Medicare Part D

Glossary of Terms

Premium	The amount you pay the insurance company for your plan (monthly, yearly, etc.).
Deductible	The amount you must pay before your benefits begin.
Copayment	A *fixed dollar amount* you pay for a service at the doctor, pharmacy, or hospital (e.g. $5, $10).
Coinsurance	A fixed percentage of cost you pay for a service at the doctor, pharmacy, or hospital (e.g. 10%, 20%).
Coverage Gap	Often called the "Donut Hole", is a temporary limit on what the Part D company will pay for your covered drugs. Not everyone will enter the Coverage Gap. In the Coverage Gap you will pay a portion (percentage) of the plan's costs for you name brand and generic drugs. The amounts to enter and exit the Coverage Gap are set by the Federal government each year.
Catastrophic Coverage	Once you get to a level of out of pocket drug costs ($5100 in 2019), you are automatically entered into Catastrophic Coverage. This assures you will only pay a small coinsurance or copayment for the rest of the *calendar* year.
Formulary	A list of covered drugs offered by a Part D drug plan. Every plan must publicly publish their formulary and provide it in both online and written form. The formulary can change during the year with advance notice from the respective company.
Tier	Every plan must divide their covered prescription drugs into tiers that determine how they are paid. Most plans use between 3 and 5 tiers. Generally, the lower the tier, the lower the cost of the medication. Most preferred and widely prescribed generics fall into the tier 1 category.
Quantity Limits	Some medications in a plan's formulary may have quantity limits imposed for drug safety and/or cost control (e.g. 30 per 30 days, 60 per 30 days, etc.). A prescribing physician may request a quantity limit be changed for a patient's specific needs, but that is not a guaranteed acceptance by the Part D company.
Prior Authorization	Some drugs on a formulary have Prior Authorization imposed for drug safety and/or cost control. Prior Authorization requires the prescribing doctor's office to notify the Part D insurer to gain authorization for the drug to be covered at pharmacy pick up.
Step Therapy	Some drugs on a formulary have Step Therapy imposed for drug safety and/or cost control. Step Therapy is when a Part D plan requires a lower cost drug be tried before authorizing coverage for a specific, higher cost drug.

Formulary Exception When a drug is not on a Part D company's formulary a member can request a Formulary Exception. The prescribing doctor's office submits information on why the drug is needed and the plan must make a determination within a set period of time (generally 14-21 days, but an emergency/expedited request must be answered within 3 business days). Formulary Exceptions are not a guarantee your drug will be covered and may be denied by your Part D insurer.

Appeal You have a right to appeal drug coverage decisions with your Part D insurer and every Part D company must have a written appeal policy in place and available to members at all times.

Grievance You have a right to file a grievance if there is an issue with your insurer. Every Part D company must have a written grievance policy in place and available to members at all times.