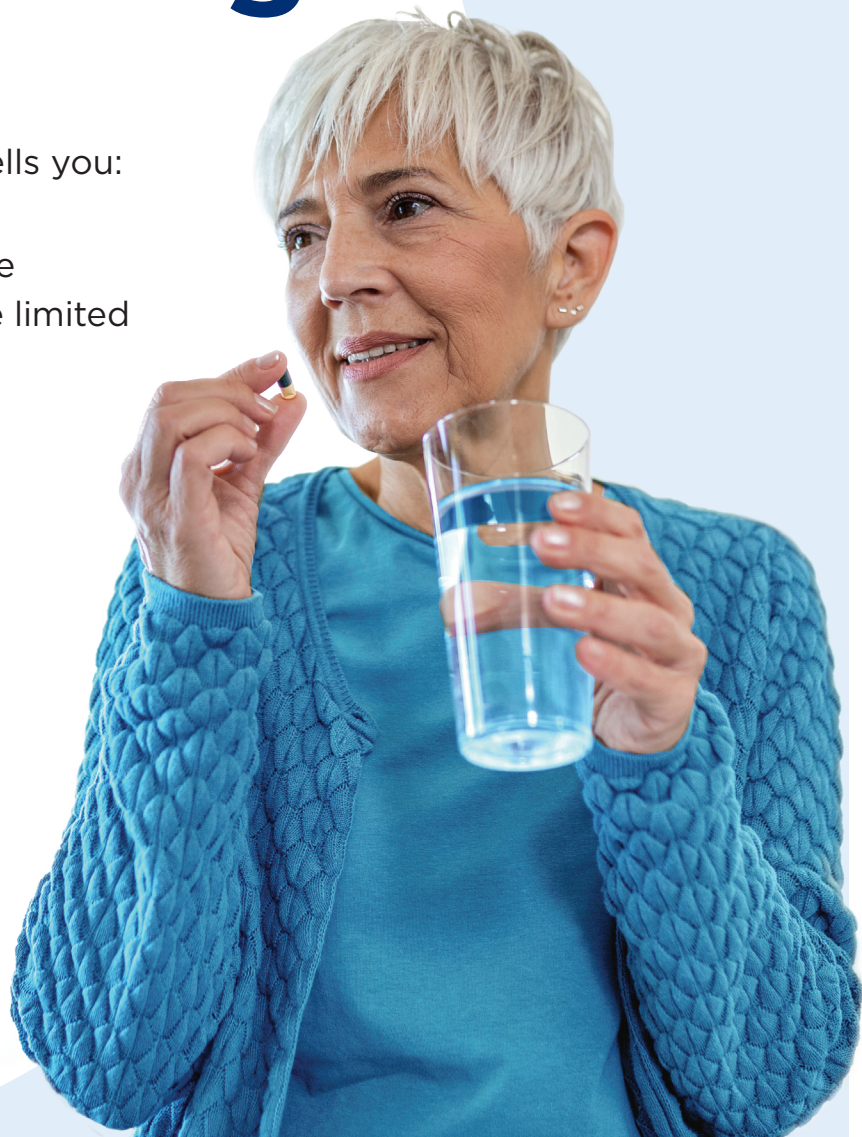


Your Guide to Medicare Drug Coverage

This **official government booklet** tells you:

- How drug coverage works
- Your choices about drug coverage
- How to get Extra Help if you have limited income and resources

[Medicare.gov](https://www.Medicare.gov)



Medicare

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Section 1

The basics

Medicare drug coverage adds to your Medicare coverage

Medicare drug coverage (also known as Medicare Part D) helps pay for the brand-name and generic drugs you need. It's offered to all people with Medicare by private companies approved by Medicare.

You can get drug coverage in one of 2 ways:

- **Add Medicare drug coverage (Part D) to Original Medicare.** Original Medicare is a fee-for-service health plan that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). You must have Part A and/or Part B to join a separate drug plan (sometimes called a Prescription Drug Plan or PDP). Medicare drug plans can also add drug coverage to some Medicare health plans, like some Medicare Private Fee-for-Service (PFFS) Plans, some Medicare Cost Plans, and Medicare Medical Savings Account (MSA) Plans.
- **Get drug coverage as part of your Medicare Advantage Plan or other Medicare health plan.** You get your Part A (Hospital Insurance), Part B (Medical Insurance), and drug coverage (Part D) through these plans, generally offered by private companies that contract with Medicare. Medicare Advantage Plans that offer prescription drug coverage are sometimes called "MA-PDs." If you join a Medicare Advantage Plan that doesn't offer drug coverage, in most cases, you won't be able to add a separate Medicare drug plan.

In this booklet, the term "Medicare drug coverage" means all Medicare drug plans and Medicare health plans that include Medicare drug coverage (Part D). The term "Medicare drug plan" means separate drug plans that add Medicare drug coverage to Original Medicare.

Joining a drug plan

To join a Medicare drug plan, you must:

- Have Medicare Part A (Hospital Insurance) **or** Medicare Part B (Medical Insurance)
- Be a United States citizen or national, lawful permanent resident, Cuban/Haitian entrant, or person residing under a Compact of Free Association

To join a Medicare Advantage Plan with drug coverage or most other Medicare health plans with drug coverage, you must:

- Have Part A **and** Part B
- Be a United States citizen or national, lawful permanent resident, Cuban/Haitian entrant, or person residing under a Compact of Free Association
- Live in the service area of the Medicare health plan or drug plan you want to join

If you have a Medicare Advantage Plan and then join a separate Medicare drug plan, in most cases, you'll lose your Medicare Advantage Plan and go back to Original Medicare for your health coverage.

As long as plans meet standards set by Medicare, they can differ in these ways:

- What drugs they cover
- How much you have to pay for prescriptions
- Which pharmacies you can use
- Which drugs have coverage rules (like prior authorization, step therapy, or quantity limits described on pages 25-26)

Get help with your choices

- Call your State Health Insurance Assistance Program (SHIP). SHIPs are state programs that give free local health insurance counseling to people with Medicare and their families. Visit shiphelp.org to get the phone number for your SHIP.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.



Section 2

When & how to get drug coverage

When can I join, switch, or drop Medicare drug coverage?

During your 7-month Initial Enrollment Period, when you first become eligible for Medicare. You can join Medicare drug coverage starting 3 months before the month you turn 65, and ending 3 months after the month you turn 65. Your coverage start date depends on the month you join.

If you sign up:	Coverage starts:
Before the month you turn 65	The month you turn 65
The month you turn 65, or during the 3 months after	The month after the plan gets your application

During the seven-month period around your 25th month of getting disability benefits. If you get Medicare due to a disability, you can join Medicare drug coverage starting 3 months before your 25th month of disability, and ending 3 months after your 25th month of disability. Your coverage start date depends on the month you join.

If you sign up:	Coverage starts:
Before your 25th month of getting disability benefits	Your 25th month of getting disability benefits
Your 25th month of getting disability benefits, or during the 3 months after	The month after the plan gets your application

If you have a disability and are under 65, you'll have another chance to join when you turn 65.

During Open Enrollment, between October 15–December 7 each year. Your coverage begins January 1 the following year.

If you currently have Medicare drug coverage, you may want to review your coverage each fall. If you're happy with your current plan's coverage, cost, and customer service, and your plan is still offered in your area, **you don't have to do anything to continue your coverage for another year.** However, if you decide another plan will better meet your needs, you can switch to a different plan.

Note: In certain limited circumstances, you may be able to join, drop, or switch Medicare drug coverage at other times. For example, if you:

- Qualify for Extra Help (go to page 29).
- Permanently move out of your plan's service area.
- Lose other coverage that was considered creditable prescription drug coverage (go to page 5).
- Enter, live in, or leave a nursing home.
- Want to switch to a plan with a 5-star overall quality rating. 5-star quality ratings are available on [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).
- Are in a plan that changes its contract with Medicare.

How do I join a plan?

Contact the company that offers the plan. You may be able to join on the plan's website, or by mailing or faxing them a completed enrollment form.

You can also join a plan directly by visiting [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare), or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What information do I need to give the plan?

- Your Medicare Number and the date your Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) coverage started, which you'll find on your Medicare card
- Name, birth date, and permanent home address
- How you want to pay your plan premiums
- Other insurance information (like any creditable coverage notices)

You may be asked for other information when you join a Medicare plan (like your email address or emergency contact). Giving the plan this information is optional.

The plan you join will send you materials you'll need, like a membership card, member handbook, formulary (drug list), pharmacy provider directory, and complaint and appeal procedures.

How do I switch plans?

You can switch to a new Medicare drug plan or Medicare Advantage Plan with drug coverage by joining another plan during one of the times listed on the previous pages. Your old drug coverage will end when your new drug coverage begins. You should get a letter from your new plan telling you when your coverage begins, so **you don't need to cancel your old plan**. You can also switch plans by calling 1-800-MEDICARE.

Note: Medicare plans aren't allowed to call you and ask you to join a plan. Call 1-800-MEDICARE to report a plan that does this.

What do I need to think about before I get Medicare drug coverage?

Before you make a decision, get answers to these questions:

- Is my current drug coverage (if I have any) considered creditable prescription drug coverage—coverage that's expected to pay, on average, at least as much as Medicare drug coverage? This could include drug coverage from a current or former employer or union, TRICARE, the Indian Health Service, or the Department of Veterans Affairs (VA).
- Your current plan must tell you if your drug coverage is creditable prescription drug coverage. If you don't get drug coverage when you're first eligible for Medicare, and you go a period of 63 or more days in a row without creditable prescription drug coverage, you may have to pay a lifetime Part D late enrollment penalty if you join Medicare drug coverage later.

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- Even if you don't use a lot of prescription drugs now, you may want to get Medicare drug coverage to lower your costs and avoid the Part D late enrollment penalty later.
- **Note:** Doctor samples, discount cards, free clinics, or drug discount websites aren't drug coverage.
- If I have employer or union coverage and add Medicare drug coverage, how will it affect my current coverage? Will I lose my current health and/or drug coverage if I join? (Your current plan can tell you.) Read all the materials you get from your insurance company or plan provider. Talk to your benefits administrator, insurance company, or plan provider before you make any changes to your current coverage.
- How would joining a particular Medicare drug or health plan affect my out-of-pocket costs?
- Will my premium be higher later if I wait to join a Medicare drug or health plan because I have to pay a Part D late enrollment penalty?
- Will my Medicare drug coverage start when I want it to?
- Does a Medicare drug or health plan in my area cover the prescription drugs I take? (Find out by visiting [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) or calling the plan you're interested in.)
- What are a particular Medicare drug plan's coverage rules, like prior authorization, step therapy, and quantity limits for prescription drugs I take?
- Can I get Extra Help paying for my drug costs if I join a Medicare drug plan? (You may qualify for Extra Help if you have limited income and resources. Go to Section 4.)
- Is there a particular pharmacy I want to use? Is that pharmacy in-network with the plan I'm considering? (Using in-network pharmacies usually costs you less than out-of-network pharmacies.)
- Do I spend part of each year in another state? (This may be important if a plan you want to join requires you to use certain pharmacies.)
- What are a particular Medicare drug plan's 5-star quality ratings? (View star ratings and compare Medicare drug plans at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).)

Get help with drug coverage decisions

Call your State Health Insurance Assistance Program (SHIP) if you need help with your Medicare drug coverage decisions. Visit shiphelp.org to get the phone number for your SHIP.

How does Medicare drug coverage work with other types of health and drug coverage?

If you have other types of health or drug coverage, make sure you understand how that coverage works with Medicare drug coverage. More than one situation below and on pages 8-14 may apply to you.

I have Part A and/or Part B and no drug coverage

If you have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) and live in a Medicare drug plan's service area, you can join that plan. Visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) or call 1-800-MEDICARE for a list of plans in your area. Not sure if you have Part A and/or Part B? Check your red, white, and blue Medicare card.

I have Part A and Part B (Original Medicare) and a Medicare Supplement Insurance (Medigap) policy

You can join a Medicare drug plan to add drug coverage to Original Medicare.

Important! When you're getting started with Medicare, you can either buy Medigap or enroll in a Medicare Advantage Plan, but you can't have both. You can't use Medigap to pay your Medicare Advantage Plan copayments, deductibles, and premiums. You may want to drop your Medigap policy if you join a Medicare Advantage Plan. However, you might not be able to get the same Medigap policy back if you leave the Medicare Advantage Plan and then go back to Original Medicare, or you may end up paying higher premiums for the Medigap policy.

Visit [Medicare.gov/health-drug-plans/medigap/basics/how-medigap-works](https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works) for more information about how Medigap works if you have other Medicare coverage.

I have Original Medicare and a Medigap policy that includes drug coverage

Before 2006, some Medigap policies included drug coverage. If you still have a Medigap policy with drug coverage, your Medigap insurance company must send you a detailed notice each year describing your choices for drug coverage and stating whether its drug coverage is creditable prescription drug coverage.

Important! Contact your Medigap insurance company before you make any changes to your drug coverage.

If you have a Medigap policy that includes drug coverage, and you decide to join a Medicare drug plan, you can keep that Medigap policy but remove its drug coverage. You'll need to tell your Medigap insurance company when your Medicare drug coverage starts. They must remove the drug coverage from your Medigap policy and adjust your premium based on this change. **Also, you may have to pay a lifetime Part D late enrollment penalty to join a Medicare drug plan if the drug coverage you've had under your Medigap policy isn't creditable prescription drug coverage.** You may have to pay this higher premium for as long as you're in a Medicare drug plan. Go to pages 19-21 for more information about the late enrollment penalty.

For more information about Medigap, visit [Medicare.gov/health-drug-plans/medigap](https://www.Medicare.gov/health-drug-plans/medigap) or call 1-800-MEDICARE. You can also call your SHIP for more information about Medigap. Visit shiphelp.org to get the phone number for your SHIP.

I have Medicare and get drug coverage from a current or former employer or union

Find out how your employer or union drug coverage works with Medicare, because your coverage may change if you get Medicare drug coverage. Your employer or union (or the plan that administers your drug coverage) will send you a notice of creditable coverage every year, letting you know if your drug coverage is creditable prescription drug coverage (prescription drug coverage that's expected to pay, on average, at least as much as Medicare drug coverage). If you don't get this information, ask your employer or union for it.

Some important questions to answer before you decide on your drug coverage:

- Will you, your spouse, or dependents lose all of your employer or union health coverage if you get Medicare drug coverage?
- How do out-of-pocket drug costs with your employer or union drug coverage compare to out-of-pocket drug costs with Medicare drug coverage?

If your (or your spouse's) employer or union tells you your current coverage IS creditable prescription drug coverage:

- You can keep this coverage as long as your employer or union still offers it.
- You won't have to pay a Part D late enrollment penalty if your employer or union stops offering creditable prescription drug coverage, as long as you join a Medicare drug plan or health plan with drug coverage within 63 days after the coverage ends.

Note: Keep materials your employer or union sends you that tell you your drug coverage is creditable. You may need to show it to your Medicare plan as confirmation of creditable prescription drug coverage if you decide to get Medicare drug coverage later.

If your (or your spouse's) employer or union tells you your current drug coverage ISN'T creditable prescription drug coverage:

- If you want Medicare drug coverage, in most cases, you must join when you're first eligible to avoid a Part D late enrollment penalty (pages 19-21). If you don't join when you're first eligible, you may have to wait until Open Enrollment (October 15–December 7) to add Medicare drug coverage.
- Find out about your options from your benefits administrator. You may be able to:
 - Keep your current employer or union health coverage **and** get Medicare drug coverage.
 - Keep your current employer or union health coverage and **not** add Medicare drug coverage. If you sign up for Medicare drug coverage later, you may have to pay a Part D late enrollment penalty if your current drug coverage isn't creditable.
 - Drop your current coverage and join a Medicare plan that covers prescription drugs.

(**Note:** If your current coverage has changed and is no longer creditable, you can get Medicare drug coverage during a Special Enrollment Period. Your chance to join lasts 2 full months after the month you lose your creditable coverage, or for 2 full months after you're notified that your current coverage is no longer creditable, whichever is later.)

Important! If you drop your employer or union drug coverage:

- You may not be able to get it back.
- You may also have to drop your employer or union health coverage.
- You may also have to drop coverage for your spouse and dependents.

Medicare doesn't have information about how your current employer or union drug coverage will be affected if you get Medicare drug coverage. Talk to your employer or union's benefits administrator before you make any decisions about your drug coverage.

I have Medicare and a Federal Employee Health Benefits (FEHB) plan

- Contact your FEHB plan before making any changes.

Important! You can't drop FEHB drug coverage without also dropping your FEHB coverage for hospital and medical services.

- If you qualify for Extra Help paying Medicare drug costs, find out how your costs with Medicare drug coverage and Extra Help would compare to your FEHB plan's drug coverage.
- If you join a Medicare drug plan, you can keep your FEHB plan. In most cases, your Medicare drug coverage pays first.
- If you ever lose your FEHB coverage and need to get Medicare drug coverage, in most cases, you won't have to pay a Part D late enrollment penalty (pages 19-21) if you join within 63 days of losing FEHB coverage.

For more information about how your FEHB plan works with Medicare, visit [OPM.gov/healthcare-insurance/healthcare/medicare](https://www.opm.gov/healthcare-insurance/healthcare/medicare) or call the Office of Personnel Management at 1-888-767-6738. TTY users can call 711. You can also call your plan.

I have Medicare and TRICARE, CHAMPVA, or benefits from the Department of Veterans Affairs (VA) that includes drug coverage

- As long as you still qualify, you can keep your TRICARE, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), or VA drug coverage. TRICARE, CHAMPVA, or your VA provider should send you information each year about your coverage and whether it's creditable prescription drug coverage. Save these materials.
- Before making any changes, contact your benefits administrator for information about your TRICARE, CHAMPVA, or VA coverage. For most people with TRICARE, CHAMPVA, or VA coverage, unless you qualify for Extra Help, it isn't cost effective to get Medicare drug coverage.

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- If you qualify for Extra Help paying Medicare drug costs, compare costs with your TRICARE, CHAMPVA, or VA drug coverage:
 - If you have TRICARE and join a Medicare drug plan, your Medicare drug plan pays first, and TRICARE pays second.
 - If you have CHAMPVA and join a Medicare drug plan, you won't be able to use the Meds by Mail program, which can mail you your maintenance medications at no charge to you (no premiums, no deductibles and no copayments).
 - If you have VA coverage and join a Medicare drug plan, you can't use both types of coverage for the same prescription.
- If you join a Medicare Advantage Plan with drug coverage, you must get prescription drugs through the Medicare Advantage Plan. The Medicare Advantage Plan is the primary payer. TRICARE may cover some or all of a claim that the Medicare Advantage Plan didn't pay for if the plan's pharmacy is a TRICARE network pharmacy that participates in online coordination of benefits.
- If you ever lose your TRICARE, CHAMPVA, or VA coverage and need to join a Medicare plan, in most cases, you won't have to pay a Part D late enrollment penalty (pages 19–21), as long as you join within 63 days of losing TRICARE, CHAMPVA, or VA coverage.

For more information on VA benefits, visit [VA.gov/health-care](https://www.va.gov/health-care), call the VA Health Benefits Service Center at 1-877-222-VETS (1-877-222-8387), or visit your local VA medical facility. TTY users can call 711.

Visit [TRICARE.mil/pharmacy](https://www.tricare.mil/pharmacy) for more information on the TRICARE Pharmacy Program, or call 1-877-363-1303. TTY users can call 1-877-540-6261.

Visit [VA.gov/communitycare/programs/dependents/champva](https://www.va.gov/communitycare/programs/dependents/champva) for more information on CHAMPVA, or call CHAMPVA at 1-800-733-8387.

I have a Medicare health plan without drug coverage

If you're in a Medicare Advantage Plan or another Medicare health plan that doesn't include drug coverage, you may want to think about getting Medicare drug coverage during the next available enrollment period:

- Find out if your current Medicare Advantage Plan offers a Medicare drug coverage option. If so, you can switch to that option.
- If your current plan doesn't offer Medicare drug coverage, you can switch to another Medicare health plan in your area that offers it.
- If your current plan doesn't offer Medicare drug coverage, you can switch to Original Medicare and join a Medicare drug plan.
- Only some Medicare Private Fee-for-Service (PFFS) Plans (a type of Medicare Advantage Plan) offer Medicare drug coverage. If your Medicare PFFS Plan doesn't offer Medicare drug coverage, you can also join a Medicare drug plan to get this coverage.

- Medicare Medical Savings Account (MSA) Plans (a type of Medicare Advantage Plan) don't offer Medicare drug coverage. If you're in a Medicare MSA Plan, you can also join a Medicare drug plan to get drug coverage.
 - If you're in a Medicare MSA Plan and a Medicare drug plan, any money you use from your MSA Plan account on Medicare drug plan deductibles or cost sharing counts toward your drug plan out-of-pocket costs (pages 15-18).
 - If you have a Medicare MSA Plan and **don't** have a Medicare drug plan, you can use money in your MSA account for prescription or non-prescription drugs. These expenses don't count toward the MSA Plan deductible.
- If your Medicare Cost Plan doesn't offer Medicare drug coverage, you can also join a separate Medicare drug plan.

If you stay in a plan that doesn't offer drug coverage and you don't join a Medicare drug plan or have other creditable prescription drug coverage, you may have to pay a Part D late enrollment penalty (pages 19-21) if you get Medicare drug coverage later.

Contact your plan for more information about your choices.

I have a Medicare health plan with drug coverage

If you have drug coverage from a Medicare Advantage Plan or other Medicare health plan, in most cases, you can't get separate drug coverage.

- If you're in a Medicare Advantage Plan with drug coverage and you join a separate Medicare drug plan, in most cases, you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.
- If you're in a Medicare Cost Plan, you can get your Medicare drug coverage from the plan (if offered), or you can join a separate Medicare drug plan to add drug coverage.

Contact your plan for more information about your choices.

I have Medicare and Medicaid

You'll need to join a Medicare drug plan for Medicare to pay for your drugs. Because you have Medicaid, Medicare automatically gives you Extra Help with your Medicare prescription drug coverage costs and will mail you a **purple** notice. Keep this notice as confirmation that you qualify for Extra Help.

If you haven't joined a Medicare drug plan, Medicare will enroll you in a drug plan to make sure you have drug coverage (unless you already have certain retiree drug coverage). Medicare sends you a **yellow** notice telling you what drug plan you're in and when your coverage starts. If the plan you've been enrolled in doesn't meet your needs, as long as you qualify for Extra Help, you can switch your Medicare drug plan once a calendar month. The change will take effect on the first day of the next month. (Note: Most people with Medicare can only make changes to their drug coverage at certain times of the year.)

If you filled any covered prescriptions before your Medicare drug plan coverage started, you may be able to get back some of the money you spent. Call Medicare's Limited Income Newly Eligible Transition (LI NET) Program at 1-800-783-1307 for more information. TTY users can call 711. Go to pages 35-36 for more information about LI NET.

If you don't want Medicare drug coverage and you don't want Medicare to enroll you in a Medicare drug plan (because you have other creditable prescription drug coverage), call 1-800-MEDICARE and tell them you want to "opt out" of (decline) Medicare drug coverage.

Important! If you call 1-800-MEDICARE and opt out of a Medicare drug plan, you could be left without any drug coverage. As long as you continue to qualify for Extra Help, you can change your mind and join a Medicare drug plan without paying a Part D late enrollment penalty.

If you continue to qualify for Medicaid, Medicaid will still cover your other health care costs that Medicare doesn't cover. If you aren't sure if you still qualify for Medicaid, call your State Medical Assistance (Medicaid) office. Get their phone number by visiting [Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip](https://www.Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip).

I have Medicare and get Supplemental Security Income (SSI) benefits or I'm enrolled in a Medicare Savings Program

If you join a Medicare drug plan and get SSI or you're enrolled in a Medicare Savings Program, Medicare will send you a **purple** notice letting you know you automatically qualify for Extra Help paying your Medicare prescription drug coverage costs.

If you don't get Medicare drug coverage on your own, Medicare will enroll you in a Medicare drug plan to make sure you have coverage (unless you already have certain retiree drug coverage). Medicare will send you a **yellow** or a **green** notice letting you know when your coverage starts. As long as you qualify for Extra Help, you can switch Medicare drug plans anytime.

If you don't want Medicare drug coverage, and you don't want Medicare to enroll you in a Medicare drug plan (like if you have other creditable prescription drug coverage), call 1-800-MEDICARE and tell them you want to "opt out" of (decline) Medicare prescription drug coverage.

Important! If you call 1-800-MEDICARE and opt out of a Medicare drug plan, you could be left without any drug coverage. As long as you continue to qualify for Extra Help, you can change your mind and join a Medicare drug plan without paying a Part D late enrollment penalty.

I have Medicare and live in a nursing home or other facility

- **If you live in a nursing home or other facility**, you'll get your covered drugs from a long-term care pharmacy that works with your Medicare drug plan. This long-term care pharmacy usually contracts with (or is owned and operated by) your facility.
- **If you live in a nursing home and have full-benefit Medicaid coverage**, you pay nothing for your covered drugs after Medicaid has paid for your stay for one full calendar month. You'll be automatically enrolled in a Medicare drug plan (unless you choose a Medicare Advantage Plan with drug coverage or a Medicare drug plan on your own).
- **If you're in a skilled nursing facility getting Medicare-covered skilled nursing care**, Medicare Part A (Hospital Insurance) will generally cover your drugs.
- **While you're living in a facility**, you can change Medicare drug plans at any time.
- **If you move into or out of a nursing home or other facility**, you can change Medicare drug plans at that time. In this situation, "other facilities" don't include assisted living, adult living facilities, residential homes, or any kind of nursing home that's not certified by Medicare or Medicaid.

I have Medicare and Program of All-Inclusive Care for the Elderly (PACE)

PACE is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility.

If you join PACE, a team of health care professionals will work with you to help coordinate your care.

Important! Joining a Medicare drug plan will disenroll you from your PACE plan. Your PACE plan gives you **all** of your health care services, including your drug coverage. If you join a Medicare drug plan, you'll be disenrolled from your PACE plan, and you'll no longer get other health care benefits through PACE. Contact your PACE plan for more information. To find contact information for your PACE plan, visit [Medicare.gov/plan-compare/#/pace](https://www.Medicare.gov/plan-compare/#/pace).

If you have both Medicare and full Medicaid coverage, you get drugs through your PACE plan at no cost to you.

If you don't qualify for Medicaid but you have Medicare, you'll pay a premium for Medicare Part D drugs to your PACE plan. There's no deductible or copayment for any drug your health care team approves.

I have Medicare and get help from my State Pharmacy Assistance Program (SPAP)

Most states have an SPAP to help certain people pay for prescription drugs. Some SPAPs may require you to get Medicare drug coverage, and then they'll cover the prescription drug costs that Medicare doesn't cover. Depending on your state's program, SPAP contributions might count toward your Medicare drug coverage out-of-pocket spending limit (cap), which is \$2,100 in 2026.

If you belong to an SPAP that required you to get Medicare drug coverage, you have one opportunity every calendar year to join a different plan, in addition to the October 15–December 7 Open Enrollment Period.

If you lose your SPAP benefits, you can choose different Medicare drug coverage during the month you lose your benefits, and for 2 months after.

Your SPAP will give you more information on how Medicare drug coverage affects the help you get now. Find your SPAP’s contact information by visiting [go.Medicare.gov/spap](https://www.medicare.gov/spap).

I get help from an AIDS Drug Assistance Program (ADAP)

Most ADAPs only cover HIV/AIDS-related medications. If they don’t cover other drugs, they **aren’t** creditable prescription drug coverage. If you don’t have creditable prescription drug coverage and delay getting Medicare drug coverage, you may have to pay a Part D late enrollment penalty (pages 19-21) when you join.

All Medicare plans with drug coverage cover all antiretroviral medications. Your ADAP may require you to have Medicare drug coverage to get ADAP benefits. An ADAP can cover Medicare drug coverage premiums, deductibles, coinsurance, and/or copayments to help with your drug costs. Check with your ADAP to find out if it requires you to have Medicare drug coverage, and if it will help pay for the costs.

ADAPs vary by state, so contact your ADAP to learn how it will work with Medicare’s drug coverage. ADAP contributions count toward your Medicare drug coverage out-of-pocket spending cap, which is \$2,100 in 2026.

I have Medicare and get drug coverage from the Indian Health Service, Tribe or Tribal Organization, or Urban Indian Organization

- You and your community may benefit if you join a Medicare plan because the plan will pay the Indian health facility for the cost of your prescription drugs. Ask your health provider or benefits coordinator if joining a plan is right for you. If you decide to join, they can help you find a plan.
- If you get prescription drugs through an Indian health pharmacy, you’ll continue to get them at no cost to you, and your coverage won’t be interrupted.
- If you have full Medicaid benefits and live in a nursing home, you pay nothing for your Medicare drug coverage. Contact your Indian health provider or check with the benefits coordinator at your local Indian health pharmacy to get more information on how to join a Medicare plan.
- Health care from the Indian Health Service, Tribe or Tribal Organization, or Urban Indian Organization includes creditable prescription drug coverage, which means you won’t have to pay a Part D late enrollment penalty (pages 19-21) if you join a Medicare plan later. Ask your Indian health care provider for a letter stating you have creditable prescription drug coverage.



Section 3

Costs & coverage

How much will my drug coverage cost?

All Medicare drug plans and health plans with drug coverage must offer at least a standard level of drug coverage set by Medicare. How much you pay for drug coverage depends on which plan you join, what drugs you take, if you go to a pharmacy in your plan's network, and if you get Extra Help paying for your drug costs. Contact the plan(s) you're interested in to get specific cost information.

Your drug coverage costs might include:

- Monthly premium
- Yearly deductible
- Copayments or coinsurance

Monthly premium

Most drug plans charge a monthly fee that varies by plan, called a premium, whether or not you get your prescriptions filled. If you have Original Medicare, you pay this fee in addition to the premium you pay for Part B. If you're in a Medicare Advantage Plan or a Medicare Cost Plan with drug coverage, your monthly premium may include an amount for drug coverage. If you don't sign up for Part D when you're first eligible, you may also have to pay a Part D late enrollment penalty (pages 19-21) that's added to your monthly premium.

If your income is above a certain amount on the most recent tax return information the IRS gave Social Security, you'll pay an extra amount in addition to your plan's premium. This is called the Part D Income-Related Monthly Adjustment Amount (sometimes called "Part D-IRMAA").

Social Security will send you a letter if you have to pay this extra amount. If you get a letter saying you have to pay a higher amount for your Part D premium but you had a life-changing event and your income has gone down, you can ask to lower an income-related monthly adjustment amount by visiting SSA.gov/medicare/lower-irmaa. Check the charts below to know if you're affected, and find out how much you'll have to pay each month.

If your yearly income in 2024 was:		You pay each month (in 2026)
Individual tax return	Joint tax return	
\$109,000 or less	\$218,000 or less	Your plan premium
above \$109,000 up to \$137,000	above \$218,000 up to \$274,000	\$14.50 + your plan premium
above \$137,000 up to \$171,000	above \$274,000 up to \$342,000	\$37.50 + your plan premium
above \$171,000 up to \$205,000	above \$342,000 up to \$410,000	\$60.40 + your plan premium
above \$205,000 and less than \$500,000	above \$410,000 and less than \$750,000	\$83.30 + your plan premium
\$500,000 or above	\$750,000 or above	\$91.00 + your plan premium

If your yearly income in 2024 was:		You pay each month (in 2026)
Married & filing separate tax returns		
\$109,000 or less		Your plan premium
above \$109,000 up to \$391,000		\$83.30 + your plan premium
\$391,000 or above		\$91.00 + your plan premium

If you owe extra because of your income, it will get taken out of your monthly Social Security, Railroad Retirement Board, or Office of Personnel Management check, no matter how you pay your plan premium. If that amount is more than what's in your check, you'll get a bill from Medicare each month.

You must pay both the extra amount and your plan's premium each month to keep Medicare drug coverage. If you don't pay your entire Part D premium (including the extra amount, if you owe it), you may lose your Medicare drug coverage.

Yearly deductible

This is the amount you must pay out of pocket for your prescriptions each year before your Medicare drug plan pays its share.

Deductibles vary between Medicare drug plans. **The maximum deductible for drug plans is \$615 in 2026.** Some Medicare drug plans don't have a deductible. In some plans, certain drugs are covered before you meet your deductible.

Copayments or coinsurance

This is what you pay for covered drugs after the deductible (if your plan has one). The exact amount you pay for each drug may vary because drug plans and manufacturers can change what they charge at any time throughout the year.

Your plan may raise the copayment or coinsurance you pay for a particular drug when the manufacturer raises their price, or when a plan starts to offer a generic form of a drug, but you keep taking the brand name drug.

The amount you pay for a covered prescription is usually for a one-month supply of a drug. However, you can ask for less than a one-month supply. You might do this if you're trying a new medication, or you want to synchronize refills for your medications.

If you get less than a one-month supply, the amount you pay is reduced based on the amount you actually get. Talk with your prescriber to get a prescription for less than a one-month supply.

Medicare drug coverage stages

Generally, all Medicare drug plans and Medicare Advantage Plans with drug coverage have 3 stages:

- **Deductible stage** (page 17).
- **Initial coverage stage:** After you meet your deductible (if your plan has one), you'll pay 25% of the cost for your generic and brand-name drugs until your out-of-pocket spending on covered Part D drugs reaches \$2,100 in 2026 (including certain payments made on your behalf, like through the Extra Help program). Then, you'll automatically get "catastrophic coverage."
- **Catastrophic coverage stage:** You won't have to pay out of pocket for covered Part D drugs for the rest of the calendar year.

How do I pay my plan's premium?

You can choose to pay your premium by:

- Having your plan deduct it from your checking or savings account.
- Charging it to a credit or debit card (fees may apply).
- Having your plan bill you each month. Some plans bill in advance for next month's coverage. Send your payment to the plan—not to Medicare. Contact your plan for their payment address.
- Having your premium withheld from your Social Security payment. **Contact your plan—not Social Security—to ask for this payment option.** It may take up to 3 months to start. In cases where premiums weren't withheld from your Social Security payment until 1 or 2 months after you joined a Medicare drug plan, you'll get a bill for the months your drug plan's premiums weren't withheld. You'll need to pay your drug plan's monthly premium directly to your plan for those months. Your plan will tell you when your premium payment is set up.
 - If you qualify for Extra Help, it will cover some or all of your drug coverage premiums. Social Security may automatically withhold your share of the monthly premiums.
 - If you switch to a different plan offered by the same company, you still need to contact your new plan to let them know you want to have your premiums withheld from your Social Security payment. You'll need to pay premiums directly to the new plan until premium withholding starts with your new plan.
 - **Note:** If you switch to a new plan toward the end of Medicare Open Enrollment, in some cases your premium withholding through your former plan might continue through January or February. If that happens, Social Security will refund you that amount.

Medicare Prescription Payment Plan

This payment option works with your current drug coverage to help you manage your out-of-pocket drug costs, by spreading them across the calendar year (January–December). This payment option might help you manage your expenses, but **it doesn't save you money or lower your drug costs**. If you select this payment option, each month you'll continue to pay your plan premium (if you have one), and you'll get a bill from your health or drug plan to pay for your prescription drugs (instead of paying the pharmacy). All plans offer this payment option, and participation is voluntary. It doesn't cost anything to participate in the Medicare Prescription Payment Plan. Contact your plan or visit [Medicare.gov/prescription-payment-plan](https://www.medicare.gov/prescription-payment-plan) for more information and to find out if this payment option is right for you.

What's the Part D late enrollment penalty?

The Part D late enrollment penalty is an amount that's permanently added to your Medicare drug coverage (Part D) premium. You may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Medicare drug coverage or other creditable prescription drug coverage (prescription drug coverage that's expected to pay, on average, at least as much as Medicare drug coverage). This could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, VA, or individual health insurance coverage. You'll generally have to pay the penalty for as long as you have Medicare drug coverage, even if you switch plans.

Note: You won't have to pay a Part D late enrollment penalty (if you have one) while you get Extra Help (pages 29–36).

How much is the Part D late enrollment penalty?

The Part D late enrollment penalty is calculated by multiplying 1% times the “national base beneficiary premium” (\$38.99 in 2026) times the number of full, uncovered months you were eligible to join Medicare drug coverage but didn't (and went without other creditable prescription drug coverage).

That amount is rounded to the nearest \$.10 and added to your monthly premium. The “national base beneficiary premium” may go up each year, so the penalty amount may also go up each year.

Example: If you waited 14 months after you were eligible for Medicare to join a Medicare drug plan, and you didn't have creditable drug coverage, you'll have to pay a 14% late enrollment penalty in addition to your monthly plan premium. **This monthly penalty is added for as long as you have Medicare drug coverage, even if you switch plans.**

Here's the math:

0.14 (14% penalty) x **\$38.99** (2026 national base beneficiary premium) = **\$5.46**

\$5.46 rounded to the nearest \$0.10 = **\$5.50**

\$5.50 = your monthly penalty for 2026.

When you join a Medicare drug plan or health plan with drug coverage, the plan will tell you if you owe a penalty and what your premium will be.

How do I avoid paying a penalty?

- **Join a Medicare drug plan or health plan with drug coverage when you're first eligible** (go to pages 3-4), unless you have other creditable prescription drug coverage at that time.
- **Don't go 63 days or more in a row without Medicare drug coverage or other creditable prescription drug coverage.** Creditable prescription drug coverage could include drug coverage from a former employer or union, TRICARE, the Department of Veteran Affairs (VA), the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), the Indian Health Service (IHS), or the Health Insurance Marketplace.[®] Your plan must tell you each year if your drug coverage is creditable. Keep this information because you may need it if you get Medicare drug coverage later.
- **Tell your Medicare drug plan or health plan with drug coverage when you join if you had other creditable prescription drug coverage.** When you join a Medicare drug plan or health plan, the plan may send you a letter asking if you had creditable prescription drug coverage. If you get a letter, you must complete the form and return it by the deadline in the letter. If you don't return the form by the deadline, the plan won't know if you had other creditable coverage, and you'll be charged a late enrollment penalty.

What if I don't agree with Medicare's Part D late enrollment penalty?

- You may be able to ask for a "reconsideration" (appeal) of the late enrollment penalty. A Medicare contractor not connected with the drug plan does the reconsideration. Your drug plan will send you information about how to ask for a reconsideration.
Note: You generally won't have another chance to ask for a reconsideration of the Part D late enrollment penalty if you joined a different drug plan earlier and were already paying a penalty.
- Complete the form, and return it to the address or fax number listed on the form. You must do this within 60 days of the date on the letter telling you that you owe a late enrollment penalty. If you send in the reconsideration after 60 days, you must explain why your request is late. Send any proof of creditable coverage that supports your case, like a copy of your prescription drug card, or a notice of creditable prescription drug coverage from an employer or union plan.
- In general, Medicare's contractor makes reconsideration decisions within 90 days. The contractor will try to make a decision as quickly as possible. However, for good cause, they may take an additional 14 days to resolve your case.

- By law, the Part D late enrollment penalty is part of the premium, so **you must pay the penalty with your premium, even if you don't agree with it. You must also pay the penalty even if you've asked for a reconsideration, while you're waiting for a decision.** Medicare plans can disenroll members who don't pay their premiums, including the late enrollment penalty portion of the premium.

What happens if Medicare's contractor decides the penalty is wrong?

If Medicare's contractor decides that all or part of your Part D late enrollment penalty is wrong, the Medicare contractor will send you and your drug plan a letter explaining its decision. Your Medicare drug plan will remove or reduce your late enrollment penalty. The plan will send you a letter showing your correct premium amount and explaining if you'll get a refund.

What happens if Medicare's contractor decides the penalty is correct?

If Medicare's contractor decides that your Part D late enrollment penalty is correct, the Medicare contractor will send you a letter explaining the decision, and you must pay the penalty.

What happens if Medicare's contractor won't review the request?

Sometimes Medicare's contractor will dismiss a reconsideration request, which means they won't review the request. For example, they may dismiss a request if you filed it late, if it's incomplete, or if someone makes the request on your behalf but isn't legally authorized to do so.

If the contractor dismisses the reconsideration, you'll get a notice explaining why they denied your request, and how you may ask for a review of the dismissal.

Which drugs are covered?

All plans must cover a wide range of drugs that people with Medicare take. Each plan can cover different drugs, so there's no single list of covered drugs that fits all plans.

Prior authorization, step therapy, and quantity limits are some of the coverage rules plans use to make sure certain drugs are used correctly and only when medically necessary. These coverage rules are described on the following pages.

How is Part D coverage different from Part B coverage for certain drugs?

Medicare Part B (Medical Insurance) includes limited drug coverage. It doesn't cover most drugs you get at the pharmacy. You'll need to join a Medicare drug plan or health plan with drug coverage to get Medicare coverage for most prescription drugs. Part D also covers all commercially available vaccines when medically necessary to prevent illness (like for shingles, RSV, tetanus, diphtheria and pertussis).

Here are some examples of Part B-covered drugs:

- Injections you get in a doctor's office
- Certain oral cancer drugs
- Drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump)
- Certain drugs you get in a hospital outpatient setting, under very limited circumstances
- Transplant immunosuppressive drugs if Medicare helped pay for your organ transplant
- Pre-exposure prophylaxis (PrEP) drugs for HIV prevention

You pay 20% of the Medicare-approved amount for these covered drugs.

Part B covers COVID-19 vaccines, flu shots, and pneumococcal shots. Medicare also covers hepatitis B shots if you meet one of these conditions:

- You've never gotten a complete series of hepatitis B shots.
- You don't know your vaccination history.
- You have any other condition that puts you at medium or high risk for Hepatitis B (like living with someone who has Hepatitis B).

You pay nothing (and the Part B deductible doesn't apply) for these vaccines.

Visit [Medicare.gov/coverage/prescription-drugs-outpatient](https://www.medicare.gov/coverage/prescription-drugs-outpatient) for more information on Part B-covered drugs.

Note: Medicare Part A (Hospital Insurance) or Part B generally don't cover self-administered drugs you get in an outpatient setting (like in an emergency room, observation unit, surgery center, or pain clinic). Your Medicare drug plan may cover these drugs under certain circumstances. You'll likely need to pay out of pocket for the entire cost of these drugs and then send a claim to your drug plan for the portion your plan does cover. Call your plan if you have any questions. Visit [Medicare.gov/coverage/prescription-drugs-outpatient](https://www.medicare.gov/coverage/prescription-drugs-outpatient) for more information on how Medicare Part B covers self-administered drugs you get in a hospital outpatient setting.

What if I have End-Stage Renal Disease (ESRD)?

If you have ESRD, you can get Medicare drug coverage. Medicare Part B (Medical Insurance) will pay for all renal dialysis drugs you need, like injectable drugs and their oral forms, biologicals including erythropoiesis stimulating agents used for dialysis, and renal dialysis drugs available only in oral form.

Visit [Medicare.gov/basics/end-stage-renal-disease](https://www.medicare.gov/basics/end-stage-renal-disease) for more information if you have ESRD. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What's a drug list (formulary)?

The list of drugs a plan covers is called a “formulary.” All Medicare drug plans and health plans with drug coverage must make sure the people in their plan can get medically-necessary drugs to treat their conditions. Each drug list includes at least 2 drugs in the most commonly prescribed categories and classes, but plans can choose which drugs they’ll cover.

All Part D plans must include most drugs in certain protected classes on their drug list. The protected classes include:

- Anticonvulsants
- Antidepressants
- Antipsychotics
- Cancer drugs
- HIV/AIDS drugs
- Immunosuppressants for organ transplants

Your plan’s drug list might not include a specific drug. However, in most cases, a similar drug should be available. If you or your prescriber believes none of the drugs on your plan’s drug list will work for your condition, you can ask for an exception.

A Medicare plan can make some changes to its drug list during the year if it follows guidelines set by Medicare. Your plan may change its drug list during the year because drug therapies change, new prescription drugs are released, or new medical information becomes available.

Plans may immediately remove drugs from their formularies if:

- The Food and Drug Administration (FDA) considers them unsafe.
- Their manufacturer removes them from the market.

For other changes involving a prescription drug you’re currently taking that will affect you during the year, your plan must do **one** of these:

- Give you written notice at least **30 days** before the change becomes effective.
- When you ask for a refill, give you written notice of the change and at least **a month’s supply** of the drug under the same rules as before the change.

If this happens, you may need to change the prescription drug you use or pay more for it. You can also ask for an exception. Visit [Medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans](https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans) to learn how.

Tiers

To lower costs, many plans place prescription drugs into different “tiers” on their drug lists. Each plan can divide its tiers in different ways. Each tier costs a different amount. Generally, a drug in a lower tier will cost you less than a drug in a higher tier.

Example of a drug plan's tiers (your plan's tiers may be different):

- Tier 1—lowest copayment: Most generic prescription drugs
- Tier 2—medium copayment: Preferred, brand-name prescription drugs
- Tier 3—higher copayment: Non-preferred, brand-name prescription drugs
- Specialty tier—highest copayment: Very high-cost prescription drugs

Your plan's drug list might not include a prescription drug you take. However, in most cases, you can get a similar drug that's just as effective.

In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug in a lower tier, you can file an exception to get a lower coinsurance or copayment for the drug in the higher tier. Plans can change their drug list at any time. Your plan must notify you of any changes to their drug list that affect drugs you're taking.

Brand-name drugs & generic drugs

Both brand-name and generic drugs must be approved by the FDA before they can be prescribed to people. Brand-name drugs are marketed under proprietary, trademark-protected names and are protected by patents. When those patents run out, other companies will often produce generic versions that use the same active ingredients. Generic drugs are copies of brand-name drugs and are the same as those brand-name drugs in:

- Dosage form
- How it's taken
- Intended use
- Performance characteristics
- Quality
- Safety
- Strength

Generic drug makers must prove to the FDA that their product works the same way as the brand-name drug. In some cases, there may not be a generic version of the exact brand-name drug you take, but there may be another generic drug that will work for you. Talk to your provider to find out if a generic version of a drug would work for you.

Plans meeting certain requirements can replace brand-name drugs on their drug lists with new generic drugs as soon as the generic becomes available. They can also change the cost or coverage rules for brand-name drugs if they add new generic drugs. If you're taking one of these drugs, your plan will notify you after the drug has been replaced or removed from their drug list.

Biological products and biosimilars

A biological product is a prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast.

A biosimilar is a biological product that must be highly similar to and have no clinically meaningful differences from the original biological product in terms of safety and effectiveness.

A pharmacy may substitute an interchangeable biological for the original biological product without a new prescription, subject to state laws.

You may save money by using biosimilars instead of original biological products. Talk to your provider to find out if a biosimilar version of a biological product would work for you.

What are coverage rules?

Plans may have some or all of these rules for the drugs you take:

- Prior authorization
- Step therapy
- Quantity limits
- Medication safety checks, drug management programs for safer use of opioid pain medications, and Medication Therapy Management (MTM) programs for people with complex health needs

When your drug coverage begins, you may get a transition fill, a one-time 30-day supply of a drug you've been taking that your plan either doesn't cover or requires prior authorization/step therapy. Check with your plan to find out their specific coverage rules.

Prior authorization

Prior authorization is approval based on a plan's specific requirements that you and/or your prescriber must get from a plan for certain drugs before your plan will cover them. Your prescriber may need to show that the drug is medically necessary, and you meet certain requirements for the plan to cover it.

Plans may also use prior authorization when they only cover a drug for some medical conditions it's approved for, but not others. When this happens, plans will likely have other drugs on their drug list for the other medical conditions that your prescriber is using the drug to treat.

You or your prescriber can ask for an exception to prior authorization. Your prescriber must give a statement supporting the request, including their belief that:

- Because of your medical condition, it's medically necessary for you to be on the drug, even if you don't meet the plan's prior authorization requirements.
- You'll have negative health effects if you take a different drug.
- A different drug would be less effective.

Step therapy

Step therapy is a type of prior authorization that requires you first to try a certain, less expensive drug on the plan's drug list that's been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. Some plans may require you to try:

- A generic drug or a biosimilar (if available).
- A biological product on their drug list.

You or your prescriber can ask for an exception to step therapy. Your prescriber must give a statement supporting the request, including their belief that:

- Because of your medical condition it's medically necessary for you to be on a more expensive drug without trying the less expensive drug first.
- You'll have adverse health effects if you take the less expensive drug.
- The less expensive drug would be less effective.

Visit [Medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans](https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans) to learn how to ask for an exception. If the exception is approved, your plan will cover the more expensive drug, even if you didn't try the less expensive drug first.

Example:

- **Step 1:** Dr. Smith wants to prescribe an ACE inhibitor to treat Mr. Mason's heart failure. There's more than one type of ACE inhibitor. Mr. Mason's plan requires him to try using a lower-cost ACE inhibitor before trying one that's more expensive, because the lower-cost drug is effective for most people.
- **Step 2:** If Mr. Mason takes the lower-cost drug but has side effects or limited improvement, Dr. Smith can give that information to the plan and ask them to cover a higher-cost drug that Dr. Smith wants to prescribe. If the exception request is approved, Mr. Mason's plan will move up a "step" to cover the higher-cost drug.

Quantity limits

Plans may limit the amount of drugs they cover over a certain period of time, for safety and cost reasons. For example, a plan may only cover 30 tablets of a drug per month.

You or your prescriber can contact the plan to ask for an exception if your prescriber believes that, because of your medical condition, a quantity limit isn't medically appropriate (for example, your doctor believes you need a higher dose). Visit [Medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans](https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans) to learn how to ask for an exception.

Safety checks

Before the pharmacy fills your prescriptions, your plan and pharmacist perform routine safety checks, like:

- Checking for drug interactions and incorrect dosages
- Checking for possible unsafe amounts of opioid pain medications (like oxycodone and hydrocodone)
- Limiting your first opioid prescription to a 7-day supply or less
- Limiting use of opioids at the same time as benzodiazepines (like alprazolam (Xanax[®]), diazepam (Valium[®]), or clonazepam (Klonopin[®])), commonly used for anxiety and sleep

Opioid pain medications can help with certain types of pain, but have risks and side effects (like dependence, overdose, and death). These can increase when you take opioids with certain other drugs, like benzodiazepines, anti-seizure medications, gabapentin, muscle relaxers, certain antidepressants, and drugs for sleeping problems. Check with your doctor or pharmacist if you have questions about risks or side effects.

If your pharmacy can't fill your prescription as written, the pharmacist will give you a notice explaining how you or your doctor can call or write to your plan to ask for a coverage decision, including an exception to a plan coverage rule. If your health requires it, you can ask the plan for a fast coverage decision. You can also ask your plan for a decision before you go to the pharmacy. To learn how to ask for an exception, visit [Medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans](https://www.Medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans).

Drug management programs

Medicare drug plans and health plans with drug coverage have drug management programs to help you safely use prescription drugs like opioids and benzodiazepines. If you get opioid prescriptions from multiple doctors or pharmacies, or if you had a recent overdose from opioids, your plan may check with your doctor(s) to make sure you need these drugs and that you're using them safely.

If your plan decides your use of prescription opioids and benzodiazepines may not be safe, the plan may limit your coverage of these drugs under its drug management program. Your plan may require you to get these drugs only from certain doctors or pharmacies to better coordinate your health care.

Your plan will send you a letter before it places you in its drug management program. You'll be able to tell your plan which doctors or pharmacies you prefer to get your prescription opioids and benzodiazepines from, and give any other information you think is important for the plan to know. Your plan will send you another letter with its decision.

You and your doctor have the right to appeal if you disagree with the plan's decision. The letter from your plan will tell you how to contact the plan if you have questions or want to appeal.

Note: Opioid safety reviews and drug management programs generally won't apply if you have cancer or sickle cell disease, are getting palliative or end-of-life care, are in hospice, or live in a long-term care facility.

Important tips if you're prescribed opioids

- Opioid medications can be an important part of pain management, but they can also have serious health risks if misused.
- Never take more opioids than prescribed. Also, talk with your doctor about any other pain medicines (prescription and non-prescription) you're taking.
- Safely store and dispose of unused prescription opioids through your community drug take-back program or your pharmacy mail-back program.
- Talk with your provider about:
 - Having naloxone or a similar drug at home as a safety measure to rapidly reverse the effects of an opioid overdose. Medicare covers opioid reversal drugs like naloxone that your doctor may prescribe. Naloxone is also available without a prescription.
 - Your dosage and the length of time you'll be taking opioids. You and your doctor may decide later you don't need to take all of your prescription.
 - Other options that Medicare covers to treat your pain, like non-opioid medications and devices, physical therapy, acupuncture for lower back pain, individual and group psychotherapy, behavioral health integration services, and more.

Medication Therapy Management (MTM) for people with complex health needs

Plans with Medicare drug coverage must offer MTM services to help people who meet certain requirements or are in a drug management program. If you qualify, you can get these services at no cost to help you understand how to manage your medications and take them safely. MTM services usually include a discussion with a pharmacist or health care provider to review your medications.

Through the MTM, you may get:

- A comprehensive review of your medications and the reasons why you take them.
- A written summary of your medication review with your doctor or pharmacist.
- A "Recommended To-Do List" and "Medication List" to help you make the best use of your medications (there will be space for you to take notes or write down any follow-up questions).

If you take many drugs for more than one chronic health condition, contact your drug plan for specific details and to find out if you're eligible for an MTM program.



Reminder: Bring your medication list with you any time you talk with your doctors, pharmacists, and other health care providers, or if you go to the hospital or emergency room.



Section 4

Medicare's Extra Help program

“Extra Help” is a Medicare program to help people with limited income and resources pay Medicare drug coverage (Part D) premiums, deductibles, coinsurance, and other costs.

Some people qualify for Extra Help automatically, while others need to apply.

Note: Extra Help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa. However, there are other programs available in those areas to help people with limited income and resources. Contact your State Medical Assistance (Medicaid) office for more information. You can get the phone number for your state Medicaid office by visiting [Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip](https://www.Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip).

What does Extra Help cover?

If you get Extra Help in 2026, you'll pay:

- \$0 for your Medicare drug plan premium and deductible
- Up to \$5.10 for each generic drug
- Up to \$12.65 for each brand-name drug
- \$0 for each covered drug once your total out-of-pocket spending (including certain payments made on your behalf, like through the Extra Help program) reaches \$2,100

You won't have to pay a Part D late enrollment penalty (if you have one) while you get Extra Help.

Who gets Extra Help automatically?

You'll get Extra Help automatically if you get:

- Full Medicaid benefits
- Help from your state paying your Part B premiums (from a Medicare Savings Program)
- Supplemental Security Income (SSI) benefits from Social Security

If you get Extra Help automatically, you'll get a purple, yellow, or green notice that tells you how much you'll pay, and that Medicare will enroll you in a Medicare drug plan (if you don't have one already).

Your eligibility for Extra Help gets reviewed every year. If you meet the income and resource limits for next year, you'll keep getting Extra Help.

You'll get a new notice if you no longer qualify for Extra Help next year, or if you get moved to a different plan for next year.

If you don't get a notice from Medicare or Social Security, you'll keep your Extra Help and same drug plan for next year.

Note: If you don't automatically qualify for Extra Help next year, you may still be able to save on your Medicare drug costs. You need to apply for Extra Help to find out.

What if I have retiree drug coverage from a former employer or union and qualify for Extra Help?

If you have employer or union coverage and you enroll in Medicare drug coverage, you may lose your employer or union coverage (for you and your dependents) even if you qualify for Extra Help. Call your employer's benefits administrator before you enroll in Medicare drug coverage. If you don't want to join a separate Medicare drug plan, call the plan listed in your letter. Tell them you don't want to join a Medicare drug plan (you want to "opt out").

What should I do if my situation changes?

Contact Social Security if you have a change in income, resources, or family size. Any changes affecting your Extra Help start January 1 of the following year. Contact Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

If you applied and qualified for Extra Help through your state, your state's rules may require you to tell them about changes in your circumstances. Contact your State Medical Assistance (Medicaid) office for more information. Visit [Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip](https://www.Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip) to get the phone number for your state Medicaid office.

Who can apply for Extra Help?

In most cases, to get Extra Help you must have income and resources below a certain limit. These limits may change each year. Even if you don't qualify for Extra Help now, you can reapply for Extra Help at any time during the year if your income and resources change.

Visit [SSA.gov/medicare/part-d-extra-help](https://www.ssa.gov/medicare/part-d-extra-help) to apply for Extra Help. You can also contact your local State Health Insurance Assistance Program (SHIP) to get free help applying. Visit shiphelp.org to get the phone number for your SHIP.

Note: You can apply for Extra Help and Medicare Savings Programs (MSPs) at the same time. MSPs can help with other Medicare costs like Part B premiums and deductibles. Social Security will send information to your state to start an MSP application unless you tell them not to on your Extra Help application. Learn more about Medicare Savings Programs at [Medicare.gov/basics/costs/help/medicare-savings-programs](https://www.medicare.gov/basics/costs/help/medicare-savings-programs).

Income and resource limits in 2026 for all states (except Alaska and Hawaii) and D.C.

Your situation:	Income limit:	Resource limit:
Individual	\$23,940	\$18,090
Married couple	\$32,460	\$36,100

Income and resource limits in 2026 for Alaska

Your situation:	Income limit:	Resource limit:
Individual	\$29,925	\$18,090
Married couple	\$40,575	\$36,100

Income and resource limits in 2026 for Hawaii

Your situation:	Income limit:	Resource limit:
Individual	\$27,540	\$18,090
Married couple	\$37,335	\$36,100

What do states count toward income and resource limits?

What states count toward income limits

Count:

- Alimony
- Annuities
- Earnings from self-employment
- Pensions
- Railroad Retirement Board (RRB) benefits
- Rental income
- Social Security benefits
- Veterans' benefits
- Wages
- Worker's compensation

Don't count:

- Assistance from others to pay for household expenses
- Disaster assistance
- Earned income tax credit payments
- Home energy assistance
- Housing assistance
- Medical treatment and drugs
- Scholarships and education grants
- Supplemental Nutrition Assistance Program (SNAP)
- Victim's compensation payments

What states count toward resource limits

Count:

- Cash
- Money in a checking, savings, or retirement account
- Real estate **other** than the home you live in (your primary residence)
- Stocks, bonds, savings bonds, mutual funds

Don't count:

- Burial plot
- Furniture
- Household and personal items
- One car
- Up to \$1,500 for burial expenses if you have put that money aside
- Your home

Check the publication "Understanding the Extra Help with Your Medicare Prescription Drug Plan" at [SSA.gov/pubs/EN-05-10508.pdf](https://www.ssa.gov/pubs/EN-05-10508.pdf) for more information on income and resource limits.

How do these limits work for married couples?

- If you're married and live with your spouse, **both** of your incomes and resources count, even if only one of you applies for Extra Help.

Note: Married couples living together who both apply for Extra Help through Social Security can use the same application (SSA-1020) available at [SSA.gov/medicare/part-d-extra-help](https://www.ssa.gov/medicare/part-d-extra-help).

- If you're married and **don't** live with your spouse, only **your** income and resources count.

Even if your yearly income is higher, you may still qualify for Extra Help if you or your spouse meet one of these conditions:

- You support other family members who live with you.
- You have earnings from work.
- You live in Alaska or Hawaii.

What if my marital status changes?

Contact Social Security if your marital status changes in one of these ways:

- Marriage
- Divorce
- Annulment
- Separation (not temporary)
- You and your spouse go back to living together after separating
- Death of spouse (in this situation, the change in your Extra Help may be delayed for one year)

A change in your marital status could increase or decrease your income and/or resources, which could change whether or not you're eligible for Extra Help. Any change will start the month after you report it to Social Security. Contact Social Security at 1-800-772-1213.

What happens once I start getting Extra Help?

If you don't already have Medicare drug coverage (Part D), we'll enroll you in a plan so you can get help with your drug costs.

You'll get a notice by mail telling you:

- About your new plan. Check to find out if the plan covers the drugs and pharmacies you use. You can pick a different Medicare drug plan if you want.
- That you get Extra Help for the rest of the calendar year. Even if your income changes in the middle of the year, you'll keep getting Extra Help through December 31.

Visit [Medicare.gov/basics/forms-publications-mailings/mailings/help](https://www.medicare.gov/basics/forms-publications-mailings/mailings/help) to learn more about letters you may get about Extra Help.

What if Medicare enrolls me in a drug plan that isn't right for me?

If you get Extra Help, you can make changes to your drug coverage once a calendar month. The change will take effect on the first day of the next month.

Note: Most people with Medicare can only make changes to their drug coverage at certain times of the year.

What if I get Extra Help and think I'm paying the wrong amount for my drugs?

Contact your drug plan if you're getting Extra Help and think you're paying the wrong amount for your drugs. Your plan may ask for proof that you get Extra Help, so they can correct your costs. Examples of proof you get Extra Help are:

- A notice from Medicare that says you qualify for Extra Help or that your Extra Help is changing next year. This notice will be on yellow, green, purple, or orange paper.
- Your award letter from Social Security (if you get monthly Supplemental Security Income (SSI) benefits).
- **If you have Medicaid:**
 - Any document from your state that shows you have Medicaid, like your Medicaid card or your Medicaid award letter.
 - Other documents, like a printout from a state electronic enrollment file or screen print from your state's Medicaid system.
 - The date you called your state Medicaid office to confirm your Medicaid coverage, the name and phone number of the state's staff person who confirmed the Medicaid period, and the Medicaid eligibility dates confirmed on the call.
- **If you have Medicaid and live in a long-term care facility (like a nursing home) or get home- and community-based services:**
 - A bill from the facility, or a copy of a state document showing Medicaid paid for your stay for at least a month.
 - A state document that shows you have Medicaid and are getting home- and community-based services.
 - Proof from a pharmacy that they billed Medicaid and that Medicaid paid.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. We can confirm you get Extra Help and help you resolve things with your plan.

Note: Tell your plan how many days of medication you have left. Your plan and Medicare will try to fix the issue before you run out.

What if I don't qualify for Extra Help?

You can apply or reapply for Extra Help at any time, if your income and resources change.

If you don't qualify for Extra Help, you can still choose and join Medicare drug coverage that meets your needs. You'll have to pay the monthly premium, yearly deductible (some plans don't have a deductible), and any copayment or coinsurance for your prescription drugs.

Note: Even if you don't qualify for Extra Help now, make sure you get Medicare drug coverage or other creditable prescription drug coverage when you're first eligible for Medicare, to avoid paying the lifetime Part D late enrollment penalty (pages 19-21).

What are my rights if I'm denied Extra Help?

If your application for Extra Help is denied, you have the right to appeal the decision. Social Security will give you a hearing by phone unless you choose a case review. Either way, they'll review the parts of the decision that you believe are wrong and will look at any new information you provide. Social Security may also review the parts you believe are correct. Someone at Social Security who wasn't involved in the first decision will decide your case.

To ask for an appeal, go to [SSA.gov/forms/ssa-1021.pdf](https://www.ssa.gov/forms/ssa-1021.pdf) to get a copy of form SSA-1021 ("Appeal of Determination for Extra Help with Medicare Prescription Drug Plan Costs") and instructions on how to fill it out. If you need help filling out this form, you can call Social Security at 1-800-772-1213.

If you want to file an appeal, keep in mind:

- You have 60 days to file an appeal.
- Your 60 days start the day after you get a letter from Social Security denying your application. Social Security will assume you got the letter 5 days after the date on it, unless you show them you didn't get it within the 5-day period.
- You can have a lawyer, friend, or someone else help you, as listed on the form.

What is Medicare's Limited Income Newly Eligible Transition (LI NET) Program?

Medicare's LI NET Program gives temporary Medicare Part D drug coverage to people who qualify for Extra Help or Medicaid but who aren't enrolled in yet. LI NET covers all covered Part D drugs, and there are no network pharmacy restrictions.

If you qualify for LI NET, you'll get temporary drug coverage (up to 2 months). You'll be covered by LI NET until your auto-enrollment takes effect or you choose and join Medicare drug coverage. Your LI NET enrollment starts the first day of the month you're identified as eligible for Extra Help, and ends after 2 months.

If you get Extra Help, LI NET covers you at all pharmacies for up to 30 days in the past. If you get both Medicaid and Medicare, or if you get Supplemental Security Income (SSI), LI NET covers you on a retroactive basis, for up to 36 months in the past.

Who gets automatically enrolled into the LI NET program?

Most people eligible for the LI NET program are automatically enrolled, for one of these reasons:

- You get both Medicaid and Medicare
- You're eligible for Extra Help and your auto-enrollment into a Medicare drug plan hasn't taken effect

You're eligible for the LI NET program if you get Medicare and qualify for a Medicare Savings Program, but you need to apply.

How do I apply to the LI NET program if I'm not automatically enrolled?

You can apply for LI NET one of these ways:

- Fill a prescription at a pharmacy and ask the pharmacy to submit your claim to LI NET. Make sure to bring your Medicare card.
- Contact the LI NET program if you ask to get paid back for out-of-pocket drug costs (described below).
- To get a LI NET program enrollment form, visit the LI NET program at provider.humana.com/pharmacy-resources/medicare-linet.

Can I get paid back for out-of-pocket drug costs?

You may be able to get some money back if you paid for covered Part D drugs after you qualified for LI NET.

Keep your receipts with your prescription drug prices, and call LI NET at 1-800-783-1307 to find out if you qualify. TTY users can call 711. Someone will be available to take your call from 8 a.m. – 7 p.m. Eastern time (ET).

Are there other ways to lower my drug costs?

If you don't get Extra Help, there may be other ways for you to save on drug costs:

- **Find out if your state offers help with drug costs.** Check State Pharmaceutical Assistance Programs (SPAPs) to find out if you qualify. Many states and the U.S. Virgin Islands offer some type of program to help people with Medicare pay Part D premiums, copayments, and/or coinsurance. Some SPAPs may require you to get Medicare drug coverage, and then they'll help with the drug costs that Medicare doesn't cover. Visit go.Medicare.gov/spap to find out if your state has an SPAP.
- **Check if the company that makes your drug offers help paying for it.** Many of the major drug manufacturers offer Pharmaceutical Assistance Programs (sometimes called Patient Assistance Programs, or PAPs) for people with Medicare drug coverage. Visit go.Medicare.gov/pap to find out if the manufacturers of the drugs you take offer a PAP.
- **Talk with your doctor.** Ask your doctor if you can take a generic drug, or a cheaper brand-name drug (if one's available).
- **Check costs for mail-order pharmacies.** Sometimes using a mail-order pharmacy is cheaper.
- **Visit TrumpRx.gov.** Find special offers and the lowest cash price on prescription drugs. (You can't buy drugs directly from TrumpRx.) Compare TrumpRx prices with what you pay under your plan to make sure you get the best price. TrumpRx and other types of discount cards aren't considered creditable coverage. When you use them (instead of your Medicare plan) to buy drugs, it doesn't count toward your Medicare deductible or out-of-pocket maximum.



Section 5

Using your Medicare drug coverage

Each company that offers Medicare drug coverage has a list of pharmacies you can use, called a network. If you want to continue filling prescriptions at the same pharmacy you use now, check to find out if that pharmacy is in-network. Contact your plan, your pharmacy, or 1-800-MEDICARE (1-800-633-4227) to find out if your pharmacy is in-network. TTY users can call 1-877-486-2048. Some Medicare drug plans or health plans with drug coverage offer a discount or only cover your drugs when you get them filled at a pharmacy in their network.

Along with local retail pharmacies, your plan's network might include preferred pharmacies or a mail-order program.

Whichever way you choose to get your drugs, you can contact your plan to find out if you can get a two- or three-month supply for drugs you take regularly. This may be a cost-effective and convenient way to get your drugs.

Within 2 weeks after your drug plan gets your completed application, you'll get a letter letting you know it got your information. Within 5 weeks, you should get a welcome package with your plan ID card.

To fill your prescription, bring:

- A photo ID (like a state driver's license or passport).
- Your card for Medicare drug coverage.

You should also bring your red, white, and blue Medicare card, as proof that you get Medicare. If you have both Medicare and Medicaid, or qualify for Extra Help, you should also bring proof that you have Medicaid or proof that you qualify for Extra Help. This will help make sure you don't pay more than you should for your prescription drugs.

Visit [Medicare.gov/basics/forms-publications-mailings/mailings/help](https://www.medicare.gov/basics/forms-publications-mailings/mailings/help) to learn more about letters you get about Extra Help, or go to page 34 for information about what you can use to prove you get Extra Help and/or Medicaid.

How do I fill a prescription without my new plan card?

If you go to the pharmacy before you get your new drug plan card, you can prove you have coverage by showing:

- The acknowledgement, confirmation, or welcome letter you got from the plan.
- An enrollment confirmation number you got from the plan, and the plan name and phone number.
- A copy of your official Medicare card.

Note: If you haven't gotten a plan membership card or any plan enrollment materials, tell your pharmacist the name of your plan. This can help them confirm your plan enrollment and get the information they need to bill your plan.

If you don't have any of the items above, your pharmacist may still be able to get your drug plan information. You'll need to give them your Medicare Number or the last 4 digits of your Social Security Number.

If your pharmacist can't get your drug plan information, your doctor may be able to give you a sample of your prescription drug until your coverage is confirmed, or you may have to pay out of pocket for the entire cost of your drug.

If you pay out of pocket for your drugs, save your receipts, and contact your plan. You may be able to get back some of what you spend, or have the amount credited toward your out-of-pocket costs.

Can I use a mail-order pharmacy?

Plans can't make you use a mail-order pharmacy, but you may have this option if you want to use it.

Plans should get your approval to deliver a prescription drug (new or refill) in the mail (unless you ask for the refill or new prescription). Some plans may ask for your approval every year, and other plans may ask before every delivery.

This policy doesn't apply to refill reminder programs (where you go in person to pick up the prescription) or long-term care pharmacies.

Note: Be sure to give your pharmacy the best way to reach you, so you don't miss a refill confirmation call or other communication.

Contact your plan if you get prescriptions from a mail-order pharmacy that you didn't approve or ask for. You may be eligible for a refund for the amount your plan charged you. If you aren't able to resolve the issue with the plan or wish to file a complaint, call 1-800-MEDICARE.

What ID card should I use?

If you join a Medicare drug plan that works with Original Medicare: Use your drug plan ID card to fill your prescriptions. You'll still use your Medicare card for hospital and doctor services, and for any prescription drugs covered under Part B.

If you join a Medicare Advantage Plan or other Medicare health plan with drug coverage: Use your plan ID card for all services, including prescriptions.

What if I'm taking a drug that isn't on my plan's drug list when my drug coverage begins?

Generally, your plan will give you a one-time, temporary supply of your current prescription drug during your first 90 days in a plan. Plans must give you this temporary supply so that you and your prescriber have time to find another drug on the plan's drug list that will work as well as what you're taking now. There may be different rules for people who move into or already live in a facility (like a nursing home or long-term care hospital).

You or your prescriber can contact the plan to ask for an exception if:

- You already tried similar prescription drugs on your plan's drug list and they didn't work.
- Your prescriber decides you need a certain drug because of your medical condition.
- Your prescriber thinks you need to have a coverage rule (like a prior authorization or quantity limit) waived.

Visit [Medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans](https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans) to learn how to ask for an exception. If the plan agrees to your request, it will cover the drug. If your plan doesn't agree to the exception, you can appeal the plan's decision. Visit [Medicare.gov/appeals](https://www.medicare.gov/appeals) for more information on appeals.

What if I join a plan, and then my doctor changes my prescription?

Your doctor can check which drugs your plan covers and the plan's coverage rules (like prior authorization, step therapy, and quantity limits) through their electronic prescribing system or the plan's website.

If your doctor needs to prescribe a drug that isn't on your Medicare plan's formulary and you don't have other coverage for outpatient prescription drugs, you or your doctor can ask the plan for an exception. Visit [Medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans](https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans) to learn how to ask for an exception.

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If your plan still won't cover a specific prescription drug you need, you can file an appeal. If you want to get the prescription drug before you file an appeal, you may have to pay out of pocket for the entire cost of the drug. Keep the receipt and give a copy of it to the person deciding your appeal. If you win the appeal, the plan will pay you back. For more information about appeals, visit [Medicare.gov/appeals](https://www.medicare.gov/appeals).

Call your plan or look on their website to find the most up-to-date list of covered drugs and what they cost, as well as the plan's coverage rules like prior authorization, step therapy, and quantity limits.



Section 6

More information

- **About Medicare:** Call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, including weekends, to get information you need. TTY users can call 1-877-486-2048.
- **About ways to help lower your Medicare costs:** Visit [Medicare.gov/basics/costs](https://www.Medicare.gov/basics/costs) help for ways to save on your Medicare health and drug costs.
- **About Medicare drug coverage (Part D):** Visit [Medicare.gov/health-drug-plans/part-d](https://www.Medicare.gov/health-drug-plans/part-d).
- **About finding Medicare Part D plans:** Visit [Medicare.gov/plan-compare](https://www.Medicare.gov/plan-compare) and enter your pharmacy and drugs to get personalized cost information.
- **About applying for Extra Help with your Medicare drug coverage costs:** Visit [SSA.gov/medicare/part-d-extra-help](https://www.SSA.gov/medicare/part-d-extra-help).
- **About free personalized health insurance counseling on your coverage choices:** Contact your State Health Insurance Assistance Program (SHIP). Visit [shiphelp.org](https://www.shiphelp.org) to get the phone number for your SHIP.

CMS Accessible Communications

Medicare provides free auxiliary aids and services, including information in accessible formats like braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. Call us:

For Medicare: 1-800-MEDICARE (1-800-633-4227)

TTY: 1-877-486-2048

For Marketplace: 1-800-318-2596

TTY: 1-855-889-4325

2. Email us:

altformatrequest@cms.hhs.gov

3. Send us a letter:

Centers for Medicare & Medicaid Services

Offices of Hearings and Inquiries (OHI)

7500 Security Boulevard

Mail Stop DO-01-20

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff (CARS)

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your state or local Medicaid office.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, state or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. Online:

[HHS.gov/civil-rights/filing-a-complaint/complaint-process/index.html](https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html).

2. By phone:

Call 1-800-368-1019.

TTY users can call 1-800-537-7697.

3. In writing: Send information about your complaint to:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

**U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services**

7500 Security Blvd.
Baltimore, MD 21244-1850

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Need a copy of this booklet in Spanish?

To get a free copy of this booklet in Spanish, visit [Medicare.gov](https://www.Medicare.gov) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en Español. Para obtener una copia gratis, visite es.Medicare.gov o llame al 1-800-MEDICARE.



Medicare

The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

“Your Guide to Medicare Drug Coverage” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

This product was produced at U.S. taxpayer expense.