Chapter 7A - Part D Enrollment Outcomes: Data Entry

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Contents

Introduction

In this chapter, you will learn about the Administration for Community Living's (ACL) Part D enrollment outcomes tracking process. Part D enrollment outcomes are tracked on the Beneficiary Contact Form (BCF) and/or Beneficiary Additional Session (BAS) form in STARS. Overall instructions for using those forms are provided in Chapter 4 of the STARS Manual. This chapter provides additional data entry instructions and guidance for using the BCF and BAS topics discussed, Special Use Fields, and attach file fields to document cost changes resulting from Part D enrollment. The content in this chapter about tracking Part D enrollment outcomes is relevant for both SHIP counselors and leaders overseeing the SHIP program.

Overview of PDP/MA-PD Cost Changes Data Collection

ACL uses STARS to collect data related to the cost changes resulting from enrollment in Part D Prescription Drug Plans or Medicare Advantage Plans with Prescription Drug coverage (PDP/MA-PD plans) available through the Medicare Plan Finder (MPF). ACL will use cost change data as another way to demonstrate the impact of SHIP work on behalf of beneficiaries in three ways:

1. Data on the number of beneficiaries who received PDP/MA-PD enrollment assistance from SHIPs;
2. Data on the average cost change per beneficiary who received PDP/MA-PD enrollment assistance from SHIPs;
3. Data on the reported total of PDP/MA-PD cost change for each state.

Definition of Enrollment Assistance

PDP/MA-PD enrollment assistance occurs when you actively assist a beneficiary with enrollment into a PDP/MA-PD, either online through the MPF or plan website, over the phone with a plan customer service representative or 1-800-Medicare, or with a paper application. There are reasons a beneficiary might enroll in a plan outside of cost considerations, like coverage or convenience. ACL collects cost change data on all PDP/MA-PD enrollments, including those that do not result in savings for the beneficiary.

Note: It is allowable for SHIP counselors who are also Medicare beneficiaries to enter their own enrollment cost change data into STARS. In this situation, the counselor is using the skills they have gained through SHIP training and is refraining from using another counselor's time for counseling.

Cost Verification Guidelines

The cost data reported for PDP/MA-PD enrollment must be auditable for ACL to verify and share the numbers reported. Therefore, for SHIPs to accurately report this element, ACL requires supporting documentation when cost change data are reported. Cost change data should be reported in the first two Special Use Fields (SUFs) dedicated for this purpose: Original PDP/MA-PD Cost SUF and New PDP/MA-PD Cost SUF. In this manual, we often refer to them as SUF 1 and SUF 2, respectively.

Cost change supporting verification should be attached to the Beneficiary Contact Form (BCF)/Beneficiary Additional Session (BAS) or stored in electronic or paper files accessible for future quality assurance audits. ACL will conduct PDEO Quality Assurance reviews for a random selection of each SHIPs verification documents to determine the state's error rate. Only SHIPs that meet the established error rate requirement may publish their cost change data publicly.

ACL Guidance: SHIPs, Medicare Plan Finder, and Beneficiary Medicare.gov

Account Credentials

Part of tracking cost changes involves working within Medicare Plan Finder (MPF) to conduct plan comparisons and helping beneficiaries enroll in new or different plans. In plan comparison and enrollment work, SHIP team members have the option to request information from beneficiaries and their caregivers to create accounts and log in to conduct personalized plan searches. If beneficiaries choose that option, ACL requires that SHIPs, at a minimum:

- Obtain verbal consent to request beneficiary Medicare.gov account information for logging into the MPF or creating a Medicare user account.
- SHIPs may choose to require a signed authorization to gather this information or create a user account if they deem it necessary.
- SHIPs should enter "Create Medicare Account" in Special Use Field (SUF) 3 of the BCF or BAS.
- SHIP counselors must guard Medicare log in information carefully and not store it in STARS.

In determining state-level policies on storing this information SHIPs must carefully consider their agency's level of comfort, potential safeguards, and risk in storing these MPF log-in information outside STARS.

See the ACL document titled "Medicare.gov Accounts: Creating and Using Medicare.gov Accounts in SHIP/SMP/MIPPA Programs" for complete ACL guidance about overall program use of those beneficiary accounts.

This document is available in the STARS menu of the password-protected SHIP TA Center website (visit **www.shiphelp.org** *and click the orange SHIP Login padlock)*

ACL Guidance for 2023 Insulin Costs and the MPF

The 2022 Medicare Open Enrollment (OEP) season for plan year 2023 comes with a few changes due to the Inflation Reduction Act and its savings for beneficiaries who use insulin. Namely, the Medicare Plan Finder does not reflect the $35 copayment for each covered insulin this OEP or during 2023 calendar year.

These changes do not impact the number of documents SHIP Team Members will need to verify cost changes. They also do not change the procedure for entering PDEO costs into STARS. For PDEO tracking purposes, use the MPF costs in the MPF, even though the MPF does not reflect

the true cost for insulin. The cost will be slightly inflated but reflect the best information available in Medicare Plan Finder at the time.

Procedures:

1. If the beneficiary takes insulin, CMS has suggested running the plan comparison twice: initially without the insulin, and again with the insulin medication to verify the plan covers their insulin.
2. For PDEO cost change tracking, save the Plan Details page WITH the insulin medications.
    a. No additional math is required for insulin users when reporting PDEO cost changes. Use the costs from the Plan Details with insulin medication as-is.
    b. Data in STARS must match the data in the Plan Details for valid PDEO reporting.

* The MPF will begin showing the true insulin costs for 2024 plans and beyond.

How to Report PDP/MA-PD Enrollment Data

Reporting PDP/MA-PD enrollment cost data on the BCF in STARS consists of 4 steps:

1. Collect Plan Cost Information
2. Assist Beneficiary with Enrollment
3. Enter Data in STARS
4. Attach Verification

Step 1: Collect Part D/MA-PD Cost Comparison Data

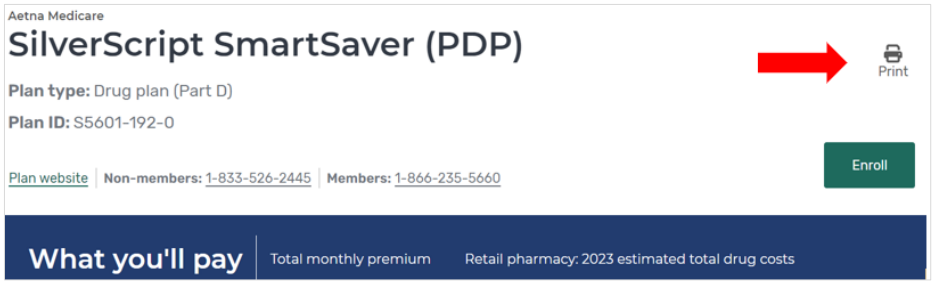
In most cases, cost comparison data will come from the Medicare Plan Finder (MPF). Starting October 1, 2022, if you are using the MPF for enrollment, all verification documentation for plan costs must include the MPF Plan Details page.

The first step is to gather the plan cost information from the MPF at https://www.medicare.gov/plan-compare/#/?lang=en. You should save and upload the Plan Details page of the beneficiary's original plan (if applicable) and new plan to demonstrate the Original and New PDP/MA-PD costs. Note:

- Be sure to capture supporting verification of cost data (*See Tips for Capturing Medicare Plan Finder Information*).
- Supporting verification may be uploaded to the BCF/BAS or stored outside STARS.
- Micro-training videos for capturing supporting verification are available in the STARS Resources Kit, password-protected at www.shiphelp.org. (See the PDEO Data Entry Example Scenarios.)

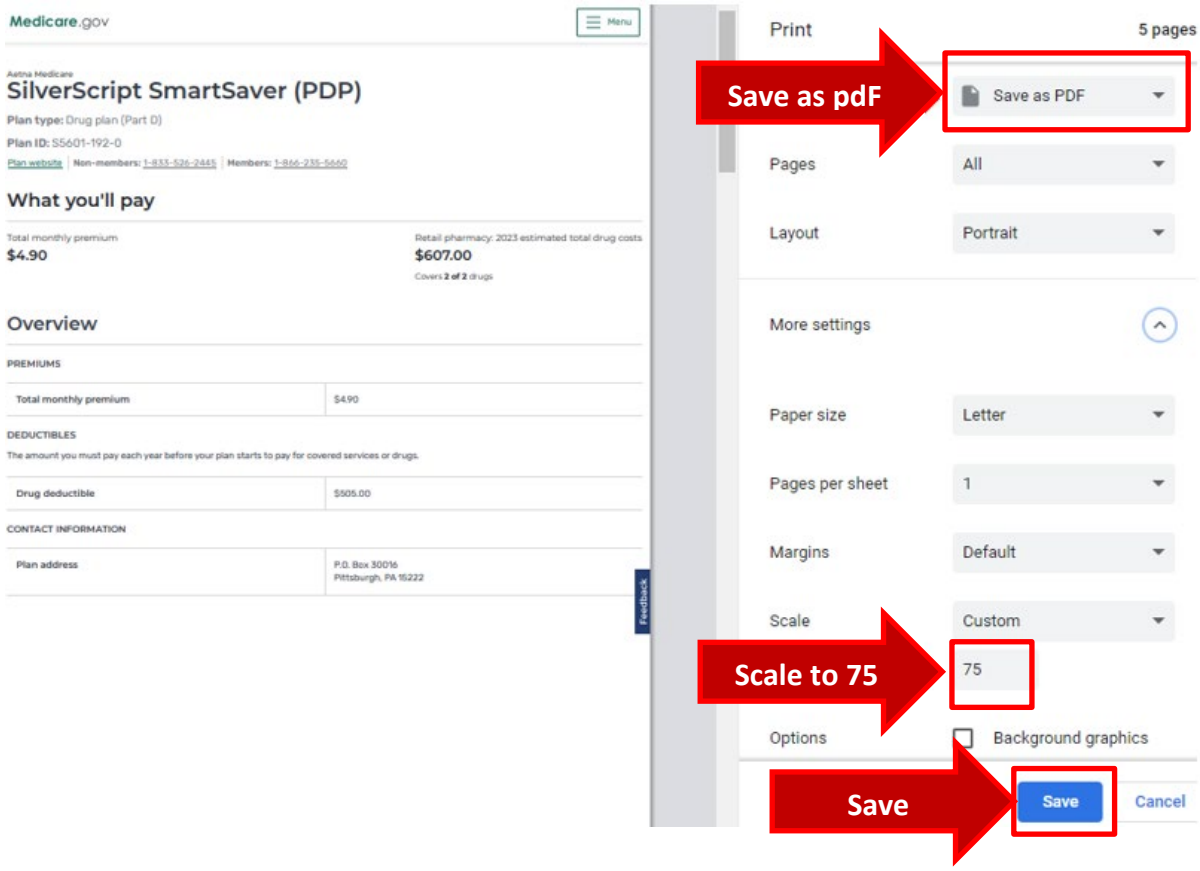
Capturing the Plan Details Page: Save to PDF

At the top of each page of the Plan Finder, there is an option to print the page. You can use this to save the Plan Details page as a PDF.



After you select "Print" (indicated with a red arrow above), you will be taken to a new window and the print options will appear. If "Print to PDF" is an option and is selected:

- **You will be able to save a PDF version of the Plan Finder page** on your computer, and then easily attach it to the BCF. See the first red arrow in the screenshot below.
- **To reduce the number of pages** in the PDF, you may reduce the scale of the document (for example, to 75%) before saving. See the second red arrow in the screenshot below for reducing the scale. See the third red arrow for **saving**.



IMPORTANT: Though taking screenshots was once an acceptable method of displaying verification data, counselors should now save and upload the Plan Details page from the MPF. Please see Appendices A and B for the for the full Plan Details pages for this example. These annotated appendices demonstrate where to find the original and new costs in the Plan Details page.

Security Reminder:

If you are saving Medicare Plan Finder data on a public computer, refer to the STARS Security Slick Sheet in the STARS Resources Kit for tips on how to delete files. Alternatively, use a password protected USB (thumb) drive handy and save them there to attach to BCFs later. The STARS Resources Kit is in the STARS menu, password-protected at **www.shiphelp.org** *(also known as www.shiptacenter.org).*

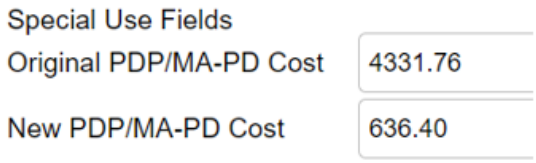
1.1 Switching from one PDP/MA-PD to another

Please see Appendices A and B for the for the full Plan Details pages for this example. These annotated appendices demonstrate where to find the original and new costs in the Plan Details page.

If you are logged into the beneficiary's Medicare.gov account*, the beneficiary's current plan appears first in the list as "Your Current Plan." During the Open Enrollment Period the text display is "Your next plan (if you don't change)."

If the beneficiary stays in their current plan, Elixir RxSecure (PDP), their estimated total drug + premium cost is $4,331.76 at the retail pharmacy of their choice (CVS Pharmacy #17656). This is the original cost.

In this example, the beneficiary decides to enroll in SilverScript SmartSaver (PDP) with an estimated total drug + premium cost of $636.40 at the retail pharmacy of their choice (CVS Pharmacy #17656). This is the new cost.



Notes:

- ✓ If the beneficiary prefers mail-order pharmacy, report mail order pricing.
- ✓ If you are conducting a Medicare Plan Finder search without being logged in as the beneficiary, the search results won't display "Your Current Plan" at the top of the screen. However, you don't have to be logged into a Medicare.gov account to get "original" and "new" costs for PDEO tracking. You just need to ensure that the "original" and "new" costs are reflected in the verification documents and that they match the entries in SUF1 and SUF2.
- ✓ In the example above, the cents were entered. However, you may round to the nearest dollar, if preferred.

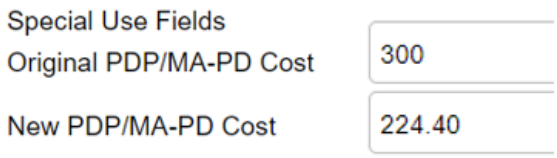
1.2 New to Medicare PDP/MA-PD

Being new to Medicare PDP/MA-PD means the person has no previous Medicare coverage or the person has previous **non**-Medicare drug coverage.

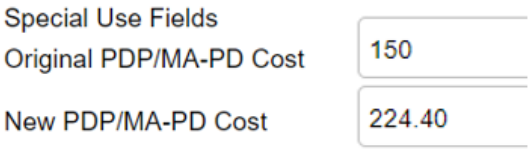
Please see Appendix C for the full Plan Details page for this example. This annotated appendix demonstrates where to find the original and new costs in the Plan Details page.

In the example shown in Appendix C, the beneficiary wants to enroll in Cigna Saver Rx (PDP) with an estimated total drug + premium cost of **$224.40** at the retail pharmacy of their choice (CVS Pharmacy #00321), as the "new cost."

1. To obtain the New PDP/MA-PD Cost, open the Plan Details page and find the "Total drug and premium cost."
2. To obtain the Original PDP/MA-PD Cost, locate the plan's negotiated retail pharmacy drug price on the Plan Details page.
3. Scroll down to find the monthly total cost at the beneficiary's retail pharmacy (or mail order if preferred). You may need to click the "+" button to expand the section with their pharmacy name under "Estimated Drug Costs During Coverage Phases." Find the monthly total under the "Retail cost" column.
4. Multiply this cost by the number of coverage months. Do not include the premium in the original cost calculation.
    a. For enrollment in a plan beginning January 1, the "Original" cost calculation is:
    $25 X 12 months = $300 for the estimated original drug cost.



    b. If the beneficiary enrolls in a plan for the current year, use the number of remaining months in the year. For example, for an enrollment in June, six coverage months apply: July, August, September, October, November, and December. A June enrollment original cost calculation is:
    $25 X 6 months =$150 for the example plan.
        i. Note: For an enrollment in a plan for the current year, the number of months used for the cost calculation should match the number of months listed in the table in the "Estimated Total Monthly Drug Cost" section of the Plan Details page.



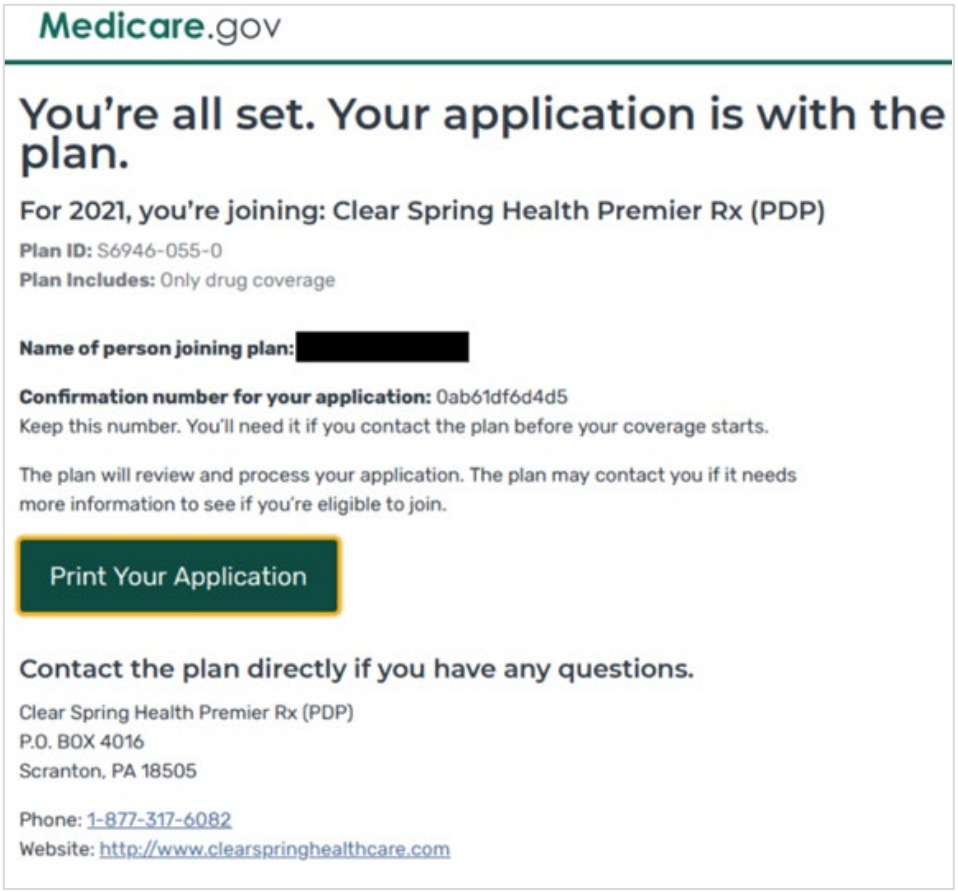
c. If enrollment occurred for the current year plan and next year plan on the same date, then sum the totals of both original costs for SUF1 and both new costs for SUF 2 and report them on the same contact form. See the Attach Verification instructions for more information.

d. Calculation of original costs for fill supplies other than 30 days: Calculate the costs based on the beneficiary's fill schedule and the remaining months of the year. For example, if a beneficiary fills a 90-day supply for a retail price of $89 and they enroll in a plan in May, enter $178 ($89 x 2, 90-day supply) as the cost of the medication June – December.

    i. See FAQ #18 for additional information.

Step 2: Assist Beneficiary with Enrollment

After you assist with enrolling the beneficiary in the new plan, save the MPF Enrollment Request Received page and attach it to the BCF or BAS (*See Tips for Capturing Medicare Plan Finder Information*). This is the other component required for verification of the cost data to be attached to the BCF or BAS. After an authenticated beneficiary submits an enrollment request, MPF will send a notice to the beneficiary's Medicare Message Center, which will provide details about their enrollment request along with their OEC confirmation number. A PDF of the OEC message or the MPF Enrollment Request Received page can be used as enrollment verification documentation.



Medicare.gov

You're all set. Your application is with the plan.

For 2021, you're joining: Clear Spring Health Premier Rx (PDP)

Plan ID: S6946-055-0
Plan Includes: Only drug coverage

Name of person joining plan: [redacted]

Confirmation number for your application: 0ab61df6d4d5
Keep this number. You'll need it if you contact the plan before your coverage starts.

The plan will review and process your application. The plan may contact you if it needs more information to see if you're eligible to join.

Print Your Application

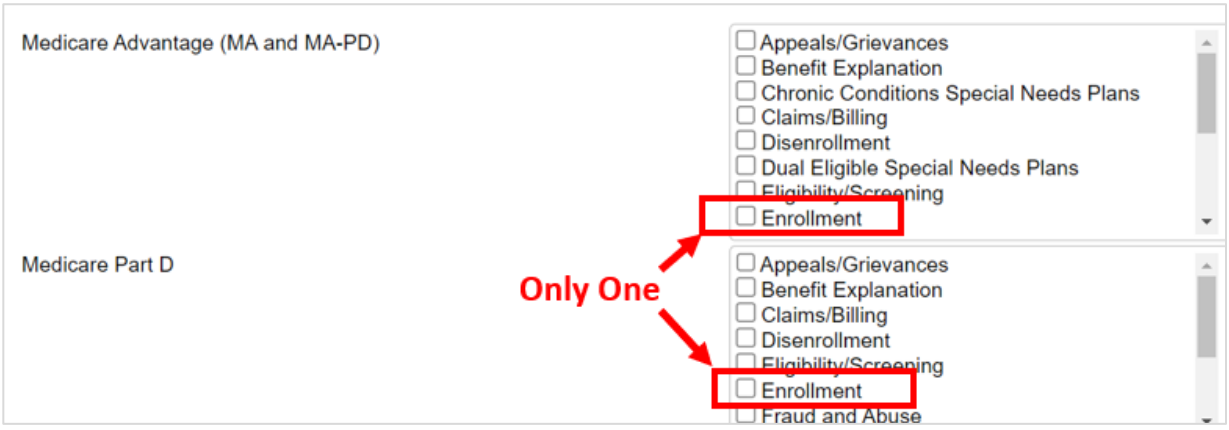
Contact the plan directly if you have any questions.

Clear Spring Health Premier Rx (PDP)
P.O. BOX 4016
Scranton, PA 18505

Phone: 1-877-317-6082
Website: http://www.clearspringhealthcare.com

Step 3: Enter Enrollment Data in STARS

A. Topics Discussed: Check the *Enrollment* topic in **either** the "Medicare Advantage (MA and MA-PD)" or "Medicare Part D" sub-category to report enrollment assistance, not **both**.



✓ Remember to select all additional topics discussed, as applicable. Multiple topics are often discussed in one counseling session.

Enrollment topics validation errors:

1. Users are unable to save a record if they have selected *both* the enrollment topics illustrated above and have cost data entered in the first two Special Use Fields (SUFs). A red validation message will remind users of their error, and it must be corrected before the form can be successfully saved:

> **Validation Error**
> - **You have entered cost into SUF1 and SUF 2, if enrollment assistance was provided, please ensure you have checked the Medicare Part D or Medicare Advantage (MA and MA-PD) enrollment box. If enrollment assistance was not provided, please remove costs from SUF1 and SUF2.**

✓ If you enroll a beneficiary in an MA-only plan and a stand-alone PDP plan in the same visit, mark only Medicare Part D enrollment. For more details, please see FAQ # 16.

2. Users are unable to save their record if they have selected *neither* of the enrollment topics illustrated above and have cost data entered in the first two Special Use Fields (SUFs). A red validation message reminds users of their error, and it must be corrected before the form can be successfully saved:

> **Validation Error**
> - **You have entered cost into SUF1 and SUF 2, please ensure that only one "Enrollment" topic is selected in Medicare Part D or Medicare Advantage (MA and MA-PD).**

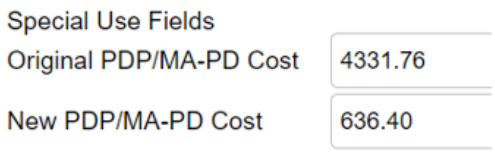
B. **If the beneficiary is <u>new to PDP/MA-PD</u>**, like example 1.2, select the *New to Medicare* topic in the "Additional Topic Details" group. (You must scroll to find this topic.)

Notes:

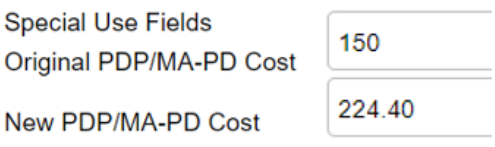
- ✓ Failing to appropriately select New to Medicare on associated contacts could impact your ability to report PDEO cost change data. This is one area that is checked when ACL reviews verification documents.
- ✓ Checking this topic will allow ACL to track cost changes based on the plan's negotiated price vs. switching from one PDP-MA-PD to another. Cost changes based on the plan's negotiated price may be significantly higher and the ability to identify these instances is important.
- ✓ Select New to Medicare if the beneficiary has been enrolled in other parts of Medicare previously (ex. Medicare A or B) but is new to Part D, or if the beneficiary dropped or lost their Part D and now wants to re-enroll.
- ✓ If you are reporting cost changes on a follow up contact on a BAS, be sure to mark *New to Medicare* on the BAS too.

C. Enter cost data from the Plan Details page of the MPF in the Special Use Fields (SUFs) toward the bottom of the BCF or BAS. (Dollar values from previous examples in this chapter appear below.)

Ex. 1.1 (Switching Plans):



Ex. 1.2 (New to Medicare):



Valid character verification errors

STARS Special Use Fields (SUFs) for PDEO tracking only accept the following types of characters: dollar signs, commas, numbers, and decimal points. You are also limited to two decimal places.

- ✓ On-screen red text appears when data is being entered in SUF1 and SUF2 that reminds users about valid characters:

  Please enter valid input into both Special Use fields. Valid input examples: "1.00"; "1.23"; "1"; "$1"; "$1.00"; "1,000"; "1,000.00"

- ✓ If the user doesn't comply with the valid character rules, they will be unable to save their record until they have edited their entries to comply. They will receive this validation error after a save attempt:

  Validation Error
  - **Please enter valid input into the PDP/MA-PD Cost fields. Valid input examples: "1.00" "1.23"; "1"; "$1"; "$1.00"; "1,000"; "1,000.00".**

- ✓ Previously entered records that do not comply with these criteria will remain as-is unless the record is resaved by a user. Resaving will require the fields to be updated to comply with new criteria.

Valid field completion verification errors

Validation criteria flag SUF entries that do not comply with a key PDEO tracking requirement. If one of the two SUFs dedicated to PDP/MA-PD cost is completed but the other is not, a red validation message reminds users of their error. The error must be corrected before the form can be successfully saved:

Validation Error
- **Please enter valid input into both Special Use fields.**

- ✓ Previously entered records that do not comply with the criteria will remain as-is unless the record is resaved by a user. Resaving will require the fields to be updated to comply with new criteria.
- ✓ Report Note: STARS does not calculate the cost change on the BCF or BAS. Calculations of cost changes will occur in the PDEO Aggregate Reports and PDEO QA Review Report. These reports are only visible to STARS users with access to the Configuration menu.

Step 4: Attach Verification

To verify the PDP/MA-PD cost data reported on the BCF or BAS, you must attach the MPF Plan Detail pages showing the costs as they appear on the MPF and enrollment verification page for the new plan from MPF. Each BCF or BAS in STARS has the capacity to accept five attachments, and they are located toward the bottom of the form.

- File types accepted in STARS: pdf, png, jpeg, rtf, doc/docx; ppt/pptx; xls/xlxs, m4a, csv, html, xml, bmp. The limit on file size attachments in STARS: 500MB per file.
- Upload the Plan Details and the enrollment verification documents into STARS or save on file (print or electronic) in the SHIP office.

Switching plans verification documents

When verifying cost changes for someone changing plans, you must upload three attachments:

1. MPF Plan Details for the original plan
2. MPF Plan Details for the new plan
3. Enrollment verification for the new plan

Plan Details requirements when switching plans:

- ✓ Original and new plan names must be listed on the Plan Details.
- ✓ Yearly drug and premium costs must be shown to verify cost entered in the Original PDP/MA-PD and New PDP/MA-PD Special Use Fields. This information can be found in the Estimated Total Drug + Premium Cost section of the Plan Details.
- ✓ If the beneficiary takes insulin, save the Plan Details page with the insulin medications showing. No additional math is required for insulin users when reporting PDEO cost changes. The 2023 cost will be slightly inflated, but it reflects the best information available in Medicare Plan Finder for 2023 plans.

New to Medicare Verification Documents

When verifying cost changes for someone new to Medicare, you must upload two attachments:

1. MPF Plan Detail pages for the plan they selected
2. Enrollment verification for the plan

Plan Details requirements when new to Medicare:

- ✓ New plan name must be listed on the Plan Details.
- ✓ Monthly totals (Retail cost) must be shown to verify the cost entered in the Original PDP/MA-PD Special Use Field.
- ✓ Yearly drug and premium costs must be shown to verify cost entered in the New PDP/MA-PD Special Use Field. This can be found in the Estimated Total Drug + Premium Cost section of the Plan Details.
- ✓ If the beneficiary takes insulin, save the Plan Details page with the insulin medications showing. No additional math is required for insulin users when reporting PDEO cost changes. The 2023 cost will be slightly inflated, but it reflects the best information available in Medicare Plan Finder for 2023 plans.

Enrollment verification requirements for all PDEO tracking:

- ✓ The new plan's name must be listed on the enrollment verification. It must also match the name listed on the Plan Details for the new plan.

New to Medicare in current year AND switching plans for the next year in the same session

During the Open Enrollment Period from October 15 – December 7 each year, you may occasionally counsel beneficiaries who are new to Medicare late in the calendar year. They may select one plan for the current year but a different plan for the next year. When verifying cost changes for someone in this situation, you must upload four attachments:

1. MPF Plan Details for the plan selected when new to Medicare
    a. This will also serve as the Plan Details for the original plan when verifying cost changes for the next year
    b. Follow the Plan Details verification requirements described earlier for people new to Medicare
2. MPF Plan Details for the different plan selected for the next year
    a. Follow the Plan Details verification requirements described earlier for people switching plans
3. Enrollment verification for the plan selected for the current year when new to Medicare
    a. Follow the enrollment verification requirements for all PDEO tracking
4. Enrollment verification for the new plan selected for the next year
    a. Follow the enrollment verification requirements for all PDEO tracking

Reminder: Report the costs on the same BCF or BAS form. Sum both original costs and enter the combined total into SUF1. Sum both new costs and enter the combined total into SUF2. Upload the required documents in STARS or save them on file in the SHIP office.

ACL Review

As a part of the PDEO QA Review process, ACL will conduct reviews of verification documents for randomly selected contacts. If your SHIP does not currently upload verification documents into STARS, ACL will reach out to the SHIP director to request that verification documents be uploaded to assist ACL with completing the review to determine the error rate for each SHIP.

What to do if you assist a beneficiary with enrollment outside of the MPF

In these limited circumstances – assisting over the phone, through 1-800-Medicare, or through the plan via phone – you should request a copy of the enrollment verification from the beneficiary. If you cannot get a copy from the beneficiary, list the enrollment confirmation number in the notes section of the BCF or BAS form.

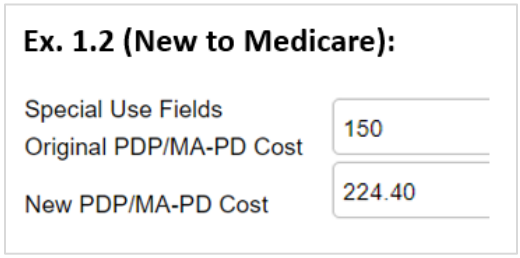
Notes	

FAQs about Reporting PDP/MA-PD Cost Data

Question 1: How should I report when a beneficiary is new to Medicare or the beneficiary's plan is no longer available (plan termination or move to new service area)?

Answer: Regardless of the previous coverage or lack of coverage, report the 'monthly retail cost X number of coverage months' associated with the new plan in the "Original PDP/MA-PD Cost" SUF 1. Find this cost by clicking the Plan Details blue box. The beneficiary decides to enroll in Cigna Saver Rx (PDP) with an estimated total drug + premium cost of $224.40. See FAQ #18 for information about fill supplies other than 30 days.

To calculate the original cost, scroll down in the Plan Details page to the drug costs for the beneficiary's pharmacy of choice, CVS Pharmacy #00321. Locate the monthly total in the retail cost column. In this instance, the monthly retail cost is $25 per month and the beneficiary needs coverage for six months, July to December. The calculation is $25 x 6 months = $150. (The premium is never factored into the original cost when beneficiaries are new to Medicare.) Enter $150 in the Original PDP/MA-PD SUF 1 field. Enter the SilverScript Plus (PDP) estimated total drug + premium cost in the New PDP/MA-PD Cost SUF 2 field: $224.40 in this example.



- ✓ **Please see Appendix C for the for the full Plan Details page for the example above.** The annotated appendix demonstrates where to find the original and new costs in the Plan Details page.

Question 2: How should I report when a beneficiary is automatically enrolled (also known as facilitated enrollment) into a plan ("Plan A"), but the SHIP assists the client in enrolling in a different plan ("Plan B")?

Answer: Report the estimated yearly drug and premium costs for Plan A in the "Original PDP/MA-PD Cost" field and report the estimated yearly drug and premium costs for Plan B in the "New PDP/MA-PD Cost" field.

Question 3: Should I report when a SHIP helps enroll a client in a new PDP/MA-PD plan, but the client doesn't experience savings, or pays more for the new PDP/MA-PD plan?

Answer: Yes, report the data. There are a number of reasons a beneficiary might select a higher cost plan. ACL collects cost change data on all PDP/MA-PD enrollments, including those that did not results in savings for the beneficiary.

Question 4: What should be reported if I provide a beneficiary assistance with PDP/MA-PD comparison, but do not help enroll the beneficiary in a different PDP/MA-PD?

Answer: Do not report any data in the Original or New PDP/MA-PD cost fields. ACL collects cost change data only on instances where the SHIP actively assisted the beneficiary in enrollment. Comparison work is critical and reflected in SHIP Performance Measure 5.

Question 5: What should be reported if I provide a beneficiary with Part D savings by assisting the beneficiary in switching to another pharmacy, but the beneficiary does not change plans?

Answer: Do not report any data in the Original or New PDP/MA-PD cost fields. ACL collects cost change data only on instances where the SHIP assisted the beneficiary with enrollment, and no enrollment took place in this instance.

Question 6: What should be reported if I help a beneficiary locate and enroll in a pharmaceutical assistance program or other form of non-Part D prescription assistance?

Answer: Even though this assistance can save the beneficiary a great deal of money, it should not be reported because no PDP/MA-PD enrollment took place.

Question 7: What should be reported if I provide a beneficiary with Extra Help/LIS application assistance?

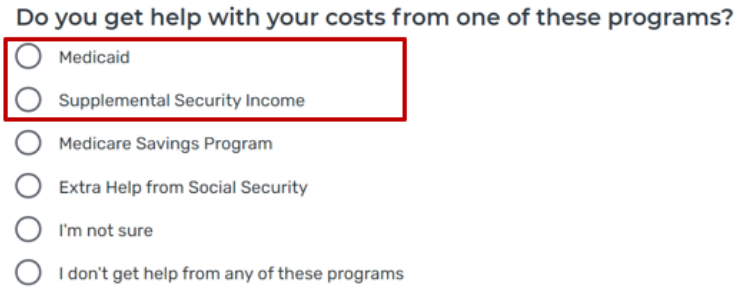
Answer: Do not report any data in the Original or New PDP/MA-PD cost fields because no PDP/MA-PD enrollment occurred. This assistance is critical and reflected in the MIPPA Performance Measures.

Question 8: What should I report for a beneficiary eligible for Limited Income Newly Eligible Transition Program (LINET)? If applicable, how should I calculate retroactive enrollment costs?

Answer: LINET is a temporary PDP coverage for beneficiaries awarded Extra Help but not yet enrolled in a PDP or MA-PD coverage. LINET enrollment occurs at the pharmacy counter, can last up to 2 months, and may be retroactive. The Medicare Plan Finder may reflect LINET costs. If so, use the LINET costs listed in the MPF. If LINET is not reflected in the MPF, LINET costs are consistent with Extra Help costs. A SHIP counselor can assist with simultaneous enrollment in both LINET and a PDP or MA-PD. Commonly, SHIP will notify the pharmacy of the beneficiary's LINET eligibility status with Best Available Evidence (Extra Help letter) and provide enrollment assistance into a PDP or MA-PD with an effective date the following month.

In these instances, report PDEO costs to begin the enrollment effective date in the PDP or MA-PD in the same manner you would for a beneficiary new to Medicare. If the beneficiary's logged in experience reflects their up-to-date Extra Help status, the SUF1 and SUF 2 costs will be

accurate. If the Extra Help status is not up to date, conduct an anonymous search and select help from Medicaid or Supplemental Security Income to obtain Extra Help costs consistent with LINET (see Medicare Plan Finder screenshot below). Do not report retroactive LINET costs.



Question 9: What should be reported if I help a beneficiary with an enrollment for the current year and a future year during a counseling session (may occur during Open Enrollment Period)?

Answer: Sum the cost changes for each plan and report on the same BCF/BAS. Because the contact occurs on the same day with the same counselor as part of the same session, these should be reported together. Be sure to attach documentation for each plan's application and all Plan Detail pages to the BCF for verification.

Question 10: What happens if no cost change verification attachments are on the BCF or BAS and there are cost amounts in the Special Use Fields?

Answer: Verification documents are a requirement. Semi-annual quality assurance reviews are a minimum requirement. In the quality assurance process, cost change data reported without required documentation should be moved from the SUFs into the notes section of the BCF or BAS while the remainder of form remains unchanged. This will allow the data to remain with the BCF or BAS but not be included in the PDEO Aggregate Report.

Question 11: Will we be able to pull a report showing the amount of money our SHIP Counselors saved beneficiaries during open enrollment?

Answer: The Part D Enrollment Outcomes Aggregate Report includes cost change calculations. The Aggregate Report and Quality Assurance (QA) Report are available in STARS within the Configuration menu. SHIP leaders must attest to completion of the QA report process prior to publishing cost change results. ACL will conduct PDEO Quality Assurance reviews for a random selection of each SHIPs verification documents (Plan Details and Enrollment Verification) to determine the state's error rate. Only those SHIPs that meet the established error rate requirement may publish their cost change data publicly.

Question 12: If we conduct a plan finder comparison for someone, but they decide to enroll later, such as through 1-800-Medicare, can we enter the cost information?

Answer: No, only enter cost information if you help them enroll, not if they decide to enroll on their own at a later date or with help from another source, such as 1-800-Medicare. Comparison work is critical and reflected in SHIP Performance Measure 5.

Question 13: Will ACL accept Plan Detail verification pages with beneficiary names blacked out?

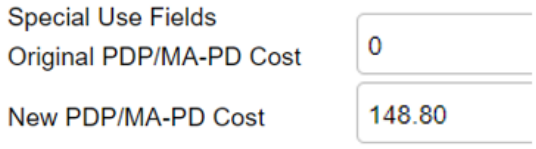
Answer: Yes, it is acceptable to black out the beneficiary's name so long as the plan name is legible. Also, the beneficiary's name is not a required field in STARS. You would be able to omit the beneficiary identity, if desired, by leaving both the name field blank and blocking out the name on any enrollment verification documentation you upload.

Question 14: What should I report if I help a beneficiary enroll in a different plan, but the beneficiary doesn't take any medication?

Answer: Enter the annual premium cost only for the current/original plan and the new plan. For example, the WellCare value Script (PDP) monthly premium is $18.70 a month x 12 months = $224.40 annual cost.

Question 15: What should I report if I help a beneficiary enroll in a plan, but the beneficiary doesn't take any medication and is new to Medicare?

Answer: Because the beneficiary is new to Medicare, the premium is not included in the original cost SUF. Because the beneficiary takes no medications, the original cost is zero. To calculate the amount for the new cost SUF and using the previous example for Cigna Saver Rx (PDP), enter the annual premium cost only. For example, the monthly premium is $12.40 a month x 12 months = $148.80 annual cost as the New PDP/MA-PD Cost.



Question 16: What should I report if I help a beneficiary enroll in a MA-only plan and PDP during the same contact?

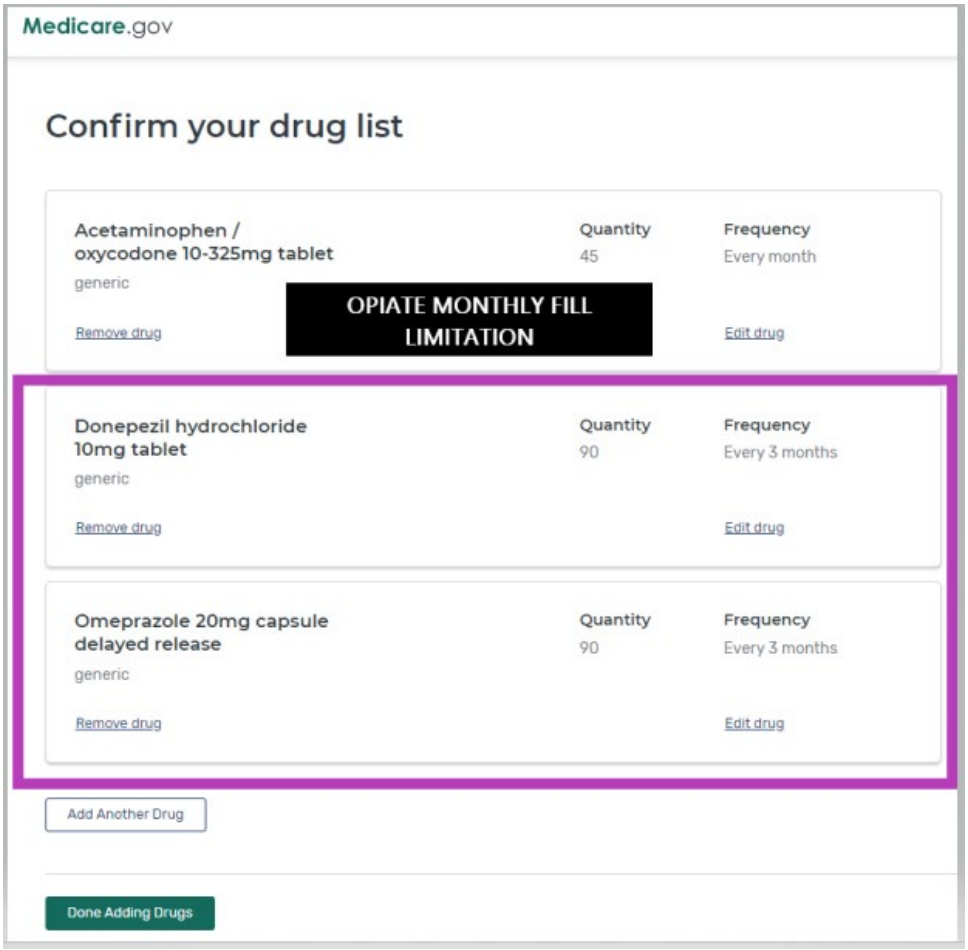
Answer: In these instances, mark only the PDP enrollment box on the contact form. While both the MA-only and PDP enrollment are valid, marking both will result in inability to save due to validation rules.

Question 17: How should I provide the enrollment confirmation if I cannot get a copy from a beneficiary that enrolls themselves or through a plan website or through 1-800-Medicare? Can I still report the cost changes?

Answer: If obtaining the enrollment confirmation in these limited circumstances is not possible (assistance over the phone, through 1-800-Medicare, or through the plan via phone), list the enrollment confirmation number in the notes section of the BCF or BAS form.

Question 18: How should I report when the beneficiary is new to Medicare and their medication fills are not on a 30-day supply? The MPF defaults to a monthly pricing and I don't want to inflate the cost.

Answer: In this example, the beneficiary fills one medication on a 30-day supply (an opiate) and two medications on a 90-day supply (purple box highlight). Be careful to check the days' supply entered in the *Confirm your drug list* page.



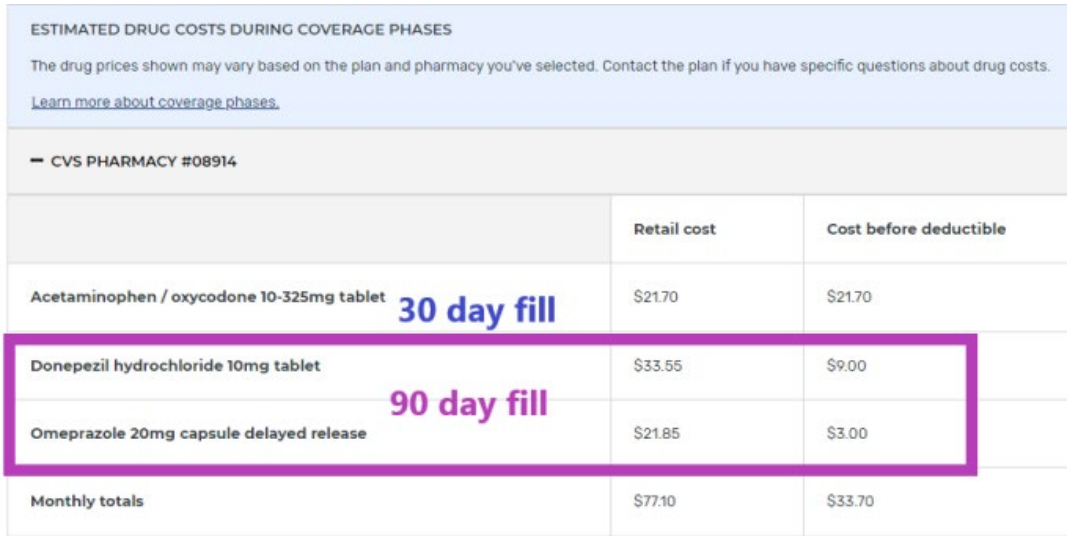
The following example reflects an August enrollment with an effective date of September 1st. In this instance, MPF automatically calculates costs for the remainder of the year, September – December.

Instructions to obtain the Original and New PDP/MA-PD Costs are as follows (next page):

Original PDP/MA-PD Cost = $197.50.

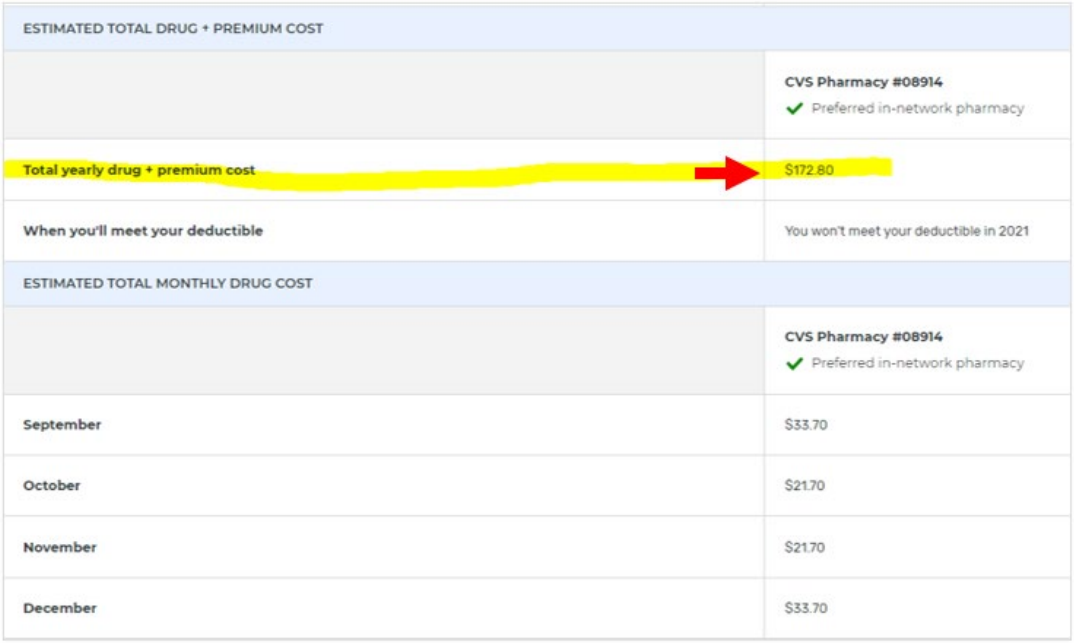
The original cost totals $197.50, accounting for a 30-day fill of one medication and 90-day fills of two medications. Do not include the premium in the original cost calculation.

	Retail cost	Day Supply	Sept.	Oct.	Nov.	Dec.	Original Cost
Acetaminophen/oxycodone	$21.70	30	$ 21.70	$ 21.70	$ 21.70	$ 21.70	$ 86.80
Donepezil hydrocholoride	$33.55	90	$ 33.55			$ 33.55	$ 67.10
Omerprazole	$21.80	90	$ 21.80			$ 21.80	$ 43.60
							$ 197.50



New PDP/MA-PD Cost = $172.80

The cost totals $172.80, listed as 'Total yearly drug + premium cost' in yellow highlight in the screenshot of the Plan Details page. This cost is automatically adjusted based on the enrollment date.



Question 19: Is tracking cost changes required?

Answer: ACL strongly encourages grantees and team members to participate in the Part D enrollment outcome tracking process to track cost changes, and this was included in the SHIP Funding Opportunity Announcement (FOA) Terms and Conditions. However, tracking Part D enrollment outcomes is not a requirement. If you are uncertain about whether your program is participating in the Part D enrollment outcome, check with your supervisor or SHIP director. Regardless of participation, all SHIPs are required to complete the Part D enrollment outcomes quality assurance process and all SHIP directors are required to submit the Part D Enrollment Outcomes Quality Assurance Report and Attestation twice annually (by March 31 and September 30).

Question 20: How do we document cost changes when a beneficiary's costs change because they chose a new pharmacy while making their enrollment decision? Would we document the original cost for SUF1 using their current pharmacy, then document the new cost in SUF2 with the new pharmacy?

Answer: Counselors can document the costs with the original and new pharmacy or choose to use only the new pharmacy costs. If you are reflecting costs at two pharmacies, be sure to capture a Plan Detail Page view to document the estimated drug costs. The verification documentation should indicate the costs of the plan at each pharmacy, matching the entries in the SUFs. This would require obtaining a Plan Detail Page view for each plan including the appropriate pharmacy's cost. Adding a note in the BCF indicating the pharmacy change is a best practice and can be helpful during the quality assurance process, but it is not required. Counselors should obtain documentation reflecting the beneficiary's pharmacy of choice, regardless of cost. The aim of PDEO is to highlight cost changes the beneficiary is estimated to experience rather than the pharmacy with the lowest available cost.

Question 21: How can I be sure the Medicare Plan Finder (MPF) costs are reflected in the right year during the Medicare Open Enrollment Period (OEP)? Does it matter if I'm logged into a Medicare.gov account?

Answer: During the Open Enrollment Period the MPF lists costs for both the current and future year in both the Medicare.gov logged in path and the anonymous path. You can toggle back and forth between the years if you need to help someone enroll in a plan in the current year and the future year. For example, if a beneficiary starts Medicare in November 2022, they may wish to enroll in a plan in October 2022 for coverage effective in November 2022. Additionally, the beneficiary may wish to enroll in October 2022 for a plan to start in January 2023. Be careful to select the appropriate year for viewing in the MPF and save the verification documentation for each year's enrollment.

Question 22: How can I show the beneficiary's current plan cost for Special Use Field 1 (SUF 1) if they do not have a Medicare.gov account or I'm not logged into their account?

Answer: When using the anonymous path (not logged into a Medicare.gov account), you will need to enter the beneficiary's zip code and indicate whether they receive benefits from Medicaid, SSI, an MSP, or Extra Help. When asked if you want to see drug costs when comparing plans, select "Yes" and enter the all the beneficiary's prescribed drugs and dosages. Then, select one or more preferred pharmacies. The beneficiary's original plan should appear in the list of available plans. To confirm the beneficiary's original plan, the counselor can ask for the plan ID number from the beneficiary's insurance card to ensure the proper plan is selected because some parent organizations sell more than one plan. Open, save, and upload the Plan Details page for the beneficiary's original plan, as well as the new plan that you help them enroll into.

Technical Assistance

Booz Allen Hamilton (a.k.a. "Booz Allen"): For difficulties with usernames, passwords, and to unlock accounts, contact the Booz Allen STARS help desk at boozallenstarshelpdesk@bah.com or 703-377-4424.

SHIP Technical Assistance Center (SHIP TA Center): The SHIP TA Center provides programmatic support for the use of STARS. They provide this support through live training, the STARS manual, handouts, pre-recorded training, and 1-on-1 technical assistance.

- **Archived webinars, manual, handouts, and pre-recorded training:** Login at www.shiphelp.org and go to "STARS" in the navigation pane.
- **Live training:** Webinars and office hours are announced by email to registered users at shiphelp.org, or you can register using the "Events" menu after logging in. To receive STARS training announcements, you must be on the Center distribution list (check the box on "My Profile" when logged in at www.shiphelp.org).

- **Technical Assistance:** A dedicated email address has been set up to receive emailed questions about STARS: stars@shiptacenter.org. You can also call for technical assistance using our toll-free number, 877-839-2675 (say "Center" when prompted).
- **Website Access Support:** For assistance accessing password-protected STARS resources, email info@shiptacenter.org or call our toll-free number, 877-839-2675 (say "Center" when prompted).

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Plan Details Pages (Appendices)

See the attached PDF file for three annotated Medicare Plan Finder results that illustrate how to collect cost change information in three circumstances. They are:

A. Appendix A: Annotated Plan Details page for Switching Plans Example (Original Plan)

a. See pages 23 – 27 of the PDF

b. Additional instructions appear in red on page 24

B. Appendix B: Annotated Plan Details page for Switching Plans Example (New Plan)

a. See pages 28 – 32 of the PDF

b. Additional instructions appear in red on page 29

C. Appendix C: Annotated Plan Details page for New to Medicare Example

a. See pages 33 – 37 of the PDF

b. Additional instructions appear in red on pages 34 and 35.

Elixir Insurance

Elixir RxSecure (PDP)

Plan type: Drug plan (Part D)

Plan ID: S7694-017-0

Plan website | **Non-members:** 1-866-250-2005 | **Members:** 1-866-250-2005

What you'll pay

Total monthly premium

$29.10

Retail pharmacy: 2023 estimated total drug costs

$4,157.16

Covers **1 of 2** drugs

Overview

PREMIUMS

Total monthly premium	$29.10

DEDUCTIBLES

The amount you must pay each year before your plan starts to pay for covered services or drugs.

Drug deductible	$505.00

CONTACT INFORMATION

Plan address	7835 Freedom Avenue NW North Canton, OH 44720

Drug Coverage

See if there's help to lower costs for drugs you take.

PHARMACIES

Check the network status of each pharmacy on your list. You can change pharmacies at any time to find lower costs for drugs.

Add pharmacies to compare costs.

We can estimate your yearly out-of-pocket drug costs at each pharmacy you add. The more pharmacies you add, the more estimates you'll get to help you compare costs.

CVS PHARMACY #17656	Preferred In-network

YEARLY DRUG COSTS BY PHARMACY

Drug costs shown vary based on the plan and pharmacy that you use. Contact the plan if you have specific questions about drug costs. Can my drug costs change by pharmacy?

	CVS Pharmacy #17656 Preferred
Atorvastatin 40mg tablet	$78.06
Farxiga 10mg tablet	$4,079.10
Total yearly drug cost	$4,157.16

ESTIMATED TOTAL DRUG + PREMIUM COST

Ensure that you are viewing the estimated total drug + premium cost for the beneficiary's preferred pharmacy.

	CVS Pharmacy #17656 Preferred
Total drug + premium cost (for the rest of 2023)	$4,331.76
When you'll meet your deductible	You won't meet your deductible in 2023
When you'll enter the coverage gap	You won't enter the coverage gap in 2023

This is the original cost. Enter this value into the Original PDP/MA-PD Cost field in STARS.

ESTIMATED TOTAL MONTHLY DRUG COST

	CVS Pharmacy #17656 Preferred
July	$692.86
August	$692.86
September	$692.86
October	$692.86
November	$692.86
December	$692.86

ESTIMATED DRUG COSTS DURING COVERAGE PHASES

The drug prices shown may vary based on the plan and pharmacy you've selected. Contact the plan if you have specific questions about drug costs.

Learn more about coverage phases.

+ CVS PHARMACY #17656

	Retail cost	Cost before deductible	Cost after deductible	Cost in coverage gap	Cost after coverage gap
Atorvastatin 40mg tablet	$13.01	$13.01	$1.00	$3.25	$4.15
Farxiga 10mg tablet [1]	$679.85	$679.85	$679.85	$679.85	$679.85
Monthly totals	$692.86	$692.86	$680.85	$683.10	$684.00

[1] This plan does not cover this drug, the price shown is the full cash price.

COSTS BY DRUG TIER

Plans group their drug lists into tiers. The drug costs below show how much you'll pay for drugs in each tier based on the coverage phase you're in.

Learn more about drug tiers.

	Initial coverage phase	Gap coverage phase	Catastrophic coverage phase
Preferred Generic	$1.00 copay	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Generic	$4.00 copay	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Preferred Brand	15%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Non-Preferred Drug	34%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Specialty Tier	25%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)

OTHER DRUG INFORMATION

	Tier	Prior authorization	Quantity limits	Step therapy
Atorvastatin 40mg tablet	Tier 1	–	–	–
Farxiga 10mg tablet	Not covered	–	–	–

MY DRUG LIST

	Package	Quantity	Frequency	Brand/Generic
Atorvastatin 40mg tablet		30	Every month	Generic
Farxiga 10mg tablet		30	Every month	Brand

PART B DRUGS

These are drugs you usually get at a doctor's office or hospital outpatient setting, like the flu shot, chemotherapy, or other shots.

Chemotherapy drugs	Not covered	
Other Part B drugs	Not covered	

Star Ratings

+ Expand All Ratings

Overall star rating

Overall rating is based on the categories below.

+ **Drug plan star rating**

Summary rating of drug plan quality

Aetna Medicare

SilverScript SmartSaver (PDP)

Plan type: Drug plan (Part D)

Plan ID: S5601-192-0

Plan website | **Non-members:** 1-833-526-2445 | **Members:** 1-866-235-5660

What you'll pay

Total monthly premium

$4.90

Retail pharmacy: 2023 estimated total drug costs

$607.00

Covers **2 of 2** drugs

Overview

PREMIUMS

Total monthly premium	$4.90

DEDUCTIBLES

The amount you must pay each year before your plan starts to pay for covered services or drugs.

Drug deductible	$505.00

CONTACT INFORMATION

Plan address	P.O. Box 30016 Pittsburgh, PA 15222

Drug Coverage

See if there's help to lower costs for drugs you take.

PHARMACIES

Check the network status of each pharmacy on your list. You can change pharmacies at any time to find lower costs for drugs.

Add pharmacies to compare costs.

We can estimate your yearly out-of-pocket drug costs at each pharmacy you add. The more pharmacies you add, the more estimates you'll get to help you compare costs.

CVS PHARMACY #17656	Preferred In-network

YEARLY DRUG COSTS BY PHARMACY

Drug costs shown vary based on the plan and pharmacy that you use. Contact the plan if you have specific questions about drug costs. Can my drug costs change by pharmacy?

	CVS Pharmacy #17656 Preferred
Atorvastatin 40mg tablet	$12.00
Farxiga 10mg tablet	$595.00
Total yearly drug cost	$607.00

ESTIMATED TOTAL DRUG + PREMIUM COST

Ensure that you are viewing the estimated total drug + premium cost for the beneficiary's preferred pharmacy.

	CVS Pharmacy #17656 Preferred
Total drug + premium cost (for the rest of 2023)	$636.40
When you'll meet your deductible	July 2023
When you'll enter the coverage gap	You won't enter the coverage gap in 2023

This is the new cost. Enter this value into the New PDP/MA-PD Cost field in STARS.

ESTIMATED TOTAL MONTHLY DRUG COST

	CVS Pharmacy #17656 Preferred
July	$522.00
August	$17.00
September	$17.00
October	$17.00
November	$17.00
December	$17.00

ESTIMATED DRUG COSTS DURING COVERAGE PHASES

The drug prices shown may vary based on the plan and pharmacy you've selected. Contact the plan if you have specific questions about drug costs.

Learn more about coverage phases.

+ CVS PHARMACY #17656

	Retail cost	Cost before deductible	Cost after deductible	Cost in coverage gap	Cost after coverage gap
Atorvastatin 40mg tablet	$2.26	$2.00	$2.00	$0.57	$2.26
Farxiga 10mg tablet	$610.92	$610.92	$15.00	$152.73	$30.55
Monthly totals	$613.18	$612.92	$17.00	$153.30	$32.81

COSTS BY DRUG TIER

Plans group their drug lists into tiers. The drug costs below show how much you'll pay for drugs in each tier based on the coverage phase you're in.

Learn more about drug tiers.

	Initial coverage phase	Gap coverage phase	Catastrophic coverage phase
Preferred Generic	$2.00 copay	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Generic	$15.00 copay	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Preferred Brand	25%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Non-Preferred Drug	50%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Specialty Tier	25%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)

OTHER DRUG INFORMATION

	Tier	Prior authorization	Quantity limits	Step therapy
Atorvastatin 40mg tablet	Tier 1	–	Yes	–
Farxiga 10mg tablet	Tier 2	–	Yes	–

MY DRUG LIST

	Package	Quantity	Frequency	Brand/Generic
Atorvastatin 40mg tablet		30	Every month	Generic
Farxiga 10mg tablet		30	Every month	Brand

PART B DRUGS

These are drugs you usually get at a doctor's office or hospital outpatient setting, like the flu shot, chemotherapy, or other shots.

Chemotherapy drugs	Not covered	
Other Part B drugs	Not covered	

Star Ratings

+ Expand All Ratings

Overall star rating

Overall rating is based on the categories below.

+ **Drug plan star rating**

Summary rating of drug plan quality

Cigna

Cigna Saver Rx (PDP)

Plan type: Drug plan (Part D)

Plan ID: S5617-352-0

Plan website | **Non-members:** 1-800-735-1459 | **Members:** 1-800-222-6700

What you'll pay

Total monthly premium

$12.40

Retail pharmacy: 2023 estimated total drug costs

$150.00

Covers **2 of 2** drugs

Overview

PREMIUMS

Total monthly premium	$12.40

DEDUCTIBLES

The amount you must pay each year before your plan starts to pay for covered services or drugs.

Drug deductible	$505.00

CONTACT INFORMATION

Plan address	P 0 Box 269005 Weston, FL 33326

Drug Coverage

See if there's help to lower costs for drugs you take.

PHARMACIES

Check the network status of each pharmacy on your list. You can change pharmacies at any time to find lower costs for drugs.

Add pharmacies to compare costs.

We can estimate your yearly out-of-pocket drug costs at each pharmacy you add. The more pharmacies you add, the more estimates you'll get to help you compare costs.

CVS PHARMACY #00321	In-network

YEARLY DRUG COSTS BY PHARMACY

Drug costs shown vary based on the plan and pharmacy that you use. Contact the plan if you have specific questions about drug costs. Can my drug costs change by pharmacy?

	CVS Pharmacy #00321 In-network
Prazosin 2mg capsule	$97.50
Sertraline 50mg tablet	$52.50
Total yearly drug cost	$150.00

ESTIMATED TOTAL DRUG + PREMIUM COST

Ensure that you are viewing the estimated total drug + premium cost for the beneficiary's preferred pharmacy.

	CVS Pharmacy #00321 In-network
Total drug + premium cost (for the rest of 2023)	$224.40
When you'll meet your deductible	You won't meet your deductible in 2023
When you'll enter the coverage gap	You won't enter the coverage gap in 2023

This is the new cost. Enter this value into the the New PDP/MA-PD Cost field in STARS.

ESTIMATED TOTAL MONTHLY DRUG COST

If the coverage is for the current year, use this table to determine the number of months the beneficiary will be on the new plan. Multiply this number of months by the monthly retail cost to find the original cost in New to Medicare examples. If the coverage begins January of next year, multiply by 12 months.

	CVS Pharmacy #00321 In-network
July	$25.00
August	$25.00
September	$25.00
October	$25.00
November	$25.00
December	$25.00

6 coverage months

ESTIMATED DRUG COSTS DURING COVERAGE PHASES

The drug prices shown may vary based on the plan and pharmacy you've selected. Contact the plan if you have specific questions about drug costs.

Learn more about coverage phases.

+ CVS PHARMACY #00321

Ensure that you are viewing the retail costs under the beneficiary's preferred pharmacy.

	Retail cost	Cost before deductible	Cost after deductible	Cost in coverage gap	Cost after coverage gap
Prazosin 2mg capsule	$16.25	$16.25	$16.25	$4.06	$4.15
Sertraline 50mg tablet	$8.75	$8.75	$8.75	$2.19	$4.15
Monthly totals	$25.00	$25.00	$25.00	$6.25	$8.30

COSTS BY DRUG TIER

Multiply the monthly total retail cost by the number of months identified in the section above. $25 x 6 coverage months = $150. This is the original cost. Enter this number into the Original PDP/MA-PD Cost field in STARS.

Plans group their drug lists into tiers. The drug costs below show how much you'll pay for drugs in each tier based on the coverage phase you're in.

Learn more about drug tiers.

	Initial coverage phase	Gap coverage phase	Catastrophic coverage phase
Preferred Generic	$0.00 copay	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Generic	$10.00 copay	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Preferred Brand	$40.00 copay	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Non-Preferred Drug	50%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)
Specialty Tier	25%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: $4.15 copay or 5% (whichever costs more) Brand-name drugs: $10.35 copay or 5% (whichever costs more)

OTHER DRUG INFORMATION

	Tier	Prior authorization	Quantity limits	Step therapy
Prazosin 2mg capsule	Tier 3	—	—	—
Sertraline 50mg tablet	Tier 1	—	Yes	—

MY DRUG LIST

	Package	Quantity	Frequency	Brand/Generic
Prazosin 2mg capsule		60	Every month	Generic
Sertraline 50mg tablet		30	Every month	Generic

PART B DRUGS

These are drugs you usually get at a doctor's office or hospital outpatient setting, like the flu shot, chemotherapy, or other shots.

Chemotherapy drugs	Not covered	
Other Part B drugs	Not covered	

Star Ratings

+ Expand All Ratings

Overall star rating

Overall rating is based on the categories below.

★★★☆☆

+ **Drug plan star rating**

Summary rating of drug plan quality

★★★☆☆