NABIP
Shaping the *future* of healthcare

OUT-OF-POCKET COSTS OF MEDICARE

PART D IN 2025

DEDUCTIBLE STAGE

You are responsible for **100%** of your prescription drug costs until your deductible is met. Your plan may have an annual deductible of no more than **$590.** Some plans carry a zero-dollar deductible. In some plans, the deductible may not apply to certain low-cost or generic drugs.

INITIAL COVERAGE

You pay up to 25% of coinsurance for medication covered in your plan's formulary or list of covered medications. Your maximum out-of-pocket cost will be **$2,000.**

CATASTROPHIC COVERAGE

Once you have incurred the maximum out-of-pocket cost of **$2,000,** your coverage does not end.
All medications covered on the formulary from this point forward will be covered at **100%.**

PLAN YEAR RESTARTS

No matter what, everything resets on January 1, and you return to the deductible stage at the beginning of the next year.

For more information, contact:

(704)618.3800 bonnie@4insuranceoptions.com www.4insuranceoptions.com

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TIER LEVELS CLASSIFICATIONS

Tier 1 — Preferred Generic
This tier consists of commonly prescribed generic drugs. Beneficiaries pay the least for drugs in this tier.

Tier 2 — Generic
Drugs in this tier are generic and slightly more costly than those in Tier 1.

Tier 3 — Preferred Brand
This tier consists of brand-name prescription drugs without a generic equivalent. It can also include higher-priced generics as well as specialty medications. Drugs in this tier are lower-cost than conventional branded drugs.

Tier 4 — Brand
Drugs in this tier are brand names or higher-priced generics that do not have a less expensive generic equivalent. This can also include specialty medications. These drugs are typically more expensive than those in Tier 3.

Tier 5 — Specialty
This tier consists of high-cost specialty drugs that treat complex conditions like cancer. They may be generic, brand names, or specialty medications. Beneficiaries typically pay the most for drugs in this tier.

PLAN COVERAGE RULES

Prior Authorization
Prescription drug plans with prior authorization require a physician to get advance approval before a specific medication can be prescribed to a plan beneficiary.

Step Therapy
As Medicare explains, "Step therapy is a type of prior authorization. In most cases, you must first try a certain, less expensive drug on the plan's formulary that's been proven effective for most people with your condition before you can move up a 'step' to a more expensive drug. For instance, some plans may require you first try a generic drug (if available), then a less expensive brand-name drug on their drug list before you can get a similar, more expensive, brand-name drug covered."

Quantity Limits
Per Medicare, "For safety and cost reasons, plans may limit the amount of prescription drugs they cover over a certain period of time. For example, most people prescribed heartburn medication take 1 tablet per day for 4 weeks. Therefore, a plan may cover only an initial 30-day supply of the heartburn medication."

Coverage Exception
As CMS explains, coverage exceptions can be "requested to obtain a Part D drug that is not included on a plan sponsor's formulary, or to request to have a utilization management requirement waived (e.g., step therapy, prior authorization, quantity limit) for a formulary drug."

COVERAGE COST METHODS

Premiums
A periodic payment to keep an insurance policy in force.

Deductible
The amount of covered expenses that the insured must pay before a plan or insurance contract starts to reimburse for eligible expenses.

Co-Pay
A fixed amount a beneficiary pays for covered medication.

Coinsurance
The percentage of costs for which a beneficiary is responsible after he or she has paid the deductible.

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