# Medicare at a Glance

Medicare is the federal health insurance program for Americans age 65 and older and for younger adults with permanent disabilities, End-Stage Renal Disease (ESRD), or Amyotrophic Lateral Sclerosis (ALS). Knowing the basics about Medicare can help you make good decisions about your health coverage and care.


- Are you Eligible for Medicare?
- What Medicare Covers
- What Medicare Does Not Cover
- Original Medicare or Medicare Advantage?
- Insurance to Supplement Original Medicare
- How and When to Enroll in Medicare


| Tip |
| --- |
| Regardless of whether your spouse receives Medicare coverage, you must still meet one of the eligibility criteria listed below in order to receive coverage through the program. For example, if you are age 63 and your spouse turns 65, only he or she can be covered by Medicare at that time (unless you meet one of the eligibility criteria for those under age 65 listed below). |

## Are you Eligible for Medicare?

If you are age 65 or older, you qualify for Medicare if:
- You collect or qualify to collect Social Security or Railroad Retirement benefits **OR**
- You are a current U.S. resident and either a U.S. citizen or a permanent U.S. resident having lived in the United States for 5 continuous years.

If you are under age 65, you qualify for Medicare if:
- You have been getting Social Security Disability Insurance (SSDI) or Railroad Disability Annuity checks for at least 24 months,
- You have Amyotrophic Lateral Sclerosis (ALS) and receive Social Security Disability Insurance (SSDI) or Railroad Disability Annuity checks, or
- You have end-stage renal disease (ESRD) and you, your spouse, or your parent have paid Medicare taxes for a sufficient period of time. ESRD means your kidneys do not work properly and you need dialysis or a kidney transplant to live.

## What Medicare Covers

The Medicare program is comprised of four parts – Part A, Part B, Part C (also known as Medicare Advantage), and Part D. Together, these four parts provide coverage for basic medical services and prescription drugs.

**Part A (Hospital Insurance):** Part A covers inpatient hospital care, some skilled nursing facility stays, home health care, and hospice care. If you or your spouse have worked for at least 40 quarters (10 years) and paid Medicare payroll taxes, you qualify for Part A coverage, and you don't have to pay a monthly premium for it. This is referred to as "premium-free Part A."

If you are not entitled to premium-free Medicare Part A because you do not have enough working quarters, you may still qualify for Part A but you will have to pay a monthly premium. In 2012, the Part A premium is $248 per month if you have worked between 30 and 39 quarters, and $451 per month if you worked fewer than 30 quarters.

For all people with Medicare, there is a charge for most health care services in the form of deductibles and coinsurance or copayments.

| Part A | |
|---|---|
| **Monthly Premium** | $0, if you or your spouse worked 40 quarters or more and paid Medicare taxes, if you are receiving disability benefits from Social Security or RRB, or if you have ESRD and meet other requirements<br>$248, if you or your spouse worked 30 – 39 quarters<br>$451, if you or your spouse worked fewer than 30 quarters |
| **BENEFITS** | **INDIVIDUAL PAYS (in 2012)** |
| **Inpatient hospital**<br>Days 1-60 in a benefit period[2]<br>Days 61-90 in a benefit period<br>Lifetime reserve days 91-150[4]<br>After lifetime reserve days used | Deductible of $1,156 per benefit period[1]<br>No coinsurance[3]<br>$289 a day<br>$578 a day<br>Not covered |
| **Skilled nursing facility**<br>Days 1-20 each benefit period<br>Days 21-100 each benefit period<br>After 100 days each benefit period | No coinsurance[3]<br>$144.50 a day<br>Not covered |
| **Home health** | No deductible or coinsurance[1,3] |
| **Hospice** | Copayment of up to $5 for outpatient drugs for pain and symptom management, and up to a 5% coinsurance for inpatient respite care. Medicare does not cover room and board when you receive hospice care where you live (i.e., at home or in a nursing home) |

[1] The deductible is the amount an individual must pay before Medicare begins to pay for services.
[2] A benefit period begins when a person is admitted to a hospital and ends 60 days after discharge from a hospital or a skilled nursing facility.
[3] Coinsurance – portion of a health care fee that must be paid by an insured patient
[4] Days 91-150 are lifetime reserve days. Each beneficiary has 60 reserve days over his or her lifetime. They can only be used once and are not renewable.
Source: Medicare & You. Centers for Medicare and Medicaid (CMS). 2012 Available at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf

**Part B (Medical Insurance)**: Part B, or the Supplementary Medical Insurance (SMI) program, helps pay for physician services, outpatient hospital care, and some home health visits not covered under Part A. It also covers laboratory and diagnostic tests, such as X-rays and blood work; durable medical equipment, such as wheelchairs and walkers; certain preventive services and screening tests, such as mammograms and prostate cancer screenings; outpatient physical, speech and occupational therapy; outpatient mental health care; and ambulance services.

As part of the 2010 health reform law, you pay no coinsurance or deductible for many preventive services under Part B (if your doctor accepts assignment). For instance, Medicare pays in full for a one-time "Welcome to Medicare" preventive visit in your first year of enrolling in Part B, and an "Annual Wellness Visit" after your first year in Part B. During the "Welcome to Medicare" visit, your doctor will review your health and provide information and counseling regarding preventive care you can receive and referrals for additional services. The "Annual Wellness Visit" is similar but takes place on a yearly basis. During your annual wellness visit, your doctor will create or update a preventive care screening plan for you for the next 5 to 10 years.

All people with Medicare pay a monthly premium for Part B. Most people who pay a Part B premium have it automatically deducted from their Social Security check. If your income is limited, you may qualify for programs that will pay the Part B premium on your behalf. For more information, see the Medicare and People with Low Incomes section.

The standard monthly Part B premium in 2012 is $99.90. Some people on Medicare with higher annual incomes (more than $85,000/individual; $170,000/couple) pay a higher monthly Part B premium, ranging from $139.90 to $319.70 per month in 2012, depending on their income.

Part B also has an annual deductible of $140 in 2012—that is, you must pay $140 out-of-pocket before Medicare begins paying. After you meet the deductible, most Part B services require a 20 percent coinsurance; this means you pay 20 percent of the cost of the service. If a doctor is a "participating provider" then the most he or she can ever charge you is 20 percent of the Medicare-approved amount for a service. This is called "accepting assignment."

Some doctors do not "accept assignment" – that is, they choose not to accept the Medicare-approved amount as payment for services and procedures. These doctors are called "non-participating providers." If a doctor does not accept the Medicare-approved amount, he or she can charge you both a 20 percent coinsurance, as well as a "limiting charge" that can be up to 15 percent above the Medicare-approved amount for non-participating providers (although some states have stricter limiting charges).

A limited number of doctors do not accept Medicare at all. These doctors face no restrictions on the amounts they can charge their Medicare patients, as long as the patient signs an agreement saying they will pay for the full cost of the services.

| Part B | | | |
|---|---|---|---|
| | **Premium** | **Income per individual** | **Income per couple** |
| **Monthly Premium**[1] | $99.90<br>$139.90<br>$199.80<br>$259.70<br>$319.70 | $85,000 or less<br>$85,001 - $107,000<br>$107,001 - $160,000<br>$160,001 - $214,000<br>More than $214,000 | $170,000 or less<br>$170,001 - $214,000<br>$214,001 - $320,000<br>$320,001 - $428,000<br>More than $428,000 |
| **Deductible** | $140 a year | | |
| **BENEFITS** | **INDIVIDUAL PAYS (in 2012)** | | |
| **Physician and other medical services**<br>Physician accepts assignment[2] (participating provider)<br>Physician does not accept assignment (non-participating provider) | 20% coinsurance<br>20% coinsurance, plus up to 15% over Medicare-approved fee for non-participating providers[3] | | |
| **Durable medical equipment and X-rays** | 20% coinsurance | | |
| **Outpatient hospital care** | 20% coinsurance; coinsurance for each service can't be more than the hospital deductible for that year ($1,156 in 2012) | | |
| **Occupational therapy** | 20% coinsurance, with annual coverage limit of $1,880 in 2012 | | |
| **Physical therapy; speech therapy** | 20% coinsurance, with annual coverage limit of $1,880 for physical and/or speech-language therapy services in 2012 | | |
| **Clinical laboratory services** | No coinsurance or deductible for Medicare-approved services | | |
| **Home health care** | No coinsurance or deductible for Medicare-approved services,<br>20% of cost of durable medical equipment that you need while receiving home health care | | |

| | |
|---|---|
| **Outpatient mental health services** | 40% coinsurance (phasing down to 20% by 2014) for most care |
| **Certain preventive services**[4]<br>Welcome to Medicare preventive visit, bone mass measurement (osteoporosis screenings), breast cancer screenings (mammograms), cardiovascular (heart disease) screenings, cervical and vaginal cancer screenings, colon cancer screenings (fecal occult blood test, colonoscopy, flexible sigmoidoscopy), prostate cancer screenings (prostate specific antigen test), tobacco use cessation counseling, diabetes screenings, medical nutrition therapy, alcohol misuse screening and counseling, yearly depression screening, HIV screening, other sexually transmitted infection screening and counseling, obesity screening and counseling, and vaccinations (flu shot, pneumococcal shot, and hepatitis B shot) | No coinsurance or deductible for covered preventive services as long as the physician accepts assignment (Original Medicare) or is in-network (Medicare Advantage) |
| Colon cancer screening (barium enema), glaucoma screening, and prostate cancer screening (digital rectal exam) | 20% coinsurance if the physician accepts assignment or is in-network (Deductible also applies to glaucoma screening and digital rectal exam but not the barium enema.) |

[1] There are higher premiums for beneficiaries with higher annual incomes (more than $85,000/individual; $170,000/couple). Low-income individuals receiving Medicaid or Medicare Savings Program benefits do not pay monthly premiums.
[2] Assignment – physicians agree to accept Medicare's predetermined fee as payment in full; patients are responsible for 20% coinsurance for most services.
[3] The limit on the percentage above the Medicare-approved amount for non-participating providers that a physician can charge known as the Medicare Limiting Charge Law. Some states have stricter limiting laws.
[4] For a full list of Medicare-covered preventive services, conditions of coverage, and charges, see the Medicare & You guide published by the Centers for Medicare and Medicaid (CMS). 2012 Available at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf

**Part C (Medicare Advantage):** Part C allows beneficiaries to enroll in a private insurance plan, called a Medicare Advantage plan. Medicare Advantage plans are managed care plans, such as Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs). Medicare Advantage plans must cover all Part A and B services and usually include Part D (prescription drug coverage) benefits in the same plan. These plans sometimes cover additional benefits not covered by traditional Medicare, such as routine vision and dental care. All plans have an annual limit on your out-of-pocket costs for Part A and B services, and once you reach that limit, you pay nothing for covered services for the rest of the calendar year. The out-of-pocket limit can be high but may help protect you if you need a lot of health care or need expensive treatment. Out-of-pocket costs include deductibles, copayments and coinsurance.

Although Medicare Advantage plans must cover Part A and B services, they can have different rules, costs and restrictions. Some plans have higher cost-sharing requirements than Original Medicare for some services, and most plans apply restrictions that limit your choices of doctors or hospitals. For more details on Medicare Advantage, see the Medicare Advantage Plans section.

**Part D (prescription drug coverage):** In 2006, Medicare began offering outpatient prescription drug coverage under Medicare Part D. Medicare drug coverage is optional for most people with Medicare and is offered only through Medicare private plans. If you have Original Medicare and want Part D drug coverage, you can get a stand-alone prescription drug plan (PDP). People who want a Medicare Advantage plan and drug coverage must generally get it through one plan called a Medicare Advantage prescription drug plan (MA-PD).

There is a monthly premium for Part D. Premiums vary widely among plans, as do the drugs that are covered and the amounts charged for prescriptions. The standard Part D benefit has a deductible, which in 2012 can be no more than $320, and 25 percent coinsurance on covered drugs up to an initial coverage limit. This is followed by a coverage gap, during which enrollees are responsible for a larger share of their total drug costs than during the initial coverage period, until they reach the catastrophic coverage limit. Thereafter, enrollees have low costs for their drugs. For people on Medicare with limited incomes and resources, financial assistance is available to reduce or eliminate premiums, deductibles, and co-pays. For more details on Part D, see the Medicare and Prescription Drug Coverage section.

## Part D

Information below applies to the standard Part D benefit; benefits and cost-sharing requirements typically vary across plans. Beneficiaries receiving low-income subsidies pay reduced cost-sharing amounts.

| | |
|---|---|
| **Deductible** | Up to $320 |
| **Monthly Premium** | $31.08 national average monthly premium |
| **BENEFITS** | **INDIVIDUAL PAYS (in 2012)** |
| **Initial Coverage** (up to $2,930 in total drug costs[1]) | 25% coinsurance |
| **Coverage Gap** (between $2,930 and an estimated $6,730 in total drug costs) | 50% coinsurance for brand-name drugs in 2012<br>86% coinsurance for generic drugs in 2012<br>(phasing down to 25% for both brand and generic drugs by 2020) |
| **Catastrophic Coverage** (above $4,700 in out-of-pocket[2] spending) | Either a 5% coinsurance for covered drugs or a copayment of $2.60 for covered generic drugs and $6.50 for covered brand-name drugs, whichever is greater. |

[1] Total drug costs include everything you paid for your drugs plus what the plan paid

[2] Out-of-pocket spending includes your deductible, what you paid during the initial coverage period, what you paid during the coverage gap, the full cost of brand-name drugs you got during the coverage gap (what you paid plus the 50 percent brand-name drug discount), and costs paid by some others, including family members, most charities or other persons, State Pharmaceutical Assistance Programs, AIDs Drug Assistance Programs and the Indian Health Service.

## What Medicare Does Not Cover

Medicare does not cover all health care services. For example, Medicare pays for a limited amount of long-term care services; it does not pay for home or community-based care, assisted living facilities, or nursing homes. Medicare also does not cover regular eye exams, most eyeglasses, hearing aids, routine dental care, or most care provided outside the United States.

## Original Medicare or Medicare Advantage?

There are two ways to get Medicare health coverage.

- **Original Medicare:** This is the traditional fee-for- service program provided through the federal government. Original Medicare (also referred to as traditional Medicare) includes Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage. Beneficiaries with Original Medicare have the option of enrolling in a Part D (Prescription Drug) plan from a private insurance company, and may also enroll in a Medicare Supplement Insurance (Medigap) Plan from a private insurance company.

- **Medicare Advantage Plan:** A Medicare Advantage plan is a private insurance plan that combines Part A and Part B. People who want a Medicare Advantage plan and Part D drug coverage must generally get both as part of the same plan (Medicare Advantage Drug Plan).

People on Medicare throughout the country have the option to get their Medicare benefits under the fee-for-service program (Original Medicare) or through a Medicare Advantage plan. Medicare Advantage plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), are offered by private insurers that receive payments from the government to provide Medicare benefits to enrollees. The majority of elderly and disabled beneficiaries today are covered under Original Medicare. One in four people with Medicare is enrolled in a Medicare Advantage plan.

An important question facing people on Medicare is whether to enroll in a Medicare Advantage plan, and if so, which plan. There are many factors to consider when choosing between Original Medicare and a Medicare Advantage plan. Some beneficiaries prefer Original Medicare because it allows them the broadest possible access to medical providers, it does not require them to receive prior authorization for services, it allows them access to any provider who accepts Medicare when they travel, and/or it works well with their supplemental plan (such as employer-sponsored retiree health plan or Medigap plan).

Others prefer Medicare Advantage plans because they are often cheaper than purchasing a supplemental plan to wrap around Original Medicare (Medigap). People might also be attracted to the lower cost sharing under some Medicare Advantage plans, the limit on out-of-pocket spending Medicare Advantage plans must have, the additional services covered by some Medicare Advantage plans that are not covered by Original Medicare, or because they may have had a positive experience with a similar HMO or PPO offered by the same company before becoming eligible for Medicare.

See the Medicare Advantage Plans section for additional information.

## Insurance to Supplement Original Medicare

To help cover gaps in Medicare coverage and cost sharing such as deductibles and coinsurance, most Medicare beneficiaries supplement their coverage in some way. There are several types of supplemental insurance that work with Original Medicare. Some options include insurance from a former employer, supplemental insurance policies such as Medigap, or programs for people with limited incomes.

If you choose Original Medicare, you may be able to get supplemental insurance from a former employer or union (retiree coverage). About one in three Medicare beneficiaries have supplemental coverage from their former or current employer. If you are not yet on Medicare, find out what employee benefits you may be eligible for when you go on Medicare, and ask how these benefits coordinate with Medicare.

If you do not get retiree coverage and choose Original Medicare, you can buy Medicare supplemental insurance directly from an insurance company. These are called "Medigap" plans, and they only work with Original Medicare. About one in five Medicare beneficiaries has a Medigap policy. For more information on Medigap, see the Medicare Supplemental Insurance section.

Depending on your income and savings, you may also qualify for supplemental coverage through the Medicaid program or a Medicare Savings Program. Twenty percent of Medicare beneficiaries are dually eligible for Medicare and Medicaid. For more information on programs for low-income Medicare beneficiaries, see the Medicare and People with Low Incomes section.

## How and When to Enroll in Medicare

**Tip**

If you are not receiving Social Security or Railroad Retirement Board (RRB) benefits when you turn 65, contact a Social Security office during the three months before the month you turn 65 to enroll in Medicare Parts A and/or B.

**Qualifying for Medicare because you are over age 65.** In general, if you are receiving Social Security or Railroad Retirement Board (RRB) retirement benefits when you turn 65, you will automatically be enrolled in Part A and Part B. If you are eligible for, but not receiving Social Security or RRB benefits yet (for example, if you are still working), you will NOT be automatically enrolled; instead, you will need to apply at a Social Security office during your Initial Enrollment Period (the seven-month period that includes the three months before you turn 65, the month you turn 65, and the three months after you turn 65).

If you plan to enroll in Part B, it is very important that you do so when you first qualify to avoid having to pay a late enrollment penalty. There are limited circumstances when you can delay enrolling in Part B without having to pay a penalty, for example, if you have a group health plan from a current employer, as discussed in the "Employer Coverage and Medicare" section below. Contact your local Social Security office to find out whether you need to enroll in Part B when you first qualify for it. The contact information to make an appointment with your local Social Security office is available in the Additional Resources section of this guide.

**Qualifying for Medicare due to disability.** If you are under age 65 and have a permanent disability or medical condition, you will automatically get Medicare Parts A and B after you have received disability benefits from Social Security or the Railroad Retirement Board (RRB) for 24 months. If you have Amyotrophic Lateral Sclerosis (ALS), you will automatically get Medicare Parts A and B when your disability benefits begin. If you have End-Stage Renal Disease (ESRD), you need to call Social Security for more information about your Medicare eligibility, and to sign up for Part A and/or Part B.

<table>
<tr><th>If you are over age 65…</th><th>You are eligible for…</th><th>How to sign up</th><th colspan="2">Coverage begins…</th></tr>
<tr><td>And receiving retirement benefits from Social Security or RRB</td><td>Premium-free Part A</td><td>No action required; you are automatically enrolled in Medicare Parts A and B[1]</td><td colspan="2">The first day of the month you turn 65</td></tr>
<tr><td rowspan="2">And eligible, but not receiving retirement benefits from Social Security or RRB</td><td rowspan="2">Premium-free Part A</td><td rowspan="2">Call Social Security to sign up for Parts A and B during initial enrollment period</td><td>If you enroll…</td><td>Coverage begins …</td></tr>
<tr><td>In the 3 months before the month you turn 65</td><td>The first day of the month you turn 65[2]</td></tr>
<tr><td rowspan="3">And NOT eligible for retirement benefits from Social Security or RRB</td><td rowspan="3">Part A, WITH premium ($248 or $451 per month in 2012, depending on number of working quarters)</td><td rowspan="3">Call Social Security to sign up for Parts A and B during initial enrollment period[1]</td><td>The month you turn 65</td><td>The first day of the 1st month after you enroll</td></tr>
<tr><td>1 month after the month you turn 65</td><td>The first day of the 2nd month after you enroll</td></tr>
<tr><td>2 or 3 months after the month you turn 65</td><td>The first day of the 3rd month after you enroll</td></tr>
<tr><th>If you are under age 65…</th><th>You are eligible for…</th><th>How to sign up</th><th colspan="2">Coverage begins</th></tr>
<tr><td>Disabled, and receiving disability benefits from Social Security or RRB</td><td>Premium-free Part A</td><td>No action required; you are automatically enrolled in Medicare Parts A and B[1]</td><td colspan="2">The first day of the 25th month after your disability benefits begin</td></tr>
<tr><td>Have ALS, and receiving disability benefits from Social Security or RRB</td><td>Premium-free Part A</td><td>No action required; you are automatically enrolled in Medicare Parts A and B[1]</td><td colspan="2">The first day of the 1st month after your disability benefits begin</td></tr>
</table>

(continued on next page)

| If you are under age 65… | You are eligible for… | How to sign up | Coverage begins |
|---|---|---|---|
| Have ESRD, and meet other requirements | Premium-free Part A | Call Social Security for more information about your Medicare eligibility, and to sign up for Parts A and B | **If you need dialysis, coverage begins:**<br>• the first day after the 3rd full month of dialysis in a clinic<br>• first month of dialysis if you do home/self-dialysis, if requirements met<br>**If you need/have a kidney transplant, coverage begins:**<br>• the month you are admitted to a Medicare-certified hospital for the transplant, or<br>• the month you are admitted for evaluation or services needed prior to transplant, if transplant is scheduled for same month, or within following 2 months<br>• two months before transplant, if transplant is delayed more than 2 months |

[1]If you do not want or need Part B coverage, you must opt-out by letting Medicare know you don't want it.
[2]If your birthday is on the first day of the month, your coverage start date will begin one month early. Your enrollment periods do not change.

See the sections on Medicare Advantage Plans, Medicare and Prescription Drug Coverage, and Medicare Supplemental Insurance, for more information on how to apply for each.

If you do not enroll in Medicare Parts A, B, or D during your Initial Enrollment Period, you can do so later on, but you may have to pay a penalty for late enrollment. More information on late enrollment penalties is below.

The official Medicare website has a Medicare Eligibility tool that may answer any questions you have about eligibility and/or enrollment; for more information, visit www.medicare.gov/medicareeligibility/home.asp.

**Employer Coverage and Medicare.** Some people decide not to take Part B when they first qualify for it because they have insurance from their current employer or their spouse's current employer. Before deciding whether or not to enroll in Part B, contact your employer plan and the Social Security Administration to find out how your employer plan will work with Medicare. Ask whether your insurance is primary or secondary to Medicare. Primary coverage pays first for your health care costs, and secondary insurance pays some or all of the remaining costs.

You should almost always take Part B when you first qualify if your current employer coverage is secondary to Medicare. If your current employer coverage is primary to Medicare, you may choose to delay enrolling in Part B to avoid duplicating coverage and paying monthly premiums for two forms of insurance.

If you have health coverage from your current employer or your spouse's current employer when you turn 65, you have a Special Enrollment Period to enroll in Medicare without penalty any time while you are still working and for up to eight months after your employer coverage ends or becomes retiree coverage, whichever comes first. Your Medicare coverage will begin the month after you enroll.

You should check with your local Social Security office or your employer before declining Part B to be sure that Medicare is not your primary insurance and that you will not have to pay a penalty for late enrollment. Information on contacting your local Social Security office is available in the Additional Resources section of this guide.

**Retiree health coverage or COBRA and Medicare.** If you have retiree health coverage, or continuation health care coverage from a former employer (COBRA), and you plan to enroll in Medicare Parts A and B, you should do so during your Initial Enrollment Period. Retiree health coverage and COBRA do not count as current employer coverage, so you must enroll in Part B when you first qualify in order to avoid having to pay a premium penalty for late enrollment and/or gaps in coverage. If you already have COBRA coverage, your COBRA coverage may end when you are eligible for Medicare. More information on Medicare and COBRA is available at http://www.ssa.gov/disabilityresearch/wi/medicare.htm#cobra.

If you have employer coverage, you may also wonder if you should enroll in Part D when you first qualify for Medicare. If you or your spouse have "creditable drug coverage" through a current or former employer, you can delay enrollment in the Medicare drug benefit without penalty. When drug coverage is "creditable," that means it is at least as good as the standard Medicare Part D benefit. You should check with your employer to see if your drug coverage is creditable. Your employer should also notify you in writing each year whether your employee or retiree drug coverage is creditable. You may avoid paying a late enrollment penalty for Part D if you enroll in Part D within 63 days of the time that your employer-sponsored creditable drug coverage ends.

**Late Enrollment Penalties.** If you do not enroll in Medicare Parts B or D during your Initial Enrollment Period, you can do so later on, but you may have to pay a penalty for late enrollment (the same is true for Part A, although most people qualify for premium-free Part A). However, if you are eligible for a Special Enrollment Period, then you may not have to pay late enrollment penalties. More information on Special Enrollment Periods is provided below.

- **Part B late enrollment penalty.** Once your Initial Enrollment Period has passed, you can only enroll in Part B during the "General Enrollment Period" (from January 1 to March 31 each year, with coverage beginning on July 1). The Part B late enrollment penalty is a 10 percent increase in your Part B premium for each full 12-month period that your enrollment was delayed; this penalty is permanent, so you will have to pay the penalty for as long as you have Medicare. For example, if you delay signing up for Part B for 30 months after your Initial Enrollment Period ends, (since 30 months only includes 2 full 12-month periods) your Part B premium penalty would be 20 percent of the Part B premium.

- **Part D late enrollment penalty.** Once your Initial Enrollment Period has passed, you can generally only enroll in Part D during the "Fall Open Enrollment Period" (from October 15 to December 7 each year, with coverage beginning on January 1). The Part D late enrollment penalty is 1 percent of the national average premium for each month enrollment was delayed. If you qualify for Extra Help, the program that helps pay for prescription drug costs for people with limited income and resources, you can enroll in Part D right away and will not need to pay a penalty for late enrollment. See the Medicare and Prescription Drug Coverage section for more information on the Part D late enrollment penalty, and an example of how it is applied. See the discussion of Extra Help with Prescription Drug Costs in the "Medicare and People with Low Incomes" section.

**Enrollment Period Summary**

| | Part A | Part B | Medicare Advantage | Part D |
|---|---|---|---|---|
| **Initial Enrollment Period** | 7-month period including the 3 months before, the month of, and 3 months after your month of Medicare eligibility | | | |
| **General Enrollment Period** | January 1 – March 31, annually (coverage will start July 1) | | If you enroll in Medicare during the General Enrollment Period, you can enroll in a Medicare Advantage plan or Medicare Part D plan April - June (coverage will start July 1) | |
| **Special Enrollment Period*** | While you and your spouse are working and the 8-month period beginning the month after employment or employer group coverage ends, whichever comes first | | Varies depending on reason for qualifying for Special Enrollment Period | |
| **Fall Open Enrollment Period** | Not Applicable | Not Applicable | October 15 – December 7, annually | |
| **Medicare Advantage Disenrollment Period** | Not Applicable | Not Applicable | January 1 – February 14, annually | January 1 - February 14, annually. (If you leave your Medicare Advantage plan and return to Original Medicare, you can usually join a stand-alone drug plan at that time.) |

There are several different ways to qualify for a Special Enrollment Period to enroll in or switch Medicare Advantage or Part D plans. You may qualify for a Special Enrollment Period if…

- You move;
- You have Medicaid or Extra Help;
- You lose Medicaid or Extra Help;
- You just moved into, currently live in, or just moved out of an institution (including a skilled nursing facility or long-term care hospital);
- You lose other drug coverage that is creditable;
- You have a chance to get other coverage from your employer or a union; or
- Your plan leaves Medicare

When you can make changes and what changes you can make depend on the reason you qualify for the Special Enrollment Period. For more information on Special Enrollment Periods, see the "Understanding Medicare Enrollment Periods" tip sheet at Medicare.gov, available here: www.medicare.gov/Publications/Pubs/pdf/11219.pdf.