NABIP
Shaping the *future* of healthcare

OUT-OF-POCKET COSTS OF MEDICARE

PART D IN 2026

DEDUCTIBLE STAGE

You are responsible for **100%** of your prescription drug costs until your deductible is met. Your plan may have an annual deductible of no more than **$615**. Some plans carry a zero-dollar deductible. In some plans, the deductible may not apply to certain low-cost or generic drugs.

INITIAL COVERAGE

You pay up to 25% of coinsurance for medication covered in your plan's formulary or list of covered medications. Your maximum out-of-pocket cost will be **$2,100**.

CATASTROPHIC COVERAGE

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

PLAN YEAR RESTARTS

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

For more information, contact:
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TIER LEVELS CLASSIFICATIONS

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

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

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

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

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

Tier 6 — Select Care Drugs
This tier covers common, low-cost generics for conditions like diabetes and high blood pressure. These medications often have very low or even $0 copays, making them an affordable option for long-term health needs.

PLAN COVERAGE RULES

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

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

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

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

COVERAGE COST METHODS

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

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

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

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

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