Sales Policy Job Aid

Prescription Drug Coverage Reference Guide

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United Healthcare®

2025 Prescription Drug Coverage Reference Guide

This guide explains the basics of Medicare Part D prescription drug coverage and includes answers to common consumer questions that may arise when enrolling consumers in a Part D plan.

Medicare Part D and Consumer Eligibility

Medicare Part D

Medicare Part D is a government program that helps Medicare beneficiaries cover the cost of their prescription drugs. Part D coverage is provided through private companies that contract with the Centers for Medicare & Medicaid Services (CMS). Enrolling in a Part D plan is voluntary, and premiums, drugs covered, and member cost-sharing obligations can vary by plan and may change from year-to-year.

Consumers can get Medicare Part D benefits in one of two ways:

1. Enrolling in a stand-alone Medicare prescription drug plans or "PDP." PDPs provide Medicare prescription drug coverage to beneficiaries with Original Medicare, as well as beneficiaries enrolled in certain Medicare Cost Plans or Medicare Private Fee-for-Service (PFFS) Plans. When a consumer is eligible to enroll in a PDP, they are also likely eligible to enroll in a Medicare Supplement Insurance (MedSupp) Plan.
2. Enrolling in a Medicare Advantage plans with prescription drug coverage or "MAPD." MAPDs offer Medicare prescription drug coverage in addition to medical coverage. Consumers enrolled in these plans receive all their Medicare Part A and Part B coverage as well as their prescription drug coverage (Part D) from the plan.

Consumer Eligibility

Generally, to enroll in a Part D plan, the consumer must permanently reside in the plan's service area, be a U.S. citizen or otherwise lawfully present in the United States, have a valid election period, and:

- For a stand-alone PDP:
  - Be entitled to Medicare Part A, **or**
  - Be enrolled in Medicare Part B*, **or**
  - Be entitled to Medicare Part A and enrolled in Part B*
- For an MAPD:
  - Be entitled to Medicare Part A, **and**
  - Be enrolled in Part B*

* A consumer enrolled in Medicare Part B must continue to pay their Part B premium in addition to any Part D plan premium.

Enrolling in a PDP or MAPD may affect the consumer's membership in other insurance plans. Before enrolling a consumer in a new plan, make sure to ask about their current coverage.

It is important to understand the consumer's needs so that they are enrolled in a plan that best meets those needs. To help ensure a positive consumer experience:

- Conduct a thorough needs assessment to understand the consumer's current medical and prescription drug coverage, current prescription medications, access to network pharmacies, and financial considerations and personal preferences.
- Advise the consumer of their options, making sure the consumer understands the benefits (i.e., what the plan covers, such as medical and prescription drug coverage, pharmacy participation, etc.) and costs (i.e., premium, deductible, and coinsurance or copayment) of each plan discussed.
- Use the formulary or drug cost estimator tool (see Formulary section for more information) to ensure any recommended plan adequately covers the consumer's prescription medications.
- Help the consumer think about any discussions with their providers or pharmacy(ies) that may be appropriate (e.g., asking their provider about lower-cost generics).

Low-Income Subsidy

The Low-Income Subsidy (LIS) program, also called “Extra Help,” is a Medicare program that helps Medicare-eligible consumers with limited resources pay for their Part D premiums, deductibles, copayments/coinsurance, and other costs. Some people automatically qualify for Extra Help, but others must apply. It is important to explain all the costs associated with a Medicare drug plan even if the consumer is eligible for Extra Help at the time of enrollment. Refer to the Low-Income Subsidy job aid, available on Jarvis, to learn more about LIS subsidy level.

Premium & Cost-Sharing

Plan Premium

The plan premium is the member's monthly payment to the MAPD or PDP for coverage. Whether the consumer enrolls in an MAPD or PDP, they generally must continue to pay their Part B premium directly to Medicare.

Consumers who have incomes over a certain amount may also have to pay the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), which is a premium amount separate from the Part D plan's monthly premium. The Part D-IRMAA is paid directly to Medicare.

Part D Drug Deductible

A plan's drug deductible is the amount the member must pay for their prescription medications before the plan begins to pay (i.e., the member enters the initial coverage stage). In 2025, our Part D plan drug deductibles range from $0 to $590, which is the maximum allowable drug deductible.

If the consumer elects to enroll in a plan that includes a dug deductible:

- The drug deductible (amount may vary by plan) must be met before the plan begins to pay.
- The drug deductible may apply to all drug tiers or only to specific drug tiers. For example, a plan may have a drug deductible that only applies to Tiers 3-5. This means the member will have no deductible for Tier 1 and 2 medications but will need to meet the deductible for Tier 3–5 medications

Coinsurance

Usually a percentage (e.g., 25%), coinsurance is the portion of the cost of prescription medications that the member is required to pay.

Copayment

Usually a set amount (e.g., $2.00), a copayment is the amount the member may be required to pay as their share of the cost of prescription medications.

Note: A plan's applicable coinsurance and/or copayment amounts may vary based on several factors, including which tier a drug is in, which Coverage Stage the member is in, and whether the member uses a preferred pharmacy.

Prescription Drug Plan Coverage Stages

	2024	2025
Deductible	Up to $545	Up to $590
Initial Coverage Stage	Ends at $5,030	Ends at $2,000
Catastrophic Stage	$0 for Medicare covered Part D medications	$0 for Medicare covered Part D medications

Ways UnitedHealthcare Helps its Members Save Time and Money on Prescription Drugs

The Savings and Convenience of a Mail Order Pharmacy

Optum Rx is an affiliate of UnitedHealthcare and every Part D plan offers home delivery as a benefit. Optum Rx is one of several mail order pharmacies available and members do not need to use Optum Rx.

- There is no charge for standard delivery to US addresses, including U.S. territories for participating plans.
- Pharmacists are available by phone to answer questions any day, any time.
- Some plans charge lower cost sharing for mail order pharmacy.
- Members can sign up by mail, phone, or online for this service.

Members can set up an online account at optumrx.com to help manage their prescriptions by:

- Setting up auto refill on many maintenance medications.
- Finding medications and searching for lower cost alternatives covered by the plan.
- Setting up text message alerts to remind them to take their medications timely.

Preferred vs. Non-Preferred Pharmacies

PDP members can choose to access pharmacies in the preferred pharmacy network for cost savings. Locate preferred pharmacies using the online drug cost estimator tool. Some MAPD plans have a preferred pharmacy network (e.g., Walgreens). To determine if an MAPD plan has a preferred pharmacy network, refer to plan documentation.

Online Tools

Members can access the Savings Center on their portal to see if there are ways they may be able to lower the costs of the prescription medications.

Drug Cost Estimator Tool: Prescription, pharmacy location and costs, and plan information can be entered to estimate drug coverage and costs for a consumer.

Late-Enrollment Penalty (LEP)

If a consumer does not enroll in Part D coverage when they are first eligible, or if they have a break in Part D coverage of 63 consecutive days or longer, they may be subject to a Part D late enrollment penalty (LEP). The Part D LEP is required by law and will be calculated by CMS and added to the consumer's monthly Part D premium for as long as they are enrolled Part D coverage, even if the consumer enrolls in a $0 premium plan. To help ensure a positive consumer experience, it is important that consumers understand what the LEP is and that it will apply regardless of which carrier or plan the consumer chooses.

Note: The LEP may be reduced or eliminated if the consumer qualifies for the Low-Income Subsidy Program (i.e., Extra Help).

Creditable Coverage

Creditable drug coverage is prescription drug coverage (for example, from an employer, union, TRICARE, Indian Health Service, or the Department of Veterans Affairs) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Consumers with creditable drug coverage when they first become eligible for Medicare Part D can generally elect to keep that coverage without paying an LEP if/when they later decide to enroll in a Part D plan.

Note: If the consumer is enrolling in a Part D plan for the first time or appears to have had a gap in creditable drug coverage for 63 or more consecutive days, advise the consumer that they will receive a letter and attestation form from UnitedHealthcare. The consumer must complete and return the form or call the Customer Service number indicated in the letter to attest to having creditable drug coverage prior to enrolling in the Part D plan. See the enrollment handbook for more details.

Drug Tiers, Formulary, and Coverage Rules

Consumers often have questions about the characteristics of a plan's prescription drug coverage including the formulary, drug tiers, and coverage rules specific to the plan. To help ensure a positive consumer experience, it is important that the consumer understands the different features of their plan.

Drug Tiers

Many Medicare Prescription Drug Plans group covered medications into tiers. The number of tiers may vary from plan to plan. Generally, a drug in a lower tier will cost less than a drug in a higher tier.

Example Plan with Five Drug Tiers

Tier	Member Pays	What is Covered?
Tier 1 Preferred Generic	Lowest copayment	Lower-cost, commonly used generic drugs
Tier 2 Generic	Low copayment	Many generic drugs
Tier 3 Preferred Brand	Medium copayment or coinsurance	Many common brand-name drugs, called preferred brands and some higher-cost generic drugs
Tier 3 **Covered Insulin Drugs**	No more than $35 for 1-month supply (retail and mail) and $105 for 3-months supply (retail and mail)	Covered insulin products
Tier 4 Non-Preferred Drug	Higher copayment or coinsurance	Non-preferred generic and non-preferred brand-name drugs
Tier 5 Specialty Tier	Coinsurance	Unique and/or very high-cost brand and generic drugs

Formulary

A “formulary” is a list of the prescription drugs covered by a Part D plan. Each Part D plan develops its own formulary with the help of providers and pharmacists. CMS guidelines require Part D plan formularies to cover at least 2 drugs in each of the most commonly prescribed drug categories and classes. CMS reviews and approves each Part D plan’s formulary.

Types of Drug Lists and Formularies:

- Comprehensive drug list: Available online for MA-PD and PDP plans or by scanning QR code inside the enrollment guide, the comprehensive drug list displays a more complete alphabetical list of covered drugs.
- Comprehensive Formulary: A complete formulary that lists all covered medications by drug class with an alphabetical index in the back. The chart includes Tier levels and special handling circumstances. The PDP or MA-PD plan formulary is available for agent download on the Sales Materials Portal.
- Alternative Covered Drug list: Available in the Enrollment Guide for PDPs, is a list of drugs not covered by the plan, with a list of alternatives that are covered.

Note: A plan’s formulary may change during the plan year. Make sure you are using the most current version of the formulary (available on Jarvis) or use the online drug cost estimator tool (available on Jarvis).

Coverage Rules

Plans may have drug coverage rules (Prior Authorization, Step Therapy, or Quantity limits that the member must follow to receive their plan benefits.

Getting plan approval in advance. For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy.**

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Important change in 2025: medications on Tier 4 and Tier 5 will be limited to 30-day supplies.

Exceptions and Appeals

A member or their provider can submit an exception request to ask the Part D plan to cover a drug that is not on the plan's formulary or remove restrictions (such as ST or QL) that apply to the drug. If an exception is approved, the drug will be covered and process on Tier 4 for PDP and Tier 5 for MAPD plans.

Medication Therapy Management Program

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take. If you qualify for the program you will be automatically enrolled into the program (with the option to opt out) and a pharmacist or other health professional will give you a comprehensive review of all your medications.

Best Practices

When discussing PDP and MA-PD plans, make sure to observe the following can help ensure a positive consumer experience:

- Verify the consumer's eligibility to enroll in a stand-alone PDP (entitled to Medicare Part A and/or enrolled in Part B) or MA-PD (entitled to Medicare Part A and enrolled in Part B).
- Explain that consumers can only be enrolled in one plan that provides Part D coverage at a time. If the consumer's current plan includes creditable drug coverage, ensure that the consumer understands that unless an exception applies, they will be automatically disenrolled from their current coverage if they enroll in a PDP or MA-PD.
- Look beyond premium and cost sharing to determine whether a plan is right for the consumer. The medications on the formulary and the drug tier they are on may impact the value of a plan to a specific consumer.
- Ask the consumer what pharmacy they use and look up each pharmacy in the pharmacy directory to confirm it is in the network. Explain how the plan's benefits may be different if the consumer uses an out-of-network pharmacy.
- Look up the consumer's currently prescribed medications in the formulary and explain whether the drug is covered and if so, the tier, applicable cost-sharing, and any applicable coverage rules (e.g., QL or ST).
- Clearly describe the drug coverage stages to consumers.
- Explain the LIS program and encourage the consumer to apply if they believe they are eligible.

If a consumer is uncertain about whether it makes sense to enroll in a Part D plan now or wait until later, make sure the consumer understands the LEP and how it may affect them.