

Understanding Your Medicare Prescription Drug Coverage



A helpful guide to provide you with information about accessing and paying for prescription drugs through Medicare.

Introduction and Purpose of This Guide

The information contained within this guide is to inform you about Medicare, including key changes in Medicare drug coverage that may lead to cost savings on your prescription drugs.

As knowledge is power, this guide is intended to encourage you to:

- ✓ **Make informed choices** related to drug coverage
- ✓ **Advocate for access** to the drug your doctor/healthcare team prescribed
- ✓ **Find ways to better manage** and/or lower your prescription drug costs

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Overview of Medicare

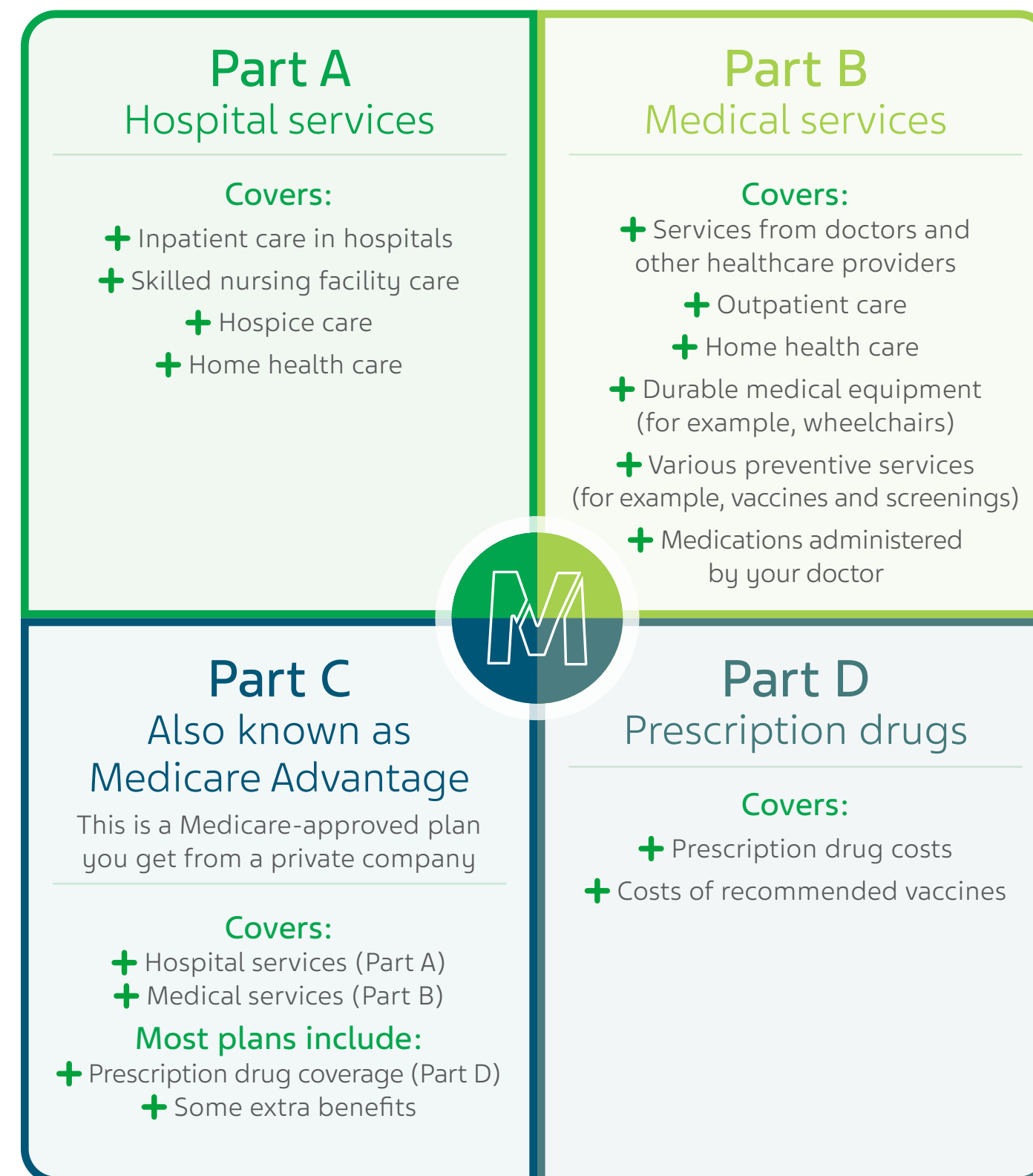
Medicare is a government health insurance program for people who are age 65 and older and other select people.

Other people who may qualify for Medicare include:

- Certain younger people with long-term disabilities
- People with specific diagnoses, for example, permanent kidney failure requiring dialysis or a transplant

Parts of Medicare

Medicare is divided into 4 “parts” that help cover the following services and treatments:



Your Medicare Choices

You can select Original Medicare coverage or a Medicare Advantage plan.

Compare your Medicare options:

Original Medicare

- ✓ **Part A** – hospital services
- ✓ **Part B** – medical services

What you can add:



- + **Part D prescription drug coverage.**
These can be stand-alone plans added to Original Medicare
- + **Medigap**, which is supplemental coverage that helps pay for some of the costs not covered by Part A and Part B
- + **Coverage from a current or former employer or union**
- + **Coverage from Medicaid** if you are enrolled in that plan

* You can visit any doctor or hospital that accepts Medicare, within the United States

Medicare Advantage and Part D plans are offered by private companies that follow rules set forth by Medicare



Medicare Advantage (also called Part C)

- ✓ **Part A** – hospital services
- ✓ **Part B** – medical services

Most plans also include:

- ✓ **Part D** – prescription drug coverage
- ✓ **Some extra benefits** (for example, fitness programs, vision, or hearing services)

* Generally, you can only visit doctors who are in your plan's network (also called "preferred providers")

Medicare Terms to Know

Before you choose what Medicare plan is right for you, it's important to understand some basic terms.

Premium	Just like your car or home insurance payments, this is the amount you pay monthly for Medicare. Premiums for Medicare Part B typically change every year and may be higher for those with higher income. Most Part D drug plans charge premiums, but premiums vary by plan. You would pay this in addition to your Part B premium.
Deductible	This is the amount you pay before Medicare Part B or your optional Part D drug plan begins to pay for a service or treatment.
Copayment	Also called a "copay," this is a fixed amount you pay for prescription drugs in a Part D plan. Copays vary by plan and are added into your annual out-of-pocket maximum.
Coinsurance	For most services covered by Original Medicare Part B, you will pay 20% coinsurance while Medicare pays the remaining 80% after you have met your deductible. If you have a Medigap plan along with your Original Medicare plan, Medigap will pay your 20% coinsurance.
Out-of-pocket limit/maximum	This is the maximum dollar amount you'll have to pay for covered healthcare services during the calendar year. For Part D plans, the maximum is \$2,000 annually, excluding premiums. Medicare Part B has no out-of-pocket limit.
Formulary	Most Medicare Advantage plans and Part D plans have their own list of covered prescription medications called formularies. Plans place drugs on "tiers" and each tier has different costs. Some drugs might not be covered at all. Lower-tier drugs come with lower out-of-pocket costs.

Learn more about your coverage options by visiting [Medicare.gov](https://www.Medicare.gov) >

Enrollment

In general, your first chance to enroll in Medicare is when you turn age 65. This is called the **Initial Enrollment Period**. Every year during the **Open Enrollment Period**, you have the option to join, change, or drop your plan. If you miss this enrollment period and/or have certain events occur in your life, such as you move or lose your insurance coverage, you may have a chance to enroll in Medicare during a **Special Enrollment Period**.



Generally, you must stay in your plan for the entire year, but if you qualify for special enrollment, you may be able make changes to your plan mid-year.



For enrollment period details and eligibility, check with your plan or visit [Medicare.gov](https://www.Medicare.gov)



Although you do not need to sign up for Medicare each year, you should still review your health and drug coverage every year.

- ✓ **Ensure** your prescription drugs are covered by your plan because formularies can change every year
- ✓ **Check** to see if your preferred healthcare providers and pharmacies are still in the plan network
- ✓ **Review** any changes to your out-of-pocket costs



By comparing your Medicare options, you may find a plan that saves you money and/or offers you more coverage.

Changes in government policies and laws are other good reasons to review your health plan every year. Policy updates can affect your coverage benefits and how much you pay for your healthcare coverage and medications. Note when you can make changes to your Medicare plan:

Open Enrollment Period

When to enroll	What you can do	When your coverage should start
Last 3 months of each year	<ul style="list-style-type: none"> • Keep your existing Medicare coverage • Change your Medicare health or drug coverage for next year • Join, switch, or drop a Medicare Advantage Plan or Medicare drug plan • Switch to Original Medicare 	January 1
First 3 months of each year	<ul style="list-style-type: none"> • Change to a different Medicare Advantage plan • Switch to Original Medicare (and join a separate Medicare drug plan) once during this time 	April 1



There are many different possible Medicare enrollment scenarios. You may have to pay a penalty if you do not sign up for Medicare when you are first eligible.

Get to Know Your Insurance Card

When you receive your Medicare insurance card, be sure to review it closely to ensure the information, such as your full name, plan details, and effective date, are correct. Take out and present all the health insurance cards you use when you visit a doctor or other healthcare provider, go for a lab test, or pick up a prescription drug.

1 HEALTH INSURANCE PLAN PLAN TYPE 2

Plan: (00000) 000-000000-00
 Member ID: 0000000-00
 Group Number: 00000000

3

Member Name: Jane Doe
 Effective Date: MM/DD/YYYY

4

RX PROVIDER
 Rx BIN: 00000
 Rx GRP: GRP Name
 Rx PCN: 000
 Rx Copay: Generic/Brand \$10/\$35

5

PCP Copay: \$20
 Specialist Copay: \$35
 Emergency Room Copay: \$75

- 1 This is where you can find the **name of the insurance company** that administers your insurance plan.
- 2 This is where you can find additional **information about your specific type** of health insurance plan.
- 3 This is your **pharmacy benefits manager, or “PBM”**—the organization that provides your pharmacy coverage. You may have a separate insurance card for your pharmacy benefit.
- 4 This is your **prescription drug, or “Rx” copay**—the amount you’ll pay per prescription for different types of medications.
- 5 This shows your **covered service copay**—the amount you will pay out of pocket for a visit to your primary care physician, or “PCP,” specialist, or emergency room.

How Do You Read Your Insurance Card?

Here are examples of the types of cards you may have, depending on your health insurance provider and your plan type.

Original Medicare

MEDICARE HEALTH INSURANCE

Name/Nombre:
Jane Doe

Medicare Number/Numero de Medicare:
0000000-00

Entitled to/Con derecho a Hospital (Part A) Medical (Part B) Coverage starts/Cobertura empieza MM/DD/YYYY MM/DD/YYYY

If your card has a similar red, white, and blue design, **you’re likely enrolled in Original Medicare.**

Medicare Advantage

If your card includes both Medicare and an insurance company, **you’re likely enrolled in a Medicare Advantage plan.**

HEALTH INSURANCE
 Medicare Gold (PPO)
 A Medicare Advantage Plan with Prescription Drug Coverage

Plan: (00000) 000-000000-00
 Member ID: 0000000-00
 Member Name: Jane Doe

Copays:
 Office Visit: \$25
 Specialist: \$35
 Hospital Emergency: \$300

Rx BIN: 00000
 Rx GRP: GRP Name
 Rx PCN: 000

Medicare Rx Prescription Drug Coverage CMS 50000 000

Medicare Part D

HEALTH INSURANCE
 Prescription Drug Plan (PDP)

Rx BIN: 00000
 Rx GRP: GRP Name
 Rx PCN: 000

Card Issued:
MM/DD/YYYY

Plan: (00000) 000-000000-00
 Member ID: 0000000-00
 Member Name: Jane Doe

Medicare Rx Prescription Drug Coverage CMS 50000 000

If you have a card that says “drug plan” or “Prescription Drug Plan (PDP),” **you’re likely enrolled in a Medicare Part D prescription drug plan.**

Dually Eligible: Medicaid and Medicare

If your card says “dual,” or you have 2 cards, one for Medicare and one for Medicaid, **you’re likely enrolled in both Medicare and Medicaid plans.**

STATE OF FLORIDA
 HEALTH BENEFITS IDENTIFICATION CARD

Member ID: 0000000-00
 Member Name: Jane Doe
 Card Issued: MM/DD/YYYY

MEDICARE HEALTH INSURANCE

Name/Nombre:
Jane Doe

Medicare Number/Numero de Medicare:
0000000-00

Entitled to/Con derecho a Hospital (Part A) Medical (Part B) Coverage starts/Cobertura empieza MM/DD/YYYY MM/DD/YYYY



Always reach out to your insurance plan if you need help obtaining or understanding the information on your card or for help in determining your coverage and plan benefits.

Medicare Drug Coverage

If you have Medicare, your medication may be covered under Part B or Part D.

B Your **Medicare Part B** typically covers medications given by a healthcare provider.

D If you have **Medicare Part D**, it typically covers medicine you give to yourself, such as a pill.



Medical benefit

Medicare Part B is referred to as your medical benefit. Part B may help cover the cost of medications administered by healthcare providers. These include medications like infusions and certain injections.

- You usually pay 20% of the Medicare-approved amount for these services and Medicare pays 80% after you have met your deductible
- If you are enrolled in Original Medicare, you have the option to buy a Medicare Supplemental plan that will pay the 20% coinsurance
- All Medicare beneficiaries have Part B



Pharmacy benefit

Medicare Part D is referred to as a pharmacy benefit. Part D may help cover the cost of medications that you administer yourself, like a pill or self-injectable medication.

Part D plans:

- Are included in most Medicare Advantage plans
- Can be purchased separately if you have Original Medicare
- Maintain a list of covered medications called formularies
- May have preferred pharmacies, including **specialty pharmacies** and mail-order pharmacies



Specialty pharmacies dispense prescription drugs that may be more costly and/or have special shipping, handling, storage, or administration requirements.

Your Part D Prescription Drug Costs

Once you sign up for a Part D plan or Medicare Advantage plan, you will pay a monthly **premium**, which will vary by plan. After that, **Part D plans have 3 distinct phases.**

Phases of Part D Drug Coverage

Deductible Phase

Until you meet your deductible, you will pay the **full price** for your covered prescription drugs. Once you have met the deductible, the plan will begin to **cover the cost of your drugs.**

Deductibles can vary by plan, but **no plan's deductible can be higher than a certain amount** (\$590 in 2025), and some plans have no deductible.

Initial Coverage Phase

Once you've met the deductible, your plan will help pay for your covered prescription drugs. The plan will pay some of the cost, and you will pay a **copayment** or **coinsurance.**

The amount of time you stay in this phase **depends on your drug costs and your plan's benefit** structure.

Catastrophic Coverage

In all Part D plans, once you reach \$2,000 in annual out-of-pocket costs, your Medicare Part D plan covers 100% of your drug cost for covered medications.*

In this phase, **you do not have to pay for your covered drugs** for the rest of the year.

*Costs that do not help you reach catastrophic coverage include monthly premiums, what your plan pays toward drug costs, the cost of non-covered drugs, the cost of covered drugs from pharmacies outside your plan's network, and discounts on generic drugs.



Not everyone with Part D coverage will advance through all phases of drug coverage. Your prescription needs and individual policy determine your actual out-of-pocket costs for your medications.

New Medicare Part D Rules Can Lower Your Prescription Drug Costs

There is a new \$2,000 annual out-of-pocket cap for 2025 that may offer significant savings in your drug costs.

\$2,000
 **2025 ANNUAL CAP**

This \$2,000 annual limit applies to stand-alone Part D plans and drug coverage in Medicare Advantage plans. It also includes your **deductibles, copayments, and coinsurance** for covered drugs. This limit doesn't apply to your premiums or to drugs your plan doesn't cover.

Medicare Prescription Payment Plan

New for 2025 is a program called the **Medicare Prescription Payment Plan.** This voluntary, free program can help you manage your Part D prescription by spreading your costs throughout the calendar year rather than pay the costs all at once at the pharmacy.

- Each month you will **pay your premium** (if you have one)
- You will **get a bill and pay your drug plan** for your prescriptions instead of the pharmacy
- You can **enroll at anytime** by contacting your health or drug plan



Getting Help With Your Medicare Costs

If your income and resources are limited, you may be eligible to get assistance paying for some of your costs through these programs:

Medicaid

Provides some benefits that Medicare does not

Medicare Savings Programs (MSPs)

Can help pay for Medicare Part A and Part B costs

The Extra Help Program

Can help pay for Medicare Part D drug costs

Medicaid

Medicaid is a joint federal and state program that helps cover medical costs for some people who have limited income and resources. The program follows federal rules, but each state runs its own Medicaid program and has its own name.

This means eligibility requirements and benefits can vary from state to state.



Medicaid offers health insurance coverage for eligible people, including:

- Low-income families and children
- Pregnant women
- Some people with disabilities

Medicaid offers benefits that Medicare doesn't normally cover, such as nursing home care and personal care services. People with Medicaid usually don't pay anything for covered medical expenses but may owe a small copayment for some items or services.

Medicaid covers medical services and prescription drugs:

- Currently, all 50 states cover prescription drugs for Medicaid beneficiaries
- States can impose copayments on prescription drugs for Medicaid beneficiaries. However, these **copayments are usually very low and may be zero**

Medicare Savings Programs

For those who qualify, the MSP is a program that can help pay for Medicare Part A and Part B premiums, and in some instances, for Part A and Part B deductibles, coinsurance, and copays.

There are 4 different MSP programs:

MSP	Helps pay for
Qualified Medicare Beneficiary (QMB)	Part A and/or Part B premiums, deductibles, coinsurance, and copays
Specified Low-Income Medicare Beneficiary (SLMB)	Part B premiums only
Qualifying Individual (QI)	Part B premiums only (only available for those who don't qualify for any other Medicaid coverage or benefits)
Qualified Disabled and Working Individuals (QDWI)	Part A premiums only (You may qualify if you have a disability, you're working, and you lost your Social Security disability benefits and premium-free Part A)

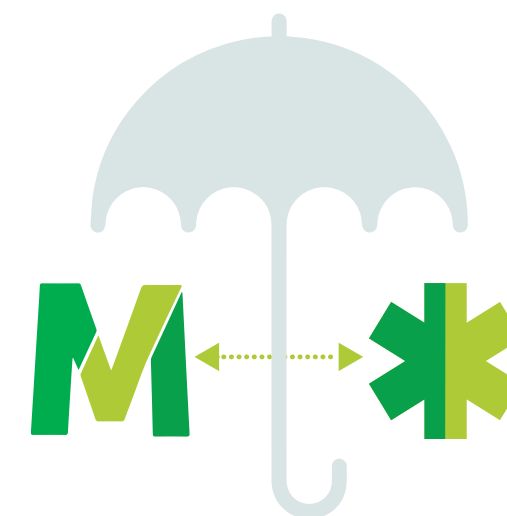
To qualify, you must have income and resources below a certain limit and those vary by each state. **Contact your State Medical Assistance (Medicaid) office to find out if you are eligible** >

Medicare + Medicaid

If you are enrolled in both Medicare **and** Medicaid, you are considered a **"dually eligible"** beneficiary.

This typically applies to people who are:

- 65 or older, or under 65 with certain disabilities
- Have limited income and resources



There are different levels of dual eligibility:

- **Full dual eligibility**, which qualifies you for full Medicare and Medicaid benefits
- **Partial dual eligibility**, where you have Medicare and some help from Medicaid with Medicare costs from one of the Medicare Savings Programs

If you are a dually eligible beneficiary, you may be able to enroll in a special Medicare Advantage plan for people in your state or region. If you have both Medicare and full Medicaid coverage, Medicare covers most of your prescription drugs, though Medicaid may cover some drugs that Medicare does not cover.

As with all who qualify for Medicaid, you also qualify automatically for **Extra Help** (also known as Low-Income Subsidy), which is a program that can help to pay for your drug costs.



Present all of your health insurance and pharmacy benefit cards to your doctor's office staff so they can verify how to ensure your costs are covered.

The Extra Help Program (Low-Income Subsidy)

The Extra Help Program helps pay some or all of your Medicare Part D costs, such as:

Monthly premiums

Annual deductibles

Copayments/coinsurance

This means that if you qualify for Extra Help, you may have no or low premiums, deductibles, and copayments and/or coinsurance.

In 2025, prescription drug costs for people who qualify for Extra Help are usually:

NO MORE THAN
\$4.90 FOR GENERIC DRUGS

NO MORE THAN
\$12.15 FOR BRAND-NAME DRUGS



In 2025, you might qualify if your income and resources meet these limits:

	Annual income limits*	Resource limits
Individual	\$22,590	\$17,220
Married couple	\$30,660	\$34,360

*Income limits are higher in Alaska and Hawaii.

You qualify automatically for Extra Help if you have Medicare and meet any of the following:



- You have **full Medicaid coverage**
- You qualify for a **Medicare Savings Program (MSP)** through your state
- You get **Supplemental Security Income benefits**

The Extra Help Program is Growing

Eligibility for the Extra Help Program has expanded to cover costs for even more people who have limited income and resources. Despite its availability, many people who qualify for Extra Help have not enrolled in the program.



Did you get a purple letter in the mail from Medicare? If so, this means you automatically qualify for Extra Help and do not need to apply to the program. Be sure to keep this letter in a safe place for your records.

Be sure to review the program details annually as eligibility and drug costs change each year. Even if you didn't qualify automatically for Extra Help, you can apply for it at any time.

Found out your prescription drug is not covered and you have Medicaid or get Extra Help?

If so, you do not have to wait to a certain time of year to switch to another plan that offers better prescription drug coverage. You may be able to change your prescription drug coverage once per month.

For more information about the Extra Help Program and to apply online, visit:

Medicare.gov



or

SSA.gov



You can also set up an appointment

Available in most U.S. time zones, Monday through Friday, 8 a.m. to 7 p.m., in English, Spanish, and other languages.



Call **+1-800-772-1213**

Tell the representative you want to set up an appointment to apply for Part D Extra Help.

Call TTY +1 800-325-0778 if you're deaf or hard of hearing.

Getting Your Part D Prescriptions Covered

All plans must cover a wide range of drugs, but every drug plan has its own formulary.

Before you join a plan, it is always important to review its formulary to ensure not only that your medications are covered, but *how* they are covered.

Coverage Rules for Medications

Medicare drug plans can put coverage rules in place for certain drugs. For example, they may require:

Prior Authorization: limits coverage of a drug for certain conditions and requires your healthcare provider request approval before you can get the medication

Step therapy: requires you to try a similar, lower-cost drug first

Quantity limits: limits how much you can get of a drug at a time

Drug plans also use tiered formularies, so if your medicine is on a higher tier, you will have to pay more versus a “preferred” medicine on a lower tier.



Although drug plans may differ in what they cover, all Medicare drug plans follow the same process for approving coverage.

Coverage Determination: You will receive a written explanation from your Medicare drug plan regarding any decisions about your drug coverage. This document outlines whether your plan covers the medication, if you meet the plan’s requirements for coverage, or what your payment responsibilities are.

Exceptions: If you or your healthcare provider believe that an exception to the plan’s rules is justified, you can request it. Consider asking for an exception if:

- You need a medication that isn’t on your plan’s formulary
- Your plan should waive a coverage rule, such as a prior authorization
- You need to pay less for a higher-tier drug because lower-tier alternatives are unsuitable for your condition

+ Drugs that you get from a specialty pharmacy may be more likely to be denied due to the higher cost. Your healthcare provider and office staff can help you access your prescribed medications.

Denials and Appeals

What if my plan denies coverage for my prescribed medication?

There may be cases when your Medicare plan issues a **“denial,”** and these can happen for many different reasons, including:

- The drug is not covered in your plan’s formulary
- The drug is not considered medically necessary for you
- There was an error when the claim was filed



You have the right to advocate for yourself and appeal your drug plan’s denial.

An appeal is the action you, with support from your healthcare provider, can take if you disagree with a coverage or payment decision made by your Medicare plan.

There are 5 levels of appeals in a Medicare drug plan:

If you disagree with the decision made at any level of the process, you can usually go to the next level. At each level you’ll get a decision letter with instructions on how to move to the next level of appeal.

> Level 1

Redetermination from your plan

> Level 2

Reconsideration by an Independent Review Committee

> Level 3

Decision by the Office of Medicare Hearings and Appeals

> Level 4

Review by the Medicare Appeals Council

> Level 5

Judicial Review in Federal District Court

For a response to a **standard appeal**, the plan has 7 days for plan benefit appeals and 14 days for payment appeals. For a response to a **fast (also called “expedited”) appeal**, the plan has 72 hours. If you disagree with the plan’s redetermination decision, you have 60 days from the date of the decision to request a reconsideration by a Qualified Independent Contractor.



Work with your doctor or other healthcare provider. Your doctor can provide information to support the appeal.

Keep a copy of everything related to your appeal, including what you send to Medicare and other health plans. Your State Health Insurance Assistance Program (SHIP) also can help you with filing an appeal.

You can find your state’s program by visiting www.shiphelp.org >



Review your plan materials, or contact your plan, for more details about your appeal rights. You can find your plan’s contact information on your plan membership card.

Tips to Help Manage Your Medication Costs

- Keep a current list of your medications** and at open enrollment, check if your medication is on the drug plan's formulary
- If you struggle paying** for your medications
 - Sign up for the Medicare Prescription Payment Plan with your Part D plan
 - Check to see if you are dually eligible and qualify for both Medicare and Medicaid
 - Look to see if you qualify for the Extra Help Program. If you are eligible or think you are, apply to the program at any time
 - Check with your state and the manufacturer of the drug you take to see if they offer any pharmaceutical assistance programs
 - Ask your doctor or pharmacist if you can switch to a less-expensive generic or biosimilar drug on your formulary
- Know your rights regarding coverage determinations,** formulary exceptions, and appeals. Ask your plan for:
 - A coverage determination for your prescription drug
 - An exception if you or your doctor or other healthcare provider think you need a drug that isn't on your plan's drug formulary; the plan's coverage rule should be waived, or you should pay less for a higher-tier drug
 - An appeal if your Medicare plan denies coverage or payment for your prescription drugs
 - If you are enrolled in the Extra Help Program or have Medicaid and your drug is not covered, check to see if you can switch to a plan that does provide coverage. You may be able to switch to a new plan once per month
- Recognize that some pharmaceutical companies offer patient support programs** to help people with Medicare understand plan benefits, coverage, and costs and help them enroll in Extra Help
- Talk to your doctor and work with their office staff,** your Medicare plan, and the drug manufacturer patient support program to advocate for yourself and get the drugs your doctor prescribed to you

Other Ways to Reduce Your Prescription Drug Costs

Pharmaceutical Assistance Programs

- Many drug manufacturers offer pharmaceutical assistance programs that can help lower prescription drug costs for people with Medicare Part D drug coverage. Each manufacturer has different eligibility requirements

Part D plan enrollees are not eligible for pharmaceutical manufacturer copay programs, as they are designed specifically for those with private, or commercial coverage.



Medicare offers a search tool to help find your medication >

State Programs

- Some states offer help with prescription drug costs to certain people based on financial need, age, or medical condition

Search for programs in your state >

Ask Your Doctor/Pharmacist About Generic and Biosimilar Options

- Talk to your doctor or pharmacist about the option of switching to a lower-cost generic or biosimilar drug
 - Like generic drugs, biosimilars are made from the same source of the original drug and are safe and effective treatments for many illnesses

Resources

Learn More About Medicare



Medicare

Visit the official Medicare website to find and compare health plans, look up healthcare providers, learn about ways to lower your costs, review your Medicare rights and protections, and access many other resources.

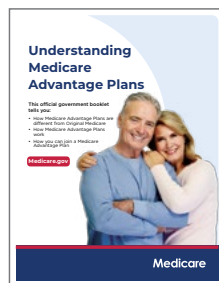
Visit [medicare.gov](https://www.medicare.gov) or call 1-800-633-4227



Medicare & You 2025

This comprehensive resource provides information on what's new in 2025 and important details about Medicare coverage.

Get the official US Government Medicare Handbook at www.medicare.gov



Understanding Medicare Advantage Plans

Get the official government booklet that tells you how Medicare Advantage plans are different from Original Medicare, how the plans work, and how to join.

Download the official government booklet



Centers for Medicare and Medicaid Services (CMS)

The federal agency that is responsible for Medicare and Medicaid programs.

Visit www.cms.gov or call 1-877-267-2323 to explore their resources

Learn More About Programs That Can Help With Your Medicare Costs



Medicaid

Here you will find links for every state's individual Medicaid website and phone number to learn about eligibility and coverage and to explore additional resources.

Visit the official Medicaid site at www.medicicaid.gov

Pharmaceutical Manufacturer Patient Assistance Programs

Visit the website of the drug that your doctor prescribed or the drug manufacturer's website for information on their patient assistance program offerings and to sign up directly. Medicare also offers a drug look-up tool.

Visit www.medicare.gov to search for your drug

State Pharmaceutical Assistance Programs

Some states offer assistance with prescription costs for certain special populations based on financial need, age, or medical condition.

Visit www.medicare.gov to find out what programs your state offers

Other Ways to Get the Help You Need

Contact the State Health Insurance Assistance Program (SHIP)

Provides local, in-depth, and objective insurance counseling and assistance to Medicare-eligible individuals, their families, and caregivers.

Visit www.shiphelp.org or call 1-877-839-2675

Contact Your Health Plan's Customer or Member Services

- Find the phone number on the back of your insurance card, or
- Use the chat function on your online member portal (this gets your information in writing)
- Talk to your doctor's office and ask if there is a staff member who can help you

Glossary of Terms

Appeal	This is a request made by a person, with support from their healthcare provider, to Medicare if they disagree with a coverage or payment decision made by the Medicare plan.
Biosimilar	This is a biologic drug that is very similar to an original biologic drug, also known as the “reference product” that is already approved by United States Food and Drug Administration.
Brand-name drug	A drug that is sold by a company under a specific name or trademark and that is protected by a patent.
Coinsurance	The percentage of costs of a covered health care service you pay after you’ve paid your deductible.
Copayment	A fixed amount you pay for a covered health care service after you’ve paid your deductible.
Coverage determination	This is a written explanation about prescription drug coverage decisions for a patient from the Medicare drug plan. This is the first decision the Medicare drug plan makes about a patient’s benefits, such as whether the plan covers the drug or how much the patient will pay for the drug.
Deductible	The amount you pay for covered health care services or prescription drugs before your insurance plan starts to pay.
Exception	This is a type of Medicare prescription drug coverage determination that involves a drug plan’s decision to cover a drug that’s not on its formulary or to waive a coverage rule, such as prior authorization.
Extra Help Program	This is a Medicare program to help people with limited income and resources pay Medicare prescription drug program costs such as premiums, deductibles, and coinsurance.
Formulary	A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Generic drugs	A drug that has the same active-ingredient formula as a brand-name drug. These types of drugs usually cost less than brand-name drugs.
Mail order pharmacy	A type of pharmacy in which a prescription drug is filled, run through insurance, and it is mailed directly to the patient who may have to pay a copay for their medication.
Premium	The amount you pay for your health insurance every month.
Prior authorization	This limits coverage of a drug to people who meet certain requirements. Before you can fill the prescription, your doctor or other healthcare provider must contact your plan to show that the drug is medically necessary and that you meet certain requirements.
Quantity limits	Some prescription drug plans may limit the amount of medications they cover over a certain period of time because of safety or cost concerns.
Reauthorization	This is a renewal of authorization for a prescription drug. This may be required after a certain amount of time to confirm that this drug is still medically necessary and effective for a your condition or disease.
Specialty pharmacy	This is a type of pharmacy that dispenses prescription drugs that may be more costly and/or have special shipping, handling, storage, or administration requirements.
Step therapy	This requires a person to first try a certain, less costly drug on the plan’s formulary that’s been proven effective for most people with a specific condition before then can move up or “step” to a more costly drug. For instance, some plans may require you try a generic drug first if it is available and less costly than a brand-name drug on their drug list before you can get a similar, more costly, brand-name drug covered.
Tier	These are a categories within a health plan’s formulary. In general, prescription drugs are placed in tiers based on the type of drug, such as generic, preferred brand, non-preferred brand, and specialty.

