

## DEDUCTIBLE STAGE

You are responsible for 100% of your prescription drug costs until your deductible\* is met.

*\*Your plan may have an annual deductible of no more than **\$505**.*

*Some plans carry a zero-dollar deductible.*

*In some plans the deductible may not apply to certain low cost or generic drugs.*

## INITIAL COVERAGE

You pay a copay or coinsurance. Your Part D plan pays the rest for prescription drugs included on your plan's formulary, or list of covered medications.

## THE COVERAGE GAP

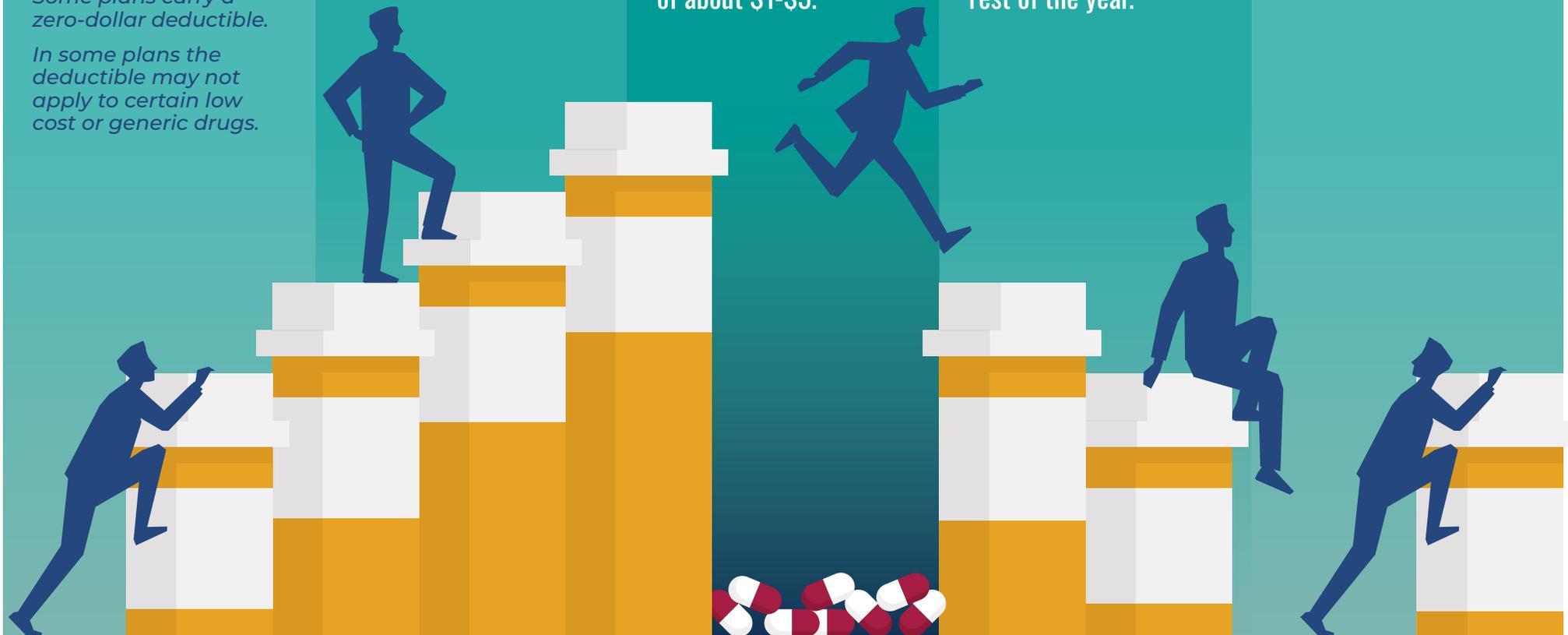
After you and your plan have together spent **\$4,660** on prescription drugs, then you enter the "coverage gap." Now you pay 25% of the cost for both generic and brand-name drugs, plus a small pharmacy dispensing fee of about \$1-\$3.

## CATASTROPHIC COVERAGE

After your True Out-of-Pocket (TrOOP) costs for prescription drugs reach **\$7,400** — including manufacturer discounts on brand name drugs — you then pay the greater of 5% or small co-pays on medications for the rest of the year.

## PLAN YEAR RESTARTS

No matter what, everything resets on January 1, and you return to the deductible stage at the beginning of the next year.



## Tier Levels Classifications

### TIER 1 – PREFERRED GENERIC

This tier consists of commonly prescribed generic drugs. Beneficiaries pay the least for drugs in this tier.

### TIER 2 – GENERIC

Drugs in this tier are generic and slightly more costly than those in Tier 1.

### TIER 3 – PREFERRED BRAND

This tier consists of brand-name prescription drugs without a generic equivalent. They're lower-cost than conventional branded drugs.

### TIER 4 – BRAND

Drugs in this tier are brand-name and do not have a generic equivalent. They're typically more expensive than those in Tier 3.

### TIER 5 – SPECIALTY

This tier consists of high-cost specialty drugs that treat complex conditions like cancer. They may be generic or brand-name. Beneficiaries typically pay the most for drugs in this tier.

## Plan Coverage Rules

### PRIOR AUTHORIZATION

Prescription drug plans with prior authorization require a physician to get advance approval before a specific medication can be prescribed to a plan beneficiary.

### STEP THERAPY

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

### QUANTITY LIMITS

Per Medicare.gov, "For safety and cost reasons, plans may limit the amount of prescription drugs they cover over a certain period of time. For example, most people prescribed heartburn medication take 1 tablet per day for 4 weeks. Therefore, a plan may cover only an initial 30-day supply of the heartburn medication."

### COVERAGE EXCEPTION

As CMS.gov explains, "Coverage exceptions can be requested to obtain a Part D drug that is not included on a plan sponsor's formulary, or to request to have a utilization management requirement waived (e.g., step therapy, prior authorization, quantity limit) for a formulary drug."

## Coverage Cost Methods

### PREMIUMS

A periodic payment to keep an insurance policy in force.

### DEDUCTIBLE

The amount of covered expenses that the insured must pay before a plan or insurance contract starts to reimburse for eligible expenses.

### CO-PAY

A fixed amount a beneficiary pays for covered medication.

### CO-INSURANCE

The percentage of costs for which a beneficiary is responsible after he or she has paid the deductible.