SECTION 6

Medicare drug coverage (Part D)

How does Medicare drug coverage work?

Medicare drug coverage (Part D) helps pay for prescription drugs you need. It's optional and offered to everyone with Medicare. Even if you don't take prescription drugs now, consider getting Medicare drug coverage. If you decide not to get it when you're first eligible, and you don't have other creditable prescription drug coverage (like drug coverage from an employer or union) or get Extra Help, **you'll likely pay a late enrollment penalty if you join a plan later.** Generally, you'll pay this penalty for as long as you have Medicare drug coverage (go to pages 83–85). To get Medicare drug coverage, you must join a Medicare-approved plan that offers drug coverage. Each plan can vary in cost and specific drugs covered. Visit Medicare.gov/plan-compare to find and compare plans in your area.

There are 2 ways to get Medicare drug coverage (Part D):

1. **Medicare drug plans.** These plans add Medicare drug coverage (Part D) to Original Medicare, some Medicare Cost Plans, some Medicare Advantage Private Fee-for-Service Plans, and Medicare Advantage Medical Savings Account (MSA) Plans. You must have Part A and/or Part B to join a separate Medicare drug plan.
2. **Medicare Advantage Plans or other Medicare health plans with drug coverage.** You get your Part A, Part B, and Medicare drug coverage (Part D) through these plans. Remember, you must have Part A and Part B to join a Medicare Advantage Plan, and not all Medicare Advantage Plans offer drug coverage.

In either case, you must live in the service area of the plan you want to join and be lawfully present in the U.S. **Medicare drug plans and Medicare health plans with drug coverage are called "Medicare drug coverage" in this handbook.**

Note: Go to pages 119–122 for definitions of blue words.

Important!

If you have employer or union coverage

Call your benefits administrator before you make any changes, or sign up for any other coverage. If you sign up for other coverage, you could lose your employer or union health and drug coverage for you and your dependents. If this happens, you may not be able to get your employer or union coverage back. If you want to know how Medicare drug coverage (Part D) works with other drug coverage you may have, go to pages 88–90.

When can I join, switch, or drop a plan?

You can join, switch, or drop a Medicare drug plan or a Medicare Advantage Plan with drug coverage during these times:

- **Initial Enrollment Period.** When you first become eligible for Medicare, you can join a plan. Go to page 17.
- **Open Enrollment Period.** From October 15 – December 7 each year, you can join, switch, or drop a plan. Your coverage will begin on January 1 (as long as the plan gets your request by December 7). Go to page 71.
- **Medicare Advantage Open Enrollment Period (only if you're already in a Medicare Advantage Plan).** From January 1 – March 31 each year, you can switch to a different Medicare Advantage Plan or switch to Original Medicare (and join a separate Medicare drug plan) once during this time. Go to page 72.

New! Starting January 1, 2024, if you have to pay for Part A, and you sign up for Part B during the General Enrollment Period (January 1 – March 31), you can also join a Medicare drug plan when you sign up for Part B. You'll have 2 months after signing up for Part B to join a drug plan. Your drug coverage will start the month after the plan gets your request to join.

Special Enrollment Periods

Generally, you must stay in your plan for the entire year. But when certain events happen in your life, like if you move or lose other insurance coverage, you may qualify for a Special Enrollment Period. You may be able make changes to your plan mid-year if you qualify. Check with your plan for more information.

New! Starting January 1, 2024, if you sign up for Part A or Part B during a Special Enrollment Period because of an exceptional condition (go to page 18), you'll have 2 months to join a Medicare Advantage Plan (with or without drug coverage) or a Medicare drug plan (Part D). Your coverage will start the first day of the month after the Medicare Advantage Plan gets your request to join.

Visit Medicare.gov, or check with your plan for more information. You can also call your State Health Insurance Assistance Program (SHIP) for help. Go to pages 115–118 for the phone number of your local SHIP.

How do I switch plans?

You can switch to a new Medicare drug plan or Medicare Advantage Plan with drug coverage simply by joining another plan during one of the times listed above. Your old drug coverage will end when your new drug coverage begins. You should get a letter from your new plan telling you when your coverage begins, so **you don't need to cancel your old plan.** You can also switch plans by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

How do I drop my plan?

If you want to drop your Medicare drug plan or **Medicare Advantage Plan** with drug coverage and don't want to join a new plan, you can only do so during certain times (go to page 80). You can disenroll by calling 1-800-MEDICARE. You can also send a letter to the plan to tell them you want to disenroll. If you drop your plan and want to join another Medicare drug plan or **Medicare health plan** with drug coverage later, you have to wait for an enrollment period. You may also have to pay a late enrollment penalty if you don't have **creditable prescription drug coverage**. Go to pages 83–85.

Read the information you get from your plan

Review the "Evidence of Coverage" and "Annual Notice of Change" your plan sends you each year. The Evidence of Coverage gives you details about what the plan covers, how much you pay, and more. The Annual Notice of Change includes any changes in coverage, costs, provider networks, **service area**, and more that will be effective in January. If you don't get these important documents in early fall, contact your plan.

How much do I pay?

Your drug costs will vary based on the plan you choose. Remember, plan coverage and costs can change each year. You may have to pay a **premium**, **deductible**, **copayments**, or **coinsurance** throughout the year. Learn more about these costs on the next page.

Your actual drug coverage costs will vary depending on:

- Your prescriptions and whether they're on your plan's list of covered drugs (**formulary**). Go to page 85.
- What "tier" a drug is in. Go to page 85.
- Which drug benefit phase you're in (like whether you've met your deductible, or if you're in the catastrophic coverage phase). Go to page 83.
- Which pharmacy you use (whether it offers preferred or standard cost sharing, is out of network, or is mail order). Your out-of-pocket drug costs may be less at a preferred pharmacy because it has agreed with your plan to charge less.
- Whether you get **Extra Help** paying your Medicare drug costs. Go to page 92.

Cost & coverage: Some ways you may be able to lower the cost of your drugs include choosing generics over brand name or paying the non-insurance cost of a drug. Ask your pharmacist—they can tell you if there's a less expensive option available. Check with your doctor to make sure the generic option is best for you.

Monthly premium

Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B **premium**. If you're in a **Medicare Advantage Plan** or a Medicare Cost Plan with drug coverage, the monthly premium may include an amount for drug coverage.

Note: Contact your plan (not Social Security or the Railroad Retirement Board (RRB)) if you want your drug premium deducted from your monthly Social Security or RRB payment. If you want to stop premium deductions and get billed directly, contact your plan.

Important!

If you have a higher income, you might pay more for your Medicare drug coverage (Part D). If your income is above a certain limit (in 2023: $97,000 if you file individually or $194,000 if you're married and file jointly), you'll pay an extra amount in addition to your plan premium (sometimes called "Part D IRMAA"). You'll also have to pay this extra amount if you're in a Medicare Advantage Plan that includes drug coverage. This doesn't affect everyone, so most people won't have to pay an extra amount.

Visit **Medicare.gov** later this fall for 2024 limits.

Usually, the extra amount will be deducted from your Social Security or RRB payment. If Medicare or the RRB bills you for the extra amount instead of deducting it from your Social Security or RRB payment, then you must pay the extra amount to Medicare or the RRB, not your plan. If you don't pay the extra amount, you could lose your Medicare drug coverage (Part D). You may not be able to join another plan right away, and you may have to pay a late enrollment penalty for as long as you have drug coverage.

You'll pay Part D IRMAA payments separately, even if your employer or another third party (like a retirement system) pays your plan premiums.

If you have to pay an extra amount and you disagree (for example, you have one or more life-changing events that lower your income), visit **SSA.gov** or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Yearly deductible

This is the amount you must pay before your plan begins to pay its share of your covered drugs. Some plans don't have a **deductible**. In some plans that do have a deductible, drugs on some tiers are covered before the deductible.

Copayments or coinsurance

These are the amounts you pay for your covered drugs after the **deductible** (if the plan has one). You pay your share and your plan pays its share for covered drugs. If you pay **coinsurance**, these amounts may vary because drug plans and manufacturers can change what they charge at any time throughout the year. The amount you pay will also depend on the tier level assigned to your drug. Go to page 85.

In 2023, once you and your plan spend $4,660 ($5,030 in 2024) combined on drugs (including deductible), you'll generally pay no more than 25% of the cost for prescription drugs until your out-of-pocket spending is $7,400 ($8,000 in 2024).

Catastrophic coverage

In 2023, once your out-of-pocket spending reaches $7,400, you'll automatically get "catastrophic coverage." Generally, this means you'll only pay a small coinsurance percentage (no more than 5%) or **copayment** for your covered Part D drugs for the rest of the calendar year.

New! Starting January 1, 2024, once your out-of-pocket spending reaches $8,000, (including certain payments made by other people or entities, including Medicare's Extra Help program, on your behalf), you won't have to pay a copayment or coinsurance for covered Part D drugs for the rest of the calendar year.

Note: If you get **Extra Help**, you won't have some of these costs. Go to pages 92–94.

Important! Visit **Medicare.gov/plan-compare** to get specific Medicare drug plan and **Medicare Advantage Plan** costs, and call the plans you're interested in to get more details. For help comparing plan costs, call your State Health Insurance Assistance Program (SHIP). Go to pages 115–118 for the phone number of your local SHIP. A trusted agent or broker may also be able to help.

What's the Medicare drug coverage (Part D) late enrollment penalty?

The late enrollment penalty is an amount that's permanently added to your Medicare drug coverage (Part D) **premium**. You may have to pay a late enrollment penalty if you enroll at any time after your Initial Enrollment Period is over and 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**. 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 late enrollment penalty.

There are 3 ways to avoid paying a penalty:

1. **Get Medicare drug coverage (Part D) when you're first eligible for it.** Even if you don't take drugs now, you should consider joining a separate Medicare drug plan or a Medicare Advantage Plan with drug coverage to avoid a penalty. You may be able to find a plan that meets your needs with little to no monthly premiums. Go to pages 10–14 to learn more about your choices.
2. **Add Medicare drug coverage (Part D) if you lose other creditable coverage.** Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, the Department of Veterans Affairs, or individual health insurance coverage. Your plan must tell you each year if your non-Medicare drug coverage is creditable coverage. If you go 63 days or more in a row without Medicare drug coverage or other creditable prescription drug coverage, you may have to pay a penalty if you sign up for Medicare drug coverage later.
3. **Keep records showing when you had other creditable prescription drug coverage, and tell your plan when they ask about it.** If you don't tell your plan about your previous creditable prescription drug coverage, you may have to pay a penalty for as long as you have Medicare drug coverage.

How much more will I pay for a late enrollment penalty?
The cost of the late enrollment penalty depends on how long you didn't have creditable prescription drug coverage. Currently, the late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" ($32.74 in 2023) by the number of full, uncovered months that you were eligible but didn't have Medicare drug coverage (Part D) and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $.10 and added to your monthly premium. The "national base beneficiary premium" may increase or decrease each year. If that occurs, the penalty amount may also increase or decrease. After you get Medicare drug coverage, the plan will tell you if you owe a penalty and what your premium will be.

Example:
Mrs. Martinez is currently eligible for Medicare, and her Initial Enrollment Period ended on May 31, 2019. She doesn't have prescription drug coverage from any other source. She didn't join by May 31, 2019, and instead joined during the Open Enrollment Period that ended December 7, 2021. Her drug coverage was effective January 1, 2022.

2022
Since Mrs. Martinez was without creditable prescription drug coverage from June 2019–December 2021, her penalty in 2022 was 31% (1% for each of the 31 months) of $33.37 (the national base beneficiary premium for 2022) or $10.34. Since the monthly penalty is always rounded to the nearest $0.10, she paid $10.30 each month in addition to her plan's monthly premium.

Here's the math:
.31 (31% penalty) × **$33.37** (2022 base beneficiary premium) = **$10.34**

$10.34 rounded to the nearest $0.10 = **$10.30**

$10.30 = Mrs. Martinez's monthly late enrollment penalty for 2022

2023
In 2023, Medicare recalculated Mrs. Martinez's penalty using the 2023 base beneficiary premium ($32.74). So, Mrs. Martinez's new monthly penalty in 2023 is 31% of $32.74, or $10.14 each month. Since the monthly penalty is always rounded to the nearest $0.10, she pays $10.10 each month in addition to her plan's monthly premium.

Here's the math:
.31 (31% penalty) × **$32.74** (2023 base beneficiary premium) = **$10.14**

$10.14 rounded to the nearest $0.10 = **$10.10**

$10.10 = Mrs. Martinez's monthly late enrollment penalty for 2023

What if I don't agree with the late enrollment penalty?
Your Medicare drug plan or Medicare Advantage Plan with drug coverage will send you a letter stating you have to pay a late enrollment penalty. If you disagree with your penalty, you can request a review (generally within 60 days from the date on the letter). Fill out the "reconsideration request form" you get with your letter by the date listed in the letter. You can provide proof that supports your case, like information about previous creditable prescription drug coverage. If you need help, call your plan.

Which drugs are covered?

All plans must cover a wide range of prescription drugs that people with Medicare take, including most drugs in certain "protected classes," like drugs to treat cancer or HIV/AIDS. Information about a plan's list of covered drugs (called a "formulary") isn't included in this handbook because each plan has its own formulary. A plan can make some changes to its drug list during the year if it follows guidelines set by Medicare. For example, your plan may change its drug list during the year because drug therapies change, new drugs are released, or new medical information becomes available. Your plan coinsurance may increase for a particular brand name drug or generic drug when the manufacturer raises the price. Your copayment or coinsurance may increase when a plan starts to offer a generic form of a brand name drug, but you continue to take the brand name drug. In some cases, the plan may cover a drug for one health condition but not another.

Note: Medicare Part B covers a limited number of outpatient prescription drugs. Go to page 39 for more information.

Your Medicare drug coverage (Part D) typically places drugs into different levels called "tiers" on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier.

What happens if my drug is in a higher tier?

In some cases, if your drug is in a higher tier and your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) thinks you need that drug instead of a similar drug in a lower tier, you or your prescriber can ask your plan for an exception to get a lower coinsurance or copayment for the drug in the higher tier. Go to page 100 for more information on exceptions.

Plans can change their formularies at any time. Your plan may notify you of any formulary changes that affect drugs you're taking.

Contact your plan for its current formulary, or visit the plan's website. You can also visit Medicare.gov/plan-compare or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Important! Each month you fill a prescription, your plan sends you an "Explanation of Benefits" notice. Review your notice and check it for mistakes. Contact your plan if you have questions or find mistakes. If you suspect fraud, call the Medicare Drug Integrity Contractor at 1-877-7SAFERX (1-877-772-3379). Go to page 106.

Plans may have coverage rules for certain drugs

- **Prior authorization:** You and/or your prescriber must contact your plan before you can fill certain prescriptions. 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 cover a drug for only certain medical conditions it's approved for, but not others. When this occurs, plans will likely have alternative drugs on their list of covered drugs (formulary) for the other medical conditions the drug is approved to treat.
- **Quantity limits:** Limits on how much medicine you can get at a time.
- **Step therapy:** You may need to try one or more similar, lower-cost drugs before the plan will cover the prescribed drug.
- **Medication safety checks at the pharmacy:** Before the pharmacy fills your prescriptions, your plan and pharmacy perform additional safety checks, like checking for drug interactions and incorrect dosages.

  These safety checks also include checking for possible unsafe amounts of opioid pain medications, limiting the day's supply of a first prescription for opioids, and use of opioids at the same time as benzodiazepines (commonly used for anxiety and sleep). Opioid pain medicine (like oxycodone and hydrocodone) can help with certain types of pain, but have risks and side effects (like addiction, overdose, and death). These can increase when you take opioids with certain other drugs, like benzodiazepines, anti-seizure medications, gabapentin, muscle relaxers, certain antidepressants, and drugs for sleeping problems. Check with your doctor or pharmacist if you have questions about risks or side effects.
- **Drug Management Programs:** Medicare drug coverage (Part D) has programs in place to help you use these opioids and benzodiazepines safely. If your opioid use could be unsafe (for example, due to getting opioid prescriptions from multiple doctors or pharmacies, or if you had a recent overdose from opioids), your plan will contact the doctors who prescribed them for you to make sure they're medically necessary and you're using them appropriately.

If your plan decides your use of prescription opioids and benzodiazepines may not be safe, the plan will send you a letter in advance. This letter will tell you if the plan will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from one doctor or pharmacy you select. You and your doctor have the right to appeal these limitations if you disagree with the plan's decision (go to page 99). The letter will also tell you how to contact the plan if you have questions or would like to appeal.

The opioid safety reviews at the pharmacy and Drug Management Programs generally don'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.

If you or your prescriber believe that your plan should waive one of these coverage rules, you can ask for an exception. Go to page 100.

Important tips if you're prescribed opioids:

- Opioid medications can be an important part of pain management, but they also can have serious health risks if misused.
- Medicare covers naloxone, a drug that your doctor may prescribe as a safety measure in case you need to rapidly reverse the effects of an opioid overdose. Talk with your doctor about having naloxone at home.
- Talk with your doctor about your dosage and the length of time you'll be taking opioids. You and your doctor may decide later you don't need to take all of your prescription.
- Talk with your doctor about 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.
- Never take more opioids than prescribed. Also, talk with your doctor about any other pain medicines you're taking.
- Safely store and discard unused prescription opioids through your community drug take-back program or your pharmacy mail-back program.

For more information on safe and effective pain management and opioid use, visit **Medicare.gov/coverage/pain-management** or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Can I get automatic prescription refills in the mail?

Some people with Medicare get their drugs through an "automatic refill" service that automatically delivers prescription drugs before they run out. To make sure you still need a prescription before they send you a refill, drug plans may offer a voluntary auto-ship program. Contact your plan for more information.

Note: Medicare drug coverage (Part D) includes drugs, like buprenorphine, to treat opioid use disorders. It also covers drugs, like methadone, when prescribed for pain.

Medication Therapy Management program

Plans with Medicare drug coverage (Part D) must offer Medication Therapy Management services to help members if they 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. Medication Therapy Management services usually include a discussion with a pharmacist or health care provider to review your medications. These services may vary by plan. Contact your plan for specific details and to find out if you're eligible.

Part D coverage for insulin

Part D covers injectable insulin used with either a disposable or non-traditional insulin pump. It also covers certain medical supplies used to inject insulin, like syringes, gauze, and alcohol swabs. Covered insulin products are included on your plan's **formulary**.

Important! Plans can't charge you more than $35 for a one-month supply of each Part D-covered insulin you take, and you don't have to pay a **deductible** for insulin. This applies to everyone who takes insulin, even if you get **Extra Help**.

Similar caps on costs apply for traditional insulin used in insulin pumps (covered under Part B). Visit **Medicare.gov/coverage/insulin** to learn more.

How do other insurance and programs work with Medicare drug coverage (Part D)?

Medicaid

If you have Medicare and full **Medicaid** coverage, Medicare covers your prescription drugs. However, Medicaid may still cover some drugs that Medicare doesn't cover.

Note: You automatically qualify for Extra Help if you have Medicare and Medicaid. Go to page 92.

Employer or union coverage

This is health coverage from your, your spouse's, or other family member's current or former employer or union. When you have employer or union coverage or other health insurance (like a retiree health plan) and Medicare, there are rules for whether Medicare or your other coverage pays first. Go to page 21 for more information. If you have drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your drug coverage is creditable. **Keep the information you get.** Call your benefits administrator for more information before making any changes to your coverage.

Important! If you get Medicare drug coverage, you, your spouse, or your dependents may lose your employer or union health coverage.

COBRA

This federal law may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. There may be reasons why you should take Part B instead of, or in addition to, COBRA coverage (go to page 18). However, if you take COBRA and you're eligible for Medicare, **COBRA may only pay a small portion of your medical costs**, and you may have to pay most of the costs yourself. Contact your COBRA plan and ask what percent they pay. To avoid unexpected medical bills, you may need to sign up for Medicare right away. Talk with your State Health Insurance Assistance Program (SHIP) for free, personalized help with this decision. Go to pages 115–118 for the phone number of your local SHIP.

If you have COBRA that includes **creditable prescription drug coverage**, you'll have a Special Enrollment Period to get Medicare drug coverage (Part D) without paying a penalty when the COBRA coverage ends. If you have questions about Medicare and COBRA, call the Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users can call 1-855-797-2627. A trusted agent or broker may also be able to help.

Medicare Supplement Insurance (Medigap) with drug coverage

Medigap policies can no longer be sold with drug coverage, but if you have an older Medigap policy that was sold with drug coverage, you can keep it. You may choose to join a separate Medicare drug plan because most Medigap drug coverage isn't creditable, and you may pay more if you join a drug plan later. Go to page 83.

You can't have drug coverage in both Medigap and your Medicare drug plan. If you decide to join a separate Medicare drug plan, tell your Medigap insurance company so they can remove the drug coverage and adjust your **premiums**. Call your Medigap insurance company for more information.

How does other government insurance work with Medicare drug coverage (Part D)?

The types of insurance listed below are all considered creditable prescription drug coverage. In most cases, it's to your advantage to keep this coverage if you have it.

Federal Employee Health Benefits Program (FEHB)

This is health coverage for current and retired federal employees and covered family members. These plans usually include creditable prescription drug coverage, so you don't need to get Medicare drug coverage (Part D). However, if you decide to get Medicare drug coverage, you can keep your FEHB plan, and in most cases, Medicare will pay first. For more information, visit **opm.gov/healthcare-insurance/healthcare**, or call the Office of Personnel Management at 1-888-767-6738. TTY users can call 711. If you're an active federal employee, contact your Benefits Officer. Visit **apps.opm.gov/abo** for a list of Benefits Officers. You can also call your plan if you have questions.

Veterans' benefits

This is health coverage for veterans and people who have served in the U.S. military. You may be able to get drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a separate Medicare drug plan, but if you do, you can't use both types of coverage for the same drug at the same time. For more information, visit **va.gov** or call the VA at 1-800-827-1000. TTY users can call 711.

CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs)

This is a comprehensive health care program in which the Department of Veterans Affairs (VA) shares the cost of covered health care services and supplies with eligible people with Medicare. You may join a separate Medicare drug plan, but if you do, you won't be able to use the Meds by Mail program which can provide your maintenance drugs at no charge (no **premiums**, **deductibles**, and **copayments**). For more information, visit **va.gov/communitycare/programs/dependents/champva** or call CHAMPVA at 1-800-733-8387.

TRICARE (military health benefits)

This is a health care program for active-duty service members, military retirees, and their families. **Most people with TRICARE who are entitled to Part A must also have Part B to keep their TRICARE drug benefits.** If you have TRICARE, you don't need to join a separate Medicare drug plan. However, if you do, your Medicare drug plan pays first, and TRICARE pays second.

If you join a **Medicare Advantage Plan** with drug coverage, your Medicare Advantage Plan and TRICARE may coordinate benefits if your Medicare Advantage Plan network pharmacy is also a TRICARE network pharmacy. Otherwise, you can file your own claim to get paid back for your out-of-pocket costs. For more information, visit **tricare.mil**, or call the TRICARE Pharmacy Program at 1-877-363-1303. TTY users can call 1-877-540-6261.

Indian Health Service (IHS)

The IHS is the primary health care provider to the American Indian/Alaska Native Medicare population. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers several clinical and preventive health services through a network of hospitals, clinics, and other entities. Many Indian health facilities participate in Medicare drug coverage (Part D). If you get prescription drugs through an Indian health facility, you'll continue to get them at no cost to you, and your coverage won't be interrupted. Joining a Medicare drug plan or Medicare Advantage Plan with drug coverage may help your Indian health facility because the plan pays the Indian health facility for the cost of your prescription drugs. Talk to your local Indian health benefits coordinator who can help you choose a plan that meets your needs and tell you how Medicare works with the Indian health care system.

Go to pages 10–14 for an overview of your Medicare options.