# MED D - 2025 SilverScript PDP Readiness Plan Design Reference

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| 2025 Overview |

In an effort to minimize the amount of time the MED D Customer Care Representative (CCR) spends searching for readiness documents, this job aid contains information on the most common topics for the **2025** Annual Enrollment Period (AEP).

MED D CCRs can use the AE tool to aid beneficiaries during the Annual Enrollment period. The AE Tool provides information on AE call handling, CMS standard benefits, enrollment periods, IRMAA, LEP, Medigap, and prescription benefits.

Click on the following hyperlink to launch the AE Tool: <https://aetnao365.sharepoint.com/sites/MedicareAE25/SSI>

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| Call Handling |

This reminder is to provide clarification to Customer Care Representatives (CCRs) about the correct call handling for Annual Enrollment related inquiries.

During the Annual Enrollment period, we stress how important it is to provide as much assistance to our beneficiaries as possible without transferring the call. The guidelines below outline the type of inquiries that CCRs will handle (as well as best practice tips) and the calls they will transfer to an Enrollment (Telesales) Agent.



### Categories of Enrollment (Telesales) Agents

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| **Unlicensed Plan Change CSRs** | Provides basic, publicly available information to the caller and can connect them to a licensed agent or get them scheduled into a beneficiary meeting. |
| **Unlicensed RSVP beneficiary Meeting CSRs** | Beneficiaries receive a flyer advertising a beneficiary meeting and to call a specific number. The CSR offers to connect the beneficiary to a licensed agent or gets them scheduled into a beneficiary meeting. |
| **Plan Change Unit Licensed Agents** | A subset of licensed MA/MAPD/PDP agents dedicated to helping beneficiaries with plan changes. |
| **Telesales**  **MA/MAPD/PDP Agents** | Plan non-renewals and migrations that impact specific markets may be handled by regular MA/MAPD/PDP Enrollment (Telesales) agents instead of through the plan change unit. PDP Enrollment (Telesales) agents handle new prospects and SEPs. |

### Annual Enrollment Call Guidelines

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| **CCRs** | **Enrollment Agent (Telesales)** |
| CCRs may provide plan information such as:   * Plan name, premium, deductible   + Check the premium for the beneficiary’s specific region   + Specify the tiers the deductible applies to * Drug coverage, tier, utilization management   + Verify the details with your client: Strength, form, quantity, generic or brand   + Never assume a drug is on all of the plan sponsor formularies or at the same tier   + Prior authorization, tier exception, and formulary exception requests are **NOT** guaranteed to be approved * Pharmacy Network Status   + Check the preferred status based on the specific location * Beneficiary’s cost share   + Explain the difference between copay (flat dollar amount) and coinsurance (percentage of contracted cost share)   + Specify the plan copay/coinsurance applies during the Initial Coverage stage   Refer to the [Annual Notice of Changes (ANOC) Mailing](#_Annual_Notice_of) for guidelines on what questions may be answered before and after October 1. | Transfer to an [Enrollment Agent (Telesales)](file:///C:/Users/C337799/Downloads/TSRC-PROD-029866) if a caller would like to:   * Enroll   + As it applies, beneficiaries need to understand that enrolling in a PDP creates a disenrollment from an MAPD * Change plans   + Attempt to provide as much assistance as possible before transferring the call * Re-enrollment   + If someone is termed for non-payment, there are steps that must be completed **before** transferring to an Enrollment Agent (Telesales).     - The beneficiary must clear any outstanding premium balance.     - They must also have a valid SEP.   Beneficiaries must verbally agree to being transferred to an Enrollment Agent (Telesales) and you must provide the standard transfer disclosures (**Example:** You will be transferred to a licensed sales representative).  If the beneficiary has multiple inquiries and a transfer is required, the transfer should take place last. Attempt to resolve the beneficiary’s other needs, that you are skilled to address, before transferring. |

Remember to provide a summary and verbal appreciation when wrapping up calls. This shows all our beneficiaries/callers that we value them!

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| Annual Notice of Changes (ANOC) Mailing |

The Annual Notice of Changes (ANOC) includes any changes in coverage, costs, or service area that will be effective January 1. Beneficiaries should think about their overall health care costs and decide whether their current plan will continue to meet their needs. They should:

* Check the changes to the plan benefits and costs including
  + Premium
  + Deductible
  + Covered benefits
  + Out of pocket costs
* Check the website for
  + Formulary
  + Pharmacy network

To make decisions about their health coverage for the upcoming plan year, beneficiaries are expected to call with questions about their plan benefits and options.

Refer to [MED D - SilverScript Plan Changes for ANOC/EOC 2025](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=406c2afe-a140-4970-9173-6ce9706c7fd8).

For information regarding Plus and SmartSaver beneficiaries moving to the Choice Plan for 2025, refer to [MED D – 2025 PLUS and SMARTSAVER Plans Consolidating to CHOICE Plan - FAQs](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=abebc764-b6ae-4d7c-ab3e-de45c94c53c2).

### Marketing Guidelines

Per CMS requirements, marketing activities for calendar year 2025 plans are permitted to **begin on October 1, 2024**

* Beneficiaries receive the ANOC package no later than September 30, 2024.
* Mailing began September 1st and goes through September 20, 2024.

**Agents and call center representatives are not permitted to discuss 2025 plan information prior to October 1 UNLESS a current SilverScript beneficiary asks questions AFTER receiving their ANOC mailing.** Please see below for important information about the details on 2025 plans that you can discuss with Aetna Medicare beneficiaries.



|  |  |  |
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| **If…** | **And…** | **Then…** |
| **Prior** to Oct 1, 2024 | The beneficiary **has received** their:   * Annual Notice of Changes (ANOC) * Evidence of Coverage (EOC) * and/or LIS Rider | You are permitted to discuss the information found in their specific ANOC, EOC and LIS Rider package. |
| The beneficiary has questions about **other plans** NOT described in their ANOC, EOC or LIS Rider | Apologize for the inconvenience and request that the beneficiary contact us on or after 10/01/2024 for that information. |
| **On or After** Oct 1, 2024 | The beneficiary **wants to keep** their current plan | No further action is required from the beneficiary |
| The beneficiary **wants to change** their current plan | * They can enroll in a different plan between October 15 and December 7 * Coverage will begin on January 1 of the new plan year |

### ANOC Contents

The ANOC kits will be mailed in a 6x9 windowed envelope (10-12 pages). Each kit will include:

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| **Each kit will include:** | **ANOC packages will NOT contain:** |
| * Table of Contents: What’s in the ANOC mailing * Annual Notice of Changes (ANOC) * Low-Income Subsidy Rider (if applicable) * Online Document Notice containing a URL directing beneficiaries to online access to:   + Pharmacy Directory   + Evidence of Coverage (EOC)   + Formulary | * Pharmacy Directory * Evidence of Coverage (EOC) * Formulary   Refer to [MED D - Digital Evidence of Coverage, Formulary and Pharmacy Directory](file:///C:/Users/C337799/Downloads/TSRC-PROD-030398). |

**Examples:**

|  |  |  |
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| Annual Notice of Changes | Low-Income Subsidy Rider | Online Document Notice |
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| Post ANOC |

Not all beneficiaries receive a Post ANOC. They are sent to beneficiaries with a negative formulary or network change. Letters will begin mailing mid-November.

The purpose of the Post ANOC is to get the beneficiary to take action prior to 1/1 to prevent the beneficiary from having a negative experience. Additionally, providers are notified of formulary changes (except tier level changes).

**Changes to a Maintenance Drug the Beneficiary Takes**

Beneficiaries are instructed to speak with their doctor to see if another drug will work or the doctor can work with us to ask for an exception.

* Drug going non-formulary
* Negative tier change
* Drug will require prior auth or step therapy

**Change to the Pharmacy a Beneficiary Typically Uses**

Beneficiaries are instructed to go to URL or call the number on their ID card to find other pharmacies.

* Going out of network
* Going from preferred to non-preferred

Refer to:

* [MED D - Post ANOC Letter Sample (SSI EGWP)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=fcaff08a-6c57-4ed5-8292-8bbf835d8fb4)

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| Digital Evidence of Coverage, Formulary and Pharmacy Directory |

Refer to [MED D - Digital Evidence of Coverage, Formulary and Pharmacy Directory](file:///C:/Users/C337799/Downloads/TSRC-PROD-030398).

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| 2025 CMS Defined Standard Benefit Stages |

Each year CMS changes the **standard benefits** for Part D. Each benefit stage determines how the contracted cost of medications are shared between the beneficiary and their plan. Review the grid below for a comparison of 2024 vs. 2025 standard benefits.

* Refer to [MED D – 3 Stages of Medicare Part D Coverage (Deductible, ICL, Catastrophic)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=9a075697-260f-4edd-a78d-91cb5b52f73b)

 Remember that some plans may offer customized benefits.

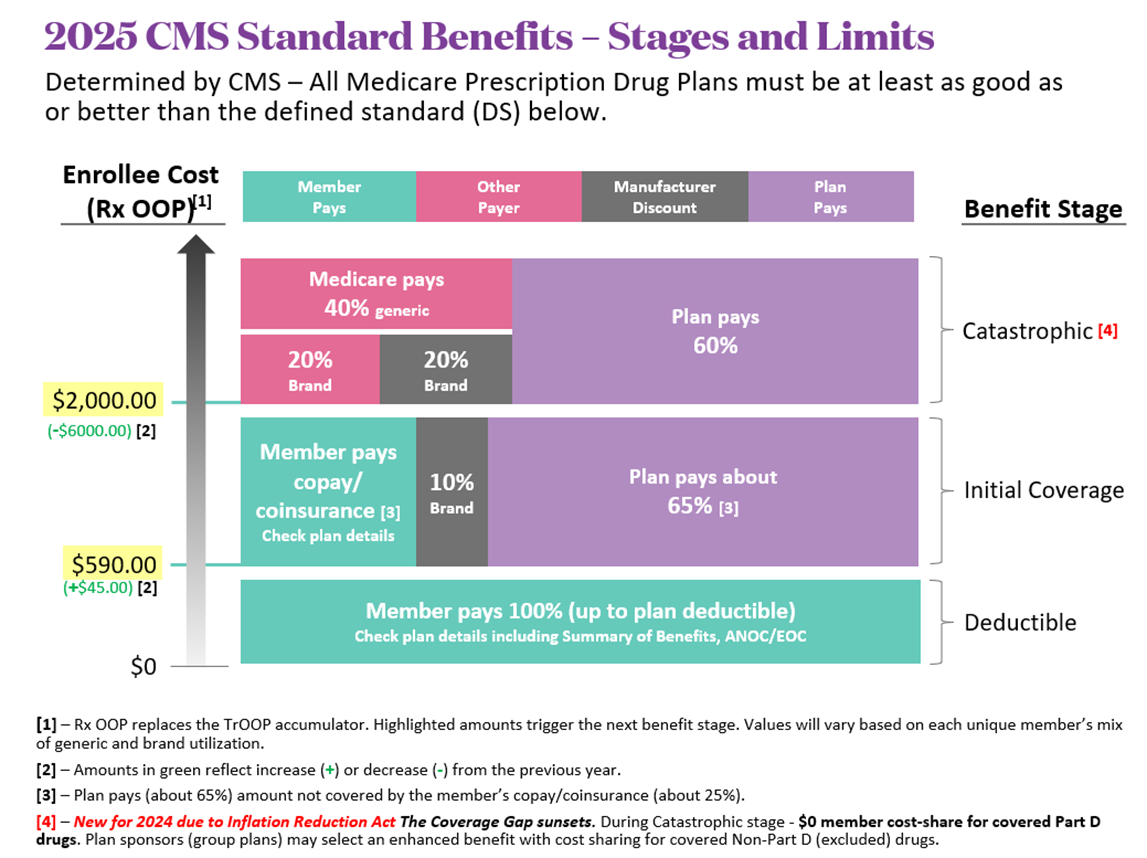
Beneficiaries enrolled in a plan with Supplemental Gap Coverage will pay the Initial Coverage phase cost-sharing for supplemental covered drugs. Be sure to look at the specific plan benefits of the EOC to identify which beneficiaries have this Supplemental Gap Coverage.



Be sure to check beneficiary or EGWP details for specifics.

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|  | **2024** | **2025** | **Difference** |
| **Drug Deductible**  The amount specified here is the CMS defined standard and only applies to plans with a deductible. The actual amount varies between plans and may be less than the defined standard. | **$545** | **$590** | The CMS standard deductible increases $45 for 2025.  The amount specified here is the CMS defined standard and only applies to plans with a deductible. The actual amount varies between plans and may be less than the defined standard.  Applies to T1-T5 for Choice |
| **During this phase, if your plan has a deductible, you'll usually pay the plan's negotiated lower cost up the deductible limit. Once you reach the deductible limit,**  **you'll pay a copayment or coinsurance in the Initial Coverage phase.** | | | |
| **Initial Coverage Limit**  When the total drug spend (negotiated drug cost) reaches this amount. | **$5,030 Total Drug**  **Spend**  **to enter the Coverage**  **Gap** | **$2,000 Rx OOP**  **Costs applied to 2025 Rx OOP:**   * Member cost share * Payments made on behalf of the member up to the standard defined benefit (about 25%)   **Costs that do not apply to Rx OOP:**   * Manufacturer discount program * Non-D drugs/riders/OHi do not apply toward Rx OOP | **New for 2025 due to IRA:**  The Coverage Gap sunsets.   * Moving forward, members will meet a maximum out-of-pocket threshold that moves them directly to the Catastrophic stage.   The 2025 out-of-pocket maximum is $6,000 less than the amount for 2024. |
| **During this phase, the plan will pay its share of the cost and you'll pay a copayment or coinsurance (your share of the cost) for each prescription you fill until your total drug costs reach $2,000.** | | | |
| **Coverage Gap**  (Donut Hole) | **Generic:**  25% beneficiary cost share  75% covered by plan  **Brand:**  25% beneficiary cost share  5% covered by plan 70% manufacturer discount | **Generic:**  25% beneficiary cost share  75% covered by plan  **Brand:**  25% beneficiary cost share  5% covered by plan 70% manufacturer discount | There is **no change to the beneficiary’s cost share**. This means the beneficiary pays 25% for generic and BRAND as long as they are in the Coverage Gap.  **Note:** The manufacturer discount for BRAND is also the same. |
| **TrOOP Threshold**  (True Out Of Pocket)  Total of:  Beneficiary’s share and any costs paid on behalf of the beneficiary (manufacturer discount, LIS, SPAP, etc.)  This does NOT include the plan's contribution. | **$8,000 TrOOP**  **to enter Catastrophic**  **stage** | **$2,000** | Once Out-of-Pocket reaches $2,000, beneficiary will pay $0 for medications at end of the plan year. |
| **During this phase, you'll receive limited coverage on certain drugs. For generics and brands, you'll pay 25% of the cost. This phase continues until your yearly out-of-pocket drug costs reach $2,000. Then, you'll move to Catastrophic Coverage.** | | | |
| **Catastrophic Copayments**  **Note:** Remember that health plans may offer customized benefits. Be sure to check Individual and Group pages on our tool and review other supporting plan documents for specifics. | **$0 member cost share for covered Part D drugs**  **until end of plan year** | **$0 member cost share for covered Part D drugs**  **until end of plan year** | There is no change to the member's cost share. |
| **In this phase, until the end of the plan year, you'll pay either a copayment or coinsurance amount for each prescription you fill.** | | | |

You can view a graphic image which depicts the 2025 Standard Benefits.



**Stage Limits for Prior Years**

The image below displays a comparison between prior years for each **standard benefit** stage limit.

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|  | **2025** | **2024** | **2023** | **2022** | **2021** | **2020** | 2019 | **2018** |
| **Deductible** | $590 | $545 | $505 | $480 | $445 | $435 | $415 | $405 |
| **ICL Limit** | $2,000 | $5,030 | $4,660 | $4,430 | $4,130 | $4,020 | $3,820 | $3,750 |
| **TrOOP** | $2,000 | $8,000 | $7,400 | $7,050 | $6,550 | $6,350 | $5,100 | $5,000 |

To view all plan designs by regions, refer to [Plan Designs by Region Index](file:///C:/Users/C337799/Downloads/TSRC-PROD-045504) section.

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| Inflation Reduction Act |

Refer to [MED D - Inflation Reduction Act](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=7c8df3ae-46e0-4729-bd5e-a42bd6496aa1).

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| Plan Designs by Regions Index |

Refer to [MED D - 2025 SilverScript CHOICE Plan Design by Region Index](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=1ed2aea3-39b1-4e3d-bcd1-889cb9584b4c).

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| Premiums by Region Index |

Refer to [MED D - 2025 SilverScript Premiums by Region](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=18373e33-3e55-4833-a5f3-aeb37f9c7a15).

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| Premium Billing Payment Information |

Beneficiaries are billed proactively (For example, the January premium is billed in December)

**Premium Billing Cycles**

* Premium payments are **due** on the **1st** of each month.
* Beneficiaries who have enrolled into an **automatic payment option** will have their **payment deducted** between the **8th** and **10th**of each month.
  + ACH/ EFT (Electronic Funds Transfer)
  + Recurring credit card deductions

**Premiums Payment Methods**

* One-time payments (credit/debit card or e-check)
* Automatic deduction options:
  + Social Security or Rail Road Board deduction

 Beneficiaries receiving Employer Group/SPAP subsidies for their premium should be made aware that SSA/RRB deduction combined with an Employer Group or SPAP subsidy can cause a double payment of the premium because CMS does not account for the client subsidy.

* + ACH/ EFT (Electronic Funds Transfer)
  + Recurring credit card deductions
* Invoice:
  + Monthly
  + Pay by Check

When paying by check, beneficiaries must write their Member ID on their check



Beneficiaries must enclose separate checks if paying for more than one beneficiary’s premium



* Beneficiary can pay:
  + Online at [www.aetnamedicare.com](http://www.aetnamedicare.com).
  + At any CVS/pharmacy

This does not include CVS pharmacies within a Target.



* + Via the IVR

Refer to the following FAQs:

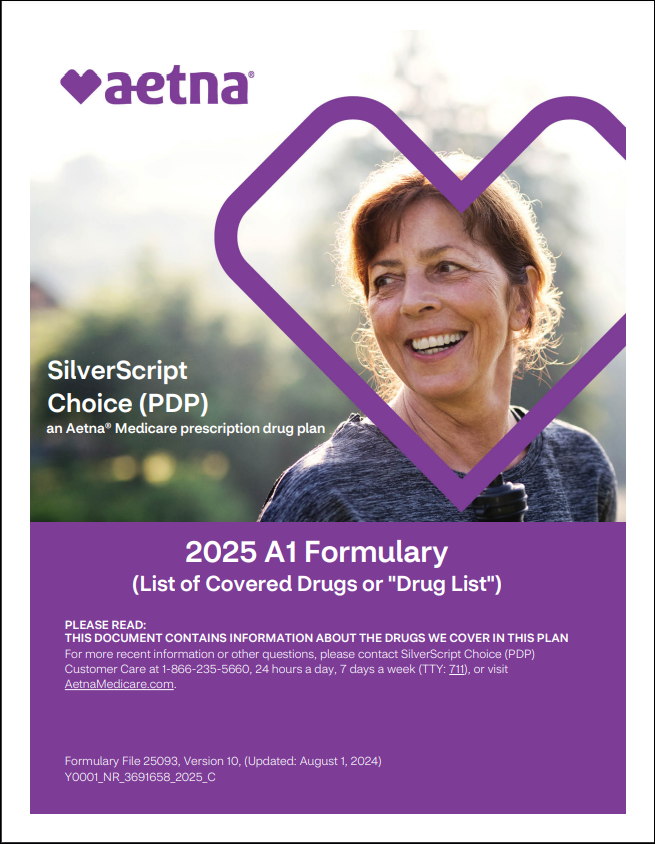
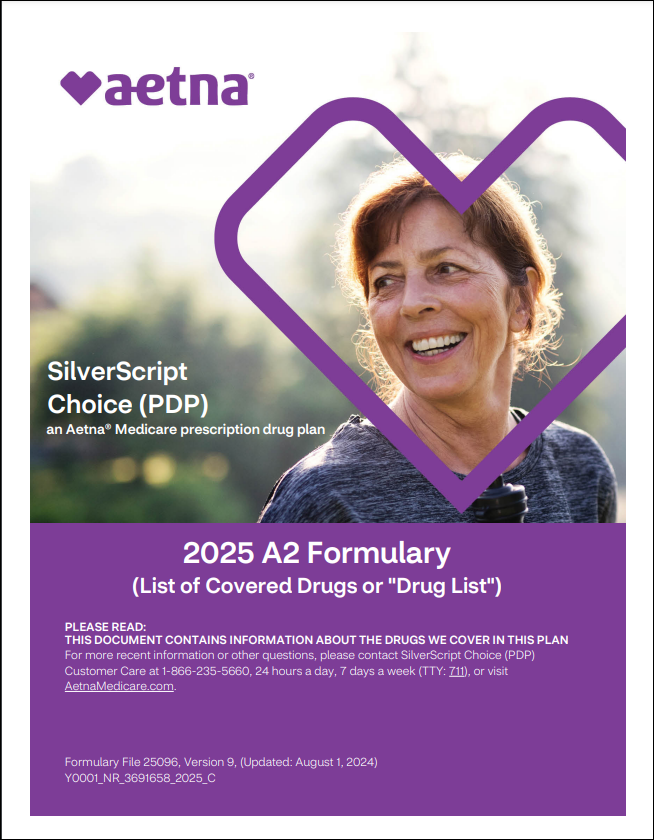
|  |  |
| --- | --- |
| **Question** | **Answer** |
| **What will my monthly premiums be for 2025?** | I would be happy to help.    **CCR Notes:**   * To confirm the beneficiary has received their ANOC, refer to [MED D - Viewing Correspondence in PeopleSafe](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8d25a915-ad65-4b9e-bfb9-2d0fc62b8b79). * Refer to [MED D - 2025 SilverScript Premiums by Region](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=18373e33-3e55-4833-a5f3-aeb37f9c7a15). |
| **If I am eligible for LIS in 2025, what will be monthly premiums be?** | I would be happy to help.      Refer to [MED D - 2025 SilverScript Premiums by Region](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=18373e33-3e55-4833-a5f3-aeb37f9c7a15). |
| **Why did my 2025 Prescription Drug Plan premium increase****?** | **CCR Process Note:**Your response will be different based on the beneficiary’s Medicare region (state).    **For CHOICE  Beneficiaries in ALL States:**   * While we use every available resource to hold down the cost of plan premiums, premium changes are sometimes unavoidable. They are impacted by several factors including changes in CMS rules and limits, overall manufacturer drug costs, new drug therapies and whether generic alternatives are available. * When evaluating the value of your plan, it’s important to consider the total cost – including your deductible, plus your monthly premium x12, plus your drug copays. * I can help you determine your total costs for 2025.     **CCR Note:**  Refer to [MED D - Drug Pricing Tool](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=57a93ef2-b94c-4b9a-87d9-5a54f99e3216).    **CCR Process Note:**If the beneficiary advises they cannot afford the premium increase.     * Medicare recipients with limited income and resources can apply for Extra Help, a government program to help pay prescription drug costs. The Extra Help program may also help pay for all or part of the monthly premium. * To see if you qualify for Extra Help, you can:   + Call Social Security at **1-800-772-1213 between 8:00 a.m. - 7:00 p.m., Monday through Friday local time**. TTY users call **1-800-325-0778**     - OR   + Visit secure.ssa.gov to apply through an online form.   + You can also contact your local State Health Insurance & Assistance Program. To locate the program in your state, go to [www.shiptacenter.org](http://www.shiptacenter.org/).   + Some drug manufacturers offer assistance programs for the drugs you are taking. You can access Medicine Assistance Tool at [www.mat.org](http://www.mat.org/).     **CCR Note:**  Refer to [MED D - Drug Pricing Tool](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=57a93ef2-b94c-4b9a-87d9-5a54f99e3216). |
| **Why are monthly premiums different from one state to another?** | * Just as regional differences in clinical and healthcare costs vary, so does the cost of offering prescription drug coverage. * Medicare monitors Part D prescription drug coverage to ensure that all Part D plans are designed to help meet the healthcare needs of regional populations throughout the U.S. |

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| 2025 Formulary Updates |

Below are the formulary updates for 2025. While there will be no changes to the formulary offerings, the drugs that are covered and the tier assignments will change.

### Example of 2025 Formulary

Refer to [MED D - 2025 SilverScript Choice Formulary](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b51771bd-f205-4a5c-9b11-622b4bcc9d50)

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### Plan Formulary Highlights

The details below are for information purposes and are not all inclusive. They should not be used to review a beneficiary’s plan coverage. **Look up the beneficiary’s specific plan benefits to provide accurate information.** Offer to look up the beneficiary’s prescription to see if they will be impacted by any changes. Go to [aetnamedicare.com](https://www.aetnamedicare.com/en/prescription-drugs/check-medicare-drug-list.html) for formulary and drug look up.

Refer to [MED D - Drug Pricing Tool](file:///C:/Users/C337799/Downloads/CMS-PCP1-040984).

**Tiers**

Formularies are organized by drug tier.

The drug tiers determine how much the beneficiary pays at the pharmacy.

* Tier 1 – Preferred Generic
* Tier 2 – Generic
* Tier 3 – Preferred Brand
* Tier 4 – Non-Preferred Drug
* Tier 5 – Specialty

**Days Supply**

Prescription supplies can be filled for:

* 1 month = 30-day supply at retail or 31-day supply in long term care (LTC)
* 2 month = 31-60 day supply
* 3 month = 61-90 day supply

 **Exception:** Tier 5 Specialty prescriptions can only be filled up to 1-month supply

**Out of Network Prescriptions**

* 10 days supply at standard pharmacy cost share when a beneficiary:
  + Runs out of or loses a covered drug
  + Becomes ill
  + Is traveling outside the service area
  + Is in an emergency situation
  + Is evacuated or displaced from home due to a state or federally declared disaster or health emergency

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| Diabetic Supplies |

**Covered Under Part D**

Medicare Part D covers insulin and the supplies necessary to inject it. This includes items such as:

* 2x2 Gauze
* Alcohol Swabs
* Insulin (when not administered by an insulin pump)
* Insulin Pens
* Insulin Syringes
* Pen Needles

The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as they are covered on the Medicare Part D plan's formulary. If the insulin is administered through a pump, then it is covered under Part B.

**Covered Under Part B**

* Glucose monitors
* Diabetic test strips
* Lancing devices
* Lancets
* Glucose-control solutions

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| Vaccines |

The content below is for information purposes. Refer to policy and the beneficiary’s Evidence of Coverage (EOC) for further information about covered vaccines.

The Inflation Reduction Act includes guidelines for all federally recommended vaccines (meeting Advisory Committee on Immunization Practices, or ACIP guidelines). Beneficiaries at least 18 years of age will pay $0 for Medicare covered vaccines. Plan deductibles do not apply to covered vaccines.

**Covered under Part D**

SilverScript PDP provides coverage for a number of Part D vaccines. Part D vaccines are typically preventive, such as vaccines for:

* Shingles
* Tetanus
* Diphtheria
* Meningitis

**Coverage**

There are two parts to coverage of vaccinations:

* The first part of coverage is the cost of the prescribed vaccine medication itself. Beneficiaries can refer to online resources and/or request the 2024 drug list for their specific Aetna SilverScript Part D plan to find covered Part D vaccines.
* The second part of coverage is the cost of giving the vaccine (also called the administration of the vaccine).

**What the beneficiary Pays**

What the beneficiary pays for a Part D vaccination depends on three things:

* The type of vaccine being given
  + Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's List of Covered Drugs (Formulary).
  + Other vaccines are considered medical benefits. They are covered under Original Medicare.
* Where the vaccine medication is obtained
* Who administers the vaccine

**For example:**

* In some instances, beneficiaries will have to pay the entire cost upfront for both the vaccine medication and for administration. They may then submit a request for reimbursement of what the plan should cover.
* Other times, beneficiaries may only pay their share of the cost.

To show how this works, here are three common ways beneficiaries might get a Part D vaccine.

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| **Situation 1** | **Situation 2** | **Situation 3** |
| **Beneficiary buys the Part D vaccine at a network pharmacy and it's administered there. [1]** | **Beneficiary gets the Part D vaccination at their doctor’s office.** | **Beneficiary buys the Part D vaccine at their pharmacy, and then take it to their doctor’s office where they are given the vaccine.** |
| **Type:** Covered Part D vaccine  **Where:** Obtained at a network pharmacy  **Who:** Administered at the same pharmacy | **Type:** Covered Part D vaccine  **Where:** Obtained at beneficiary’s in-network doctor's office  **Who:** Administered at the same doctor's office | **Type:** Covered Part D vaccine  **Where:** Obtained at a network pharmacy  **Who:** Administered at beneficiary’s in-network doctor's office |
| * The beneficiary will have to pay the pharmacy the amount of their coinsurance or copayment for the vaccine and the cost of giving the vaccine. * Their Part D plan will pay the remainder of the costs. | * When a beneficiary gets their vaccination, they will pay for the entire cost of the vaccine and its administration. * They can then request reimbursement to recover the amount covered by their Part D plan. * They will be reimbursed the amount they paid less their normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what their Part D plan would normally pay. (If the beneficiary gets "Extra Help," they will be reimbursed for this difference.) | * The beneficiary will have to pay the pharmacy for the amount of their coinsurance or copayment for the vaccine itself. * When their doctor administers the vaccine, they will pay the entire cost for this service. They can then request reimbursement to recover the amount covered by their Part D Plan. * They will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what their Part D Plan would normally pay. (If the beneficiary gets "Extra Help," they will be reimbursed for this difference.) |

**[1]**Some states do not allow pharmacies to administer a vaccination.

**Requesting Reimbursement**

If a beneficiary needs to submit a request for reimbursement, they may find a claim form online or they may request one be sent to them. The beneficiary should include a receipt for the vaccine and/or services rendered (as necessary) and mail in the claim to the address found on the claim form.

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| [www.aetnamedicare.com](http://www.aetnamedicare.com) | Beneficiaries can access the claim forms via the [Get a form](https://www.aetnamedicare.com/en/contact-us/print-forms.html) page on aetnamedicare.com. |
| [www.caremark.com](http://www.caremark.com) | Beneficiaries must log into the caremark.com member portal via the link below. The link will route them to the [forms page](https://www.caremark.com/wps/myportal/PRINT_FORMS) where they can access the claim form(s). |

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| Transition of Coverage |

With 2025 formulary changes, communicating Aetna's Transition of Coverage (TOC) policy and the required CMS exceptions process accurately to prospective and existing beneficiaries is extremely important. Beneficiaries may access our Aetna Medicare TOC process on aetnamedicare.com.

TOC allows both renewing and new beneficiaries to fill an existing prescription that would otherwise not be allowed – either due to not being covered by our formulary and/or one that requires prior authorization or step-therapy under our utilization management rules with the exceptions noted below.

A TOC or transition supply for non-long-term care residents consists of up to a 30-day supply of the medication during the first 90 days of enrollment. This also applies to multiple fills with a combined supply of no greater than 30 days. The applicable copay will apply to each fill. Short cycle dispensing will prorate the copay/cost share.

**New beneficiaries**

New beneficiaries will receive one TOC fill for a Part D drug that:

* Requires prior authorization (except when Part B vs. Part D determination is required)
* Has step therapy
* Has quantity limits (unless the prescribed quantity exceeds safety limits)
* Is non-formulary (except for CMS excluded drugs)

For new beneficiaries, the TOC period is the first 90 days of the new plan year. For enrollees with plans starting after 01/01, the TOC period is the first 90 days of the new plan starting with the effective date.

New beneficiaries will receive coverage for each Part D drug not on the Aetna Medicare Formulary (for the days supply described above).

**Renewing beneficiaries**

Renewing beneficiaries will only receive one TOC fill for a Part D drug which has one or more of the following changes from 2024 to 2025

* Requires prior authorization (except when Part B vs. Part D determination is required)
* Has step therapy
* Has quantity limits (unless the prescribed quantity exceeds safety limits)
* Is non-formulary (except for CMS excluded drugs)

For renewing beneficiaries, the TOC period is the beneficiary’s first 90 days of enrollment during the new plan year.

**Point of Sale**

Transition of Coverage (TOC) will occur at the point-of-sale at the pharmacy. The pharmacy will receive specific TOC messaging notifying them how many days' supply of the medication is remaining under TOC.

A TOC fill will not occur for the following conditions:

* Determination of Part B vs. Part D coverage
* To prevent coverage of non-Part D drugs, such as excluded drugs
* To promote safe utilization of a Part D drug, for example certain quantity limits based on FDA maximum, recommended daily dose or other safety concerns, early refill edits
* Medications that are only covered by Part B, for example ESRD or transplant medications when a CD/CT indicator is present.

**Communication**

Communications are sent to both beneficiaries and physicians. Beneficiaries will receive a TOC letter within three business days of the transition fill. A copy of this letter is also sent to the beneficiary’s physician. These letters are required by statute.

**Long Term Care (LTC)**

As of 2019, Long Term Care (LTC) one-month supply is defined as 31 days which means that beneficiaries in LTC facilities receive a temporary supply that is also 31 days (prior to 2019 it was defined as up to 98 days of medication). The applicable copay will apply to each fill.

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| Medication Therapy Management Program (MTMP) |

Medication Therapy Management Programs (MTMP) are clinical programs designed for Medicare beneficiaries. This program provides telephonic support and education, depending on level of attention required, including physician, family and caregiver involvement.

Centers for Medicaid and Medicare Services (CMS) established MTMP as required by the 2003 Medicare Modernization Act (MMA). MTMP helps targeted beneficiaries reach the best healthcare outcome by improving medication use and reducing adverse drug events.

For 2025, eligible beneficiaries will receive a welcome letter and telephonic offer(s) to complete the review.

Encourage beneficiaries to complete the Comprehensive Medication Review (CMRs).



**Program Eligibility**

CMS set the criteria for inclusion in the MTMP Program. Only those Medicare beneficiaries who meet the following MTMP criteria are eligible and can participate:

* Have 3 or more of the targeted chronic diseases
* Are taking 8 or more prescription maintenance medications
* Are likely to have drug costs that exceed $1623 per year for 2025
  + **Note**: This is total drug cost and not beneficiary out-of-pocket cost

This is a voluntary program. The beneficiary may opt out of the program at any time.



**Comprehensive Medication Reviews (CMRs)**

Outcomes MTM is the downstream vendor. Comprehensive Medication Reviews (CMRs) can be done via telephone or at many community pharmacies.

The pharmacist will screen for a variety of factors including, but not limited to:

* Assessment for standards of care in therapy
* Drug/age interactions
* Drug/drug interactions
* Duplicate therapy regimens
* Medication non-compliance
* Over and under-use of medication
* Polypharmacy (use of 4 or more medications by a patient)
* Therapeutic alternatives that might
* Avoid possible drug interactions (drug/drug, drug/age, drug/disease)
* Be more cost effective
* Be more clinically appropriate
* Improve compliance
* Improve outcomes
* Provide lower side effect profile
* Provide more convenient dosing​

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| 2025 Pharmacy Networks |

Aetna contracts with a nationwide network of pharmacies to provide convenient access to medications for their plan beneficiaries. The Choice plan offers consistent pricing across all pharmacies in the standard network (S7).

Go to [aetnamedicare.com](https://www.aetnamedicare.com/en/prescription-drugs/find-pharmacy.html) for pharmacy look up:

* Offer to look up the beneficiary’s pharmacy location to see if they will be impacted by status changes.
* As needed, offer to locate another in-network/preferred pharmacy in their area.
* Educate beneficiaries about [Mail Order Delivery](#_Mail_Order_Delivery) which may be another cost-effective solution.

Refer to [MED D - Pharmacy Locator](file:///C:/Users/C337799/Downloads/CMS-PRD1-070836).

**Network Pharmacy Quality Standards**

Individual PDP network pharmacies are held to high standards for service quality and clinical excellence and are monitored for their effectiveness.

* Aetna’s network pharmacies provide quality service and clinical support including:
  + Face-to-face or telephonic clinical support to manage plan beneficiary medications and address questions or concerns about drug side effects or missed doses
  + Assistance with questions that the beneficiary can ask their doctor on possible gaps in medication therapies that may help to prevent or lower chances of having some problems caused by diabetes such as heart attack and/or stroke
  + Opportunity for beneficiaries to discuss potential savings to address financial barriers that may keep beneficiaries from taking their medications
  + One-on-one medication review with a pharmacist for beneficiaries having hard time taking a lot of medications and who have many chronic conditions (by invitation only to beneficiaries who meet Medicare’s guidelines)
* Beneficiaries build relationships with pharmacists at one of the participating network pharmacies
  + Conversations are typically brief and easily fit into a beneficiary’s pharmacy visit or short telephonic conversation

SilverScript Pharmacy Directory contains over 25 of the nearest pharmacies, based on beneficiary’s address.

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| Mail Order Delivery |

The only in-network Mail Order Delivery (MOD) service continues to be CVS Caremark Mail Service Pharmacy. We cannot steer to one pharmacy over another, but we can inform beneficiaries of their options, including mail order delivery.

* Continues to offer preferred cost share for 2025.
* Beneficiaries can receive up to a 90-day supply with free standard shipping.
* Some plans may provide copay incentives to fill eligible medications as 90 day supply.
* All medication is securely packed and reviewed by a registered pharmacist.
* Beneficiaries can order from mail order by:
  + Asking their provider to e-prescribe;
  + Calling the number on the back of their ID card; or
  + Logging into the secure beneficiary website.
* To obtain specific plan information:
  + Current enrollees should consult the Evidence of Coverage (EOC)
  + Prospective enrollees should consult the Summary of Benefits (SB)

 Some retail pharmacies deliver to the home or by mail 30 to 90-day fills in the local area as a convenience (there also may be an additional cost). This **IS NOT** the same as CVS Caremark Mail Service Pharmacy. There is no additional cost share break for utilizing a network retail pharmacy’s delivery option.

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| Fill and Bill |

Fill and Bill refers to submitting a prescription fill request and if any further action is required, including payment, the beneficiary will be contacted.

Refer to [Payment Fill and Bill](file:///C:/Users/C337799/Downloads/CMS-PCP1-025493).

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| Specialty Pharmacy |

Caremark Specialty Pharmacy will continue to be the in-network specialty pharmacy for 2025. Specialty pharmacies are pharmacies equipped to provide the types of services that specialty drugs often require (e.g. special handling, packaging via dry ice, reconstitution of the drug and solution for injection, etc.).

Beneficiaries pay the retail cost-share for our Specialty Pharmacy dispensed medications.

Although our Specialty Pharmacy sends prescriptions through mail, beneficiaries will pay the retail cost share. Some beneficiaries may think they pay the Mail Order Delivery cost share for their specialty pharmacy prescriptions.



* Educate beneficiaries to use our Specialty Pharmacy for their specialty pharmacy needs.
* There are clinicians available round the clock to assist beneficiaries with administration of specialty drugs and other questions they may have.
* They also provide educational materials on specialty drugs and the diseases they treat.
* They are equipped to provide special handling and shipping right to the beneficiary’s door for no additional cost.
* Specialty Tier Supply

Specialty Tier medications are limited to one-month supply (applies to retail, CVS Caremark Mail Service Pharmacy and Caremark Specialty Pharmacy). There is no extended days supply for 60 or 90 days.

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| 2025 Low Income Subsidy (LIS) Riders, Notifications |

There are several notices a beneficiary may receive from CMS or Aetna regarding their Part D coverage and LIS status.

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| **LIS Rider** | |
| Sent from Aetna to beneficiaries who either qualify for Low Income Subsidy or have a change in their LIS level. The LIS Rider for the upcoming plan year is included in the 2025 ANOC package. If a beneficiary’s LIS Level changes after the 2025 ANOC package is mailed, CMS will notify the plan and an additional LIS Rider will be sent to the beneficiary.  The LIS Rider includes the deductibles and copays that the beneficiary pays.  **First paragraph:** “Our records show that you qualify for Extra Help paying for your prescription drug coverage. This means that you will get help paying your <monthly premium, yearly deductible, and prescription drug cost-sharing>”  **Example of Letter:** | |
| **CMS Letters** | |
| Throughout the year, CMS will send different color notices to beneficiaries regarding Extra Help to inform them of their LIS status and benefits. Below are letters that are sent around the same time as the Annual Enrollment Period and may drive beneficiary inquiries.  See "Resources to apply for Extra Help (LIS) Benefits" below for beneficiaries that need assistance with applying for Extra Help.  Refer to [MED D - Guide to Consumer Mailings From CMS, Social Security, and Plans](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ac45f76c-29ba-4a18-9680-906285f9de83) for additional information. | |
| **Gray Letters**  Loss of Deemed  LIS Status | The gray letter is sent each September to deemed beneficiaries who will no longer automatically qualify for Extra Help. They will lose the Extra Help as of December 31st. In addition, this notice includes an SSA subsidy application, along with a postage-paid return envelope.  Beneficiaries who receive the gray letter for Loss of Extra Help also qualify for a Special Election Period (SEP) that allows them to switch plans or drop Part D coverage until March 31st. If the beneficiary drops Part D coverage, they may have to pay a Late Enrollment Penalty when they rejoin the Part D program.  If the beneficiary makes no changes to their coverage, they will pay the full premium for their plan and are subject to usual processes for non-payment.  The beneficiary is encouraged to apply for extra help as soon as they can in order to avoid a lapse in assistance. If a beneficiary who applies for extra help before December 31 is approved, the start date of the extra help will be January 1.  Also, in September of each year, CMS sends to Aetna/SilverScript files of beneficiaries who received notice of loss of deemed status. This information helps plans outreach to the affected beneficiaries. |
| **Orange Letters**  Cost Share Level Change | In October, CMS sends an orange notice to individuals who qualify automatically for LIS in the next calendar year and will have a change in their co-payment level triggered by a change in their Medicaid eligibility. |
| **Blue Letters**  Plan Reassignment | Beneficiaries that are being reassigned by CMS receive a blue letter. CMS re-assigns any LIS-eligible beneficiaries that qualify for Extra Help in the upcoming year. In this situation, reassignment occurs for those that were auto-enrolled, facilitated enrolled and/or voluntarily enrolled in the plan. This includes beneficiaries with full or partial subsidies. Beneficiaries who are scheduled to receive a blue letter will NOT receive an Annual Notification of Changes (ANOC).  The blue letter is sent from late October through mid-November to the following beneficiaries:   * Auto-enrollees who are being removed from an Aetna/SilverScript plan to another Part D plan in order to continue to have a $0 premium.   + Changes will be effective Jan 1st.   + Their letter has other plans that qualify for a $0 premium for the beneficiary to consider.   + Alert If the beneficiary is wanting to stay with Aetna/SilverScript, they must submit an application and there may be a monthly premium due. * Auto-enrollees who are being enrolled into an Aetna/SilverScript plan from another Part D plan in order to continue to have a $0 premium.   + Changes will be effective Jan 1st.   + Their letter has other plans that qualify for a $0 premium for the beneficiary to consider.   + Alert If the beneficiary is wanting to stay with their current plan, they will need to contact that plan.   + Both sets of beneficiaries will get another blue letter in December. This follow up letter will remind them of the change and will also show which of their current drugs will be covered by their new plan.   Blue letters are also sent if a plan is terminating its contract at the end of the year with the Centers for Medicare and Medicaid Services (CMS). |

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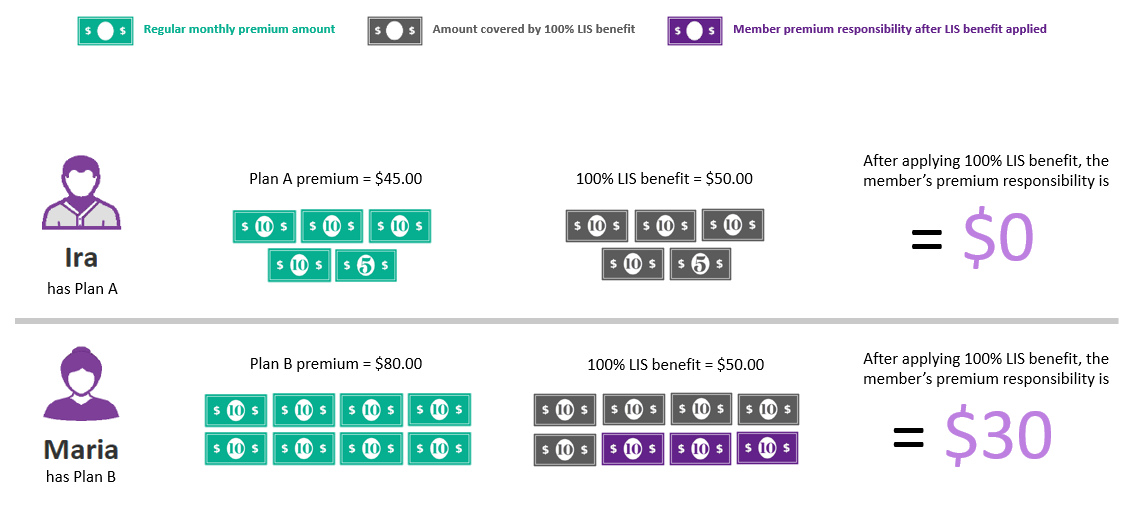
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| LIS Levels |

When a beneficiary qualifies for LIS, the LIS Level will include any premium and cost sharing. The LIS Eligibility categories correspond to premium and/or cost-sharing benefits.

* LIS Level – Cost Share for Prescriptions – beneficiaries are designated LIS level 1, 2, or 3, which determines what the beneficiary will pay out of pocket for their prescriptions.
* LIS Level 1 - Non-institutional FBDE beneficiaries with incomes between 100% and 150% of the FPL and are fully subsidized by the government.
* LIS Level 2 – Non-institutional FBDE beneficiaries with incomes up to 100% of the FPL.
* LIS Level 3 – FBDE beneficiaries who are institutionalized or receiving Home and Community-Based Services (HCBS).

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| **LIS Level**  **(Cost Share)** | **Percentage**  **(of Premium Benefit)** |
| 1 | 100% |
| 2 | 100% |
| 3 | 100% |

 Receiving 100% of the premium benefit does NOT mean 100% of the premium is covered.



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| LIS Plan Premiums |

For 2025, Extra Help beneficiaries that choose to enroll in the SilverScript Choice plan may be responsible for a premium, even with 100% subsidy.

Refer to the Low Income Subsidy Premium FAQs within [MED D - SilverScript Plan Changes for ANOC 2025](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4a634331-4e61-4196-a82b-845126529d03).

For specific state by state plan premiums, refer to:

* [MED D - 2025 SilverScript CHOICE LIS Information](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e11d24c8-838e-4fba-8d76-5e820cee1b9d).

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| LIS Cost Share |

The Extra Help beneficiary's cost share applies across all service areas and prescription plans.

Refer to [MED D - Low Income Subsidy (LIS) Informational Overview](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=39c4d667-eb19-4bde-9ec0-bdcda34aa0dd).

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| SEP for LIS Beneficiaries |

Individuals who receive Extra Help are limited to one Special Election Period (SEP) per quarter. This applies to the first 9 months of the year. This applies to:

* Low Income Subsidy (LIS) beneficiaries
* Full dual eligible beneficiaries
* Partial dual eligible beneficiaries

The SEP for LIS begins the month the individual becomes dual-eligible and exists as long as they receive Medicaid benefits; however, there are limits in how often it can be used. The beneficiaries can make one election within three months of any change or notification of a change.

Individuals may enroll in, or disenroll from, a plan once per calendar quarter during the first 9 months of the year. The LIS SEP is considered "used" based on the month in which the individual makes the election (i.e., application date of the enrollment request).

**For example:**

If the plan receives an election in March (effective April 1st) this counts as "using" the SEP for the 1st quarter (March received date), and not the 2nd quarter (April effective date).

**Other SEPs for LIS**

If a LIS beneficiary is making an election such as moving out of the service area, the plan should use the Out of Area Move SEP vs. the LIS SEP.

An SEP is also available for those who gain, lose, or have a change in their LIS Level as follows:

* Become eligible for any type of assistance through Medicaid or LIS
* Lose eligibility for any type of assistance through Medicaid or LIS
* Have a change in the level of assistance (stop receiving Medicaid but still qualify for LIS)

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| Resources to Apply for LIS Benefits |

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| Anyone that needs help finding assistance programs local to them | State Health Insurance Assistance Program (SHIP) Counselors are available by [state](https://www.shiptacenter.org/). |
| The Social Security Administration | 1-800-772-1213  1-800-325-0778 (TTY users) |

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| State Pharmaceutical Assistance Programs (SPAP) |

Some beneficiaries may receive State Pharmaceutical Assistance Program (SPAP) benefits.

SPAPs provide help with Medicare Part D premiums and prescription drug plan costs. Each program works differently. Some states offer programs that can help people with certain illnesses pay for their prescription drugs. For example, certain states offer programs for people who have End Stage Renal Disease (ESRD).

 Not all SPAPs coordinate with Aetna Medicare Part D plans.

Refer to [MED D - Handling State Pharmaceutical Assistance Program (SPAP) Calls](file:///C:/Users/C337799/Downloads/CMS-PRD1-109846).

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| Employer Group Waiver Plan (EGWP) Formulary Changes |

[SilverScript EGWP Formulary Changes](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=91b190c3-ad1c-4521-940b-c9536458705a) will be available when ANOC has been sent for EGWP beneficiaries.

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| EGWP Premium Billing Inquiries |

Refer to the CIF and the **Rate Data** on the **Premium Billing**tabof the Medicare D Landing Pagein Compass to determine how Premium Billing is handled.

* Refer to the CIF for questions regarding **WHO PAYS IRMAA** and **LEP*.***
  + Some plans pay LEP and some beneficiaries are responsible.
  + For IRMAA, some plans may reimburse the beneficiary.
* LEP attestations are always handled by Customer Care regardless of who pays the LEP.
* Refer to the following documents:
  + [MED D - Income Related Monthly Adjustment Amount (D-IRMAA)](file:///C:/Users/C337799/Downloads/CMS-PCP1-041559)
  + [MED D – Late Enrollment Penalty (LEP) Attestation and Appeals](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=081c89cb-f3be-4d57-bd49-5b175ad1cc71)
  + [MED D - SilverScript Late Enrollment Penalty FAQ (LEP)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=2f2f1ef3-0379-4791-92a8-f55d2ee52391)
  + [MED D - Blue MedicareRx (NEJE) Late Enrollment Penalty (LEP)](file:///C:/Users/C337799/Downloads/CMS-PCP1-024700)

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| EGWP Disenrollment Inquiries |

Prior to discussing disenrollment with an EGWP beneficiary, the CCRs **MUST:**

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| **Step** | **Action** |
| **1** | Access the **CIF** in theSource. |
| **2** | Navigate to the **Open/Annual Enrollment Period** section. |
| **3** | Review the details found in the **Open Enrollment/Disenrollment** section.  For many EGWPs, when an EGWP beneficiary chooses to disenroll from their plan, they will **ALSO** be cancelling any other benefit provided by the EGWP (i.e. medical, vision, etc.).   * Verify which benefits, if any, are lost by checking the Pre-Enrollment CIF. |

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| Multi-Language Interpreter Service |

We have free interpreter services to answer any questions you may have about your health or drug plan. Someone who speaks [language] can help you. This is a free service.

**Languages include (but are not limited to):**

Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese

Refer to [MED D Language Assistance - Language Line Services](file:///C:/Users/C337799/Downloads/CMS-2-028005).

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| SilverScript Tax ID |

Refer to [MED D SilverScript Tax ID](file:///C:/Users/C337799/Downloads/CMS-PRD1-060869).

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| Enrollment Periods |

The following is a list of common enrollment periods. It is meant for information purposes and is not inclusive of all enrollment periods.

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| Annual Enrollment Period (AEP)  October 15 - December 7 | The AEP is from October 15 until December 7 each year. This is the set time when a beneficiary can change their health or drug plan, or switch to Original Medicare. Enrollments submitted and accepted timely during AEP have a January 1st effective date. | | |
| Initial Enrollment Period (IEP) | This allows a newly eligible beneficiary to enroll in a Medicare plan. Their 7 month enrollment period starts 3 months before the month of eligibility and ends 3 months after the month of eligibility. The plan effective date is based on when their application is submitted: | | |
| **Application submitted…** | **Effective date is…** | |
| Any of the 3 months before the beneficiary’s eligibility month | First day of the beneficiary’s eligibility month | |
| During the beneficiary’s eligibility month or any month after up to the end of the enrollment period | First day of the month following the month of the application date | |
| Special Enrollment Period (SEP) for those who receive Extra Help | If a dual or other LIS eligible beneficiary is making an election and is also eligible for another SEP, the organization should use the other SEP instead of this SEP.  Individuals who receive extra help are limited to one Special Election Period (SEP) per quarter. This applies to the first 9 months of the year. This applies to:   * Low Income Subsidy (LIS) beneficiaries * Full dual eligible beneficiaries * Partial dual eligible beneficiaries   The SEP for LIS begins the month the individual becomes dual-eligible and exists as long as they receive Medicaid benefits; however, there are limits in how often it can be used.  Individuals may enroll in, or disenroll from, a plan once per calendar quarter during the first 9 months of the year. The LIS SEP is considered "used" based on the month in which the individual makes the election (i.e., application date of the enrollment request).  **For Example:**  If the plan receives an election in March (effective April 1st) this counts as "using" the SEP for the 1st quarter (March received date), and not the 2nd quarter (April effective date).  An SEP is also provided for those who have a change in eligibility status:   * Become eligible for any type of assistance through Medicaid or via LIS * Lose eligibility for any type of assistance through Medicaid or via LIS * Have a change in the level of assistance (stop receiving Medicaid but still quality for LIS)   The beneficiaries can make one (1) election within three (3) months of any change or notification of a change. | | |
| Special Enrollment Period (SEP) for Individuals Affected by a Weather-related Emergency or Major Disaster | A SEP exists for individuals affected by a weather-related emergency or major disaster who were unable to and did not make an election during another valid election period.  This includes both enrollment and disenrollment elections.  Individuals will be considered "affected" and eligible for this SEP if they:   * Reside, or resided at the start of the incident period, in an area for which FEMA has declared an emergency or a major disaster and has designated affected counties as being eligible to apply for individual or public level assistance * Had another valid election period at the time of incident period and * Did not make an election during that other valid election period.   In addition, the SEP is available to those individuals who don't live in the affected areas but rely on help making healthcare decisions from friends or family beneficiaries who live in the affected areas.  The SEP is available from the start of the incident period and for four full calendar months thereafter.  The SEP is being added to the different source options for enrollment:   * Online enrollment processes available with the plan * OEC- Medicare Online Enrollment * Paper Applications | | |
| Special Election Periods (SEP) for Enrollment in Five-Star MA/PDP Plans  December 8 - November 30 | The Medicare 5-Star Special Election Period is a special opportunity for beneficiaries to switch to a 5-star-rated plan. This election period applies:   * If beneficiary loses other insurance coverage and/or * If beneficiary wants to enroll in five-star plan.   Plan coverage typically begins the first day of the following month after the plan receives the application.  Medicare updates its plan star ratings every fall. This can affect which plans you can sign up for.  For **Example:** | | |
| **If…** | **A beneficiary CAN…** | **A beneficiary can NOT…** |
| A plan has a 5-star rating for the current year but loses a star for the following year… | Only use the 5-Star SEP to enroll in this plan up until November 30, for an effective date beginning December 1. | Enroll in the plan after December 1, since the effective date would be January 1 the following year when the plan no longer has the 5-star rating. |
| A Medicare beneficiary already enrolled in a Five-Star plan can use this SEP to change to a different Five-Star plan.   * Once this SEP is used for a given plan year, the Medicare beneficiary must qualify for another SEP to make a change or wait for the Annual Enrollment Period. * Each year, CMS reviews all MA, MAPD and PDP plans for quality measures and assigns each plan a rating. Plans are given a rating between one and five stars. One star is a poor rating and five stars is an excellent rating. Star ratings are assigned for the plan contract year (January - December). * This SEP is based on the overall plan rating, not the rating the plan receives in each category. Medicare beneficiaries can view Coventry or Aetna Medicare Plan ratings for all Medicare carriers on [medicare.gov.](file:///C:/Users/C337799/Downloads/medicare.gov) | | |

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| LEP (Late Enrollment Penalty) |

Late Enrollment Penalty (LEP) is assessed to a beneficiary for not having creditable prescription drug coverage for 63 days or more while eligible for a Medicare Prescription Drug Plan. The LEP is assessed to the beneficiary when they join a Medicare Prescription Drug Plan.

**How Medicare Determines the LEP Amount**

Medicare, not the plan, calculates the late enrollment penalty when a person subject to the penalty first joins a Medicare drug plan.

This is for information purposes; it should NOT be used to calculate information with a beneficiary.

The late enrollment penalty amount is typically 1% of the national base beneficiary premium for each full, uncovered month that the person didn't have Part D or creditable coverage.

The monthly penalty is rounded to the nearest $0.10 and added to the monthly Part D premium.

The 2025 national base beneficiary premium is $36.78 (up from $34.70 in 2024).

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| IRMAA (Income Related Monthly Adjusted Amount) |

Part D Income Related Monthly Adjustment Amount (Part D-IRMAA) is a premium amount separate from the Part D plan's monthly premium for enrollees who have incomes over a certain amount.

* Social Security Administration (SSA) assesses the amount annually based on the enrollee's available tax information.
* PDP plans do not collect the Part D-IRMAA as part of their plan premium.
* Most enrollees pay the Part D-IRMAA through their Social Security, Office of Personnel Management or Railroad Retirement Board (RRB) benefit checks.
* Some enrollees are directly billed for their Part D-IRMAA through invoices sent by CMS or the RRB.

All Part D enrollees who are assessed the Part D-IRMAA are required to pay the IRMAA even if the Part D coverage is provided through an employer-sponsored plan.

**Part D IRMAA Information in the ANOC/EOC**

There is a paragraph about Part D IRMAA in the beneficiary’s EOC - "Do you have to pay an extra Part D amount because of your income?" This may generate beneficiary questions about how this impacts their premium.

 The monthly plan premium amounts reflected in the ANOC/EOC for PDP beneficiaries are for their Aetna PDP plan coverage and do not include this income-related Part D premium increase.

If the beneficiary meets the criteria to be assessed the income-related Part D premium adjustment, they will be notified by Social Security in November along with information about payment options.

 PDP plans do not collect the Part D-IRMAA as part of their plan premium.

**Part D IRMAA Amounts**

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| **Individual**  **Modified Adjusted Gross Income (MAGI)** | **Married**  **Modified Adjusted Gross Income (MAGI)** | **Prescription drug coverage monthly premium amount for 2025** |
| Less than or equal to $106,000 | Less than or equal to $212,000 | 2025 Plan premium |
| Greater than $106,000 and less than or equal to $133,000 | Greater than $212,000 and less than or equal to $266,000 | 2025 Plan premium + $13.70 |
| Greater than $133,000 and less than or equal to $167,000 | Greater than $266,000 and less than or equal to $334,000 | 2025 Plan premium + $35.30 |
| Greater than $167,000 and less than or equal to $200,000 | Greater than $334,000 and less than or equal to $400,000 | 2025 Plan premium + $57.00 |
| Greater than $200,000 and less than $500,000 | Greater than $400,000 and less than $750,000 | 2025 Plan premium + $78.60 |
| Greater than or equal to $500,000 | Greater than or equal to $750,000 | 2025 Plan premium + $85.80 |

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| Top Grievance Drivers |

Refer to [MED D - Top Grievance Drivers](file:///C:/Users/C337799/Downloads/TSRC-PROD-029562).

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| Log Activity |

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| Related Documents |

**Parent Document:** CALL-0048: [Medicare Part D Customer Care Call Center Requirements-CVS Caremark Part D Services, L.L.C.](https://policy.corp.cvscaremark.com/pnp/faces/SecureDocRenderer?documentId=CALL-0048&uid=pnpdev1)

**Abbreviations/Definitions:** [Abbreviations / Definitions](file:///C:/Users/C337799/Downloads/CMS-2-017428)

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