



CARDINAL ADVISORS

2025 Medicare And You Handbook

In the video entitled “2025 Medicare And You Handbook” Hans and Tom address Medicare and its components.

2025 MEDICARE AND YOU HANDBOOK

S.S.

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MED.

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LTC

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401K/
IRA

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9-12 PART A HOSPITAL, PART B MEDICAL
PART C ADVANTAGE, PART D DRUGS

15-24 SIGNING UP FOR MEDICARE @ 65,
LATER GROUP PLAN PENALTIES EMPLOYMENT,
NO COBRA, NO HSA, PART B = 185 + IRMAA

55-56 NOT COVERED - EYE EXAMS, LONG-TERM
CARE, COSMETIC SURGERY, MASSAGE, PHYSICAL
EXAM, HEARING AIDS, CONCIERGE CARE,
MOST DENTAL CARE

57-60 ORIGINAL MEDICARE

- ANY DOCTOR / HOSPITAL TAKING MEDICARE
- NO PRIMARY DOCTOR, NO NETWORK,
NO REFERRALS
- NO YEARLY LIMIT OUT OF POCKET

75-78 MEDICARE SUPPLEMENT (MEDIGAP)

- PAYS CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES
- STANDARDIZED A-D, E.G. K-N
EXCEPT MN, MASS, WI
- COMPARISON CHART
- COSTS VARY FOR EXACTLY SAME
- 6 MONTH OPEN ENROLLMENT
- CANT HAVE MEDIGAP + ADVANTAGE

79-83 MEDICARE DRUG COVERAGE (PART D)
PENALTIES - LATE SIGN-UP
GAP IN COVERAGE
DEDUCTIBLE + CO-PAYMENTS
MAX OOP \$2000⁰⁰

23-24.82 - IRMAA

- EXTRA PART B + D PREMIUM
- \$106.000 + SINGLE \$212.000 + JOINT
- AS MUCH AS 6,236.40 EXTRA

INCOME

☐

ESTATE

☐

TAXES

☐

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July 2025



Medicare & You 2025

The official U.S. government
Medicare handbook



Medicare

What are the parts of Medicare?



Part A – Hospital Insurance

Helps cover:

- Inpatient care in hospitals
- **Skilled nursing facility care**
- Hospice care
- Home health care

Go to pages 25–29.



Part B – Medical Insurance

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many **preventive services** (like screenings, shots or vaccines, and yearly “Wellness” visits)

Go to pages 29–55.



Part D – Drug Coverage

Helps cover the cost of prescription drugs (including many recommended shots or vaccines).

Plans that offer Medicare drug coverage (Part D) are run by private insurance companies that follow rules set by Medicare.

Go to pages 79–90.

Your Medicare options

When you first sign up for Medicare, and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

Original Medicare

- **Original Medicare** includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).
- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- You can also use or shop for and buy supplemental coverage that helps pay your out-of-pocket costs (like your 20% **coinsurance**).

☒ **Part A**



☒ **Part B**



You can add:

☐ **Part D**



You can also add:

☐ **Supplemental coverage**



It can help pay some costs that other parts don't cover. This includes Medicare Supplement Insurance (**Medigap**). Go to page 75 to learn more about Medigap. Or you can use coverage from a current or former employer or union, or **Medicaid** (if you have it).

Go to page 57 to learn more about Original Medicare.

Medicare Advantage (also known as Part C)

- Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These plans bundle your Part A, Part B, and usually Part D together.
- In many cases, you can only use doctors who are in the plan's network.
- In many cases, you may need to get approval from your plan before it covers certain drugs or services.
- Plans often have different out-of-pocket costs than Original Medicare or supplemental coverage like Medigap. You may also have an additional **premium**.
- Plans may offer some extra benefits that Original Medicare doesn't.

☒ **Part A**



☒ **Part B**



Most plans include:

☒ **Part D**



☒ **Some extra benefits**

Go to page 61 to learn more about Medicare Advantage.

At a glance: Original Medicare vs. Medicare Advantage Plan



Doctor & hospital choice

Original Medicare	Medicare Advantage (Part C)
You can use any doctor or hospital that takes Medicare, anywhere in the U.S.	In many cases, you can only use doctors and other providers who are in the plan's network and service area (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost.
In most cases, you don't need a referral to use a specialist.	You may need to get a referral to use a specialist.



Cost

Original Medicare	Medicare Advantage (Part C)
For Part B-covered services, you usually pay 20% of the Medicare-approved amount after you meet your deductible . This amount is called your coinsurance .	Out-of-pocket costs vary. Plans may have different out-of-pocket costs for certain services.
You pay the monthly premium for Part B . If you choose to join a Medicare drug plan, you'll pay a separate premium for your Medicare drug coverage (Part D).	You pay the monthly Part B premium and may also have to pay the plan's premium . Some plans may have a \$0 premium and may help pay all or part of your Part B premium. Most plans include Medicare drug coverage (Part D).
There's no yearly limit on what you pay out of pocket, unless you have supplemental coverage—like Medicare Supplement Insurance (Medigap), Medicaid , employer, retiree, or union coverage.	Plans have a yearly limit on what you pay for covered Part A and Part B services (with different limits for in-network and out-of-network services). Once you reach your plan's limit, you'll pay nothing for covered services for the rest of the year.
You can choose to buy Medigap to help pay your out-of-pocket costs that Medicare doesn't cover (like your 20% coinsurance). Go to page 77. Or, you can use coverage from a current or former employer or union, or Medicaid.	You can't buy Medigap to cover your out-of-pocket costs.



Coverage

Original Medicare	Medicare Advantage (Part C)
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some services, like routine physical exams, eye exams, and most dental care. Go to page 55.	Plans must cover all medically necessary services that Original Medicare covers. For some services, plans may use their own coverage criteria to determine medical necessity. Plans may also offer some extra benefits that Original Medicare doesn't cover .
In most cases, you don't need approval (prior authorization) for Original Medicare to cover your services or supplies.	In many cases, you may need to get approval (prior authorization) from your plan before it covers certain services or supplies.
You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).	Medicare drug coverage (Part D) is included with most plans. In most types of Medicare Advantage Plans , you can't join a separate Medicare drug plan.



Foreign travel

Original Medicare	Medicare Advantage (Part C)
Original Medicare generally doesn't cover medical care outside the U.S. You may be able to buy a Medicare Supplement Insurance (Medigap) policy that covers emergency care outside the U.S.	Plans generally don't cover medical care outside the U.S. Some plans may offer an extra benefit that covers emergency and urgently needed services when traveling outside the U.S.

Section 1:

Signing up for Medicare

Will I get Part A and Part B automatically?

If you're already getting benefits from Social Security or the Railroad Retirement Board (RRB), you'll automatically get Part A and Part B starting the first day of the month you turn 65. If your birthday is on the first day of the month, Part A and Part B starts the first day of the prior month.

If you're under 65 and have a disability, you'll get Part A and Part B automatically after getting 24 months of disability benefits, either from Social Security or certain disability benefits from the RRB.

If you live in Puerto Rico, you don't get Part B automatically. You must sign up for it. Go to page 16.

If you have ALS (amyotrophic lateral sclerosis, also called Lou Gehrig's disease), you'll get Part A and Part B automatically the month your Social Security disability benefits begin.

If you get Medicare automatically, you'll get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday or 25th month of disability benefits, and you don't need to pay a **premium** for Part A (sometimes called "premium-free Part A"). Most people choose to keep Part B. If you don't want Part B, let us know before the coverage start date on your Medicare card. If you do nothing, you'll keep Part B and pay Part B premiums through your Social Security or RRB benefits. If you have other coverage and need help deciding if you should keep Part B, go to page 19.

If you choose not to keep Part B but decide you want it later, you may have a delay in getting Medicare Part B coverage because you can only sign up at certain times. You may also have to pay a late enrollment penalty for as long as you have Part B. Go to page 23.

Will I have to sign up for Part A and/or Part B?

If you're close to 65, but NOT getting Social Security or RRB benefits, you'll need to sign up for Medicare. Visit [SSA.gov/medicare](https://ssa.gov/medicare) to apply for Part A and Part B. You can also contact Social Security 3 months before you turn 65 to set up an appointment. If you worked for a railroad, visit [RRB.gov](https://rrb.gov), or call the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

In most cases, if you don't sign up for Part B when you're first eligible, you may have a delay in getting Medicare Part B coverage in the future because you can only sign up at certain times. **You may also have to pay a late enrollment penalty for as long as you have Part B.** Go to page 23.

If you have End-Stage Renal Disease (ESRD) and want Medicare, you'll need to sign up for it. Contact Social Security to find out when and how to sign up for Part A and Part B. For more information, visit [Medicare.gov/publications](https://www.medicare.gov/publications) to review the booklet, "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

Important! If you live in Puerto Rico and get benefits from Social Security or the Railroad Retirement Board (RRB), you'll get Part A automatically starting on the first day of the month you turn 65 or after you get disability benefits for 24 months. However, if you want Part B, you'll need to sign up for it by completing an "Application for Enrollment in Part B Form" (CMS-40B). To get this form in English and Spanish, visit [Medicare.gov/basics/forms-publications-mailings/forms/enrollment](https://www.medicare.gov/basics/forms-publications-mailings/forms/enrollment), or call 1-800-MEDICARE (1-800-633-4227) to have a copy mailed to you. TTY users can call 1-877-486-2048. If you don't sign up for Part B when you're first eligible, you may have a delay in getting Part B coverage in the future because you can only sign up at certain times. **You may also have to pay a late enrollment penalty for as long as you have Part B.** Go to page 23.

Where can I get more information?

Visit [SSA.gov/medicare/sign-up](https://www.ssa.gov/medicare/sign-up) for more information about your Medicare eligibility and to sign up for Part A and/or Part B if you don't get them automatically. If you worked for a railroad or get RRB benefits, visit [RRB.gov](https://www.rrb.gov) or call the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

You can also get free, personalized, and unbiased health insurance counseling from your State Health Insurance Assistance Program (SHIP). Go to pages 114–117 for the phone number of your local SHIP, or visit [shiphelp.org](https://www.shiphelp.org).

After you've signed up for Medicare Part A and/or Part B, it's time to look at your coverage options. People get Medicare coverage in different ways. To get the most out of your coverage, review all of your options and decide what best meets your needs. Go to pages 11–13 for more details.

If I didn't get Part A and Part B automatically, when can I sign up?

If you didn't get **premium-free Part A** automatically (for example, because you're still working and not yet getting Social Security or RRB benefits), you can sign up for it any time after you're first eligible for Medicare. Go to page 22.

In this example, your Part A coverage will go back (retroactively) 6 months from when you signed up for Part A or applied for Social Security or RRB benefits, but no earlier than the first month you're eligible for Medicare. Depending on how you become eligible for Part A, the retroactive period may be different.

You can only sign up for Part B during the enrollment periods shown on pages 17–18.

Important! Remember, in most cases, if you don't sign up for Part A (if you have to buy it) and Part B when you're first eligible, your enrollment may be delayed and you may have to pay a late enrollment penalty. Go to pages 22-23.

What are the Part A and Part B enrollment periods?

You can only sign up for Part B (and/or Part A if you have to buy it) during these enrollment periods.

Initial Enrollment Period

Generally, you can first sign up for Part A and/or Part B during the 7-month period that begins 3 months before the month you turn 65 and ends 3 months after the month you turn 65. If your birthday is on the first of the month, your 7-month period starts 4 months before the month you turn 65 and ends 2 months after the month you turn 65.

Example: If you turn 65 on June 2, your 7-month period would begin in March and end in September. If you turn 65 on June 1, your 7-month period would begin in February and end in August.

If you sign up for Part A and/or Part B during the first 3 months of your Initial Enrollment Period, in most cases, your coverage begins the first day of your birthday month. However, if your birthday is on the first day of the month, your coverage starts the first day of the prior month.

If you sign up the month you turn 65 or during the last 3 months of your Initial Enrollment Period, your coverage starts the first day of the month after you sign up.

Special Enrollment Period

After your Initial Enrollment Period is over, you may have a chance to sign up for Medicare during a Special Enrollment Period. For example, if you didn't sign up for Part B (or Part A if you have to buy it) when you were first eligible **because you have group health plan coverage based on current employment** (your own, a spouse's, or a family member's if you have a disability), you can sign up for Part A and/or Part B:

- Any time you're still covered by the group health plan
- During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first

Your coverage generally starts the first day of the month after you sign up. If you sign up for Part B while you're still working, or within the first full month after losing employer coverage, you can request to delay your Part B start date up to 3 months. Usually, you won't have to pay a late enrollment penalty if you sign up during a Special Enrollment Period. This Special Enrollment Period doesn't apply if you're eligible for Medicare based on End-Stage Renal Disease (ESRD), or you're still in your Initial Enrollment Period.

To sign up for Part A and/or B, visit [SSA.gov/medicare/sign-up](https://ssa.gov/medicare/sign-up).

Important! COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage isn't considered coverage based on current employment and doesn't count as employer coverage for a Special Enrollment Period.

The same is true for retiree health plans, VA coverage, and individual health insurance coverage (like coverage through the Health Insurance Marketplace®). If you're considering COBRA, there may be reasons why you should take Part B instead of, or in addition to, COBRA coverage. You have 8 months after your coverage based on **current employment** ends to sign up for Part B without a penalty, whether or not you choose COBRA. However, if you have COBRA and you're eligible for Medicare, **COBRA may only pay a small portion of your medical costs**. You generally aren't eligible for a Special Enrollment Period to sign up for Medicare when that COBRA coverage ends. Go to page 89 for more information about COBRA coverage. To avoid paying a penalty, make sure you sign up for Medicare when you're first eligible. If you have retiree coverage, it **may not** pay for your health services if you don't have both Part A and Part B.

Exceptional situations for a Special Enrollment Period

There are other circumstances where you may be able to sign up for Medicare during a Special Enrollment Period. You may be eligible if you miss an enrollment period because of certain exceptional circumstances, like being impacted by a natural disaster or an emergency, incarceration, employer or health plan error, losing **Medicaid** coverage, or other circumstances outside of your control that Medicare determines to be exceptional. For more information, visit [Medicare.gov](https://www.medicare.gov) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Important! If you recently lost Medicaid and you now qualify for Medicare, but didn't sign up for Medicare when you first became eligible, you may be able to sign up for Part A and Part B without paying a late enrollment penalty. If you already have Medicare but lost Medicaid, you also have coverage options. For more information, check out the "Losing Medicaid?" fact sheet at [Medicare.gov/media/document/12177-2023-02-508.pdf](https://www.medicare.gov/media/document/12177-2023-02-508.pdf).

General Enrollment Period

You can sign up for Part B during the General Enrollment Period (January 1–March 31 each year) if you missed your Initial Enrollment Period and don't qualify for a Special Enrollment Period. You can also buy Part A during this time if you don't qualify for premium-free Part A and missed your Initial Enrollment Period. **You may have to pay a higher Part A and/or Part B premium for late enrollment.** Go to pages 22–23.

When you sign up during the General Enrollment Period, your coverage starts the first day of the month after you sign up.

Not sure if you qualify for an enrollment period? Visit [Medicare.gov](https://www.medicare.gov), or call 1-800-MEDICARE.

I have other health coverage. Should I get Part B?

This information can help you decide if you should get Part B based on the type of health coverage you may have.

Employer or union coverage

If you or your spouse (or family member if you have a disability) **are still working** and you have health coverage through that employer or union, go to page 21 to find out how your coverage works with Medicare. You can also contact the employer or union benefits administrator for information. This includes federal or state employment and active-duty military service. **It might be to your advantage to delay Part B enrollment while you still have health coverage based on your or your spouse's current employment.**

Coverage based on current employment doesn't include:

- COBRA (or similar continuation coverage after employment ends)
- Retiree coverage
- VA coverage
- Individual health insurance coverage (like through the Health Insurance Marketplace®)
- Former employer coverage you get through severance or a layoff

TRICARE

If you have TRICARE (health care program for active-duty and retired service members and their families), **you generally must sign up for Part A and Part B when you're first eligible to keep your TRICARE coverage.** However, if you're an active-duty service member or an active-duty family member, you don't have to sign up for Part B to keep your TRICARE coverage. For more information, contact your TRICARE contractor. Go to page 90.

If you have CHAMPVA coverage, you must sign up for Part A and Part B to keep it. Call 1-800-733-8387 for more information about CHAMPVA.

Medicaid

If you have **Medicaid** and don't have Part B, Medicare will pay first for the Part A services Medicare covers. You may also be able to get help from your state to pay for Part A and Part B **premiums** through a Medicare Savings Program. Go to pages 91-92. To learn more about signing up for Part B, go to page 15.

For more information on Medicaid and to find out if you qualify, visit [Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu](https://www.Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu), or call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your state's Medicaid office. TTY users can call 1-877-486-2048.

Health Insurance Marketplace®

Even if you have Marketplace coverage (or other individual health coverage that isn't based on current employment), you should sign up for Medicare when you're first eligible to avoid the risk of a delay in Medicare coverage and the possibility of a Medicare late enrollment penalty.

If you have Marketplace coverage:

- You should end your Marketplace coverage in a timely manner when you become eligible for Medicare to avoid an overlap in coverage.
- Once you're considered eligible for premium-free Part A, or already have Part A with a premium, you won't qualify for help from the Marketplace to pay your Marketplace plan premiums or other medical costs. If you continue to get help paying for your Marketplace plan premiums, you may have to pay back some or all of the help you got when you file your federal income taxes.

To find out how to end your Marketplace plan or Marketplace savings when your Medicare coverage begins, visit [HealthCare.gov/medicare/changing-from-marketplace-to-medicare](https://www.healthcare.gov/medicare/changing-from-marketplace-to-medicare). You can also call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

Health Savings Account (HSA)

You aren't eligible to make contributions to an HSA after you have Medicare. To avoid a tax penalty, you should make your last HSA contribution the month before your Part A coverage begins. Premium-free Part A coverage will go back (retroactively) 6 months from when you sign up for Part A or apply for benefits from Social Security or the Railroad Retirement Board (RRB), but no earlier than the first month you're eligible for Medicare. Depending on how you become eligible for Part A, the retroactive period may be different. Review the chart below to help decide when it's best to stop your HSA contributions.

If you sign up for Medicare:	During your Initial Enrollment Period	You can avoid a tax penalty by making your last HSA contribution the month before you turn 65.
	2 months after your Initial Enrollment Period ends	
	And your birthday is on the 1st day of the month	Generally, your Medicare coverage starts the first day of the month before you turn 65. You can avoid a tax penalty by making your last HSA contribution 2 months before you turn 65.
If you wait to sign up for Medicare:	Less than 6 months after you turn 65	You can avoid a tax penalty by stopping HSA contributions the month before you turn 65.
	6 or more months after you turn 65	You can avoid a tax penalty by stopping HSA contributions 6 months before the month you apply for Medicare.

Note: A Medical Savings Account (MSA) Plan is similar to an HSA. Go to page 67.

How does my other insurance work with Medicare?

When you have other insurance (like group health plan, retiree health, or **Medicaid** coverage) and Medicare, there are rules for whether Medicare or your other coverage pays first.

If you have retiree health coverage, like insurance from your or your spouse's former employment...	Medicare pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees ...	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has fewer than 20 employees ...	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees ...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has fewer than 100 employees ...	Medicare pays first.
If you have group health plan coverage based on your or a family member's employment or former employment, and you're eligible for Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan pays first for the first 30 months after you become eligible for Medicare. Medicare pays first after this 30-month period.
If you have TRICARE...	Medicare pays first, unless you're on active duty, or get items or services from a military hospital or clinic, or other federal health care provider.
If you have Medicaid...	Medicare pays first.

Important! If you're still working and have employer coverage through work, contact your employer to find out how your employer's coverage works with Medicare.

Remember:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary payer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your group health plan or retiree health coverage is the secondary payer, you'll likely need to sign up for Part B before your insurance will pay.

Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to review the booklet, "How Medicare Works with Other Insurance" or call 1-800-MEDICARE (1-800-633-4227) to learn more. TTY users can call 1-877-486-2048.

Important! If your group health plan coverage ends, call 1-800-MEDICARE to update your record. If you have other changes to your insurance, you can also call Medicare's Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users can call 1-855-797-2627. If you're retiring, call 1-800-MEDICARE to make sure your primary insurance information is correct.

If you have Part A, you may get a "Health Coverage" form (IRS Form 1095-B) from Medicare. This form verifies that you had health coverage in the past year. Keep the form for your records. Not everyone will get this form. If you don't get Form 1095-B, don't worry. Even though you don't need it to file your taxes, you can request a copy from Medicare.

Do I have to pay for Part A?

You usually don't pay a monthly **premium** for Part A coverage if you or your spouse paid Medicare taxes while working for a certain amount of time. This is sometimes called premium-free Part A. If you aren't eligible for premium-free Part A, you may be able to buy it. For more information on how to pay your Part A premium, go to page 24.

If you buy Part A, you'll pay a premium of either \$285 or up to \$518 each month in 2025 depending on how long you or your spouse worked and paid Medicare taxes. If you need help paying your Part A premium, go to pages 91-92. If you have questions about paying for Part A, visit [Medicare.gov](https://www.medicare.gov) or call 1-800-MEDICARE.

In most cases, if you choose to **buy** Part A, you must also have Part B and pay monthly premiums for both. If you choose NOT to buy Part A, you can still buy Part B if you're eligible.

What's the Part A late enrollment penalty?

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could have had Part A but didn't sign up. For example, if you were eligible for Part A for 2 years but didn't sign up, you'll have to pay a 10% higher premium for 4 years.

How much does Part B coverage cost?

The standard Part B **premium** amount in 2025 is \$185. Most people pay the standard Part B premium amount every month.

If your modified adjusted gross income is above a certain amount (in 2025 it's \$106,000 if you file individually or \$212,000 if you're married and file jointly), you may pay an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium.

To determine if you'll pay the IRMAA, **Medicare uses the modified adjusted gross income reported on your IRS tax return from 2 years ago.** Visit [Medicare.gov](https://www.Medicare.gov) to learn more about IRMAA.

Note: You may also pay an extra amount for your Medicare drug coverage (Part D) premium if your modified adjusted gross income is above a certain amount. Go to page 82.

If you have to pay an extra amount and you disagree (for example, your income is lower due to a life event), visit [SSA.gov/medicare/lower-irmaa](https://www.SSA.gov/medicare/lower-irmaa).

What's the Part B late enrollment penalty?

Important! If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Your monthly Part B premium may go up 10% for each full 12 months in the period that you could've had Part B, but didn't sign up. If you're allowed to sign up for Part B during a Special Enrollment Period, you usually don't pay a late enrollment penalty. Go to pages 17-18.

Example: Mr. Smith's Initial Enrollment Period ended December 2021. He waited until March 2024 (during the General Enrollment Period) to sign up for Part B. His Part B premium penalty is 20%, and he'll have to pay this penalty in addition to his standard Part B premium for as long as he has Part B. (Even though Mr. Smith didn't have Part B for 27 months, this included only 2 full 12-month periods.)



Cost & coverage: To learn how to get help with Medicare costs, go to page 91.

How can I pay my Part B premium?

If you get Social Security or Railroad Retirement Board (RRB) benefits, your Part B premium will be deducted from your monthly benefit payment.

Note: If you get a bill from the RRB, mail your premium payments to:
RRB Medicare Premium Payments
PO Box 979024
St. Louis, MO 63197-9000

If you have questions about bills you get from the RRB, call 1-877-772-5772. TTY users can call 1-312-751-4701.

If you're a federal retiree with an annuity from the Office of Personnel Management and you aren't entitled to Social Security or RRB benefits, you can ask to have your Part B **premiums** deducted from your annuity. Contact your local Social Security office to make your request. Visit [SSA.gov/locator](https://ssa.gov/locator) to find your local office.

If you don't get Social Security or RRB benefit payments, you'll get a bill for your Part B premium. Typically, Part B premiums are billed quarterly (every 3 months). If you also pay for Part A or Part D IRMAA, or use Medicare Easy Pay to pay your premiums, you'll get a monthly bill (pages 23 and 82).

There are 4 ways to pay your premium bill:

- 1. Pay online through your secure Medicare account:** Visit [Medicare.gov/account/login](https://medicare.gov/account/login) to log into (or create) your Medicare account. Then, select "Pay my premium" to make a payment by credit card, debit card, Health Savings Account (HSA) card, or from your checking or savings account. You'll get a confirmation number when you make your payment. **This service is free and is the fastest way to pay your premium.**
- 2. Through Medicare Easy Pay:** This free service automatically deducts your payment from your savings or checking account each month. Visit [Medicare.gov/medicare-easy-pay](https://medicare.gov/medicare-easy-pay), or call 1-800-MEDICARE (1-800-633-4227) to find out how to sign up. TTY users can call 1-877-486-2048.
- 3. Through your bank:** Contact your bank to set up a one-time or recurring payment from your checking or savings account. Not all banks offer this service, and some charge a fee. Enter your information carefully to make sure your payment goes through on time. Give the bank this information:
 - **Your 11-character Medicare Number:** Enter the numbers and letters without dashes, spaces, or extra characters.
 - **Payee name:** CMS Medicare Insurance
 - **Payee address:**
Medicare Premium Collection Center
PO Box 790355
St. Louis, MO 63179-0355
 - The amount of your payment
- 4. Through the mail:** You can pay by check, money order, credit card, debit card, or HSA card. Fill out the payment coupon at the bottom of your bill and include it with your payment. Payments made by mail take longer to process than payments made quickly and securely through your online Medicare account. Use the return envelope that came with your bill, and mail your Medicare payment coupon and payment to:
Medicare Premium Collection Center
PO Box 790355
St. Louis, MO 63179-0355

If you have questions about your premiums, call 1-800-MEDICARE or visit [Medicare.gov/basics/costs/pay-premiums](https://medicare.gov/basics/costs/pay-premiums).

If you need to change your address on your bill, visit [SSA.gov/mycontact](https://ssa.gov/mycontact).

You may be able to get help from your state to pay your Part A and Part B premiums through a Medicare Savings Program. Go to pages 91–92.

New! Your doctor or health care provider may also use a questionnaire to better understand your social needs and refer you for appropriate services and support. This is called a “social determinants of health risk assessment,” and it’s free when you get it as part of your yearly “Wellness” visit. For more information, visit [Medicare.gov/coverage](https://www.medicare.gov/coverage).

Your doctor or health care provider will also perform a cognitive assessment to look for signs of dementia, including Alzheimer’s disease. Signs of cognitive impairment include trouble remembering, learning new things, concentrating, managing finances, and making decisions about your everyday life. If your doctor or health care provider thinks you may have cognitive impairment, Medicare covers a separate visit to do a more thorough review of your cognitive function and check for conditions like dementia, depression, anxiety, or delirium, and design a care plan (page 35).

Your doctor or health care provider will also evaluate your potential risk factors for a substance use disorder and refer you for treatment, if needed. If you use opioid medication, your provider will review your pain treatment plan, share information about non-opioid treatment options, and refer you to a specialist, as appropriate.

Note: Your first yearly “Wellness” visit can’t take place within 12 months of your Part B enrollment or your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” preventive visit to qualify for a yearly “Wellness” visit.

You pay nothing for the yearly “Wellness” visit if the doctor or health care provider accepts **assignment**.

Important! If your doctor or health care provider performs additional tests or services during your “Wellness” visit that Medicare doesn’t cover under this preventive benefit, you may have to pay a **coinsurance**, and the Part B **deductible** may apply. If Medicare doesn’t cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.

What ISN'T covered by Part A and Part B?

Medicare doesn’t cover everything. If you need certain services Part A or Part B doesn’t cover, you’ll have to pay for them yourself unless:

- You have other coverage (including **Medicaid**) to cover the costs.
- You’re in a **Medicare Advantage Plan** or Medicare Cost Plan that covers these services. Medicare Advantage Plans and Medicare Cost Plans may cover some extra benefits, like fitness programs and vision, hearing, and dental services.

Some of the items and services that **Original Medicare** doesn’t cover include:

- ✗ Eye exams (for prescription eyeglasses).
- ✗ Long-term care.
- ✗ Cosmetic surgery.
- ✗ Massage therapy.

- ✗ Routine physical exams.
- ✗ Hearing aids and exams for fitting them.
- ✗ Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care).
- ✗ Covered items or services you get from a doctor or other provider that has opted out of participating in Medicare (except in the case of an emergency or urgent need). Go to page 60.
- ✗ Most dental care: In most cases, **Original Medicare** doesn't cover dental services like routine cleanings, fillings, tooth extractions, or items like dentures. However, in some cases, Original Medicare may pay for some dental services closely related to certain covered services like:
 - A heart valve repair or replacement.
 - An organ transplant.
 - Cancer-related treatments.

Paying for long-term care

Medicare and most health insurance, including Medicare Supplement Insurance (Medigap), don't pay for non-medical long-term care services (go to page 43 for home health services). This includes personal care assistance, like help with everyday activities, including dressing, bathing and using the bathroom. Non-medical long-term care services may also include home-delivered meals, adult day health care, home and community-based services and others. You may be eligible for some of this care through **Medicaid**, or you can choose to buy private long-term care insurance.

You can get non-medical long-term care services at home, in the community, in an assisted living facility, or in a nursing home. **It's important to start planning for non-medical long-term care now to maintain your independence and to make sure you get the care you may need, in the setting you want, now and in the future.**

Long-term care resources

Use these resources to get more information about long-term care:

- Visit [ACL.gov/ltc](https://acl.gov/ltc) to learn more about planning for long-term care.
- Visit the Eldercare Locator at eldercare.acl.gov, or call 1-800-677-1116 to find help in your community.
- Call your Long-Term Care Ombudsman, or visit ltcombudsman.org for help with services you need and to be advised of your rights, and to find an Ombudsman program near you.
- Call your State Medical Assistance (Medicaid) office or visit [Medicaid.gov](https://medicaid.gov) and ask for information about long-term care coverage.
- Call your State Health Insurance Assistance Program (SHIP). Go to pages 114-117 for the phone number of your local SHIP.
- Call your State Insurance Department for information on long-term care insurance. Call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.
- Get a copy of "A Shopper's Guide to Long-Term Care Insurance" from the National Association of Insurance Commissioners at content.naic.org/sites/default/files/publication-ltc-lp-shoppers-guide-long-term.pdf.

Section 3:

Original Medicare

How does Original Medicare work?

Original Medicare is one of your Medicare health coverage choices. You'll have Original Medicare unless you choose a **Medicare Advantage Plan** or other type of **Medicare health plan**. Original Medicare includes two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

You generally have to pay a portion of the cost for each service Original Medicare covers. There's no limit to what you'll pay out of pocket in a year unless you have other coverage (like **Medigap**, **Medicaid**, employer, retiree, or union coverage).

Original Medicare

Can I get my health care from any doctor, other health care provider, or hospital?	In most cases, yes. You can go to any Medicare-enrolled doctor, other health care provider, hospital, or other facility that accepts Medicare patients anywhere in the U.S. Visit Medicare.gov/care-compare to find and compare providers, hospitals, and facilities in your area.
Does it cover prescription drugs?	Medicare Part B doesn't cover most drugs. But there are some exceptions like immunosuppressive drugs (page 52) or drugs for pain and symptom management for hospice care (pages 26–27). Part B may also cover some infused and injected drugs given in a doctor's office and insulin used with a traditional pump. Go to pages 39, 44, and 47. You can add Medicare drug coverage (Part D) by joining a separate Medicare drug plan. Go to pages 79–90.
Do I need to choose a primary care doctor?	No.
Do I have to get a referral to use a specialist?	In most cases, no.

<p>Should I get a supplemental policy?</p>	<p>You may already have Medicaid, or employer, retiree, or union coverage that may pay costs that Original Medicare doesn't. If not, you may want to buy a Medicare Supplement Insurance (Medigap) policy if you're eligible. Go to pages 75–78. You can also check with your State Medical Assistance (Medicaid) office to see if you're eligible for Medicaid.</p>
<p>What else do I need to know about Original Medicare?</p>	<ul style="list-style-type: none"> • You generally pay a set amount for your health care (deductible) before Medicare begins to pay its share. Once Medicare pays its share, you pay a coinsurance or copayment for covered services and supplies. There's no yearly limit for what you pay out of pocket unless you have other insurance (like Medigap, Medicaid, or employer, retiree, or union coverage). • You usually pay a monthly premium for Part B. This premium may change each year. • You generally don't need to file Medicare claims. Providers and suppliers must file your claims for the covered services and supplies you get.

What do I pay?

Your out-of-pocket costs in Original Medicare depend on:

- Whether you have Part A and/or Part B. Most people have both.
- Whether your doctor, other health care provider, or supplier accepts **assignment**. Go to pages 59–60.
- The type of health care you need and how often you need it.
- If you choose to get services or supplies Medicare doesn't cover. If so, you pay all costs unless you have other insurance that covers them.
- Whether you have other health insurance that works with Medicare. Go to page 21.
- Whether you have full Medicaid coverage or get help from your state to pay your Medicare costs through a Medicare Savings Program. Go to pages 91–92.
- Whether you have Medicare Supplement Insurance (Medigap).
- Whether you and your doctor or other health care provider sign a private contract. Go to page 60.

How do I know what Medicare paid?

If you have Original Medicare, you'll get a "Medicare Summary Notice" (MSN) that lists all the services billed to Medicare. The MSN isn't a bill. It shows what Medicare paid and what you may owe the provider. Review your MSNs to be sure you got all the services, supplies, or equipment listed. If you disagree with Medicare's decision not to cover a service, the MSN will tell you how to appeal. Go to page 99 for information on how to file an appeal.



New! You'll get this notice in the mail every 4 months unless you sign up to get it electronically.

If you need to change your address on your MSN, visit [SSA.gov/mycontact](https://www.ssa.gov/mycontact). If you get Railroad Retirement Board (RRB) benefits, call the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

Your MSN will tell you if you're enrolled in the Qualified Medicare Beneficiary (QMB) program. If you're in the QMB program, Medicare providers aren't allowed to bill you for Medicare Part A and/or Part B **deductibles**, **coinsurance**, or **copayments**. In some cases, you may be billed a small copayment through **Medicaid**, if one applies. For more information about QMB and steps to take if a provider bills you for these costs, go to page 91.

Important! Get your Medicare Summary Notices electronically

Get your "Medicare Summary Notices" electronically. Visit [Medicare.gov](https://www.Medicare.gov) to log into (or create) your secure Medicare account. If you sign up for electronic MSNs, we'll send you an email each month when they're available in your Medicare account, instead of paper copies in the mail. As of late 2024, people who signed up for electronic MSNs helped save the Medicare Program close to \$42 million.

You have options for how you get your Medicare claims information:

- You can check your MSN for claims information.
- You can access your claims in your account on [Medicare.gov](https://www.Medicare.gov) and share this information with doctors, pharmacies, and others by visiting 'Check my claims.'
- You can access your claims through Medicare's connected apps. Connected apps are Medicare-approved applications or websites that a third party (not Medicare) creates. When you connect to an app and log in with your [Medicare.gov](https://www.Medicare.gov) account information, you can use the app's services without manually entering your health information. These third parties can only access your Medicare data if you choose to share it with them. It's always your choice if you want to connect (or stay connected) to a third-party app. Go to page 109.

What's assignment?

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the **Medicare-approved amount** as full payment for covered services. Most doctors, providers, and suppliers accept assignment, but always check to make sure that yours do.

If your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less.
- They agree to charge you only the Medicare deductible and coinsurance amount and usually wait for Medicare to pay its share before asking you to pay your share.
- They have to submit your claim directly to Medicare and can't charge you for submitting the claim.

Some providers haven't agreed and aren't required by law to accept **assignment** for all Medicare-covered services, but they can still choose to accept assignment for individual services. The providers who haven't agreed to accept assignment for all services are called "non-participating." You might have to pay more for their services if they don't accept assignment for the care they provide to you. Here's what happens if your doctor, provider, or supplier doesn't accept assignment:

- **You might have to pay the entire charge at the time of service.** Your doctor, provider, or supplier is supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- **They can charge you more than the Medicare-approved amount.** In many cases, the charge can't be more than 15% above the Medicare-approved amount for non-participating healthcare providers. This amount is called "the limiting charge."



Compare: If you have **Original Medicare**, you can use any provider you want that takes Medicare, anywhere in the U.S. If you're in a **Medicare Advantage Plan**, in most cases, you'll need to use doctors and other providers who are in the plan's network.

Find out if someone accepts assignment or participates in Medicare:

[Medicare.gov/care-compare](https://www.Medicare.gov/care-compare)

Find out if a medical equipment supplier accepts assignment:

[Medicare.gov/medical-equipment-suppliers](https://www.Medicare.gov/medical-equipment-suppliers)

You can also call your State Health Insurance Assistance Program (SHIP) to get free help with these topics. Go to pages 114-117 for the phone number of your local SHIP.

What if I want to use a provider who opts out of Medicare?

Certain doctors and other health care providers who don't want to work with the Medicare Program may "opt out" of Medicare. Medicare doesn't pay for any covered items or services you get from an opt-out doctor or other provider, except in the case of an emergency or urgent need. If you still want to use an opt-out provider, you and your provider can set up payment terms that you both agree to through a private contract.

A doctor or other health care provider who chooses to opt out must do so for 2 years, and the choice renews automatically every 2 years unless the provider requests not to renew their opt-out status.

If you're unsure if a provider has opted out of Medicare, check with them so you'll know ahead of time if you'll need to pay out of pocket for your care.

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

Section 5:

Medicare Supplement Insurance (Medigap)

How does Medigap work?

Original Medicare doesn't pay all of the cost for covered health care services and supplies. Medicare Supplement Insurance (**Medigap**) policies sold by private insurance companies can help pay some of the remaining health care costs for covered services and supplies, like **copayments**, **coinsurance**, and **deductibles**.

Some Medigap policies also cover services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. Generally, Medigap doesn't cover long-term care (like care in a nursing home), vision or dental services, hearing aids, eyeglasses, or private-duty nursing.

Medigap policies are standardized

Medigap must follow federal and state laws designed to protect you, and they must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only "standardized" plans, which are named in most states by letters A-D, F, G, and K-N. All plans with the same letter offer the same basic benefits, no matter where you live or which insurance company you buy the policy from. Some offer additional benefits. Compare the benefits of each lettered plan to find one that meets your needs. In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. Get information and find Medigap policies in your area:



[Medicare.gov/medigap-supplemental-insurance-plans](https://www.medicare.gov/medigap-supplemental-insurance-plans)

You can also visit [Medicare.gov/publications](https://www.medicare.gov/publications) to review the booklet, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

Important! Medigap plans sold to people who are new to Medicare on or after January 1, 2020 aren't allowed to cover the Part B deductible. Because of this, Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but haven't yet enrolled, you may be able to buy Plan C or Plan F. While people new to Medicare on or after January 1, 2020, can't buy Plans C and F, they have the right to buy Plans D and G (instead of Plans C and F), which provide the same benefits with the exception of coverage for the Part B deductible.



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

How do I compare Medigap plans?

The chart below shows basic information about the different benefits covered by Medicare Supplement Insurance (**Medigap**) in 2025. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest.

Benefits	Medigap plans									
	A	B	C	D	F*	G*	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood benefit (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2025**			
							\$7,220	\$3,610		

*Plans F and G also offer a high-deductible plan in some states. You must pay Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of \$2,870 in 2025 before your policy pays anything. (You can't buy Plans C and F if you were new to Medicare on or after January 1, 2020. Go to page 75.)

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$257 in 2025), the Medigap plan pays 100% of covered services for the rest of the calendar year.

***Plan N pays 100% of the Part B coinsurance. You must pay a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don't result in an inpatient admission.

What else should I know about Medigap?

Before you can buy Medicare Supplement Insurance (**Medigap**), you must generally have Part A and Part B. With Medigap, you pay a monthly **premium** to a private insurance company in addition to the monthly Part B premium you pay to Medicare. **If you're thinking about buying Medigap, be sure to compare plans. The costs can vary between plans offered by different companies for exactly the same coverage, and may go up as you get older. Some states limit Medigap premium costs.** A Medigap policy only covers one person. Spouses must buy separate coverage.

Note: In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. It requires you to use hospitals and, in some cases, doctors within its network to be eligible for full insurance benefits (except in an emergency). If you buy Medicare SELECT, you have rights to change your mind within 12 months and switch to standard Medigap.

Can I buy Medigap and a separate Medicare drug plan from the same company?

Yes. But you may need to make 2 separate premium payments. Contact the company to find out how to pay your premiums.

Can I have drug coverage in both Medigap and my Medicare drug plan?

No. Go to page 89 for more information.

When does a Medigap policy start?

Generally, your Medigap policy will begin the first of the month after you apply, but you can decide when you want it to start.

When's the best time to buy a Medigap policy?

- The best time to buy a Medigap policy is during your Medigap Open Enrollment Period. This 6-month period begins the first month you have Medicare Part B (Medical Insurance), **and you're 65 or older.** (Some states have additional Open Enrollment Periods.) **After this enrollment period, you may not be able to buy a Medigap policy or it may cost more.** In certain situations, you may have rights to buy a Medigap policy (guaranteed issue rights) outside of your Medigap Open Enrollment Period.
- If you delay signing up for Part B because you have group health coverage based on your (or your spouse's) current employment, your Medigap Open Enrollment Period won't start until you get Part B.
- Federal law generally doesn't require insurance companies to sell Medigap to people under 65. If you're under 65, you might not be able to buy the policy you want, or any policy, until you turn 65. However, some states require Medigap insurance companies to sell Medigap policies to people under 65. If you're able to buy one, it may cost more.

Call your State Health Insurance Assistance Program (SHIP) (go to pages 114–117 for the phone number of your local SHIP), or your State Insurance Department to learn more about your rights to buy a Medigap policy. A trusted agent or broker may also be able to help.

Can I have Medigap and a Medicare Advantage Plan?

- If you're in a **Medicare Advantage Plan**, it's illegal for anyone to sell you a **Medigap** policy unless you're switching back to **Original Medicare**. If you aren't planning to drop your Medicare Advantage Plan, and someone tries to sell you a Medigap policy, report it to your State Insurance Department.
- If you have Medigap and join a Medicare Advantage Plan, you may want to drop Medigap. You can't use Medigap to pay your Medicare Advantage Plan **copayments, deductibles, and premiums**.

Important! If you want to cancel your Medigap policy, contact your insurance company. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, **you may not be able to get the same policy back, or in some cases, any Medigap policy** unless you leave your Medicare Advantage Plan during your trial right period.

- If you drop a Medigap policy to join a Medicare Advantage Plan for the first time, you'll have a single 12-month period (your trial right period) to get your Medigap policy back **if the same insurance company still sells it** once you return to Original Medicare. If it isn't available, you can buy a Medigap policy you qualify for that's sold by an insurance company in your state (except for Plans M or N). You may also have an opportunity to join a Medicare drug plan at this time.
- If you joined a Medicare Advantage Plan when you were first eligible for Medicare Part A at 65, you can choose from any Medigap policy that's sold by an insurance company in your state if you switch to Original Medicare within the first year of joining the Medicare Advantage Plan. You may also have an opportunity to join a Medicare drug plan at this time.
- Some states provide additional special rights to buy a Medigap policy.

Where can I get more information?

- Call your State Insurance Department. Call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.
- Visit [Medicare.gov/medigap-supplemental-insurance-plans](https://www.medicare.gov/medigap-supplemental-insurance-plans) to find policies and pricing in your area.
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to review the booklet, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."
- Call your State Health Insurance Assistance Program (SHIP). Go to pages 114–117 for the phone number of your local SHIP. A trusted agent or broker in your area may also be able to help.

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

Section 6:

Medicare drug coverage (Part D)

How does Medicare drug coverage work?

Medicare drug coverage (Part D) helps pay for your prescription drugs. 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 (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](https://www.medicare.gov/plan-compare) to find and compare plans in your area. You can also call your State Health Insurance Assistance Program (SHIP) for help comparing plans. Go to pages 114–117 for the phone number of your local SHIP, or visit shiphelp.org.

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 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.

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, 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.

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.

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

Visit [Medicare.gov](https://www.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 114–117 for the phone number of your local SHIP.

How do I switch plans?

You can switch Medicare drug coverage simply by joining another plan during one of the times listed on page 80. 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 plan and don't want to join a new plan, you can only do so during certain times (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.

New! Your out-of-pocket drug costs are capped at \$2,000 in 2025. Go to page 83.

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 reached your out-of-pocket limit). 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 prescriptions or biosimilars over original biological products. You might also pay for a drug without insurance (like using pharmacy savings programs or manufacturer discounts). Ask your pharmacist—they can tell you if there's a less expensive option available. Check with your doctor to make sure the generic or biosimilar option is best for you.

Monthly premium

Most drug plans charge a monthly fee that varies by plan. If you have Part B, 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 2025 \$106,000 if you file individually or \$212,000 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 pay an extra amount.

Usually, Medicare or the RRB will deduct the extra amount 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 the Part D IRMAA and you disagree (for example, you have one or more life-changing events that lower your income), visit [SSA.gov/medicare/lower-irmaa](https://www.ssa.gov/medicare/lower-irmaa).

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.

Out-of-pocket limit on drug costs

New! Your yearly out-of-pocket drug costs for drugs covered by your plan are capped at \$2,000 in 2025. Once you reach this limit (from your out-of-pocket spending plus certain payments other people or entities make, including Medicare's **Extra Help** program), 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 Part D costs. Go to pages 92–94.

Important! Visit [Medicare.gov/plan-compare](https://www.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 114–117 for the phone number of your local SHIP. A trusted agent or broker may also be able to help.

Medicare Prescription Payment Plan

New! This new payment option works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by your plan by spreading them across the calendar year (January–December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

If you select this payment option, each month you'll continue to pay your plan **premium** (if you have one), **and** you'll get a bill from your health or drug plan to pay for your prescription drugs (instead of paying the pharmacy). All plans offer this payment option, and **participation is voluntary**. There's no cost to participate in the Medicare Prescription Payment Plan. Contact your plan or visit [Medicare.gov/prescription-payment-plan](https://www.medicare.gov/prescription-payment-plan) for more information and to find out if this payment option is right for you.

Note: This payment option may not be the best choice for you if you get or are eligible for Extra Help from Medicare.

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.