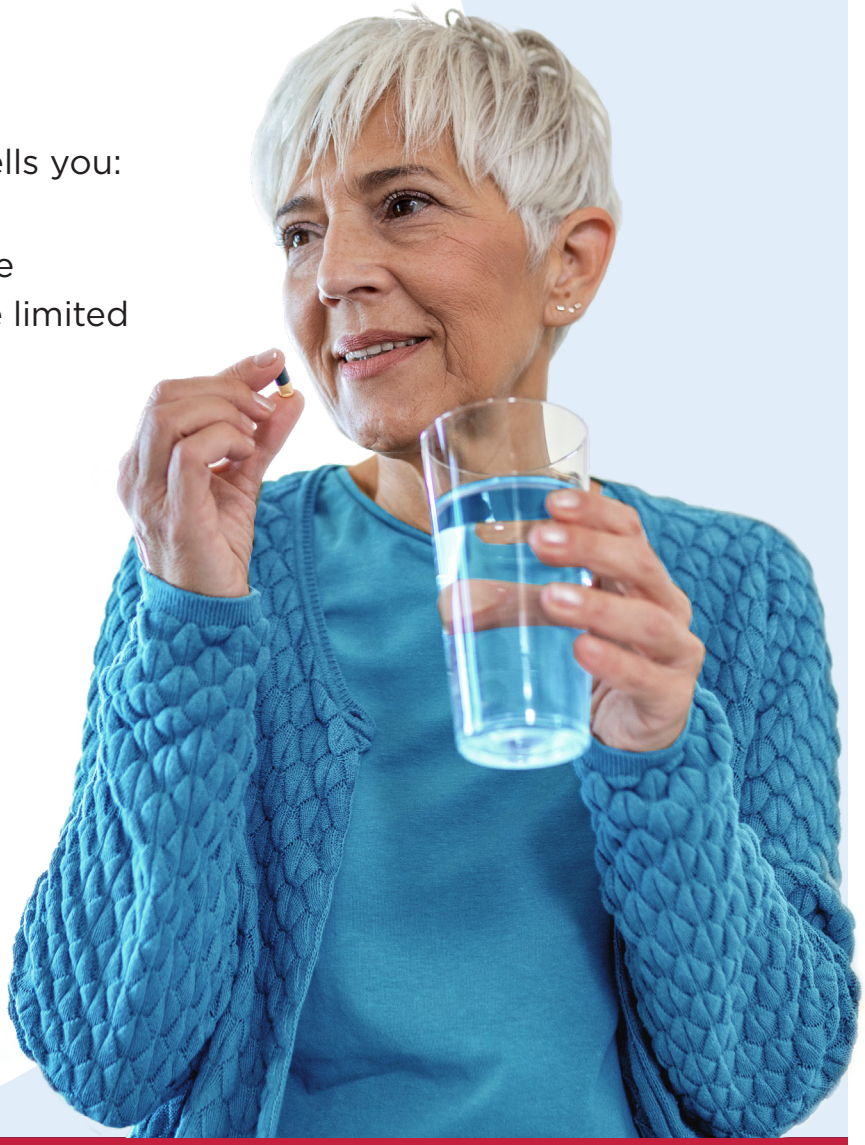
Your Guide to Medicare Drug Coverage

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



Medicare

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Section 1:

The basics

Medicare drug coverage adds to your Medicare health 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 everyone with Medicare by insurance companies and other private companies approved by Medicare.

You can get drug coverage 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 can add a separate drug plan (sometimes called a Prescription Drug Plan or PDP) to Original Medicare. 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 generally get your Part A (Hospital Insurance), Part B (Medical Insurance), and drug coverage (Part D) through these plans. 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. If you choose a type of Medicare health plan called a "Medicare Cost Plan" you can either get your Medicare drug coverage from the plan (if offered), or you can join a separate Medicare drug plan to add drug coverage.

In this booklet, the term "Medicare drug coverage" means all Medicare drug plans and Medicare health plans that offer 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 lawfully present in the United States

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 lawfully present in the United States
- 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.

Plans can offer different combinations of what drugs they cover, what pharmacies are in-network, and what things cost, as long as they meet standards set by Medicare.

Note: If you don't get drug coverage when you're first eligible for Medicare, and you don't have drug coverage that's expected to pay, on average, at least as much as standard Medicare prescription drug coverage (called creditable prescription drug coverage), you may have to pay a lifetime Part D late enrollment penalty if you join later. The penalty is added to your monthly premium for as long as you have Medicare drug coverage. Go to pages 20–22 for more information about the late enrollment penalty.

Things to consider when deciding whether or not to get Medicare drug coverage

- If you already have creditable drug coverage, like from an employer or union, TRICARE, the Department of Veterans Affairs (VA), or the Indian Health Service.
- If you're new to Medicare but don't have creditable drug coverage, you may want to get Medicare drug coverage, even if you don't use a lot of prescription drugs now. This will help you lower your drug costs and avoid the Part D late enrollment penalty later.
- If you have (or are eligible for) other types of drug coverage, 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.
- If you have drug coverage currently, compare it to Medicare drug coverage. Your current drug coverage may change if you get Medicare drug coverage.

Note: Prescription drug coverage is insurance. Doctor samples, discount cards, free clinics, or drug discount websites aren't drug coverage.

Go to Section 2 for details about how Medicare drug coverage can affect your other coverage.

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** for the most up-to-date SHIP phone numbers.
- 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 you turn 65, and ending 3 months after 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 next month

During the 7-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 next month

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 35).
- Permanently move out of your plan's service area.
- Lose creditable prescription drug coverage.
- Enter, live in, or leave a nursing home.
- Want to switch to a plan with a 5-star overall quality Star Rating. Quality Star Ratings are available on **Medicare.gov**.
- Are in a plan that's no longer offered.

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**, 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 switch plans by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: Medicare plans aren't allowed to call to 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? (Any prescription drug coverage that's expected to pay, on average, at least as much as Medicare drug coverage, is considered creditable prescription drug coverage.)
  - If you don't get drug coverage when you're first eligible for Medicare, and you don't have creditable prescription drug coverage, you may have to pay a lifetime Part D late enrollment penalty if you join Medicare later.
  - Your current plan can tell you if your drug coverage is creditable prescription drug coverage. Go to pages 20–22 for more information about the Part D late enrollment penalty.

- How will joining a Medicare drug or health plan and keeping my current drug coverage affect my current coverage? (Your current plan can tell you.)
- How would joining a particular Medicare drug or health plan affect my out-of-pocket costs?
- Would 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?
- Would my 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**.)
- 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?
- 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 quality Star Ratings? (Compare Medicare drug plans at **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 of your SHIP.

How Medicare drug coverage works with your current health or 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 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** or call 1-800-MEDICARE (1-800-633-4227) for a list of plans in your area. TTY users can call 1-877-486-2048. You can also look in your "Medicare & You" handbook. Not sure if you have Part A and/or Part B? Check your red, white, and blue Medicare card.

I have Medicare and a Medicare Supplement Insurance (Medigap) policy

You can join a Medicare drug plan by:

- Keeping your current Medigap policy and joining a Medicare drug plan.
- Joining a Medicare Advantage Plan in your area that includes drug coverage. You'd get all your health care benefits and drug coverage from the plan.

Note: If you join a Medicare Advantage Plan, you don't need a Medigap policy. If you already have a Medigap policy, you can't use it to pay for out-of-pocket costs under your Medicare Advantage Plan. 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** for more information about how Medigap works if you join Medicare drug coverage.

I have 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.

Check with your State Insurance Department to find other options you may have for 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 20–22 for more information about the late enrollment penalty.

For more information about Medigap policies, visit **Medicare.gov** or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also call your State Health Insurance Assistance Program (SHIP) for more information about Medigap. Visit **shiphelp.org** or call 1-800-MEDICARE to get the phone number of 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. 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 drug coverage, or 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 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 (go to pages 20–22 for more information). 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 drug coverage **and** get Medicare drug coverage.
- Keep your current employer or union drug 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 changes, and is no longer creditable, you can get Medicare drug coverage during a Special Enrollment Period. Go to page 11 for more information.)

Important! If you drop your employer or union 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 by you getting 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. If you have an FEHB plan, it's almost always to your advantage to keep your current coverage without any changes. It isn't cost effective for most people covered under a FEHB plan to get Medicare drug coverage unless they qualify for Extra Help.

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

- If you qualify for Extra Help paying Medicare drug costs, find out how your costs with a Medicare plan and any Extra Help would compare to your FEHB plan drug coverage.
- If you join a Medicare plan with drug coverage, 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 if you join within 63 days of losing FEHB coverage. Go to pages 20–22 for more information about the late enrollment penalty.

For more information about how your FEHB plan works with Medicare, visit 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.

- 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 the claim unpaid by the Medicare Advantage Plan 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, if you join within 63 days of losing TRICARE, CHAMPVA, or VA coverage. Go to pages 20–22 for more information about the late enrollment penalty.

Note: For more information on VA benefits, visit **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.

For more information on the TRICARE Pharmacy Program, visit **TRICARE.mil/pharmacy** or call 1-877-363-1303. TTY users can call 1-877-540-6261.

For more information on CHAMPVA, visit **VA.gov/communitycare/programs/dependents/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 other ways to get Medicare drug coverage:

- 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 (go to pages 16–19).
  - 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 if you get Medicare drug coverage later. Go to pages 20–22 to learn more about the late enrollment penalty.

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 drug plan costs, and will mail you a **purple** notice. Keep this notice as confirmation that you qualify for Extra Help.

Unless you choose a Medicare Advantage Plan with drug coverage or a Medicare drug plan on your own, Medicare automatically enrolls people with both Medicare and full Medicaid coverage who live in facilities (like nursing homes) into Medicare drug plans.

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, you can change plans once a quarter during the calendar 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 page 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 (1 800-633-4227) and tell them you want to "opt out" of (decline) Medicare drug coverage. TTY users can call 1-877-486-2048.

> **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 during the next available enrollment period 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. You can get the phone number for your state Medicaid office by visiting **Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu**.

I have Medicare and get Supplemental Security Income (SSI) benefits or belong to a Medicare Savings Program

If you join a Medicare drug plan and get SSI or belong to a Medicare Savings Program, Medicare will send you a **purple** notice letting you know you automatically qualify for Extra Help paying your Medicare 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 have chances to switch Medicare drug plans during the year.

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 (1-800-633-4227) and tell them you want to "opt out" of (decline) Medicare prescription drug coverage. TTY users can call 1-877-486-2048.

> **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 during the next available enrollment period 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 Medicaid coverage,** you pay nothing for your covered drugs after Medicaid has paid for your stay for one full calendar month.
- **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)

Program of All-inclusive Care for the Elderly (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, not only your drug coverage. If you join a Medicare drug plan, you'll become disenrolled from your PACE plan, and you'll no longer get other health care benefits through PACE. Contact your PACE plan for more information. Visit **Medicare.gov/plan-compare/#/pace** to find contact information for your PACE plan.

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 a State Pharmacy Assistance Program (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 threshold (or limit), which is $8,000 in 2024.

If you belong to an SPAP, you may have another opportunity each year to join a plan in addition to the October 15–December 7 Open Enrollment Period. You can switch one time in a calendar year to a different plan from the one your SPAP enrolled you in.

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.

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

Most AIDS Drug Assistance Programs (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 when you join. Go to pages 20–22 for more information about the late enrollment penalty.

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 threshold (or limit), which is $8,000 in 2024.

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

- 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 coverage from Medicaid 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, Tribal Health Program, or Urban Indian Health Program includes creditable prescription drug coverage, which means you won't have to pay a Part D late enrollment penalty if you join a Medicare plan later. Ask your Indian health care provider for a letter stating you have creditable prescription drug coverage. Go to pages 20–22 for more information about the late enrollment penalty.

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

Your total yearly costs may also be affected by:

- Coverage gap (also called the "donut hole")
- Catastrophic coverage

Monthly premium

Most drug plans charge a monthly fee that varies by plan, called a premium, whether you get services or not. 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 that's added to your monthly premium.

Note: Go to pages 20–22 for information on how to avoid the late enrollment penalty.

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 and you think the income information it's based on is wrong, visit SSA.gov/medicare/lower-irmaa. Check the charts below to know if you're affected, and found out how much you'll have to pay each month.

If your yearly income in 2022 was:		You pay each month (in 2024)
Individual tax return	**Joint tax return**	
$103,000 or less	$206,000 or less	Your plan premium
above $103,000 up to $129,000	above $206,000 up to $258,000	$12.90 + your plan premium
above $129,000 up to $161,000	above $258,000 up to $322,000	$33.30 + your plan premium
above $161,000 up to $193,000	above $322,000 up to $386,000	$53.80 + your plan premium
above $193,000 and less than $500,000	above $386,000 and less than $750,000	$74.20 + your plan premium
$500,000 or above	$750,000 or above	$81.00 + your plan premium

If your yearly income in 2022 was:	You pay each month (in 2024)
Married & filing separate tax returns	
$103,000 or less	Your plan premium
above $103,000 up to $397,000	$74.20 + your plan premium
$397,000 or above	$81.00 + your plan premium

If you owe extra because of your income, it'll get taken out of your monthly Social Security, Railroad Retirement, 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 for your prescriptions each year before your Medicare drug plan pays its share.

Deductibles vary between Medicare drug plans. **No Medicare drug plan can have a deductible higher than $545 in 2024.** 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.

Under the standard drug benefit, once you and your plan spend $5,030 combined on drugs (including your deductible) in 2024, you'll pay no more than 25% of the cost for prescription drugs until your out-of-pocket spending reaches $8,000 (including certain payments made on your behalf, like through the Extra Help program).

The amount you pay for a covered prescription is usually for a one-month supply of a drug. However, you can request 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.

How does the coverage gap work?

Before you're in the coverage gap

Your drug costs will depend on the plan you choose and which drug benefit phase you're in. To begin, you pay your deductible and copayment or coinsurance as out-of-pocket costs.

For most Medicare drug coverage, if your out-of-pocket costs reach $5,030 on covered drugs in 2024 (this amount may change each year), then you'll enter the coverage gap phase. This means there's a temporary change in what you're expected to pay for covered drugs, until you reach $8,000 in out-of-pocket costs.

Note: If you get Extra Help, you won't enter the coverage gap.

When you're in the coverage gap (also called the "donut hole")

You'll pay no more than 25% of the cost for covered brand-name drugs or generic drugs. These costs will count towards helping you get out of the coverage gap:

- Out-of-pocket costs include certain payments made by you, or other people or entities on your behalf
- Your yearly deductible, coinsurance, and copayments (your plan premium does not count as an out-of-pocket cost)
- The 70% discount on covered brand-name drugs (that the manufacturer pays) while you're in the coverage gap
- Payments made by Medicare's Extra Help program

When you leave the coverage gap

After you reach $8,000 in out-of-pocket costs in 2024, you'll exit the coverage gap and automatically enter the "catastrophic coverage" phase. This means you won't pay anything for drugs covered by Part D for the rest of the year.

This example shows the costs for covered drugs in 2024 for someone who enters the coverage gap:

1. Yearly deductible	Ms. Smith pays the first $545 of her drug costs before her plan starts to pay its share
2. Copayment or coinsurance	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (including the deductible) reaches $5,030.
3. Coverage gap	Once Ms. Smith and her plan have spent $5,030 for covered drugs, she's in the coverage gap. Ms. Smith pays a copayment or coinsurance for each covered drug. She gets a 70% discount from the drug manufacturer on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. She gets an additional 5% coverage from her plan on covered brand-name drugs and 75% coverage on covered generic drugs while in the coverage gap.
4. Catastrophic coverage	Once Ms. Smith has spent $8,000 out of pocket for the year, her coverage gap ends. Now, she pays nothing for each prescription drug until the end of the year.

Visit Medicare.gov/plan-compare to view estimated yearly costs for each plan and prescription drug for each month. You can also compare costs at different pharmacies.

How do I pay my plan premium?

You can choose one of these options to pay your premium:

- Sign up to have your plan deduct it from your checking or savings account.
- Charge it to a credit or debit card.
- Have your plan bill you each month directly. 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.
- Have funds 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 is set up.

Note: If you get Extra Help to pay part of your drug coverage premium, Social Security may automatically withhold your share of the monthly premiums. If you qualify for Extra Help, it will cover some or all of your drug coverage premiums.

If you have an employer health plan and your plan pays part of your drug coverage premium, Social Security can't 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 benefit 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.

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.

Note: If you get Extra Help, you don't pay a Part D late enrollment penalty.

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" ($34.70 in 2024) 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 **$34.70** (2024 national base beneficiary premium) = **$4.86**
$4.86 rounded to the nearest $0.10 = **$4.90**
$4.90 = your monthly penalty for 2024. This amount is added to your plan's monthly premium.

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 4–5), 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 join 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. Complete the form and return it by the deadline in the letter.

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

- You may be able to ask for a "reconsideration." Your drug plan will send you information about how to request a reconsideration.
- 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 (however, you may request an extension). Send any proof that supports your case, like a copy of your 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, Medicare's contractor 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 drug 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.

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.

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

Part B also covers flu shots, pneumococcal shots and COVID-19 vaccines. Medicare also covers hepatitis B shots for certain people, and some other vaccines when they're related directly to the treatment of an injury or illness. You pay nothing (and the Part B deductible doesn't apply) for these vaccines.

Visit **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** for more on how Medicare covers self-administered drugs you get in a hospital outpatient setting.

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

If you have End-Stage Renal Disease (ESRD), you can get Medicare drug coverage. Medicare Part B (Medical Insurance) will pay for some of the drugs you need, like injectable drugs and their oral forms, and biologicals including erythropoiesis stimulating agents used for dialysis. Part D will continue to cover most ESRD-related drugs that are available only in oral form.

Visit **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:

- Cancer drugs
- HIV/AIDS drugs
- Antidepressants
- Antipsychotics
- Anticonvulsants
- 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 (your doctor or other health care provider who's legally allowed to write prescriptions) 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; or
- 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/claims-appeals/how-do-i-file-an-appeal** 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 and ask your plan for a lower copayment for the drug in the higher tier.

Brand name drugs and 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
- Safety
- Strength
- Route of administration
- Quality
- Performance characteristics
- Intended use

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 is 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.

An interchangeable biosimilar may be substituted for the original biological product at the pharmacy 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?

Medicare drug 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

If you've been taking a drug and your new plan either doesn't cover it or requires prior authorization/step therapy for it, you may get a one-time 30-day supply (called a "transition fill"). Check with your plan to find out their specific coverage rules.

Prior authorization

Prior authorization is approval that you and/or your prescriber must get from a Medicare drug plan for certain drugs before your plan will cover them. Your prescriber may need to show that the drug is medically necessary 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 have other drugs on their drug list for the other medical conditions that drug is approved 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 rule that requires you to try a certain, less expensive drug on the plan's drug list that's been proven effective for most people with your condition, first, 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/medicare-prescription-drug-coverage-appeals** 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 Medicare 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/medicare-prescription-drug-coverage-appeals** to learn how to ask for an exception.

Safety reviews at the pharmacy

When you fill a prescription at the pharmacy, Medicare plans and pharmacists check to make sure the prescription is correct and that there are no interactions with other drugs you take. They also conduct safety reviews to monitor the use of opioids and other frequently abused medications. These reviews are especially important if you have more than one doctor who prescribes these drugs. In some cases, the Medicare plan or pharmacist may need to talk to your doctor first, before the prescription can be filled.

Your plan or pharmacist may do a safety review when you fill a prescription if you:

- Take potentially unsafe opioid amounts as determined by the plan or pharmacist.
- Take opioids with benzodiazepines like alprazolam (Xanax®), diazepam (Valium®), and clonazepam (Klonopin®).
- Are taking opioids for the first time—you may be limited to an initial 7-day supply or less. If you switch drug plans, your new plan may not know about your past opioid prescriptions.

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 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. Visit **Medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans** to learn how to ask for an exception.

Drug management programs

Medicare drug plans and health plans with drug coverage have drug management programs in place to help people at risk for prescription drug abuse. If you get opioid prescriptions from multiple doctors or pharmacies, or if you have a history of opioid-related overdose, your plan may talk with your doctor(s) to make sure you need these drugs and 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 the plan any other information you think is important. After you've had the opportunity to respond, if your plan decides to limit your coverage for these drugs, it will send you another letter confirming the decision.

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

Note: 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.
- Talk with your doctor about any other pain medicines (prescription and non-prescription) you're taking.
- Safely dispose of unused prescription opioids through a community drug take-back program or a pharmacy take-back program.

- Talk with your provider about:
  - Having naloxone at home. Naloxone is a drug Medicare covers that your doctor may prescribe as a safety measure to rapidly reverse the effects of an opioid overdose.
  - Your dosage and the length of time you'll be taking them. 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 for people with complex health needs

Plans with Medicare drug coverage must offer Medication Therapy Management (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.

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.

MTM services vary by plan, but may include:

- A comprehensive review of your medications and why you take them with a pharmacist or other provider.
- A written summary of your medication review from your pharmacist or provider.
- A list of recommendations to help you make the best use of your medications.

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, and other people have to apply.

Note: Extra Help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa. But there are other programs available in those areas. 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/beneficiary-resources/index.html#statemenu.

What Extra Help covers

If you get Extra Help in 2024, you'll pay:

- $0 for your Medicare drug plan premium and deductible
- Up to $4.50 for each generic drug
- Up to $11.20 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 $8,000

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

Getting Extra Help automatically

You'll get Extra Help automatically if you get:

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

You'll get a color-coded notice that tells you things like how much you'll pay, and your new Medicare drug plan (if you don't have one already).

If you meet the income and resource limits for the next year, and have a Medicare drug plan, you'll keep getting Extra Help.

We'll only mail you a notice if:

- You no longer qualify for Extra Help next year
- You get moved to a different plan for next year

If your 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. You can get the phone number for your state Medicaid office by visiting **Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu**.

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

Applying for Extra Help

Visit SSA.gov/extrahelp to apply for Extra Help.

You can also contact your local State Health Insurance Assistance Program to get free help applying. Visit shiphelp.org to get the phone number for your SHIP.

To get Extra Help, in most cases you must have income and resources below a certain limit. These limits may go up each year. Even if you don't qualify for Extra Help now, **you can reapply for Extra Help any time if your income and resources change**.

Note: You can apply for Extra Help and Medicare Savings Programs at the same time. These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate a Medicare Savings Program 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.

Income and resource limits in 2024 for all states (except Alaska and Hawaii) and D.C.

Your situation:	Income limit:	Resource limit:
Individual	$22,590	$17,220
Married couple	$30,660	$34,360

Income and resource limits in 2024 for Alaska

Your situation:	Income limit:	Resource limit:
Individual	$28,215	$17,220
Married couple	$38,310	$34,360

Income and resource limits in 2024 for Hawaii

Your situation:	Income limit:	Resource limit:
Individual	$25,965	$17,220
Married couple	$35,250	$34,360

How income and resource limits work

What counts 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 counts toward resource limits

Count:

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

Don't count:

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

Check the publication "Understanding the Extra Help with Your Medicare Prescription Drug Plan" at SSA.gov/pubs/EN-05-10508.pdf to find out which other types of income and resources count and which are excluded.

How 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) at SSA.gov/extrahelp.
- If you're married and you 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.

Let Social Security know 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 affect whether you get Extra Help. Any change will start the month after you report it to Social Security. 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. You can get the phone number for your state office by visiting **Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu**.

Note: You can apply for Extra Help and Medicare Savings Programs (MSPs) at the same time. MSPs 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 the Extra Help application. Learn more about Medicare Savings Programs at **Medicare.gov/basics/costs/help/medicare-savings-programs**.

Once you start getting Extra Help

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

You'll get a notice 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.

If Medicare enrolls you in a drug plan, we'll send you one of these notices letting you know when your coverage begins:

- A **yellow** "Auto-Enrollment Notice," if you get full Medicaid coverage
- A **green** "Facilitated Enrollment Notice," if you belong to a Medicare Savings Program or get Supplemental Security Income (SSI) benefits

Visit **Medicare.gov/basics/forms-publications-mailings/mailings/help** to learn more about letters you may get about Extra Help.

If Medicare enrolls you in a drug plan that doesn't meet your needs

When you get Extra Help, you may be able to change plans one time during each of these periods:

- January–March
- April–June
- July–September

Your new plan will begin the first day of the next month.

You can also switch drug plans during Medicare Open Enrollment (October 15–December 7), and the new plan will take effect on January 1.

If you have retiree drug coverage from a former employer or union and qualify for Extra Help

If you have employer or union coverage and you join 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 join 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").

If you get Extra Help and think you're paying the wrong amount for your drugs

Contact your drug plan. 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:

- The 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
  - Your Medicaid award letter
  - Other documents

- **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
  - A copy of a state document showing Medicaid paid for your stay for at least a month
  - A document from your state that shows you have Medicaid and are getting home- and community-based services.

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 of your medication.

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.

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

The LI NET program temporary Medicare Part D coverage to people with low income and Medicare not already in a Medicare drug plan.

This program:

- Includes all Part D-covered drugs
- Works at all pharmacies
- Will cover prescriptions you filled within the last 30 days

If you paid for prescription drugs out of pocket before you joined a Medicare drug plan, but after you qualified for both Medicare and Medicaid or SSI, you may be able to get paid back for those costs.

You may be able to get some money back if you:

- Paid for prescriptions after you started getting Extra Help
- Aren't in a Medicare drug plan

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.

If you don't qualify for Extra Help

You can still choose and join a Medicare drug plan that meets your needs. You'll have to pay the monthly premium, yearly deductible (some plans don't have a deductible), and a share of the cost of your prescription drugs.

Even if you don't qualify for Extra Help now, you can apply or reapply at any time if your income and resources change.

Your right to appeal if your application for Extra Help is denied

If your application for Extra Help is denied, you have the right to appeal the decision. If you applied for Extra Help through Social Security, they'll give you a hearing by phone unless you choose a case review. Either way, Social Security will 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 who wasn't involved in the first decision will decide your case.

To file an appeal with Social Security, fill out form SSA-1021 ("Appeal of Determination for Help with Medicare Prescription Drug Costs") by going to SSA.gov/forms/ssa-1021.pdf. You can get instructions on how to fill it out at SSA.gov/forms/ssa-1021-inst.pdf.

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

- You have 60 days to file an appeal, starting 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.

If you apply for Extra Help with your state, your decision letter should include appeal rights and procedures. Contact your State Medical Assistance (Medicaid) office for more information on your state's appeals process. You can get the phone number for your state Medicaid office by visiting Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu.

Other ways to lower your prescription drug costs

If you don't get Extra Help, you may be able to save money by:

- **Checking for state programs:** Many states offer State Pharmaceutical Assistance Programs (SPAPs) or other types of help with drug costs. Some SPAPs may require you to get Medicare drug coverage, and then they'll help with the drug costs that Medicare doesn't cover. Find out if your state has an SPAP at go.Medicare.gov/spap.
- **Checking for manufacturer programs:** Many of the major drug manufacturer's offer Pharmaceutical Assistance Programs (sometimes called Patient Assistance Programs, or PAPs) for people with Medicare drug coverage. Find out if the manufacturers of the drugs you take offer a PAP at go.Medicare.gov/pap.
- **Talking to your doctor:** Ask your doctor if you can take a generic drug, or a cheaper brand-name drug (if one is available).
- **Using a mail-order pharmacy:** Sometimes using a mail-order pharmacy is cheaper.

Section 5:

Using your Medicare drug coverage

Come to the pharmacy with as much information as possible the first time you use your new Medicare drug coverage. Bring your:

- Red, white, and blue Medicare card. Visit **Medicare.gov** to log into (or create) your secure Medicare account to print an official copy of your Medicare card.
- Photo ID (like a state driver's license or passport).
- Plan membership card.

If you don't have a plan membership card, bring:

- An acknowledgement or confirmation letter from the plan, if you have one.
- An enrollment confirmation number from the plan, if you have one.
- The name of the Medicare drug plan or health plan you joined.

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 that confirm your plan membership, and your pharmacist can't get your drug coverage information any other way, you may have to pay out of pocket for the entire cost of your drugs. **If you do pay for your drugs out of pocket, save the receipts and contact your plan. You may be able to get back some of what you spent, or have the amount credited toward your out-of-pocket costs.**

Where can I fill my prescriptions?

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.

Can I get automatic prescription refills in the mail?

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, 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 (1-800-633-4227). TTY users can call 1-877-486-2048.

What ID card should I use?

If you join a Medicare drug plan that works with Original Medicare: Use your drug plan ID card when you fill your prescriptions. You'll still use your Medicare card for hospital and doctor services.

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 need to fill a prescription before I get my plan ID membership card?

Within 2 weeks after your 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.

I have both Medicare and Medicaid, or I qualify for Extra Help

If you have both Medicare and Medicaid, or qualify for Extra Help, you should also bring proof you have Medicaid or proof that you qualify for Extra Help with you to the pharmacy. This will help make sure you pay the right amount for your prescription drugs.

- Visit **Medicare.gov/basics/forms-publications-mailings/mailings/help** to learn more about letters you get about Extra Help, or go to pages 35–36 for information about what you can use to prove you get Extra Help.
- Go to pages 35–36 for a list of documents that prove you have Medicaid.

You don't need to have all these items, but anything you can bring will help the pharmacist confirm that you qualify for Medicaid or Extra Help, so you don't pay more than you should for your drugs.

What if the pharmacist can't confirm my Medicare drug coverage or Extra Help status?

In rare cases, the pharmacist may not be able to confirm your plan enrollment or that you qualify for Medicaid or Extra Help. If this happens, your doctor may be able to give you a sample of your prescription drug to help until your coverage is confirmed. You can also pay out of pocket for your drugs, but you should save the receipt. Work with your new Medicare plan to get paid back for the drugs that your plan normally covers.

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 quantity limit) waived.

Visit **Medicare.gov/medicare-prescription-drug-coverage-appeals** 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. For more information on appeals, visit **Medicare.gov/claims-appeals/how-do-i-file-an-appeal**.

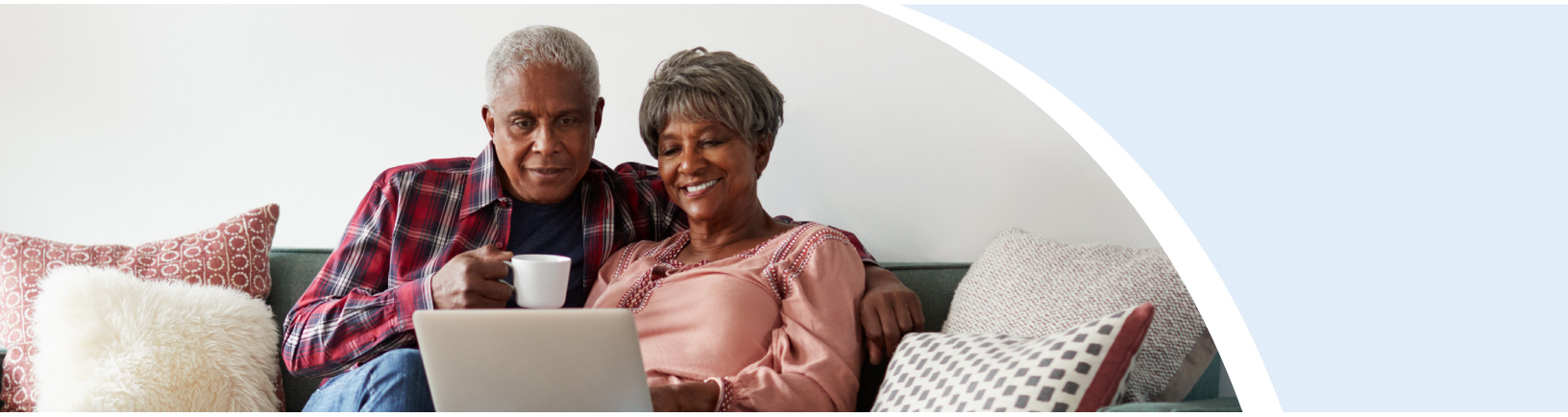
What if I join a plan, and then my doctor changes my prescription?

Your doctor can check which drugs your plan covers through their electronic prescribing system.

If your doctor needs to prescribe a drug that isn't on your Medicare plan's formulary and you don't have any other health coverage that covers outpatient prescription drugs, you or your doctor can ask the plan for an exception. Visit **Medicare.gov/medicare-prescription-drug-coverage-appeals** to learn how to ask for an exception.

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/claims-appeals/how-do-i-file-an-appeal.**

Plans can change their drug list and costs for drugs. Call your plan or look on their website to find the most up-to-date list of covered drugs and what they cost.



Section 6:

More information

- **About Medicare drug coverage:** Visit Medicare.gov/plan-compare and enter your current plan and drugs to get personalized cost information. You can also 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 your current drug coverage:** Contact your benefits administrator, insurance company, or plan.
- **About giving someone you choose access to your personal health information:** You need to let Medicare know in writing, by filling out and signing a "Medicare Authorization to Disclose Personal Health Information" form (CMS Form Number 10106). You can get the form one of these ways:
  - Visit CMS.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1193148.
  - Log into (or create) your secure Medicare account at Medicare.gov/account.
  - Call 1-800-MEDICARE.
- **About applying for Extra Help with your Medicare drug coverage costs:** Visit SSA.gov/medicare/part-d-extra-help.
- **About free personalized counseling on your coverage choices:** Contact your State Health Insurance Assistance Program (SHIP). Visit shiphelp.org or call 1-800-MEDICARE for the phone number of 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 fax:
1-844-530-3676

4. 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.

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

Attention: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-MEDICARE (TTY: 1-877-486-2048).

ةيبرعلا (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برق 1-800-MEDICARE (رقم هاتف الصم والبكم: 1-877-486-2048).

հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-MEDICARE (TTY (հեռատիպ)՝ 1-877-486-2048)

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800 MEDICARE（TTY：1 -877-486-2048）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-MEDICARE (TTY: 1-877-486-2048) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-MEDICARE (ATS: 1-877-486-2048).

Kreyòl Ayisyen (French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-MEDICARE (TTY: 1-877-486-2048).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-MEDICARE (TTY: 1- 877-486-2048).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-MEDICARE (TTY: 1-877-486- 2048).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800- MEDICARE（TTY: 1-877-486-2048）まで、お電話にてご連絡ください。

한국어(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-MEDICARE (TTY: 1-877-486-2048) 번으로 전화해 주십시오.

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-MEDICARE (TTY: 1-877-486-2048).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-MEDICARE (TTY: 1-877-486-2048).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-MEDICARE (телетайп: 1-877-486-2048).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-MEDICARE (TTY: 1-877-486-2048).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-MEDICARE (TTY: 1-877-486-2048).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-MEDICARE (TTY: 1-877-486-2048).

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Official Business
Penalty for Private Use, $300

Need a copy of this booklet in Spanish?

To get a free copy of this booklet in Spanish, visit 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

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