The True Out-Of-Pocket Costs of Medicare Part D

2025

1. Deductible Stage

You are responsible for 100% of your prescription drug costs until your deductible* is met.

**Your plan may have an annual deductible of no more than $590.*

Some plans carry a zero-dollar deductible.

In some plans, the deductible may not apply to certain low cost or generic drugs.

2. Initial Coverage

You pay a copay or coinsurance. Your Part D plan pays the rest for your prescription drugs included on your plan's formulary, or list of covered medications.

3. Catastrophic Coverage

After your True Out-of-Pocket (TrOOP) costs for prescription drugs reach $2,000 (including payments by Part D sponsors and Employer Group Waiver Plans (EGWPs)) you no longer face any cost-sharing for the rest of the year.

4. Plan Year Restarts

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

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Tier Levels Classification

TIER 1 - PREFERRED GENERIC

This tier consists of commonly prescribed generic drugs. Beneficiaries pay the least for drugs in this tier.

TIER 2 - GENERIC

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

TIER 3 - PREFERRED BRAND

This tier consists of brand-name prescription drugs without a generic equivalent. They're lower-cost than conventional branded drugs.

TIER 4 - BRAND

Drugs in this tier are brand-name and do not have a generic equivalent. They're typically more expensive than those in Tier 3.

TIER 5 - SPECIALTY

This tier consists of high-cost specialty drugs that treat complex conditions like cancer. They may be generic or brand-name. Beneficiaries typically pay the most for drugs in this tier.

Plan Coverage Rules

PRIOR AUTHORIZATION

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

STEP THERAPY

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

QUANTITY LIMITS

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

COVERAGE EXCEPTION

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

Coverage Cost Methods

PREMIUMS

A periodic payment to keep an insurance policy in force.

DEDUCTIBLE

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

CO-PAY

A fixed amount a beneficiary pays for covered medication.

CO-INSURANCE

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