal.

For prescription coverage, medication must be purchased in the United States. Only drugs that are approved by the Food and Drug Administration are covered. When a drug is prescribed for an off-label use not specifically approved by FDA, it can only be covered if the use is supported by a citation in a compendium such as DRUGDEX. Drugs brought in from Mexico, Canada, or elsewhere are not covered, nor do expenditures on such medicines count towards a beneficiary’s deductible or out-of-pocket expenses. Over-the-counter drugs also generally are not covered. These choice restrictions may not be appealed.

***Note:** Transitions between plans can cause disruption. A plan must provide a 30-day supply (unless less is prescribed) on an ongoing prescription within the first 90 days of membership in the new plan. Transition supplies also are available when a plan changes its formulary at the start of a plan year. Special transition protections apply to nursing home residents and people changing care settings, for example, someone returning to the community after a nursing home stay. For details, see “Medicare Part D-2017 Transition Rights” at [www.justiceinaging.org](http://www.justiceinaging.org).*

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## Common Medicare Part D Problems and Solutions

### Medicare Beneficiary Isn't Enrolled in a Part D Plan

**Problem:** Medicare beneficiaries may think that they have prescription drug coverage, but the pharmacist is unable to find a record of enrollment in a particular plan.

**Solution:** Most Medicare beneficiaries (other than dual eligibles and other low income individuals) must take affirmative action to sign up for Medicare Part D. They can sign up by calling 1-800-MEDICARE, by using the “Plan Finder” on [www.medicare.gov](http://www.medicare.gov), by calling the plan, or by contacting their local HICAP (contact information for HICAPs is at the end of this chapter). In general, Medicare participants can only sign up during the annual open enrollment period (October 15 - December 7) or during a “Special Enrollment Period” (SEP) (for instance, after losing other creditable drug coverage). Low income beneficiaries have more options for enrollment. Medicare will automatically enroll dual eligible beneficiaries and other recipients of the Low Income Subsidy who are not already in a drug plan. The LI-NET program will assist these individuals in getting immediate coverage and provides retroactive coverage for dual eligibles (see Supplemental Materials for more on LI-NET).

These individuals may also pick their own plan via 1-800-MEDICARE or [www.medicare.gov](http://www.medicare.gov), by calling a plan, or with assistance from HICAP. Recipients of the Low Income Subsidy also have a special right to switch plans in any month, effective the next month, if the plan that they are in does not meet their needs.

Dual eligible beneficiaries and Low Income Subsidy recipients who go to the pharmacy and learn that they are not in a plan can get immediate temporary coverage at the pharmacy through LI-NET. They will remain in LI-NET for two months and then be auto-enrolled in a benchmark plan unless they affirmatively choose a plan.

**Note:** Starting in January 2019, low income beneficiaries with Extra Help will only have one opportunity per quarter to change plans, unless they also qualify for another Special Enrollment Period.

### Low Income Subsidy Doesn't Show Up at Pharmacy

**Problem:** Sometimes a Medicare beneficiary who is already enrolled in a plan will go to the pharmacy and find that he is being charged full cost-sharing (e.g., a deductible or 25% of the drug cost) because the pharmacist does not have current Low Income Subsidy information.

**Solution:** The beneficiary should contact the Part D plan he is enrolled in and provide evidence showing current eligibility for either Medi-Cal or the Low Income Subsidy. Evidence could be a Medi-Cal card, a letter from the Social Security Administration, or contact information for a Medi-Cal caseworker who can verify that the individual is eligible for Medi-Cal. Sometimes the pharmacist can help to forward the information, so that the beneficiary can get needed drugs right away. Part D plans are supposed to accept evidence that a person is entitled to the Low Income Subsidy. If a plan still refuses to update its system with current Low Income Subsidy status, beneficiaries or advocates should file a complaint with 1-800-MEDICARE or the Centers for Medicare and Medicaid Services (CMS) Regional Office. *(cont'd on next page)*

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Individuals who cannot provide the required evidence of Medi-Cal eligibility can contact the plan and ask for assistance. The plan is required to contact the Regional Office, which will contact Medi-Cal to confirm the individual's Medi-Cal eligibility. If a plan refuses to provide this assistance, advocates should file a complaint.

In some cases, dual eligible beneficiaries and other Low Income Subsidy recipients who overpaid for drugs can get retroactively reimbursed. Beneficiaries should save their receipts and contact the Part D plan about reimbursement. If there are long delays, they should contact HICAP or a local advocacy office for help.

***Note:** Beneficiaries should tell their plan that they are calling about “best available evidence” of Low Income Subsidy status. Using that term will help ensure that their call is handled properly.*

## Plan Refuses to Pay for a Drug

**Problem:** Part D plans will refuse to pay for specific drugs that are not on the plan's formulary, its list of covered drugs. Plans may also refuse to pay for a drug because the prescription does not meet the plan's special restrictions. For instance, a plan may have a dosage limitation that limits covered drugs to a certain number of doses per month.

**Solution:** The beneficiary should talk to her doctor to decide whether to switch to a different medication that is on the plan's formulary. If the doctor and beneficiary decide that switching would not be appropriate for the beneficiary's health, then the beneficiary can file an exception with the plan, requesting coverage for the drug. The doctor must provide a supporting statement showing that the requested drug is “medically necessary.” If the plan denies the request, there are several levels of appeal. The denial letter will explain why coverage was denied and how to ask for reconsideration. To be successful in an appeal, beneficiaries need the cooperation of their doctor.

If the beneficiary is new to the plan and has already been taking a drug, she may be entitled to a 30-day transition supply of the drug. If a current member is taking a drug and the plan takes the drug off its formulary for a new plan year, the member also is entitled to a 30-day transition supply. Nursing home residents are entitled to 90-day transition supplies. For newly prescribed drugs, plans are not required to give transition supplies. Again, nursing home residents have more protections.

Because people who qualify for the Low Income Subsidy (including dual eligible beneficiaries) and institutionalized individuals have the right to change plans once a month, they often find that the simplest way to get the drugs they need is to change to another plan that covers their prescribed medications. Advocates can help the beneficiary choose a different plan using the Plan Finder at [www.medicare.gov](http://www.medicare.gov), by calling 1-800-MEDICARE, or by contacting their local HICAP. Plan enrollment changes are effective the first day of the month following the date of the request.

Medi-Cal will cover some drugs for dual eligibles, including certain over-the-counter drugs, if Medicare Part D does not. Also some drugs that are not covered by Medicare Part D are covered by Medicare Part B.

Detailed information on how to appeal a plan's denial of prescription drug coverage is available at [www.medicareinteractive.org/get-answers-medicare-rights-and-appeals/](http://www.medicareinteractive.org/get-answers-medicare-rights-and-appeals/)

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## Filing a Medicare Part D Complaint

The Centers for Medicare and Medicaid Services (CMS, the agency that administers Medicare Part D) recommends that beneficiaries try first to fix problems directly with their plan. If they are unsuccessful, they should file a complaint with 1-800-MEDICARE. When filing a complaint, it's important to explain if a beneficiary has little or no medication left, stating the number of days of medication the beneficiary has remaining, because urgent complaints are given higher priority.

Sometimes people have trouble reaching the 1-800-MEDICARE number, experience long wait times or receive incorrect information. If you receive information that sounds wrong to you, or if you are unable to get a response, hang up and call again. Whenever possible, write down the time you called and the name of the person with whom you spoke.

If calling 1-800-MEDICARE does not resolve a complaint, Justice in Aging also recommends sending complaints to CMS in writing. This provides proof of when the complaint was made. Complaints can be filed online with CMS using a complaint form available at [www.medicare.gov](http://www.medicare.gov). You can also file complaints with the CMS regional office. The email address for Region 9 (which includes California) is [Part-DComplaints\\_RO9@cms.hhs.gov](mailto:Part-DComplaints_RO9@cms.hhs.gov), and the mailing address is CMS Region 9, 90 Seventh Street, Suite 5-300 (5W), San Francisco, CA 94103-6706. The phone number for the regional office is 415-744-3605. Complaints are worth filing because they provide CMS with important information about problems faced by beneficiaries.

**Note:** *Complaints, also referred to as “grievances,” are different from appeals of decisions to deny drug coverage because a drug is not on the plan formulary or because a utilization management requirement has not been met. Complaints cover such things as a plan not following its own procedures, rude service, inability to reach a representative and similar matters.*

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## Consumer Information

- CMS - (Centers for Medicare and Medicaid Services) 1-800-MEDICARE, [www.medicare.gov](http://www.medicare.gov)
- Justice in Aging, [www.justiceinaging.org](http://www.justiceinaging.org)
- HICAP – (Health Insurance Counseling and Advocacy Program) 1-800-434-0222
- Medicare Rights Center, [www.medicarerights.org](http://www.medicarerights.org)
- California Health Advocates 916-231-5110, [www.cahealthadvocates.org](http://www.cahealthadvocates.org)
- Medicare and You Handbook 2018, [www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf](http://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf)
- Legal Services Programs (Bet Tzedek, local legal aid organization)
- Center for Medicare Advocacy, [www.medicareadvocacy.org](http://www.medicareadvocacy.org)
- Kaiser Family Foundation, [www.kff.org/medicare](http://www.kff.org/medicare)

## Legal Citation, Reference

### Statute

42 U.S.C. §1395w-101 et. seq.

### Regulations, Program Manuals

42 C.F.R. § 423 et. seq.

20 C.F.R. § 418.3001 (Low Income Subsidy Regulations)

POMS HI 03001.001, HI 03001.015, HI 03050.005 (POMS is the Social Security Administration's Program Operations Manual System, the manual used by Social Security Administration employees to administer its programs.)

CMS Prescription Drug Benefit Manual,

[www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html)

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## Supplemental Materials

CMS, Understanding Medicare Part C & D Enrollment Periods,  
[www.medicare.gov/Pubs/pdf/11219-Understanding-Medicare-Part-C-D.pdf](http://www.medicare.gov/Pubs/pdf/11219-Understanding-Medicare-Part-C-D.pdf).....5-10

CMS, Medicare's Limited Income NET Program,  
[www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11328-P.pdf](http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11328-P.pdf)..5-22

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Revised December 2017

## **Understanding Medicare Part C & Part D Enrollment Periods**

Enrollment in Medicare is limited to certain times. You can't always sign up when you want, so it's important to know when you can enroll in the different parts of Medicare. This tip sheet is designed to help you learn more about enrolling in Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D), including who can sign up, when you can sign up, and how the timing, including signing up late, can affect your costs.

**Note:** For information about signing up for Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), visit [Medicare.gov/publications](https://www.Medicare.gov/publications) to view the booklet "Enrolling in Medicare Part A & Part B."

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## **When can I sign up?**

There are specific times when you can sign up for a Medicare Advantage Plan (like an HMO or PPO) or Medicare prescription drug coverage, or make changes to coverage you already have:

- During your Initial Enrollment Period when you first become eligible for Medicare or when you turn 65. See page 3.
- During certain enrollment periods that happen each year. See page 5.
- Under certain circumstances that qualify you for a Special Enrollment Period (SEP), like:
  - You move.
  - You're eligible for Medicaid.
  - You qualify for Extra Help with Medicare prescription drug costs.
  - You're getting care in an institution, like a skilled nursing facility or long-term care hospital.
  - You want to switch to a plan with a 5-star overall quality rating. Quality ratings are available on Medicare.gov.

See the charts beginning on page 7 for a list of different SEPs, including rules about how to qualify.

## **Note about joining a Medicare Advantage Plan**

You must have Medicare Part A and Part B to join a Medicare Advantage Plan. In most cases, if you have End-Stage Renal Disease (ESRD), you can't join a Medicare Advantage Plan.

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## Initial Enrollment Periods

If this describes you...	You can...	At this time...
<p><b>You're newly eligible for Medicare because you turn 65.</b></p>	<p>Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.</p>	<p>During the 7-month period that starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.</p> <p>If you sign up for a Medicare Advantage Plan during this time, you can drop that plan at any time during the next 12 months and go back to Original Medicare.</p>
<p><b>You're newly eligible for Medicare because you have a disability and you're under 65.</b></p>	<p>Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.</p>	<p>Starting 21 months after you get Social Security or Railroad Retirement Board (RRB) disability benefits. Your Medicare coverage begins 24 months after you get Social Security or RRB benefits. Your chance to sign up lasts through the 28th month after you get Social Security or RRB benefits.</p>
<p><b>You're already eligible for Medicare because of a disability, and you turn 65.</b></p>	<ul style="list-style-type: none"> <li>▪ Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.</li> <li>▪ Switch from your current Medicare Advantage or Medicare Prescription Drug Plan to another plan.</li> <li>▪ Drop a Medicare Advantage or Medicare Prescription Drug Plan completely.</li> </ul>	<p>During the 7-month period that starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.</p>
<p><b>You have Medicare Part A coverage, and you get Part B for the first time by enrolling during the Part B General Enrollment Period (January 1–March 31).</b></p>	<p>Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.</p>	<p>Between April 1–June 30.</p>

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## **Part D late enrollment penalty**

The late enrollment penalty is an amount that's added to your Part D premium. You may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. If you have a penalty, you may have to pay it each month for as long as you have Medicare drug coverage. For more information about the late enrollment penalty, visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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## Enrollment periods that happen each year

Each year, you can make changes to your Medicare Advantage or Medicare prescription drug coverage for the following year. There are 2 separate enrollment periods each year. See the chart below for specific dates.

During this enrollment period...	You can...
<p><b>October 15–December 7</b>  <b>Medicare Open Enrollment Period</b>            (Changes will take effect on January 1.)</p>	<ul style="list-style-type: none"> <li>▪ Change from Original Medicare to a Medicare Advantage Plan.</li> <li>▪ Change from a Medicare Advantage Plan back to Original Medicare.</li> <li>▪ Switch from one Medicare Advantage Plan to another Medicare Advantage Plan.</li> <li>▪ Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage.</li> <li>▪ Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage.</li> <li>▪ Join a Medicare Prescription Drug Plan.</li> <li>▪ Switch from one Medicare Prescription Drug Plan to another Medicare Prescription Drug Plan.</li> <li>▪ Drop your Medicare prescription drug coverage completely.</li> </ul>
<p><b>January 1–February 14</b>  <b>Medicare Advantage Disenrollment Period</b></p>	<ul style="list-style-type: none"> <li>▪ If you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare. Your Original Medicare coverage will begin the first day of the following month.</li> <li>▪ If you switch to Original Medicare during this period, you'll have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Your prescription drug coverage will begin the first day of the month after the plan gets your enrollment form.</li> </ul> <p><b>Note:</b> During this period, you <b>can't</b>:</p> <ul style="list-style-type: none"> <li>▪ Switch from Original Medicare to a Medicare Advantage Plan.</li> <li>▪ Switch from one Medicare Advantage Plan to another.</li> <li>▪ Switch from one Medicare Prescription Drug Plan to another.</li> <li>▪ Join, switch, or drop a Medicare Medical Savings Account Plan.</li> </ul>

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## **Special Enrollment Periods**

You can make changes to your Medicare health and Medicare prescription drug coverage when certain events happen in your life, like if you move or you lose other insurance coverage. These chances to make changes are called Special Enrollment Periods (SEPs) and are in addition to the regular enrollment periods that happen each year. Rules about when you can make changes and the type of changes you can make are different for each SEP.

The SEPs listed on the next pages are examples. **This list doesn't include every situation.** For more information about SEPs, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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## Changes in where you live

If this describes you...	You can...	At this time...
You move to a new address that isn't in your plan's service area.*	Switch to a new Medicare Advantage or Medicare Prescription Drug Plan.	If you tell your plan <b>before</b> you move, your chance to switch plans begins the month before the month you move and continues for 2 full months after you move.
You move to a new address that's still in your plan's service area, but you have new plan options in your new location.	* <b>Note:</b> If you're in a Medicare Advantage Plan and you move outside your plan's service area, you can also choose to return to Original Medicare. If you don't enroll in a new Medicare Advantage Plan during this SEP, you'll be enrolled in Original Medicare when you're disenrolled from your old Medicare Advantage Plan.	If you tell your plan <b>after</b> you move, your chance to switch plans begins the month you tell your plan, plus 2 more full months.
You move back to the U.S. after living outside the country.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you move back to the U.S.
You just moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital).	<ul style="list-style-type: none"> <li>▪ Join a Medicare Advantage or Medicare Prescription Drug Plan.</li> <li>▪ Switch from your current plan to another Medicare Advantage or Medicare Prescription Drug Plan.</li> <li>▪ Drop your Medicare Advantage Plan and return to Original Medicare.</li> <li>▪ Drop your Medicare prescription drug coverage.</li> </ul>	Your chance to join, switch, or drop coverage lasts as long as you live in the institution and for 2 full months after the month you move out of the institution.
You're released from jail.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you're released from jail.

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## Changes that cause you to lose your current coverage

If this describes you...	You can...	At this time...
<p><b>You're no longer eligible for Medicaid.</b></p>	<ul style="list-style-type: none"> <li>▪ Join a Medicare Advantage or Medicare Prescription Drug Plan.</li> <li>▪ Switch from your current plan to another Medicare Advantage or Medicare Prescription Drug Plan.</li> <li>▪ Drop your Medicare Advantage Plan and return to Original Medicare.</li> <li>▪ Drop your Medicare prescription drug coverage.</li> </ul>	<p>Your chance to change lasts for 2 full months after the month you find out you're no longer eligible for Medicaid.</p>
<p><b>You find out that you won't be eligible for Extra Help for the following year.</b></p>	<ul style="list-style-type: none"> <li>▪ Join a Medicare Advantage or Medicare Prescription Drug Plan.</li> <li>▪ Switch from your current plan to another Medicare Advantage or Medicare Prescription Drug Plan.</li> <li>▪ Drop your Medicare Advantage Plan and return to Original Medicare.</li> <li>▪ Drop your Medicare prescription drug coverage.</li> </ul>	<p>Your chance to change is between January 1–March 31.</p>
<p><b>You leave coverage from your employer or union.</b></p>	<p>Join a Medicare Advantage or Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month your coverage ends.</p>
<p><b>You involuntarily lose other drug coverage that's as good as Medicare drug coverage (creditable coverage), or your other coverage changes and is no longer creditable.</b></p>	<p>Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month you lose your creditable coverage or are notified of the loss of creditable coverage, whichever is later.</p>
<p><b>You have drug coverage through a Medicare Cost Plan and you leave the plan.</b></p>	<p>Join a Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month you drop your Medicare Cost Plan.</p>
<p><b>You drop your coverage in a Program of All-inclusive Care for the Elderly (PACE) Plan.</b></p>	<p>Join a Medicare Advantage or Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month you drop your PACE plan.</p>

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## You have a chance to get other coverage

<b>If this describes you...</b>	<b>You can...</b>	<b>At this time...</b>
<b>You have a chance to enroll in other coverage offered by your employer or union.</b>	Drop your current Medicare Advantage or Medicare Prescription Drug Plan to enroll in the private plan offered by your employer or union.	Whenever your employer or union allows you to make changes in your plan.
<b>You have or are enrolling in other drug coverage as good as Medicare prescription drug coverage (like TRICARE or VA coverage).</b>	Drop your current Medicare Advantage Plan with drug coverage or your Medicare Prescription Drug Plan.	Anytime.
<b>You enroll in a Program of All-inclusive Care for the Elderly (PACE) Plan.</b>	Drop your current Medicare Advantage or Medicare Prescription Drug Plan.	Anytime.
<b>You live in the service area of one or more Medicare Advantage or Medicare Prescription Drug Plans with an overall quality rating of 5 stars.</b>	Join a Medicare Advantage, Medicare Cost, or Medicare Prescription Drug Plan with an overall quality rating of 5 stars.	One time between December 8–November 30.

## Changes in your plan's contract with Medicare

<b>If this describes you...</b>	<b>You can...</b>	<b>At this time...</b>
<b>Medicare takes an official action (called a “sanction”) because of a problem with the plan that affects you.</b>	Switch from your Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Your chance to switch is determined by Medicare on a case-by-case basis.
<b>Your plan's contract ends (terminates) during the contract year.</b>	Switch from your Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Your chance to switch starts 2 months before and ends 1 full month after the contract ends.
<b>Your Medicare Advantage Plan, Medicare Prescription Drug Plan, or Medicare Cost Plan's contract with Medicare isn't renewed for the next contract year.</b>	Switch from your Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Between October 15 and the last day in February.

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## Changes due to other special situations

<b>If this describes you...</b>	<b>You can...</b>	<b>At this time...</b>
<b>You're eligible for both Medicare and Medicaid.</b>	Join, switch, or drop a Medicare Advantage Plan or Medicare prescription drug coverage.	Anytime.
<b>You qualify for Extra Help paying for Medicare prescription drug coverage.</b>	Join, switch, or drop Medicare prescription drug coverage.	Anytime.
<b>You're enrolled in a State Pharmaceutical Assistance Program (SPAP).</b>	Join either a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.	Once during the calendar year.
<b>You're enrolled in a State Pharmaceutical Assistance Program (SPAP) and you lose SPAP eligibility.</b>	Join either a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.	Your chance to switch starts either the month you lose eligibility or are notified of the loss, whichever is earlier. It ends 2 months after either the month of the loss of eligibility or notification of the loss, whichever is later.
<b>You dropped a Medicare Supplemental Insurance (Medigap) policy the first time you joined a Medicare Advantage Plan.</b>	Drop your Medicare Advantage Plan and enroll in Original Medicare. You'll have special rights to buy a Medigap policy.	Your chance to drop your Medicare Advantage Plan lasts for 12 months after you join the Medicare Advantage Plan for the first time.
<b>You have a severe or disabling condition, and there's a Medicare Chronic Care Special Needs Plan (SNP) available that serves people with your condition.</b>	Join a Medicare Chronic Care SNP that serves people with your condition.	You can join anytime, but once you join, your chance to make changes using this SEP ends.

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<b>If this describes you...</b>	<b>You can...</b>	<b>At this time...</b>
<p><b>You joined a plan, or chose not to join a plan, due to an error by a federal employee.</b></p>	<ul style="list-style-type: none"> <li>▪ Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.</li> <li>▪ Switch from your current plan to another Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.</li> <li>▪ Drop your Medicare Advantage Plan with drug coverage and return to Original Medicare.</li> <li>▪ Drop your Medicare prescription drug coverage.</li> </ul>	<p>Your chance to change coverage lasts for 2 full months after the month you get a notice of the error from Medicare.</p>
<p><b>You weren't properly told that your other private drug coverage wasn't as good as Medicare drug coverage (creditable coverage).</b></p>	<p>Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month you get a notice of the error from Medicare.</p>
<p><b>You weren't properly told that you were losing private drug coverage that was as good as Medicare drug coverage (creditable coverage).</b></p>	<p>Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month you get a notice of the error from Medicare.</p>
<p><b>You don't have Part A coverage, and you enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31).</b></p>	<p>Sign up for a Medicare Prescription Drug Plan.</p>	<p>Between April 1–June 30.</p>

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## **Get more information**

For more detailed information about signing up, including instructions on how to join, visit [Medicare.gov](https://www.Medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### **Extra Help is available!**

If you have limited income and resources, you may be able to get Extra Help paying your prescription drug coverage costs. People who qualify may be able to get their prescriptions filled and pay little or nothing out of pocket. You can apply for Extra Help at any time. There's no cost to apply for Extra Help, so you should apply even if you're not sure if you qualify. To apply online, visit [socialsecurity.gov/i1020](https://www.socialsecurity.gov/i1020). Or, call Social Security at 1-800-772-1213 to apply by phone or get a paper application. TTY users can call 1-800-325-0778.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html](https://www.CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.



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Information partners can use on:

## Medicare's Limited Income NET Program for people at the pharmacy counter

### Medicare's Limited Income NET Program

Medicare's Limited Income NET provides immediate prescription drug coverage for people with Medicare who are at the pharmacy counter and qualify for Extra Help, but aren't enrolled in a Medicare Prescription Drug Plan. Medicare's Limited Income NET Program covers all Part D covered drugs, and there are no network pharmacy restrictions during the time period covered by this program. The person will be charged the reduced copayment based on the level of Extra Help they get.

Medicare's Limited Income NET Program also covers prescriptions that eligible people filled within the last 30 days. See "Medicare's Limited Income NET Program for People with Retroactive Medicaid & SSI Eligibility" tip sheet in the "Publications for Partners" section on [cms.gov](http://cms.gov) for more details about how Medicare's Limited Income NET Program works.

### How does the pharmacist know if a person is eligible?

If a pharmacy has reasonable assurance that a person is eligible for Medicaid or Extra Help (and they have no other Part D drug coverage), the pharmacy can submit the claim to Medicare's Limited Income NET Program.

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## How does the pharmacist know if a person is eligible? (continued)

A pharmacy can confirm if a person qualifies for Extra Help either through an E1 query to Medicare's online eligibility/enrollment system (TrOOP Facilitator), or with one of these:

- A copy of the person's Medicaid card that includes his/her name and effective eligibility date
- Documentation that shows Medicaid status, such as a copy of a state document, a printout from the state electronic enrollment file, or a screen print from the state's Medicaid system
- A copy of one of these Extra Help letters from Social Security:
  - "Notice of Award"
  - "Notice of Change" indicating an award increase
  - "Notice of Planned Action" indicating an award reduction
  - "Notice of Important Information" indicating no change to the person's award

## What if a person's eligibility can't be confirmed?

If Medicare's Limited Income NET Program can't confirm if a person is eligible for Medicaid or Extra Help through a Medicare system, they'll send a notice to the person asking for proof of eligibility. Proof of Medicaid or Extra Help eligibility can be faxed to Medicare's Limited Income NET Program at 1-877-210-5592. A state or county Medicaid staff person can also call Medicare's Limited Income NET Program on behalf of a person with Medicare at 1-800-783-1307 to verify the person qualifies for Medicaid or Extra Help.

If the person fails to provide proof, then the person (not the pharmacy) will have to pay out-of-pocket for the prescription.

## For more information

- To learn more about Medicare's Limited Income NET Program, call 1-800-783-1307. TTY users should call 711. Someone will be available to take your call from 8 a.m. – 8 p.m. in each U.S. time zone (may be different in Alaska and Hawaii).
- Call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your State Medical Assistance (Medicaid) office. TTY users should call 1-877-486-2048. Or, visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts).

