



MAKING THE CONNECTION

Medicare And Beyond

146 West Roosevelt Road, Villa Park, Illinois 60181
Telephone: (630) 782-4782 Fax: (630) 516-1306

MEDICARE D

Medicare D provides prescription drug coverage to individuals who are enrolled in Medicare A or B. Medicare D is purchased through private insurance companies and is funded by premiums and federal subsidy.

The basic Medicare D program (Prescription Drug Plan/PDP) requires participants to pay:

- ❖ Premiums for coverage (average \$30/mo)
- ❖ Meet a \$275 deductible (this can vary by plan), then
- ❖ Pay 25% of the Rx costs up to \$2,510
- ❖ Pay 100% of Rx costs between \$2,511-\$5,726.25 (the donut hole)
- ❖ Pay 5% of Rx costs over \$5,726.25 (catastrophic coverage)

How to pick a Part D plan?

Call 1-800-MEDICARE (633-4227) or go to the Medicare website www.medicare.gov. In many areas, persons can also contact a local senior center or center for individuals with disabilities to get help choosing a plan.

EXTRA HELP (LIMITED INCOME SUBSIDY/LIS)

Some limited income and special households qualify for help to pay the premium and other costs associated with the Medicare D program (the deductibles, coverage gap during the donut hole). This is called Extra Help.

There are 2 types of extra help – Full and Partial.

Eligibility for the type of help is based on the family income and assets and whether or not the person has Medicaid coverage. Persons complete an application each year between November 15th and December 31st for Extra Help if enrolled in:

- ❖ Medicare D alone
- ❖ Illinois Cares Rx

Some persons are “deemed” eligible for Extra Help and do not have to complete a separate application for Extra Help if they are enrolled in:

- ❖ Medicaid and Medicare (Dual Eligible)
- ❖ Medicaid and Medicare with spenddown met between August and December
- ❖ Medicare Savings Programs (QMB, SLIB, QI-1)
- ❖ Receive SSI and Medicare

If the person is automatically enrolled for the Extra Help, and has not selected a Medicare D plan, they will be randomly assigned to a plan. If a person has a plan that is not subsidized by Extra Help, a new plan will be selected by CMS, or can choose to pay the difference between the Extra Help and the actual premium.

MEDICAID AND MEDICARE SAVINGS PROGRAM (MSP) DUAL ELIGIBLES

Medicaid is a jointly Federal and state funded program that is targeted to covering medical expenses for low income and low asset persons who are aged (65+), blind, or disabled and who are Illinois residents who are US citizens or qualified immigrants. When persons become eligible for Medicare, the Medicaid program no longer pays for most prescription drug expenses. This requires the person to be enrolled in Medicare D. Medicare will automatically enroll the person, if they do not independently enroll. The only exception is if the person has another insurance plan that would cover drugs as good as the Medicare drug coverage, and the person contacted Medicare to “Opt Out” of the Part D coverage.

If a person has Medicare and Medicaid both, she/he is called “dual eligible” since they are eligible under both programs. This includes regular Medicaid, spenddown, nursing home cases, Medicare Savings Program (QMB, SLIB, & QI-1) and Medicaid Buy-in cases (Medicaid through the Health Benefits for Workers with Disabilities program).

Dual eligible persons are automatically given Extra Help for Medicare Part D. This means they won't pay monthly Part D premiums, the annual deductible, coinsurance, or have a coverage gap (the “donut hole”). You will only pay basic co pays of \$1 to \$5 for each covered drug.

Limited income individuals with Medicare may also be eligible for help to pay Medicare premium expenses through programs called **Medicare Savings Programs**. Following are the Medicare Savings Programs:

- ❖ **QMB** (Qualified Medicare Beneficiaries) – Income has to be under 100% FPL, and assets under \$4000 single/ \$6000 couple.
- ❖ **SLIB** (Specified Low Income Medicare Beneficiaries) – Income under 120% FPL and assets under \$4000 single/ \$6000 couple

- ❖ **QI-1** (Qualified Individuals) – income under 135% FPL and assets under \$4000 single/ \$6000 couple. Cannot be eligible for Medicaid to be enrolled in this program. Having a spenddown is considered the same as not having Medicaid.

To apply for Medicaid or a MSP a person goes to the local IDHS/Medicaid office in his/her area. Individuals can choose the program to apply for. If applying for only a Medicare Savings Program, a short form application (Form 2378M) is used and no interview is needed. To find an office call 1-800-843-6154 or www.dhs.state.il.us Once enrolled, if the person's income and assets meet the MSP requirements, enrollment is to remain in effect, even if Medicaid coverage is stopped.

TIP: Often when Medicaid ends this does not happen, and the first clue the client has is a reduction in Social Security benefits. If this happens the client can call the IDHS worker to get the Medicare Savings Program benefit re-instated, and receive a refund in premiums. This process can take up to 3-6 months to solve.

ILLINOIS CARES RX

Illinois Cares Rx is a State of Illinois prescription drug assistance program. This program has 2 parts: the Illinois Cares Rx Plus and Illinois Cares Rx Basic.

TIP: Dual eligible persons do not need Illinois Cares Rx because the Extra Help received from the combined Medicare/Medicaid benefit will be better than Illinois Cares Rx. If enrolled in a Medicare Savings Plan (SLIB/QI-1) you can apply for Illinois Cares Rx, however, the benefit received may not be as good. It is best to talk with a SHIP counselor.

The **Illinois Cares Rx Plus** helps meet the prescription costs of Illinois residents age 65+ who are US citizens or qualified immigrants with income below 250% of FPL. This program coordinates with Medicare Part D and will help to pay the Part D premium if enrolled in a coordinating plan (or provides a \$25 **rebate** if enrolled in a non-coordinating plan). **Illinois Cares Rx Basic** is available to limited income persons with disabilities age 16-64. It provides prescription coverage for specific illnesses: Alzheimer's disease, arthritis, cancer, diabetes, glaucoma, heart and blood pressure problems, HIV/AIDS (if eligible for Medicare), lung disease and smoking-related illnesses, multiple sclerosis, osteoporosis and Parkinson's disease. **HIV/ADAP** drugs are covered if HIV positive and on Medicare, and qualify for Illinois Cares Rx based on income. A person is also eligible if qualified for partial Extra Help. The person, however, is not eligible if on Medicaid or receiving full Extra Help. If income is over drugs will continue through the ADAP program.

Application can be made at <http://www.illinoiscaresrx.com/>. If you have Medicare D you will have to apply for the Extra Help, and select a drug plan that coordinates with Illinois Cares Rx.

ENROLLMENT PERIODS

Individuals first become eligible for Medicare when they turn 65, or have received Social Security Disability Insurance (SSDI) for 2 years. They have an Initial Enrollment Period to enroll for Medicare including Part D. There are also strict time frames for when person can enroll or change the plans.

- **Initial Enrollment Period:** is a 7 month period that begins 3 months before and ends 3 months after the month of either (a) the 65th birthday, or (b) the month the person begins to receive Medicare based on disability (the second anniversary of receiving SSDI).
- **Annual coordinated Election Period (AEP):** is from November 15 - December 31 of each year. Plan changes can be made. The change take effect on January 1 of the following year. If someone did not enroll at the IEP and is not eligible for a special enrollment period, they may have a **Late Enrollment Penalty**. The penalty is permanent and is added to the cost of the premiums each year. For late enrollment in Part B, a person is charged 10% higher premiums for each year delayed and for Part D there is a 1% per month penalty for each month delayed. The Part D penalties are currently being waived for a person receiving Extra Help.
- **Special Enrollment Periods (SEPs):** There are at least 35 different SEPs. See the SEP chart created by the Medicare Rights Center, at <http://medicarerights.org/sepchart.html>. Persons who are eligible for Extra Help or Medicare Savings Plans have a permanent SEP.
- **Open Enrollment Period:** from January 1 – March 31 of each year when a person can make changes in plans, such as change a Medicare Advantage plan, or add additional coverage.
- **Medicaid Dual Eligibles** may change plans at any time

MEDICARE D: DRUGS COVERED

Each Prescription Drug Plan has a **formulary** or a list of covered drugs. The Center for Medicare & Medicaid Services (CMMS) requires the PDP to include in its formulary at least 2 drugs in each Therapeutic Category (e.g., Antidepressants, Cardiovascular Agents), and each Pharmacologic Class (e.g., MAO Inhibitors, Reuptake Inhibitors). Plans must also include biological agents, like insulin. and medical supplies used to inject insulin.

In addition, some drugs are not covered by federal regulations. These include benzodiazepines, such as Valium, Ativan, and Xanax, barbiturates, drugs for weight loss or weight gain, and over the counter drugs and vitamins. Go to: <http://www.cms.hhs.gov/States/Downloads/PartDExcludedDrugs.pdf> for a list of excluded drugs. (Illinois Cares Rx and Medicaid may still be able to cover these drugs). The excluded drugs *may not* be included in the "basic" drug benefit. However, a Part D plan can offer "enhanced" coverage that includes these drugs. Plans that provide better coverage often charge higher premiums.

An **exception by you or your physician can be requested of the plan** to cover a drug not on the formulary. Plans also often have a **Utilization Management (UM)** process for drugs on the formulary. This may mean **Prior Authorization** to get certain drugs has to be obtained. Plans also organize drugs into **Tiers** or use **Step Therapy, Dosage Limits** or **Quantity Limits** to help contain costs. Each plan decides its own criteria for which drugs these restrictions apply to and what must be done to fill the Rx.

PLANS MAY CHANGE FORMULARIES ANY TIME – If a plan decides to change its formulary, the plan must provide members, physicians, pharmacists, and CMS with a 60 day notice of the change. The notice has to include information about other available drugs and explain how to request an exception. If the plan does not provide advance notice, they must provide a 60 day supply of the drug and notice at the time of the refill.

Term	Definition
Tiers	Drugs on a formulary are often organized into different drug "tiers," or groups of different drug types. Your cost depends on which drug tier your drug is in. For example, a plan may form tiers this way: Tier 1 - Generic drugs. Tier 2 - Preferred brand-name drugs Tier 3- Non-preferred brand name drugs. Tier 4 & 5 – Usually non-formulary, slightly reduced-price drugs
Term	Definition
Prior Authorization	Prior approval from an insurance plan before you get care or fill a prescription. In many instances, your doctor or health care provider must first contact the plan and show there is a medically-necessary reason why you must use that particular drug for it to be covered.
Term	Definition
Quantity Limitation	For safety and cost reasons, plans may limit the quantity of drugs that they cover over a certain period of time.
Term	Definition
Step Therapy	In some cases, plans require you to first try one drug to treat your medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, a plan may require your doctor to prescribe Drug A first. If Drug A does not work for you, then the plan will cover Drug B

EXCEPTIONS AND APPEALS PROCESS

If a Part D enrollee disagrees with a decision made by their Rx plan (this usually is a decision not to cover a prescribed drug), they can request an **exception (coverage determination)**. Exceptions are made when: a drug is prescribed that is not covered and the doctor says it is medically necessary, or a drug is needed that has been removed from the plan's formulary mid-year. To request a

coverage determination most plans permit a call, but it is recommended that it is done in writing. The Rx plan has 72 hours to respond to the request. The doctor can also request an expedited determination, which requires a 24 hour response.

A great resource is published by the Medicare Rights Center called the **Medicare Part D Appeals: An advocate's manual to navigating the Medicare private drug plan appeals process** and is available for download at www.medicarerights.org

MEDICARE PART D AND MEDICAID HOW THEY WORK TOGETHER FOR DRUG COVERAGE

What if I have Medicare and then go on Medicaid?

It will take a few months, but you will no longer have to pay your monthly Part D premium. Once your Part D plan is notified that you are now a dual eligible, you will only have to pay basic copays for each drug.

***Example:** Martha has Medicare and applies in January for the Medicare Savings Program to help with her Medicare premiums. She is eligible under SLIB. The worker back-dates her eligibility to 3 months before her application month (October). This means Martha will get a refund of her Medicare premiums for Part B and can get a Part D refund if she requests it from her plan starting with October. Martha is also eligible for a refund for her out-of-pocket drug costs. She only has to pay basic copays for each drug she received since October.*

What if I have Medicaid and then start Medicare?

When your Medicare Part A or B starts, your Medicaid drug coverage will end immediately even if you have not picked a Part D plan. If you do not pick a plan, you will be assigned to one automatically. (NOTE: If the plan selected does not meet the Rx needs, the plan can be changed with the change effective the following month.) This may take a few months and you will be without drug coverage. You can ask your pharmacy to help you by doing a **Point of Sale (also called facilitated) enrollment**. The pharmacy enters the Medicare and Medicaid information and gets immediate coverage under Part D. Most pharmacies will help by doing a Point of Sale (POS) enrollment because they want to keep you as a customer, but they are not required to. The POS enrollment covers you until you are under a Part D plan. The initial POS enrollment is for a 14-day supply. If you have enrolled in a Part D plan prior to seeing the pharmacist, the pharmacist should contact the plan rather than doing a POS enrollment, since the POS enrollment triggers an auto-enrollment process.

***Example 1:** Joe is on Medicaid and begins Medicare coverage on December 1st. Joe did not pick a Part D plan. When he goes to his pharmacy on December 10th, he has no drug coverage so he has to pay \$385 to pick up his medicine. Joe doesn't know about the POS enrollment option and the pharmacy doesn't offer. He picks a Part D plan through Medicare and asks the pharmacy to re-bill the prescriptions to his Part D plan. He waits for a \$373 refund from the pharmacy (\$385 minus his \$12 copays).*

Example 2: Mary is on Medicaid and begins Medicare coverage on December 1st. Mary did not pick a Part D plan. When she goes to her pharmacy on December 10th, she has no drug coverage. Mary requests a Point of Sale enrollment and pays \$11 in copays for her 3 drugs. She picks a Part D plan through Medicare for ongoing drug coverage.

How do a get a refund for out-of-pocket drug costs?

If you have paid for drugs covered by the Part D plan, you can get a refund. Show your Part D card and your Medicaid coverage to your pharmacy and request a refund. The pharmacy may rebill your prescriptions to your part D plan and issue you a refund or you can request a refund directly from your Part D plan. This process may take a few weeks before you receive payment. Follow up regularly until the refund is received. The refund is required under Federal Law. The only thing that can subtract from your refund is the copays you should have been charged. There is no time limit to request this refund.

Helping the client to know when to enroll

TIP: As an advocate you can help your client's identify when they are approaching being Medicare eligible and help them choose a drug plan in advance. This can help avoid confusion and possible gaps in coverage.

Changing a Part D Plan

When **changing Part D** plans, it is important to know that enrolling in a new plan may result in being IMMEDIATELY disenrolled from the old plan. This should not create a coverage gap; however, it is best to make this change after prescriptions have been filled for the month. In order to ensure the change is in place for the next month the plan change needs to be done in the first 3 weeks of the month. Call 1-800-Medicare if there are problems with enrollment.

TIP: If enrolled in Illinois Cares Rx it is important to talk to someone at one of the state's help lines, to ensure the best PDP is selected.

Dual eligible and told the pharmacy computer shows higher co-pay has to be charged Present proof of dual eligibility. The pharmacy may be able to make edits to charge the correct co-pay, but most likely a refund will need to be requested from the drug plan.

Drugs not covered by Part D but enrolled in Illinois Cares Rx If the drugs were formerly covered by the old Senior Care or Circuit Breaker program, then Illinois Rx and Medicaid will continue to cover them. Also drugs such as benzodiazepines, barbiturates and some over the counter drugs will also be covered. If the drug is just not on the Part D formulary, Illinois Cares Rx will not cover the drug, and an exception will need to be requested through the Part D plan.

Senior Health Insurance Program (SHIP)



800-548-9034

IL Department of Healthcare and Family Services/Medicaid Health Benefits Hotline



1-800-226-0768

Elder Abuse Hotline



1-866-800-1409

IDOA Senior HelpLine



1-800-252-8966

US Department of Health and Human Services Center for Medicare Services www.medicare.gov



1-800-MEDICARE

EXTRA HELP: ELIGIBILITY, COVERAGE AND WHERE TO APPLY

Program	Maximum Income FPL	Assets at or below ¹	% of LIS	Where to apply	Benefit
Medicaid and Medicare (QMB enrolled)	100%	\$2000 (1) \$3000 (2)	100% FULL SUBSIDY	Local IDHS	<ul style="list-style-type: none"> Part A², B and D Premiums paid as well as Medicare A and B co-pays and co-insurance costs Rx: \$1.05 generic/\$3.10 brand name; No deductible or donut hole Rx co-pays stop when Rx costs exceed \$5,726.25 Expenses not paid by Medicare A and B are covered by Medicaid
QMB only MSP	100%	\$2000 (1) \$3000 (2)	100% FULL SUBSIDY	Local IDHS	<ul style="list-style-type: none"> Part A², B and D Premiums paid as well as Medicare A and B co-pays and co-insurance costs Rx: \$1.05 generic/\$3.10 brand name; No deductible or donut hole Medicare D co-pays end when Rx costs exceed \$5,726.25
SLIB MSP	100%-120%	\$4000 (1) \$6000 (2)	100% FULL SUBSIDY	Local IDHS	<ul style="list-style-type: none"> Part B and D Premiums paid Rx: \$2.25 generic/\$5.60 brand name No deductible or donut hole
QI-1 MSP	120%-135%	\$4000 (1) \$6000 (2)	100% FULL SUBSIDY	Local IDHS	<ul style="list-style-type: none"> Part B and D Premiums paid Rx: \$2.25 generic/\$5.60 brand name No deductible or donut hole
HBWD Medicaid Buy-In	0%-200% <i>Pending increase to 350%</i>	\$10,000 <i>Pending increase to \$25,000</i>	100% FULL SUBSIDY	HBWD	<ul style="list-style-type: none"> Premium payment for B made based on eligibility for QMB/SLIB, Part D Premiums paid Rx: \$2.25 generic/ \$5.60 brand name; \$2 for doctor visits; \$3/day for hospital stays or \$0/\$3 if no Medicare Part D; No deductible or donut hole
Medicaid Spenddown	NA Medical expenses have to exceed spenddown	NA Medical expenses have to exceed spenddown	100% FULL SUBSIDY	Local IDHS	<ul style="list-style-type: none"> Premium payment for B made based on eligibility for SLIB, QI-1 eligibility Part D Premiums paid for full year Rx: \$1.05 generic/\$3.10 brand name; No deductible or donut hole Premium paid for the balance of the year after spenddown was met. If met July-December also receives subsidy for the following year.
Medicaid Nursing Home Care	NA	NA	100% FULL SUBSIDY	Local IDHS	<ul style="list-style-type: none"> Premium payment for A and B made based on eligibility for QMB, SLIB, QI-1. If QMB eligible, Medicare co-pays and co-insurance are paid. Part D Premiums paid, no deductible or donut hole Rx: No co-pays
Extra Help with no Medicaid	0-135%	\$6,290 (1) ¹ \$10,490 (2)	100% FULL SUBSIDY	SSA	<ul style="list-style-type: none"> Part D Premiums paid Rx: \$2.25 generic/\$5.60 brand name; No deductible or donut hole
Extra Help with no Medicaid	Above 135% but below 140%	\$9,440 (1) \$20,970 (2)	75% PARTIAL SUBSIDY	SSA	<ul style="list-style-type: none"> Part D Premiums reduced by 75% Rx: \$2.25 generic/\$5.60 brand name 15% after the \$56 deductible. When drug expenses reach \$5,726.25, then Rx price is reduced to \$2.25 for generic and \$5.60 brand name.
Extra Help with no Medicaid	Above 140% but below 145%	\$9,440 (1) \$20,970 (2)	50% PARTIAL SUBSIDY	SSA	<ul style="list-style-type: none"> Part D Premiums reduced by 50% Rx: \$2.25 generic/\$5.60 brand name 15% after the \$56 deductible. When drug expenses reach \$5,726.25, then price is reduced to \$2.25 for generic and \$5.60 brand name.
Extra Help with no Medicaid	Above 145% but below 150%	\$9,440 (1) \$20,970 (2)	25% PARTIAL SUBSIDY	SSA	<ul style="list-style-type: none"> Part D Premium reduced by 25% Rx: \$2.25 generic/\$5.60 brand name 15% after the \$56 deductible. When drug expenses reach \$5,726.25, then Rx price is reduced to \$2.25 for generic and \$5.60 brand name.
Illinois Cares Rx Plus With Medicare	0%-225%	NA	100% FULL SUBSIDY	Illinois Cares Rx	<ul style="list-style-type: none"> Part D Premiums paid; must participate in a plan that coordinates both Part D and Illinois Care Rx Rx: \$2.25 generic/\$5.60 brand name for costs between \$0 to \$2,510, \$15 non-preferred Rx; HIV/ADAP drugs covered Pays 20% of Rx costs over \$2,510 to \$5726.25 plus Rx co-pays Pays 5% of Rx costs over \$5,726.25 or \$2.25/\$5.60 whichever is greater
Illinois Cares Rx Plus without Medicare	0%-225%	NA	100% FULL SUBSIDY	Illinois Cares Rx	<ul style="list-style-type: none"> Rx: \$2.25 generic/\$5.60 brand name, \$15 non-preferred Rx Person pays 20% of Rx costs over \$1,750
Illinois Cares Rx Basic	0%-225%	NA	NA	Illinois Cares Rx	<ul style="list-style-type: none"> Citizenship is not a factor Must apply for Extra Help if enrolled in Medicare Pays for Rx for specific conditions: Alzheimer's disease, arthritis, cancer, diabetes, glaucoma, heart and blood pressure problems, HIV/AIDS (if eligible for Medicare), lung disease and smoking-related illnesses, multiple sclerosis, osteoporosis and Parkinson's disease.

¹ Money set aside for burial expenses is not counted toward the assets: \$1,500 (1) and \$3,000 (2).

² Part A is paid if enrolled in Part A that has a premium and enrolled prior to eligibility for QMB

FAMILY SIZE	MONTHLY GUIDELINES PERCENT OF POVERTY				
	100%	135%	140%	145%	150%
1	867	1170	1213	1257	1300
2	1167	1575	1633	1692	1750
3	1467	1980	2053	2127	2200
4	1767	2385	2473	2562	2650



Medicare has to be informed of any other insurance coverage, so benefits between the plans can be coordinated. In addition, employers must provide the Centers for Medicare & Medicaid Services (CMS) with information regarding health coverage of their Medicare-eligible workers and spouses of Medicare-eligible individuals when the Center for Medicare Services requests this information. Data Matches with IRS and Social Security are done to help Medicare intermediaries and carriers identify claims on an ongoing basis for which Medicare should not be the primary payer. Medicare records are to be kept up to date and you are to inform your doctor and other providers about other insurance changes. If there are general questions about Medicare Coordination of Benefits, contact the COB Customer Service Department: **1-800-999-1118** or **TTY/TDD: 1-800-318-8782** for the hearing and speech impaired Monday through Friday, from 8:00 a.m. to 8:00 p.m., ET.

Who pays first if the person has Part D and another insurance?	ACTION
Is covered by Part D and Illinois Cares Rx	Illinois Cares Rx is secondary to Part D so the Part D plan pays first. The two programs coordinate. If Illinois Cares Rx had previously covered a drug under Senior Care or Circuit Breaker, and the Part D plan does not cover the drug, Illinois Cares Rx will continue to pay for the drug
Coverage is provided through a former employers retiree Group Health Plan	When a person is covered through a retiree Group Health Plan, the Group Health Plan is secondary to Part D, so the rules regarding Part D apply.
The person is insured through a retired spouse's Group Health Plan	When a person is covered through a retired spouse's Group Health Plan, the Group Health Plan is secondary to Part D, so the rules regarding Part D apply. Before enrolling in Part D first check with your retiree health plan, since some retiree plans may drop all health coverage if you enroll in Part D. If you have to apply for Medicaid, also contact your retiree health plan first, since the state automatically enrolls you in Part D and this can cause your retiree plan to terminate your coverage.
Has both a retiree Group Health Plan and coverage through a retired spouse's Group health Plan	Both plans are secondary to Part D. The Part D plan pays first, then the person's own plan, and finally the spouse's plan. Before enrolling in Part D first check with your retiree health plan, since some retiree plans may drop all health coverage if you enroll in Part D. If you have to apply for Medicaid, contact your retiree health plan first, since the state will automatically enroll you in Part D and this can cause your retiree plan to terminate your coverage.
The person has both a retiree's Group Health Plan and Illinois Cares Rx	Part D is the primary coverage so it will pay first, then the Group Health Plan is billed, and then Illinois Cares Rx will wrap around what is left. Before enrolling in Part D first check with your retiree health plan, since some retiree plans may drop all health coverage if you enroll in Part D. If you have to apply for Medicaid, contact your retiree health plan first, since the state will automatically enroll you in Part D and this can cause your retiree plan to terminate your coverage.
Is also covered by Medicaid (dual eligible)	Medicaid only pays for drugs for Part D enrollees when those drugs are not allowed to be covered by Part D (such as benzodiazepines). Therefore dual eligible persons will never have drugs paid for both plans. One or the other plan will pay for the drug.
Is covered by through a retiree Group Health Plan and Medicaid	The retiree plan is secondary to Part D. For medical expenses other than Prescriptions, the retiree plan will be primary. Medicaid is a "payor of last resort" and Medicaid rules require that all other insurance is billed before Medicaid is billed. For Rx, if the drug is covered under Part D the Part D plan is billed first, then the Group Health Plan. Medicaid will not be billed, unless the drug is not able to be covered by the Part D plan (such as benzodiazepines). Then the Group Health Plan is billed, then Medicaid. Before enrolling in Part D first check with your retiree health plan, since some retiree plans may drop all health coverage if you enroll in Part D. If you have to apply for Medicaid, contact your retiree health plan first, since the state will automatically enroll you in Part D and this can cause your retiree plan to terminate your coverage.
Currently employed and has coverage through employers Group Health Plan	Usually the employers plan will be the primary coverage, with Part D being secondary. This however can vary if working for a small company, or the plan is designed as a secondary insurer. It is important to read the employer's policy.
Is covered by the an employed spouse's Group Health Plan	Usually the employers plan will be the primary coverage, with Part D being secondary. This however can vary if working for a small company, or the plan is designed as a secondary insurer. It is important to read the employer's policy.
Is covered by Workman's Compensation	Workman's Compensation is usually primary to Part D for all drugs that are related to the workman's compensable injury. The Workman's Compensation insurer will be billed first, then the Part D plan second. Due to claim disputes, the Part D plan may cover the drug and establish a claim for later recovery should the Workman's Compensation claim be approved. Attorney's are instructed to notify Medicare when settlement is reached in instances Medicare D has paid prescription expenses pending final resolution.
Has other liability coverage (car insurance, Crime Victims, etc)	Usually this happens when a person is injured in a car accident and another insurance is having to pay for the medical care. In these instances the liability coverage is responsible for payment if the prescription is related to the injury, so this insurance should be billed first. Due to claim disputes, the Part D plan may cover the drug and establish a claim for later recovery should the liability coverage be approved. Attorney's are instructed to notify Medicare when settlement is reached in instances Medicare D has paid prescription expenses pending final resolution.
Adapted from Centers for Medicare and Medicaid Coordination of Benefits and You: http://www.cms.hhs.gov/EmployerServices/02_COBandYou.asp	

