CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare & You 2010

This is the official government handbook with important information about the following:

- ★ What's new
- ★ Medicare costs
- ★ What Medicare covers
- ★ Health and prescription drug plans
- ★ Your Medicare rights
- ★ Health information technology

Want to Save?

Extra Help is available!

More than 2 million people qualify to get Extra Help paying their Medicare prescription drug costs, but don't know it. Don't miss out on a chance to save. See pages 78–81 to learn more.

Choose to get future handbooks electronically.

Save tax dollars and help the environment by signing up to access your future "Medicare & You" handbooks electronically (also called the eHandbook). Visit www.MyMedicare.gov to request future eHandbooks, including the 2011 version. We'll email you next October when the new eHandbook is available. The email will include a link to the handbook on www.medicare.gov. You won't get a copy of your handbook in the mail if you choose to get it electronically.

Did your household get more than one copy of "Medicare & You?"

This may happen if there is a slight difference in how your or your spouse's address is entered in Social Security's mailing system. If you would like to get only one copy in the future, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Welcome to Medicare & You 2010

I am honored and excited to introduce this handbook—your best and official source of answers to your Medicare questions. At the U.S. Department of Health and Human Services, we are doing more than ever to carry Medicare into the future. Every day brings new commitment to advance the goals of health reform by reducing costs, offering choices, and making sure you have access to quality, affordable health care.

Your good health is our top priority. On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act. This law targets two areas, among many, to ensure the health and well-being of the Nation:

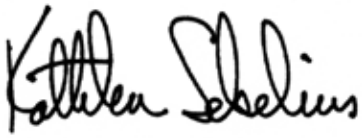
1. **Strengthening preventive care and wellness** to enable Americans to live longer, healthier lives.
2. **Investing in health information technology** to improve the quality of health care and reduce medical errors.

There are some things that you can do to help these efforts:

- Take advantage of Medicare's preventive services. Use the checklist on page 40, and ask your doctor or other health care provider what preventive services you need.
- Learn about the technology available to help improve your health care. Look on page 123 to learn more about health information technology.

This handbook also includes other important facts and changes you will need for 2010. For the latest information about changes to Medicare, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Yours in good health,



Kathleen Sebelius

Secretary
U.S. Department of Health and Human Services

How to Use This Handbook

Please keep this handbook for future reference. Information was correct when it was printed. Call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to get the most current information. TTY users should call 1-877-486-2048.

Find What You Need

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	Highlights important information	Throughout handbook
	Highlights preventive services	Pages 26–38, 40

"Medicare & You" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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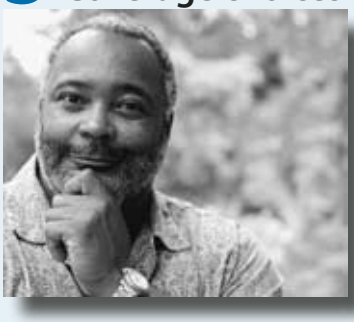

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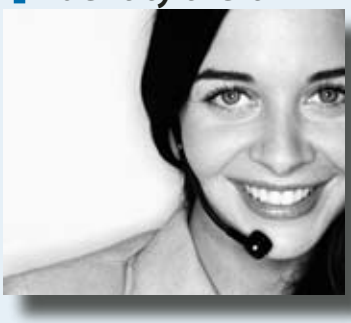

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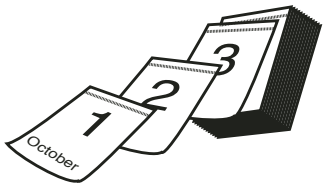
What's New and Important in 2010

- **Mental Health**—Lower costs for outpatient treatment. See page 33.
- **Medigap (Medicare Supplement Insurance) Policies**—Plan changes. See page 74.
- **Children's Health Insurance Program**—Your children or grandchildren may qualify for health insurance through this expanded program. See page 84.
- **Caregiver Information**—If you help someone with Medicare-related decisions, there are two new resources to help you get the information you need. See page 109.
- **Medicare Health and Prescription Drug Plans**—Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.
- **What You Pay for Medicare (Part A and Part B)**—Costs are on pages 119–122.
- **New Ways to Manage Your Health Information**—Exciting tools to help reduce paperwork and improve your quality of care. See page 123.

Coverage and Costs Change Yearly.



Mark your calendar with these important dates! Your health, finances, or coverage may have changed in the last year. Look at what your coverage would be for next year and see if the cost, coverage, quality, and convenience meet your needs.

October 2009: Compare Your Medicare Coverage Choices

Compare your coverage to others to see if there's a better choice for you. See page 13.

November 15, 2009–December 31, 2009: Stay or Switch

You can switch your Medicare health or prescription drug coverage for 2010. See pages 58 and 63 for other times when you can switch your coverage.

January 1, 2010: 2010 Coverage and Costs Begin

New coverage begins if you switched. New costs and coverage changes also begin if you stay with your current coverage.

At the end of the year, health and prescription drug plans can decide not to participate in Medicare. See page 59 and 64 for more information about your options.

Medicare Basics

What Is Medicare?

Medicare is health insurance for the following:

- People age 65 or older
- People under age 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

The Different Parts of Medicare

The different parts of Medicare help cover specific services. Medicare has the following parts:

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home health care

See pages 16–20.

Medicare Part B (Medical Insurance)

- Helps cover doctors' services, outpatient care, and home health care
- Helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse

See pages 21–38.

Medicare Part C (Medicare Advantage Plans) (like an HMO or PPO)

- A health coverage option run by private insurance companies approved by and under contract with Medicare
- Includes Part A, Part B, and usually other coverage like prescription drugs

See pages 50–59.

Medicare Part D (Medicare Prescription Drug Coverage)

- A prescription drug option run by private insurance companies approved by and under contract with Medicare
- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

See pages 62–72.

Your Medicare Coverage Choices

With Medicare, you can choose how you get your health and prescription drug coverage. Below are brief descriptions of your coverage choices. Section 2 has more details about these choices and information to help you decide.

Original Medicare See pages 45–49.

- Run by the Federal government.
- Provides your Part A and/or Part B coverage.
- You can go to any doctor or hospital that accepts Medicare.
- You can join a Medicare Prescription Drug Plan to add drug coverage.
- You can buy a Medigap (Medicare Supplement Insurance) policy (sold by private insurance companies) to help fill the gaps in Part A and Part B.

Medicare Advantage Plans (like an HMO or PPO) See pages 50–59.

- Run by private insurance companies approved by and under contract with Medicare.
- Provides your Part A and Part B coverage but can charge different amounts for certain services. May offer extra coverage and prescription drug coverage, sometimes for an extra cost. **Cost for items and services vary by plan.**
- If you want drug coverage, you must get it through your plan (in most cases).
- You don't need and you can't use a Medigap policy with a Medicare Advantage Plan.

Other Medicare Health Plans See pages 60–61.

- Plans that aren't Medicare Advantage Plans but are still part of Medicare.
- Include Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).
- Most plans provide Part A and Part B coverage, and some also provide prescription drug coverage (Part D).

Note: You might also have health and/or prescription drug coverage from a former or current employer or union that could affect your choices.

See page 43 for a chart that explains your Medicare coverage choices and the decisions you need to make.

Where to Get Your Medicare Questions Answered

1-800-MEDICARE To get general Medicare information and other important telephone numbers.	1-800-633-4227 TTY 1-877-486-2048
State Health Insurance Assistance Program (SHIP) To get free Medicare counseling and personalized help making coverage decisions; information on programs for people with limited income and resources; and help with claims, billing, and appeals.	See pages 110–113.
Social Security To replace a Medicare card; change your address or name; get information about Part A and/or Part B eligibility, entitlement, and enrollment; apply for Extra Help with Medicare prescription drug costs; ask questions about premiums; and report a death.	1-800-772-1213 TTY 1-800-325-0778
Coordination of Benefits Contractor To get information on whether Medicare or your other insurance pays first and to report changes in your insurance information.	1-800-999-1118 TTY 1-800-318-8782
Department of Defense To get information about TRICARE for Life.	1-866-773-0404 TTY 1-866-773-0405
Department of Health and Human Services **Office of Inspector General** If you suspect billing fraud.	1-800-447-8477 TTY 1-800-377-4950
Office for Civil Rights If you think you were discriminated against or if your health information privacy rights were violated.	1-800-368-1019 TTY 1-800-537-7697
Department of Veterans Affairs If you are a veteran or have served in the U.S. military.	1-800-827-1000 TTY 1-800-829-4833
Office of Personnel Management To get information about the Federal Employee Health Benefits Program for current and retired Federal employees.	1-888-767-6738 TTY 1-800-878-5707
Railroad Retirement Board (RRB) If you have benefits from the RRB, call them to change your address or name, check eligibility, enroll in Medicare, replace your Medicare card, and report a death.	Local RRB office or 1-877-772-5772
Quality Improvement Organization (QIO) To ask questions or report complaints about the quality of care for a Medicare-covered service or if you think your service is ending too soon.	Call 1-800-MEDICARE to get the telephone number for your QIO.

SECTION 1

Medicare Part A and Part B (What's Covered)

This section has information that can help you make informed health care decisions. It also explains what Medicare Part A and Part B cover and how to enroll.

Section 1 includes information about the following:

Part A (Hospital Insurance)

What is it and signing up 16–18

Covered Services 19–20

Part B (Medical Insurance)

What is it and signing up 21–25

Covered Services 26–38

What's NOT Covered by Part A and Part B? 39

Preventive Services Checklist 40

What Services Does Medicare Cover?

Medicare covers certain medical services and supplies in hospitals, doctors' offices, and other health care settings. Services are either covered under Medicare Part A (Hospital Insurance) or Medicare Part B (Medical Insurance). If you have both Part A and Part B, you can get all of the Medicare-covered services listed here, no matter what type of Medicare coverage you choose.

See pages 19–20 for a list of services covered by Part A and the conditions you must meet. See pages 26–38 for the Part B-covered services list.

What Is Part A (Hospital Insurance)?

Part A helps cover the following:

- Inpatient care in hospitals (such as critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals)
- Inpatient care in a skilled nursing facility (not custodial or long-term care)
- Hospice care services
- Home health care services
- Inpatient care in a Religious Nonmedical Health Care Institution (Medicare will only cover the non-medical, non-religious health care items and services in this type of facility for people who qualify for hospital or skilled nursing facility care but for whom medical care isn't in agreement with their religious beliefs.)

Blue words in the text are defined on pages 115–118.

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working.

If you aren't eligible for premium-free Part A, you may be able to buy Part A if you meet one of the following conditions:

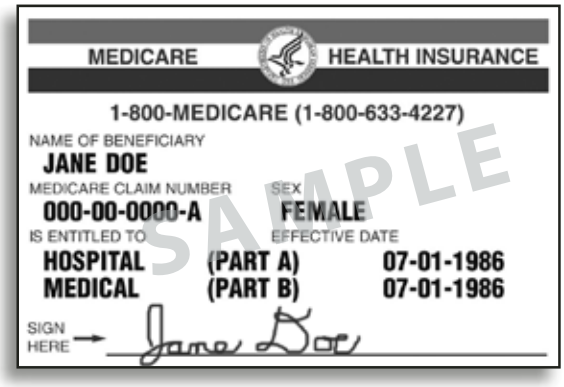
- You are age 65 or older, and you are entitled to (or enrolling in) Part B and meet the citizenship or residency requirements.
- You are under age 65, disabled, and your premium-free Part A coverage ended because you returned to work.

Call Social Security at 1-800-772-1213 for more information about the Part A premium. TTY users should call 1-800-325-0778.

Note: The premium amount for people who buy Part A is on page 119.

What Is Part A (Hospital Insurance)? (continued)

In most cases, if you choose to **buy** Part A, you must also have Part B and pay monthly premiums for both. **If you have limited income and resources, your state may help you pay for Part A and/or Part B. See page 83.**



You can find out if you have Part A by looking at your Medicare card.

Note: Keep this card safe. If you have Original Medicare, you will use this card to get your Medicare-covered services. If you join a Medicare plan, you must use the card from the plan to get your Medicare-covered services.

Is Your Medicare Card Lost or Damaged?

To order a new card, call Social Security at 1-800-772-1213, or visit www.socialsecurity.gov. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board (RRB), visit www.rrb.gov, and select "Benefit Online Services," or call the RRB at 1-877-772-5772.

Signing Up for Part A

Many People Automatically Get Part A

If you get benefits from Social Security or the Railroad Retirement Board (RRB), you automatically get Part A starting the first day of the month you turn age 65. If you are under age 65 and disabled, you automatically get Part A after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. You will get your Medicare card in the mail 3 months before your 65th birthday or your 25th month of disability.

If you have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), you automatically get Part A the month your disability benefits begin.

Signing Up for Part A (continued)

Some People Need to Sign Up for Part A

Blue words in the text are defined on pages 115–118.

If you aren't getting Social Security or RRB benefits (for instance, because you are still working), you will need to sign up for Part A (even if you are eligible to get it premium-free). You should contact Social Security 3 months before you turn age 65. If you worked for a railroad, contact the RRB to sign up.

If you need to sign up for Part A, you can sign up during the following times:

- **Initial Enrollment Period**—When you are first eligible for Medicare. (This is a 7-month period that begins 3 months before the month you turn age 65, includes the month you turn age 65, and ends 3 months after the month you turn age 65.)
- **General Enrollment Period**—Between January 1–March 31 each year. Your coverage will begin July 1. You may have to pay a higher premium for late enrollment. See below.
- **Special Enrollment Period**—If you or your spouse (or family member if you are disabled) is currently working, and you are covered by a group health plan through the employer or union. See page 22.
- **Special Enrollment Period for International Volunteers**—If you are serving as a volunteer in a foreign country. See page 22.

If you aren't eligible for premium-free Part A, you may be able to buy it. However, if you don't buy Part A when you are first eligible, your monthly premium may go up 10%. You will have to pay the higher premium for twice the number of years you could have had Part A, but didn't join. For example, if you were eligible for Part A, but didn't join for 2 years, you will have to pay the higher premium for 4 years. You don't have to pay a penalty if you are eligible for a special enrollment period.

For more information on Part A, call Social Security, or visit www.socialsecurity.gov. If you get benefits from the RRB, call 1-877-772-5772.

If you have End-Stage Renal Disease (ESRD), different rules apply. Visit your local Social Security office, or call Social Security at 1-800-772-1213 to sign up for Part A. TTY users should call 1-800-325-0778. For more information, visit www.medicare.gov/Publications/Pubs/pdf/10128.pdf to view the booklet, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services."

Part A-Covered Services

Blood	In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.
Home Health Services	Limited to medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment (see page 30), and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort.
Hospice Care	For people with a terminal illness. Your doctor must certify that you are expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, social services; and other covered services as well as services Medicare usually doesn't cover, such as grief counseling. A Medicare-approved hospice usually gives hospice care in your home (or other facility like a nursing home). Medicare covers some short-term inpatient stays for pain and symptom management that can't be addressed in the home. These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility. Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness. You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you are terminally ill.

Copayments, coinsurance, and deductibles may apply for each service. See page 120 for specific costs and other information about these services.

Part A-Covered Services

Hospital Stays (Inpatient)	Includes semi-private room, meals, general nursing, drugs as part of your inpatient treatment, and other hospital services and supplies. Examples include inpatient care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This **doesn't** include private-duty nursing, a television or telephone in your room (if there is a separate charge for these items), or personal care items like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it covers the doctor and emergency room services you get while you are in a hospital.
Skilled Nursing Facility Care	Includes semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies (only after a 3-day minimum inpatient hospital stay for a related illness or injury). To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy. Medicare **doesn't** cover long-term care or custodial care in this setting.

Copayments, coinsurance, and deductibles may apply for each service. See page 120 for specific costs and other information about these services.

If you join a Medicare Advantage Plan (like an HMO or PPO) or have other insurance (like a Medigap policy, or employer or union coverage), your costs may be different. Contact the plans you are interested in to find out about the costs.

What Is Part B (Medical Insurance)?

Part B helps cover medically-necessary services like doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services. You can find out if you have Part B by looking at your Medicare card.

How Much Does It Cost?

You pay the Part B premium each month. Most people will pay the standard premium amount. However, if your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you may pay more.

Your modified adjusted gross income is your taxable income plus your tax exempt interest income. Social Security will notify you if you have to pay more than the standard premium. If you have to pay a higher amount for your Part B premium and you disagree (even if you get RRB benefits), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

See page 119 to find out if your Part B premium will be higher based on your income.

If you don't sign up for Part B when you are first eligible, you may have to pay a late enrollment penalty. See page 23.

If you have limited income and resources, see page 83 for information about help paying your Medicare premiums.

See page 121 for other Part B costs.

How You Get Part B

If you get benefits from Social Security or the Railroad Retirement Board (RRB), in most cases, you will automatically get Part B starting the first day of the month you turn age 65. If your birthday is on the first day of the month, your Part B will start the first day of the prior month. If you are under age 65 and disabled, you will automatically get Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. You will get your Medicare card in the mail about 3 months before your 65th birthday or your 25th month of disability. If you don't want Part B, follow the instructions that come with the card, and send the card back. If you keep the card, you keep Part B and will pay Part B premiums.

Blue words in the text are defined on pages 115–118.

How You Get Part B (continued)

If you have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), you automatically get Part B the month your disability benefits begin.

When Can You Sign Up for Part B?

If you didn't sign up for Part B when you first became eligible, you may be able to sign up during one of these times:

- **General Enrollment Period**—Between January 1–March 31 each year. Your coverage will begin on July 1. You may have to pay a late enrollment penalty.
- **Special Enrollment Period**—If you wait to sign up for Part B because you or your spouse is currently working, and you are covered by a group health plan based on that work, or if you are disabled and you or a family member is working, and you are covered by a group health plan based on that work. You can sign up for Part B anytime while you have group health plan coverage based on current employment or during the 8-month period that begins the month after the employment ends, or the group health plan coverage ends, whichever happens first. If you have COBRA coverage, you must enroll during the 8-month period that begins the month after the employment ends. This Special Enrollment Period doesn't apply to people with End-Stage Renal Disease (ESRD).
- **Special Enrollment Period for International Volunteers**—If you waited to sign up for Part B because you had health insurance while volunteering outside of the U.S. for a tax exempt organization for at least a year. You can sign up during the 6-month period that begins the first month that any one of the following happens:
    1. You are no longer volunteering outside the U.S.
    2. The sponsoring organization is no longer tax exempt.
    3. You no longer have health insurance coverage outside the U.S.

When Can You Sign Up for Part B? (continued)

If you have Medicare because of End-Stage Renal Disease (ESRD), you can sign up for Part B when you sign up for Part A. See page 18. If you delay signing up for Part B, you can only get it during the general enrollment period, and you may have to pay a late enrollment penalty.

If you live in Puerto Rico, and you want Part B, you will need to sign up for it. Contact your local Social Security office for more information.

If you aren't getting Social Security or RRB benefits, and you want to get Part B, you will need to sign up for Part B during your initial enrollment period (the 7-month period that begins 3 months before the month you turn age 65, includes the month you turn age 65, and ends 3 months after the month you turn age 65).

If you don't sign up for Part B when you are first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it. Usually, you don't pay a late enrollment penalty if you sign up for Part B during a special enrollment period.

Note: If you are age 65 or older, after you sign up for Part B, you have a 6-month Medigap open enrollment period which gives you a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can't be delayed or replaced. See page 75.

Call Social Security at 1-800-772-1213 for more information about your Medicare eligibility and to sign up for Part B. TTY users should call 1-800-325-0778. If you get RRB benefits, call the RRB at 1-877-772-5772. For general information about enrolling, visit www.medicare.gov, and select "Find Out if You Are Eligible for Medicare and When You Can Enroll." You can also get free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). See pages 110–113 for the telephone number.

Blue words in the text are defined on pages 115–118.

Medicare and TRICARE Coverage

If you have Medicare Part A and TRICARE (coverage for active-duty military or retirees and their families), you must have Part B to keep your TRICARE coverage. However, if you are an active-duty service member, or the spouse or dependent child of an active-duty service member, the following applies to you:

- You don't have to enroll in Part B to keep your TRICARE coverage while the service member is on active duty.
- When the active-duty service member retires, you must enroll in Part B to keep your TRICARE coverage.
- You can get Part B during a special enrollment period if you have Medicare because you are age 65 or older, or you are disabled.

Note: If you are in a Medicare Advantage Plan or choose to join a plan, tell the plan that you have TRICARE, so your bills can be paid correctly.

Part B and Employer or Union Coverage

Having coverage through an employer (including the Federal Employee Health Benefits Program) or union while you or your spouse is still working can affect your Part B enrollment rights. You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if it would be to your advantage to delay Part B enrollment.

When the employment ends, three things happen:

1. You may get a chance to elect COBRA coverage, which continues your health coverage through the employer's plan (in most cases for only 18 months) and probably at a higher cost to you.

2. You may get a special enrollment period to sign up for Part B without a penalty. This period will run for 8 months and begins the month after your employment ends. This period will run whether or not you elect COBRA. If you elect COBRA, don't wait until your COBRA ends to enroll in Part B. If you enroll in Part B after the 8-month special enrollment period, you may have to pay a late enrollment penalty.

3. When you sign up for Part B, you have a 6-month Medigap open enrollment period which gives you a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can't be delayed or repeated. See page 75.

Part B-Covered Services

There are two kinds of Part B-covered services:

Medically-necessary services—Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.

Preventive services—Health care to prevent illness or detect it at an early stage, when treatment is most likely to work best (for example, Pap tests, flu shots, and colorectal cancer screenings).

Use the chart on page 40 to talk to your doctor or other health care provider about Medicare's preventive services and ask which services you need.

You will see this symbol next to the preventive services on the following pages.

Pages 26–38 include an alphabetical list of common services that Medicare Part B covers. To find out if Medicare covers a service not on this list, visit www.medicare.gov, and select "Find Out What Medicare Covers," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What You Pay

Costs for Part B services depend on whether you have Original Medicare or are in a Medicare health plan. The charts on the following pages give general information about what you must pay if you have Original Medicare. For some services, there are no costs, but you may have to pay for the doctor's visit. If the Part B deductible applies, you must pay all costs until you meet the yearly Part B deductible before Medicare begins to pay its share. See page 121 for the Part B deductible amount. Then, after your deductible is met, you typically pay 20% of the Medicare-approved amount of the service. You can save money if you choose doctors or providers who accept assignment. See page 47. You also may be able to save money on your Medicare costs if you have limited income and resources. See pages 78–84.

Blue words in the text are defined on pages 115–118.

If you join a Medicare Advantage Plan (like an HMO or PPO) or have other insurance (like a Medigap policy, or employer or union coverage), your costs may be different. Contact the plans you are interested in to find out about the costs.

Part B-Covered Services

Abdominal Aortic Aneurysm Screening	A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your one-time "Welcome to Medicare" physical exam. See "Physical Exam." You pay 20% of the Medicare-approved amount.
Ambulance Services	Emergency ground transportation when you need to be transported to a hospital or skilled nursing facility for medically-necessary services, and transportation in any other vehicle could endanger your health. Medicare will pay for transportation in an airplane or helicopter if you require immediate and rapid ambulance transportation that ground transportation can't provide. In some cases, Medicare may pay for limited non-emergency transportation if you have orders from your doctor. Medicare will only cover services to the nearest appropriate medical facility that is able to give you the care you need. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Ambulatory Surgical Centers	Facility fees for approved surgical procedures provided in an Ambulatory Surgical Center (facility where surgical procedures are performed, and the patient is released within 24 hours). You pay 20% of the Medicare-approved amount (except for screening flexible sigmoidoscopies and screening colonoscopies, for which you pay 25%), and the Part B deductible applies. You pay all facility charges for procedures Medicare doesn't allow in ambulatory surgical centers.
Blood	In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. However, you will pay a copayment for the blood processing and handling services for every unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else. You pay a copayment for additional units of blood you get as an outpatient (after the first 3), and the Part B deductible applies.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Bone Mass Measurement (Bone Density)	Helps to see if you are at risk for broken bones. This service is covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Cardiovascular Screenings	Helps detect conditions that may lead to a heart attack or stroke. This service is covered every 5 years to test your cholesterol, lipid, and triglyceride levels. No cost for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.
Chiropractic Services (limited)	Helps correct a subluxation (when one or more of the bones of your spine move out of position) using manipulation of the spine. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Clinical Laboratory Services	Includes certain blood tests, urinalysis, some screening tests, and more. No cost to you.
Clinical Research Studies	Clinical research studies test different types of medical care, like how well a cancer drug works. They help doctors and researchers see if the new care works and if it's safe. Medicare covers some costs, like doctor visits and tests, in qualifying clinical research studies. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B deductible and coinsurance amounts are on page 121.

Medicare may cover some services and tests more often than the timeframes listed if needed to diagnose a condition.

Part B-Covered Services

Colorectal Cancer Screenings	To help find precancerous growths and help prevent or find cancer early, when treatment is most effective. One or more of the following tests may be covered. Talk to your doctor. ▪ Fecal Occult Blood Test—Once every 12 months if age 50 or older. No cost for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit. ▪ Flexible Sigmoidoscopy—Generally, once every 48 months if age 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk. You pay 20% of the Medicare-approved amount. ▪ Colonoscopy—Generally once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. No minimum age. You pay 20% of the Medicare-approved amount. ▪ Barium Enema—Once every 48 months if age 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy. You pay 20% of the Medicare-approved amount. **Note:** If you get a screening flexible sigmoidoscopy or screening colonoscopy in an outpatient hospital setting or an ambulatory surgical center, you pay 25% of the Medicare-approved amount.
Defibrillator (Implantable Automatic)	For some people diagnosed with heart failure. You pay 20% of the Medicare-approved amount for the doctor's services. You pay a copayment but no more than the Part A hospital stay deductible (see page 120) if you get the device as a hospital outpatient. The Part B deductible applies.

Part B deductible and coinsurance amounts are on page 121.

Medicare may cover some services and tests more often than the timeframes listed if needed to diagnose a condition.

Part B-Covered Services

Diabetes Screenings	Checks for diabetes. These screenings are covered if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests are also covered if you answer yes to two or more of the following questions: ▪ Are you age 65 or older? ▪ Are you overweight? ▪ Do you have a family history of diabetes (parents, siblings)? ▪ Do you have a history of gestational diabetes (diabetes during pregnancy), or did you deliver a baby weighing more than 9 pounds? Based on the results of these tests, you may be eligible for up to two diabetes screenings every year. No cost for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.
Diabetes Self-Management Training	For people with diabetes. Your doctor or other health care provider must provide a written order. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Diabetes Supplies	Including blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Insulin is covered only if used with an insulin pump. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **Note:** Insulin and certain medical supplies used to inject insulin, such as syringes, may be covered by Medicare prescription drug coverage (Part D).

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Doctor Services	Services that are medically necessary (includes outpatient and some doctor services you get when you are a hospital inpatient) or covered preventive services. Doesn't cover routine physicals except for the one-time "Welcome to Medicare" physical exam. See "Physical Exam." You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Durable Medical Equipment (like walkers)	Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds your doctor orders for use in the home. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. You must get your covered equipment or supplies from a supplier enrolled in Medicare. You should also check if the supplier is a participating supplier. Participating suppliers must accept assignment (see page 47), and your out-of-pocket costs may be less.
NEW EKG Screening	Medicare covers a one-time screening EKG if you get a referral for it as a result of your one-time "Welcome to Medicare" physical exam. See "Physical Exam." You pay 20% of the Medicare-approved amount, and the Part B deductible applies. An EKG is also covered as a diagnostic test. See page 36.
Emergency Room Services	When you believe your health is in serious danger. You may have a bad injury, a sudden illness, or an illness that quickly gets much worse. You pay a specified copayment for the hospital emergency department visit, and you pay 20% of the Medicare-approved amount for the doctor's services. The Part B deductible applies.
Eye Exams for People with Diabetes	Checks for diabetic retinopathy once every 12 months by an eye doctor who is legally allowed by the state to do the test. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Eyeglasses (limited)	One pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Federally-Qualified Health Center Services	Includes many outpatient primary care and preventive services you get through certain community-based organizations. You pay 20% of the Medicare-approved amount.
Flu Shots	Helps prevent influenza or flu virus. Covered once a flu season in the fall or winter. You need a flu shot for the current virus each year. No cost to you for the flu shot if the doctor accepts assignment for giving the shot.
Foot Exams and Treatment	If you have diabetes-related nerve damage and/or meet certain conditions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Glaucoma Tests	Helps find the eye disease glaucoma. Covered once every 12 months for people at high risk for glaucoma. You are considered high risk for glaucoma if you have diabetes, a family history of glaucoma, are African-American and age 50 or older, or are Hispanic and age 65 or older. An eye doctor who is legally authorized by the state must do the tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Hearing and Balance Exams	If your doctor orders it to see if you need medical treatment. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **Note:** Medicare doesn't cover hearing aids and exams for fitting hearing aids.
Hepatitis B Shots	Helps protect people from getting Hepatitis B. This is covered for people at high or medium risk for Hepatitis B. Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (ESRD), or a condition that increases your risk for infection. Other factors may increase your risk for Hepatitis B, so check with your doctor. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Home Health Services	Limited to medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor must order it, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort. No cost to you for home health services. For Medicare-covered durable medical equipment, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Kidney Dialysis Services and Supplies	For people with End-Stage Renal Disease (ESRD). Medicare covers dialysis either in a facility or at home when your doctor orders it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
NEW **Kidney Disease Education Services**	Medicare may cover kidney disease education services if you have kidney disease, and your doctor refers you for the service. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Mammograms (screening)	A type of X-ray to check women for breast cancer before they or their doctor may be able to find it. Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35–39. You pay 20% of the Medicare-approved amount.

Part B deductible and coinsurance amounts are on page 121.

Medicare may cover some services and tests more often than the timeframes listed if needed to diagnose a condition.

Part B-Covered Services

Medical Nutrition Therapy Services	Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you have had a kidney transplant in the last 36 months, and your doctor refers you for the service. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Mental Health Care (outpatient)	To get help with mental health conditions such as **depression**, **anxiety**, or **substance abuse**. Includes services generally given outside a hospital or in a hospital outpatient department, including visits with a doctor, psychiatrist, clinical psychologist, or clinical social worker, and lab tests. Certain limits and conditions apply. What you pay will depend on whether you are being diagnosed and monitored or whether you are getting treatment. ▪ For visits to a doctor or other health care provider to **diagnose** your condition, or to **monitor** or **change** your prescriptions, you pay 20% of the Medicare-approved amount. ▪ For outpatient **treatment** of your condition (such as counseling or psychotherapy), you pay 45% in 2010 (which is lower than in 2009) of the Medicare-approved amount. This copayment amount will continue to decrease over the next 4 years. The Part B deductible applies for both visits to diagnose or monitor your condition as well as treatment. **Note:** Inpatient mental health care is covered under Part A hospital stays. See page 20. Talk to your doctor if you feel sad, have little interest in things you used to enjoy, feel dependent on drugs or alcohol, or have thoughts about ending your life.
Non-doctor Services	Medicare covers services provided by non-doctors, such as physician assistants and nurse practitioners. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Occupational Therapy	Evaluation and treatment to help you return to usual activities (such as dressing or bathing) after an illness or accident when your doctor certifies you need it. There may be limits on physical therapy, occupational therapy, and speech-language pathology services and exceptions to these limits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Outpatient Hospital Services	Services you get as an outpatient as part of a doctor's care. You may pay more for a doctor's care in an outpatient department of a hospital than you will pay for the same care in a doctor's office. You pay a specified copayment for each service. The copayment can't be more than the Part A hospital stay deductible. See page 120. The Part B deductible applies.
Outpatient Medical and Surgical Services and Supplies	For approved procedures (like X-rays, a cast, or stitches). You pay a copayment for each service you get in an outpatient hospital setting. For each service, this amount can't be more than the Part A hospital stay deductible. See page 120. The Part B deductible applies, and you pay all charges for items or services that Medicare doesn't cover.
Pap Tests and Pelvic Exams (includes clinical breast exam)	Checks for cervical, vaginal, and breast cancers. Medicare covers these screening tests once every 24 months, or once every 12 months for women at high risk, and for women of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past 3 years. No cost to you for the Pap lab test. You pay 20% of the Medicare-approved amount for Pap test specimen collection, and pelvic and breast exams.
Physical Exam (one-time "Welcome to Medicare" physical exam)	A one-time review of your health, and education and counseling about preventive services, including certain screenings, shots, and referrals for other care if needed. Medicare will cover this exam if you get it within the first 12 months you have Part B. You pay 20% of the Medicare-approved amount. When you make your appointment, let your doctor's office know that you would like to schedule your "Welcome to Medicare" physical exam.
Physical Therapy	Evaluation and treatment for injuries and diseases that change your ability to function when your doctor certifies your need for it. There may be limits on these services and exceptions to these limits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Pneumococcal Shot	Helps prevent pneumococcal infections (like certain types of pneumonia). Most people only need this preventive shot once in their lifetime. Talk with your doctor. No cost if the doctor or supplier accepts assignment for giving the shot.
Prescription Drugs (limited)	Includes a limited number of drugs such as injections you get in a doctor's office, certain oral cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or infusion pump) and under very limited circumstances, certain drugs you get in a hospital outpatient department. You pay 20% of the Medicare-approved amount for these covered drugs. If the covered drugs you get in a hospital outpatient department are part of the service you get, you pay the copayment for the services. However, if you get other types of drugs in a hospital outpatient department, what you pay depends on whether you have Part D or other prescription drug coverage, whether the drug is covered by your drug plan, and whether the hospital is in your drug plan's network. Contact your prescription drug plan to find out what you pay for drugs you get in a hospital outpatient department. Keep in mind that under Part B, you pay 100% for most prescription drugs, unless you have Part D or other drug coverage. See page 69 for more information.
Prostate Cancer Screenings	Helps detect prostate cancer. Medicare covers a digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for all men with Medicare over age 50. You pay 20% of the Medicare-approved amount, and the Part B deductible applies for the doctor's visit. You pay nothing for the PSA test.
Prosthetic/ Orthotic Items	Including arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when your doctor orders it. For Medicare to cover your prosthetic or orthotic, you must go to a supplier that is enrolled in Medicare. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Rural Health Clinic Services	Includes many outpatient primary care services. You pay 20% of the amount charged, and the Part B deductible applies.
Second Surgical Opinions	Covered in some cases for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Smoking Cessation (counseling to stop smoking)	Includes up to 8 face-to-face visits in a 12-month period if you are diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Speech-Language Pathology Services	Evaluation and treatment given to regain and strengthen speech and language skills including cognitive and swallowing skills when your doctor certifies your need for it. There may be limits on these services and exceptions to these limits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Surgical Dressing Services	For treatment of a surgical or surgically-treated wound. You pay 20% of the Medicare-approved amount for doctor services. You pay a fixed copayment for these services when you get them in a hospital outpatient department. You pay nothing for the supplies. The Part B deductible applies.
Telehealth	Includes a limited number of medical or other health services, like office visits and consultations provided using an interactive two-way telecommunications system (like real-time audio and video) by an eligible provider who is at a location different from the patient's. Available in some rural areas, under certain conditions, and only if the patient is located at one of the following places: a doctor's office, hospital, rural health clinic, federally-qualified health center, hospital-based dialysis facility, skilled nursing facility, or community mental health center. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Tests	Including X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. See "Clinical Laboratory Services" on page 27 for other Part B-covered tests. If you get the test at a hospital as an outpatient, you pay a specified copayment that may be more than 20% of the Medicare-approved amount, but it can't be more than the Part A hospital stay deductible. See page 120.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Transplants and Immunosuppressive Drugs	Including doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and only in a Medicare-certified facility. Medicare covers bone marrow and cornea transplants under certain conditions. Immunosuppressive drugs are covered if Medicare paid for the transplant, or an employer or union group health plan that was required to pay before Medicare paid for the transplant. You must have been entitled to Part A at the time of the transplant, and you must be entitled to Part B at the time you get immunosuppressive drugs. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. If you are thinking about joining a Medicare Advantage Plan and are on a transplant waiting list or believe you need a transplant, check with the plan before you join to make sure your doctors and hospitals are in the plan's network. Also, check the plan's coverage rules for prior authorization. **Note:** Medicare drug plans (Part D) may cover immunosuppressive drugs, even if Medicare or an employer or union group health plan didn't pay for the transplant.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Travel (health care needed when traveling outside the United States) (limited)	Medicare generally doesn't cover health care while you are traveling outside the U.S. (the "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). There are some exceptions including some cases where Medicare may pay for services that you get while on board a ship within the territorial waters adjoining the land areas of the U.S. In rare cases, Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in the following situations: **1)** If an emergency arose within the U.S. and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition **2)** If you are traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency **3)** If you live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Urgently-Needed Care	To treat a sudden illness or injury that isn't a medical emergency. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B deductible and coinsurance amounts are on page 121.

What's NOT Covered by Part A and Part B?

Medicare doesn't cover everything. If you need certain services that Medicare doesn't cover, you will have to pay out-of-pocket unless you have other insurance to cover the costs. Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and copayments.

Blue words in the text are defined on pages 115–118.

Items and services that Medicare doesn't cover include, **but aren't limited to**, long-term care (see page 100), routine dental care, dentures, cosmetic surgery, acupuncture, hearing aids, and exams for fitting hearing aids.

To find out if Medicare covers a service you need, visit www.medicare.gov, and select "Find Out What Medicare Covers," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

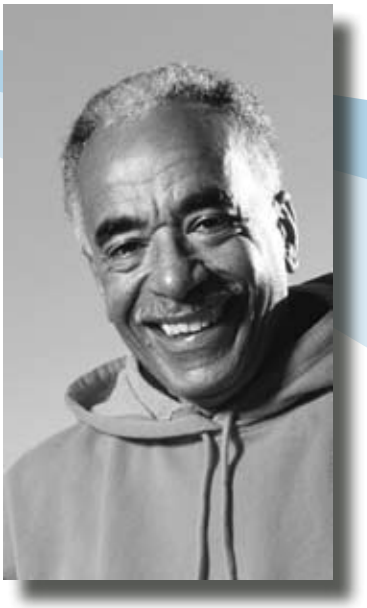
Preventive Services Checklist

Take this checklist to your doctor or other health care provider, and ask which preventive services are right for you. You can also keep track of your preventive services by visiting www.MyMedicare.gov. See page 107.

Medicare-covered Preventive Service		Details on Page	Notes
	Abdominal Aortic Aneurysm Screening	26	
	Bone Mass Measurement	27	
	Cardiovascular Screenings	27	
	Colorectal Cancer Screenings	28	
	Fecal Occult Blood Test	28	
	Flexible Sigmoidoscopy	28	
	Colonoscopy	28	
	Barium Enema	28	
	Diabetes Screenings	29	
	Diabetes Self-management Training	29	
	EKG Screening	30	
	Flu Shots	31	
	Glaucoma Tests	31	
	Hepatitis B Shots	31	
	Mammogram (screening)	32	
	Medical Nutrition Therapy Services	33	
	Pap Test and Pelvic Exam (includes breast exam)	34	
	Physical Exam (one-time "Welcome to Medicare" physical exam)	34	
	Pneumococcal Shot	35	
	Prostate Cancer Screenings	35	
	Smoking Cessation (counseling to stop smoking)	36	

For some services, you will need to wait a full 12 or 24 months before getting the service again. See the page numbers listed for more information.

SECTION 2



Your Medicare Choices

You have choices for how you get your Medicare health and prescription drug coverage. Before making any decisions, learn as much as you can about the types of coverage available to you.

Section 2 includes information about the following:

Decide How to Get Your Medicare 42–44
Original Medicare 45–49
Medicare Advantage Plans (Part C) 50–59
Other Medicare Health Plans 60–61
Medicare Prescription Drug Coverage (Part D) 62–72
Who Pays First When You Have Other Insurance 73
Medigap (Medicare Supplement Insurance) Policies 74–76

This handbook has basic information. You will need more detailed information than this handbook provides to make a choice. See page 42 to get help with your Medicare decisions.

Decide How to Get Your Medicare

You can choose different ways to get your Medicare coverage. If you choose Original Medicare and you want drug coverage, you must join a Medicare Prescription Drug Plan (Part D). If you choose to join a Medicare Advantage Plan, the plan may include Medicare prescription drug coverage. In most cases, if you don't make a choice, you will have Original Medicare. See the next page for more information about your coverage choices and the decisions you need to make.

Note: If you have End-Stage Renal Disease (ESRD), you will usually get your health care through Original Medicare. See page 53 for more information.

Each year you should review your health and prescription needs because your health, finances, or plan's coverage may have changed. If you decide other coverage will better meet your needs, you can switch plans during certain times. See pages 58 and 63. If you are satisfied with your current plan's coverage for the following year, you don't need to change plans.

Need Help Deciding?

1. Visit www.medicare.gov, and select "Compare Health Plans and Medigap Policies in Your Area" or "Compare Medicare Prescription Drug Plans."
2. Get free personalized counseling about choosing coverage. See pages 110–113 for the telephone number of your State Health Insurance Assistance Program (SHIP).
3. Call 1-800-MEDICARE (1-800-633-4227), and say "Agent." TTY users should call 1-877-486-2048. If you need help in a language other than English or Spanish, let the customer service representative know.

Blue words in the text are defined on pages 115–118.

Note: The Medicare plan you join will use and release your personal information to other entities as permitted or required by law including for treatment, payment, health care operations, and for research and other purposes. See pages 92–93 to find out more about how Original Medicare uses and releases your personal information. If you have a Medicare Advantage Plan, contact your plan.

There are Two Main Choices for How You Get Your Medicare

Use These Steps to Help You Decide

Step 1

Decide if You Want Original Medicare or a Medicare Advantage Plan

Original Medicare

Part A (Hospital Insurance) and Part B (Medical Insurance)

- Medicare provides this coverage.
- You have your choice of doctors, hospitals, and other providers.
- Generally, you or your supplemental coverage pay deductibles and coinsurance.
- You usually pay a monthly premium for Part B.

See pages 45–49.

Step 2

Decide If You Want Prescription Drug Coverage (Part D)

- If you want this coverage, you must choose and join a Medicare Prescription Drug Plan.
- These plans are run by private companies approved by Medicare.

See pages 62–70.

Step 3

Decide If You Want Supplemental Coverage

- You may want to get coverage that fills gaps in Original Medicare coverage. You can choose to buy a Medigap (Medicare Supplement Insurance) policy from a private company.
- Costs vary by policy and company.
- Employers/unions may offer similar coverage.

See pages 74–76.

Medicare Advantage Plan

(like an HMO or PPO)

Part C—Includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance)

- Private insurance companies approved by Medicare provide this coverage.
- In most plans, you need to use plan doctors, hospitals, and other providers or you pay more or all of the costs.
- You usually pay a monthly premium (in addition to your Part B premium) and a copayment or coinsurance for covered services.
- Costs, extra coverage, and rules vary by plan.

See pages 50–59.

Step 2

Decide If You Want Prescription Drug Coverage (Part D)

- If you want prescription drug coverage, and it's offered by your plan, in most cases you must get it through your plan.
- If your plan doesn't offer drug coverage, you can choose and join a Medicare Prescription Drug Plan.

See pages 55–57.

Note: If you join a Medicare Advantage Plan, you don't need a Medigap policy. If you already have a Medigap policy, you can't use it to pay for out-of-pocket costs you have under the Medicare Advantage Plan. If you already have a Medicare Advantage Plan, you can't be sold a Medigap policy.
See pages 74–76.

In addition to Original Medicare or a Medicare Advantage Plan, you may be able to join other types of Medicare health plans. See pages 60–61. You may be able to save money or have other choices if you have limited income and resources. See pages 77–84. You may also have other coverage, like employer or union, military, or Veterans' benefits. See pages 71–72.

Things to Consider When Choosing or Changing Your Coverage

Blue words in the text are defined on pages 115–118.

- **Coverage**—Are the services you need covered?
- **Your other coverage**—Do you have, or are you eligible for, other types of health or prescription drug coverage? If so, read the materials you get from your insurer or plan, or call them to find out how the coverage works with, or is affected by, Medicare. If you have coverage through a former or current employer or union, or get your health care from an Indian Health or Tribal Health Program, talk to your benefits administrator, insurer, or plan before making any changes to your coverage.
- **Cost**—How much are your premiums, deductibles, and other costs? How much do you pay for services like hospital stays or doctor visits? Is there a yearly limit on what you could pay out-of-pocket for medical services? Your costs vary and may be different if you don't follow the coverage rules.
- **Doctor and hospital choice**—Do your doctors accept the coverage? Are the doctors you want to see accepting new patients? Do you have to choose your hospital and health care providers from a network? Do you need to get referrals?
- **Prescription drugs**—What are your drug needs? Do you need to join a Medicare drug plan? Do you already have creditable prescription drug coverage? Will you pay a penalty if you join a drug plan later? What will your prescription drugs cost under each plan? Are your drugs covered under the plan's formulary (drug list)?
- **Quality of care**—The quality of care and services given by plans and other health care providers can vary. Medicare has information to help you compare plans and providers. See page 108.
- **Convenience**—Where are the doctors' offices? What are their hours? Which pharmacies can you use? Can you get your prescriptions by mail? Do the doctors use electronic health records or E-prescribe? See page 123.
- **Travel**—Will the plan cover you in another state?

If you are in a Medicare plan, review the Evidence of Coverage (EOC) and Annual Notice of Change (ANOC) your plan sends you each year. The EOC gives you details about what the plan covers, how much you pay, and more. The ANOC includes any changes in coverage, costs, or service area that will be effective in January. If you don't get an EOC or ANOC, contact your plan.

Original Medicare

Original Medicare is one of your health coverage choices as part of the Medicare Program. You will be in Original Medicare unless you choose a Medicare health plan.

How Does It Work?

Original Medicare is fee-for-service coverage (generally, there is a cost for each service). The Federal government manages it. Here are the general rules for how it works:

	Original Medicare
Can I get my health care from any doctor or hospital?	Yes. You can go to any doctor, supplier, hospital, or other facility that is enrolled in Medicare and is accepting new Medicare patients.
Are prescription drugs covered?	With a few exceptions (see pages 20 and 35), most prescriptions aren't covered. You can add comprehensive drug coverage by joining a Medicare Prescription Drug Plan (Part D).
Do I need to choose a primary care doctor?	No.
Do I have to get a referral to see a specialist?	No.
Do I need a supplemental policy?	You may already have employer or union coverage that may pay costs that Original Medicare doesn't. If not, you may want to buy a Medigap (Medicare Supplement Insurance) policy.
What else do I need to know about Original Medicare?	▪ You generally pay a set amount for your health care (deductible) before Medicare pays its share. Then, Medicare pays its share, and you pay your share (coinsurance/copayment) for covered services and supplies. See pages 120–121 to find out what you pay. ▪ You usually pay a monthly premium for Part B. See page 83 for more information about Medicare Savings Programs. ▪ You generally don't need to file Medicare claims. The law requires providers (like doctors, hospitals, skilled nursing facilities, and home health agencies) and suppliers to file Medicare claims for the covered services and supplies you get.

What You Pay

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

- Whether you have Part A and/or Part B (most people have both).
- Whether your doctor or supplier accepts "assignment." See the next page.
- Whether you and your doctor sign a private contract. See page 48.
- The type of health care you need and how often you need it.
- Whether you choose to get services or supplies Medicare doesn't cover. If you do, you pay all the costs for these services.
- Whether you have other health insurance that works with Medicare.
- Whether you have Medicaid or get state help paying your Medicare costs.
- Whether you have a Medigap (Medicare Supplement Insurance) policy.

For more information on who pays first when you have other insurance, see page 73. For more information about help to cover the costs that Original Medicare doesn't cover, see pages 74–83.

Medicare Summary Notices

If you get a Medicare-covered service, you will get a Medicare Summary Notice (MSN) in the mail. The MSN shows all the services or supplies that providers and suppliers billed to Medicare during each 3-month period, what Medicare paid, and what you may owe the provider. **The MSN isn't a bill.** When you get your MSN, read it carefully and do the following:

- If you have other insurance, check to see if it covers anything that Medicare didn't.
- Keep your receipts and bills, and compare them to your MSN to be sure you got all the services, supplies, or equipment listed. See page 96 for information on billing fraud.
- If you paid a bill before you got your MSN, compare your MSN with the bill to make sure you paid the right amount for your services.
- If an item or service is denied, call your doctor's office to make sure the claim is coded correctly. If not, the office can resubmit. If you want to file an appeal, see page 87.

MSNs are mailed every 3 months. If Medicare owes you a refund, the MSN will be mailed as soon as the claim is processed. If you need to change your address on your MSN, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get RRB benefits, call the RRB at 1-877-772-5772.

Visit www.MyMedicare.gov to track your Medicare claims. See page 107.

Keeping Your Costs Down ("Assignment" in Original Medicare)

Assignment means that your doctor, provider, or supplier has signed an agreement with Medicare to accept the Medicare-approved amount as full payment for covered services.

Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. You may also want to find out how much you have to pay for each service or supply before you get it. In some cases they must accept assignment, like when they have a participation agreement with Medicare and give you Medicare-covered services.

If your doctor, provider, or supplier **accepts** assignment:

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

If your doctor, provider, or supplier **doesn't accept** assignment:

- They still must submit a claim to Medicare when they give you Medicare-covered services. If they don't submit the claim, ask them to file a Medicare claim for your services. If they still don't file your claim, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You might have to pay the entire charge at the time of service, and then submit your claim to Medicare to get paid back.
- They may charge you more than the Medicare-approved amount, but there is a limit called "the limiting charge." They can only charge you up to 15% over the Medicare-approved amount. The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment.

Blue words in the text are defined on pages 115–118.

To find doctors and suppliers who accept assignment (participate in Medicare), visit www.medicare.gov and select, "Find a Doctor or Other Healthcare Professional" or "Find Suppliers of Medical Equipment in Your Area." You can also call 1-800-MEDICARE.

What Is a Private Contract?

A "private contract" is a written agreement between you and a doctor or other health care provider who has decided not to provide services to anyone through Medicare. The private contract only applies to the services provided by the doctor or other provider who asked you to sign it. You don't have to sign a private contract. You can always go to another doctor who does provide services through Medicare.
If you sign a private contract with your doctor or other provider, the following rules apply:

- **Medicare won't pay any amount for the services you get from this doctor or other provider.**
- You will have to pay the full amount of whatever this doctor charges you for the services you get.
- If you have a Medigap (Medicare Supplement Insurance) policy, it won't pay anything for the services you get. Call your Medigap insurance company before you get the service if you have questions.
- Your doctor must tell you if the service is one that Medicare would pay for if you got it from another doctor who accepts Medicare.
- Your doctor must tell you if he or she has been excluded from Medicare.

You can't be asked to sign a private contract for emergency or urgent care.

You are always free to get services not covered by Medicare if you choose to pay for a service yourself.

You may want to contact your State Health Insurance Assistance Program (SHIP) to get help before signing a private contract with any doctor or other health care provider. See pages 110–113 for the telephone number.

See pages 86–98 for information about your appeal rights and how to protect yourself and Medicare from fraud.

Adding Medicare Drug Coverage (Part D)

In Original Medicare, if you don't already have creditable prescription drug coverage and you would like prescription drug coverage, you must join a Medicare Prescription Drug Plan. These plans are available through private companies approved by and under contract with Medicare. If you don't currently have creditable prescription drug coverage, you should think about joining a Medicare Prescription Drug Plan as soon as you are eligible. If you don't join a Medicare Prescription Drug Plan when you are first eligible and you decide to join later, you may have to pay a late enrollment penalty. See pages 62–72 for more information.

If you have creditable prescription drug coverage, call your employer or union's benefits administrator before you make any changes to your coverage. If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union **drug** coverage without also dropping your employer or union **health** (doctor and hospital) coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependants.

Extra Help Paying for Drug Coverage

People with limited income and resources may qualify for Extra Help paying their Medicare prescription drug coverage costs. If you automatically qualify for Extra Help, you won't pay a premium if you join certain Medicare drug plans. If you don't automatically qualify, you may still get help to pay your prescription drug costs. See pages 78–81 to find out if you may qualify for Extra Help.

Blue words in the text are defined on pages 115–118.

Medicare Advantage Plans (Part C)

A Medicare Advantage Plan (like an HMO or PPO) is another health coverage choice you may have as part of Medicare. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, the plan will provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. In all plan types, you are always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care. Original Medicare covers hospice care even if you are in a Medicare Advantage Plan. Medicare Advantage Plans aren't considered supplemental coverage.

Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage. In addition to your Part B premium, you usually pay one monthly premium for the services provided.

Medicare pays a fixed amount for your care every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to only doctors, facilities, or suppliers that belong to the plan).

Medicare Advantage Plans include the following:

- Health Maintenance Organization (HMO) Plans. See page 55.
- Preferred Provider Organization (PPO) Plans. See page 55.
- Private Fee-for-Service (PFFS) Plans. See page 56.
- Medical Savings Account (MSA) Plans. See page 56.
- Special Needs Plans (SNP). See page 57.

Make sure you understand how a plan works before you join. See pages 55–57 for more information about Medicare Advantage Plan types.

Medicare Advantage Plans include the following: (continued)

There are other less common types of Medicare Advantage Plans that may be available:

- Point of Service (POS) Plans—Similar to HMOs, but you may be able to get some services out-of-network for a higher cost.
- Provider Sponsored Organizations (PSOs)—Plans run by a provider or group of providers. In a PSO, you usually get your health care from the providers who are part of the plan.

Not all Medicare Advantage Plans work the same way, so before you join, find out the plan's rules, what your costs will be, and whether the plan will meet your needs. Find out what types of plans are available in your area by visiting www.medicare.gov and selecting "Compare Health Plans and Medigap Policies in Your Area." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Contact the plans you are interested in to get more information.

More About Medicare Advantage Plans

- As with Original Medicare, you still have Medicare rights and protections, including the right to appeal. See pages 86–89.
- Check with the plan before you get a service to find out whether they will cover the service and what your costs may be.
- You must follow plan rules, like getting a referral to see a specialist or getting prior approval for certain procedures to avoid higher costs. Check with the plan.
- You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease.
- You can only join a plan at certain times during the year. See page 58. In most cases, you are enrolled in a plan for a year.
- If you go to a doctor, facility, or supplier that doesn't belong to the plan, your services may not be covered, or your costs could be higher, depending on the type of Medicare Advantage Plan.
- If the plan decides to stop participating in Medicare, you will have to join another Medicare health plan or return to Original Medicare. See page 59.

Blue words in the text are defined on pages 115–118.

More About Medicare Advantage Plans (continued)

- You usually get prescription drug coverage (Part D) through the plan. **If you are in a Medicare Advantage Plan that includes prescription drug coverage and you join a Medicare Prescription Drug Plan, you will be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.**
- You don't need to buy (and can't be sold) a Medigap (Medicare Supplement Insurance) policy while you are in a Medicare Advantage Plan. It won't cover your Medicare Advantage Plan deductibles, copayment, or coinsurance.

Blue words in the text are defined on pages 115–118.

Who Can Join?

You can generally join a Medicare Advantage Plan if you meet these conditions:

- You have Part A and Part B.
- You live in the service area of the plan.
- You don't have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) except as explained on page 53.

Note: In most cases, you can join a Medicare Advantage Plan only at certain times during the year. See page 58.

If You Have Other Coverage

Talk to your employer, union, or Indian or Tribal Health Program benefits administrator about their rules before you join a Medicare Advantage Plan. In some cases, joining a Medicare Advantage Plan might cause you to lose employer or union coverage. In other cases, if you join a Medicare Advantage Plan, you may still be able to use your employer or union coverage along with the plan you join. **Remember, if you drop your employer or union coverage, you may not be able to get it back.**

If You Have a Medigap (Medicare Supplement Insurance) Policy

If you already have a Medigap policy, you can't use it to pay for any expenses you have under a Medicare Advantage Plan. If you drop your Medigap policy to join a Medicare Advantage Plan, in most cases, you won't be able to get it back. See pages 74–75.

If You Have End-Stage Renal Disease (ESRD)

If you have End-Stage Renal Disease (ESRD) and Original Medicare, you may join a Medicare Prescription Drug Plan. However, you usually can't join a Medicare Advantage Plan.

- If you are already in a Medicare Advantage Plan when you develop ESRD, you can stay in your plan or join another plan offered by the same company under certain circumstances.
- If you have an employer or union health plan or other health coverage through a company that offers Medicare Advantage Plans, you may be able to join one of their Medicare Advantage Plans.
- If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan.

If you have ESRD and are in a Medicare Advantage Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan. You don't have to use your one-time right to join a new plan immediately. If you go directly to Original Medicare after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan later.

You may also be able to join a Medicare Special Needs Plan (SNP) for people with ESRD if one is available in your area.

For questions or complaints about kidney dialysis services, call your local ESRD Network Organization. An ESRD Network Organization is a group of kidney care experts paid by the Federal government to check and improve the care given to Medicare patients who get dialysis treatments for kidney care. Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number. TTY users should call 1-877-486-2048.

For more information about ESRD, visit www.medicare.gov/Publications/Pubs/pdf/10128.pdf to view the booklet, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services."

What You Pay

Your out-of-pocket costs in a Medicare Advantage Plan depend on the following:

- Whether the plan charges a monthly premium in addition to your Part B premium.
- Whether the plan pays any of the monthly Part B premium. Some plans offer this option, usually for an extra cost.
- Whether the plan has a yearly deductible or any additional deductibles.
- How much you pay for each visit or service (copayments).
- The type of health care services you need and how often you get them.
- Whether you follow the plan's rules, like using network providers.
- Whether you need extra coverage and what the plan charges for it.
- Whether the plan has a yearly limit on your out-of-pocket costs for all medical services.

To learn more about your costs in specific Medicare Advantage Plans, contact the plans you are interested in to get more details. Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

If you have limited income and resources, you may qualify for the following:

- Extra Help paying your Part D premium and other prescription drug coverage costs. See pages 78–81.
- Help from your state to pay your Part B premium. See page 83.

Blue words in the text are defined on pages 115–118.

How Do Medicare Advantage Plans Work?

(Chart continues on next page.)

	Health Maintenance Organization (HMO) Plan	Preferred Provider Organization (PPO) Plan
Can I get my health care from any doctor or hospital?	No. You generally must get your care and services from doctors or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services usually for a higher cost.	Yes. PPOs have network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want drug coverage, you must join an HMO Plan that offers prescription drug coverage.	In most cases, yes. Ask the plan. If you want drug coverage, you must join a PPO Plan that offers prescription drug coverage.
Do I need to choose a primary care doctor?	In most cases, yes.	No.
Do I have to get a referral to see a specialist?	In most cases, yes. Yearly screening mammograms and in-network Pap tests and pelvic exams (at least every other year) don't require a referral.	No.
What else do I need to know about this type of plan?	▪ If your doctor leaves the plan, your plan will notify you. You can choose another doctor in the plan. ▪ If you get health care outside the plan's network, you may have to pay the full cost. ▪ It's important that you follow the plan's rules, like getting prior approval for a certain service when needed.	▪ There are two types of PPOs—Regional PPOs and Local PPOs. ▪ Regional PPOs serve one of 26 regions set by Medicare. ▪ Local PPOs serve the counties the PPO Plan chooses to include in its service area.

Medicare Advantage Plans can vary. Read individual plan materials carefully to make sure you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered and how much it costs. Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

How Do Medicare Advantage Plans Work? (continued)

	Private Fee-for-Service (PFFS) Plan	Medical Savings Account (MSA) Plan
Can I get my health care from any doctor or hospital?	In some cases, yes. **You can go to any Medicare-approved doctor or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will. If you join a PFFS Plan that has a network, you will usually pay more to see out-of-network providers.**	Yes. Some plans may have preferred doctors and hospitals you could go to for a lower cost.
Are prescription drugs covered?	Sometimes. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan to get coverage.	No. You can join a Medicare Prescription Drug Plan to get drug coverage.
Do I need to choose a primary care doctor?	No.	No.
Do I have to get a referral to see a specialist?	No.	No.
What else do I need to know about this type of plan?	▪ **PFFS Plans aren't the same as Original Medicare or Medigap.** ▪ The plan decides how much you must pay for services. ▪ **Doctors, hospitals, and other providers may decide on a case-by-case basis not to treat you even if you've seen them before.** ▪ For each service you get, check to make sure your doctors, hospitals, and other providers will agree to treat you under the plan, and that they will accept the PFFS Plan's payment terms. ▪ In an emergency, doctors, hospitals, and other providers must agree to treat you.	▪ Medicare MSA Plans have two parts: a high deductible health plan and a bank account. Medicare gives the plan an amount each year for your health care, and the plan deposits a portion of this money into your account. The amount deposited is less than your deductible amount, so you will have to pay out-of-pocket before your coverage begins. ▪ Money spent for Medicare-covered Part A and Part B services counts toward your plan's deductible. After you reach your out-of-pocket limit, your plan will cover your Medicare-covered services in full. ▪ Any money left in your account at the end of the year remains in your account along with the deposit for next year.

Note: In 2010, Medicare MSA Plans are only available in Pennsylvania.

How Do Medicare Advantage Plans Work? (continued)

	Special Needs Plan (SNP)
Can I get my health care from any doctor or hospital?	You generally must get your care and services from doctors or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). Plans typically have specialists for the diseases or conditions that affect their members.
Are prescription drugs covered?	Yes. All SNPs must provide Medicare prescription drug coverage (Part D).
Do I need to choose a primary care doctor?	Generally, yes, or you may need to have a care coordinator to help plan your care.
Do I have to get a referral to see a specialist?	In most cases, yes. Yearly screening mammograms and an in-network Pap test and pelvic exam (at least every other year) don't require a referral.
What else do I need to know about this type of plan?	▪ A plan must limit plan membership to people in one of the following groups: 1) people who live in certain institutions (like a nursing home) or who require nursing care at home, or 2) people who are eligible for both Medicare and Medicaid, or 3) people who have one or more specific chronic or disabling conditions (like diabetes, congestive heart failure, a mental health condition, or HIV/AIDS). ▪ Plans may further limit membership within these groups. ▪ Plans should coordinate the services and providers you need to help you stay healthy and follow your doctor's orders. ▪ If you have Medicare and Medicaid, your plan should make sure that all of the plan doctors or other health care providers you use accept Medicaid. ▪ If you live in an institution, make sure that plan doctors or other health care providers serve people where you live.

Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

When Can You Join, Switch, or Drop a Medicare Advantage Plan?

You can join, switch, or drop a Medicare Advantage Plan at these times:

- When you first become eligible for Medicare (the 7-month period that begins 3 months before the month you turn age 65, includes the month you turn age 65, and ends 3 months after the month you turn age 65).
- If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of disability. You will have another chance to join 3 months before the month you turn age 65 to 3 months after the month you turn age 65.
- Between November 15–December 31 each year. Your coverage will begin on January 1 of the following year, as long as the plan gets your enrollment request by December 31.
- Between January 1–March 31 of each year. Your coverage will begin the first day of the month after the plan gets your enrollment form. During this period, you can't do the following:
    - Join or switch to a plan with prescription drug coverage unless you already have Medicare prescription drug coverage (Part D).
    - Drop a plan with prescription drug coverage.
    - Join, switch, or drop a Medicare Medical Savings Account Plan.

Blue words in the text are defined on pages 115–118.

In most cases, you must stay enrolled for that calendar year starting the date your coverage begins. However, in certain situations, you may be able to join, switch, or drop a Medicare Advantage Plan at other times. Some of these situations include the following:

- If you move out of your plan's service area
- If you have both Medicare and Medicaid
- If you qualify for Extra Help to pay for your prescription drug costs (see pages 78–81)
- If you live in an institution (like a nursing home)

You can call your State Health Insurance Assistance Program (SHIP) for more information. See pages 110–113 for the telephone number.

No one should call you or come to your home uninvited to sell Medicare products. See pages 94–97 for more information about how to protect yourself from identity theft and fraud. If you believe a plan has misled you, call 1-800-MEDICARE (1-800-633-4227).

How Do You Join?

If you choose to join a Medicare Advantage Plan, you may be able to join by completing a paper application, calling the plan, or enrolling on the plan's Web site or on www.medicare.gov. You can also enroll by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Talk with the plan to find out how you can join. When you join a Medicare Advantage Plan, you will have to provide your Medicare number and the date your Part A and/or Part B coverage started. This information is on your Medicare card.

How Do You Switch?

If you are already in a Medicare Advantage Plan and want to switch, this is what you need to do:

- To switch to a new Medicare Advantage Plan, simply join the plan you choose. You will be disenrolled automatically from your old plan when your new plan's coverage begins.
- To switch to Original Medicare, contact your current plan, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You will also need to decide about Medicare prescription drug coverage (Part D).

Note: You can only switch plans at certain times. See page 58.

If Your Plan Decides Not to Participate in Medicare

Your plan will send you a letter about your options. Generally, you will automatically return to Original Medicare if you don't choose to join another Medicare Advantage Plan. You will also have the right to buy certain Medigap policies.

If Your Plan Stops Providing Service in Your Area

You may be able to keep your coverage with that plan if there are no other Medicare Advantage Plans in your area. If your plan offers this option, you must agree to travel to the plan's service area to get all your services (except for emergency and urgently-needed care). If your plan doesn't have this option, you will automatically return to Original Medicare. In this case you will have the right to buy a Medigap policy. If you decide to return to Original Medicare and you want drug coverage, you will need to join a Medicare Prescription Drug Plan.

Other Medicare Health Plans

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage Plans but are still part of Medicare. Some of these plans provide Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage, and some also provide Part D (Medicare prescription drug coverage). These plans have some of the same rules as Medicare Advantage Plans. Some of these rules are explained briefly below and on the next page. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details.

Medicare Cost Plans

Medicare Cost Plans are a type of Medicare health plan available in certain areas of the country. Here's what you should know about Medicare Cost Plans:

- You can join even if you only have Part B.
- If you go to a non-network provider, the services are covered under Original Medicare. You would pay the Part B premium, and the Part A and Part B coinsurance and deductibles.
- You can join anytime the plan is accepting new members.
- You can leave anytime and return to Original Medicare.
- You can either get your Medicare prescription drug coverage from the plan (if offered), or you can join a Medicare Prescription Drug Plan to add prescription drug coverage.

Blue words in the text are defined on pages 115–118.

There is another type of Medicare Cost Plan that only provides coverage for Part B services. These plans never include Part D. Part A services are covered through Original Medicare. These plans are either sponsored by employer or union group health plans or offered by companies that don't provide Part A services.

For more information about Medicare Cost Plans, contact the plans you're interested in. You can also visit www.medicare.gov. Your State Health Insurance Assistance Program (SHIP) can also give you more information. See pages 110–113 for the telephone number.

Other Medicare Health Plans (continued)

Demonstrations/Pilot Programs

Demonstrations and pilot programs, sometimes called "research studies," are special projects that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time for a specific group of people and/or are offered only in specific areas. Check with the demonstration or pilot program for more information about how it works.

For more information about current Medicare demonstrations and pilot programs, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227), and say "Agent." TTY users should call 1-877-486-2048.

Programs of All-inclusive Care for the Elderly (PACE)

PACE combines medical, social, and long-term care services, and prescription drug coverage for frail elderly and disabled people. This program provides community-based care and services to people who otherwise need a nursing home-level of care.

To qualify for PACE, you must meet the following conditions:

- You are age 55 or older.
- You live in the service area of a PACE organization.
- You are certified by your state as meeting the need for a nursing home-level of care.
- At the time you join, you are able to live safely in the community with the help of PACE services.

PACE uses Medicare and Medicaid funds to cover all of your medically-necessary care and services. You can have either Medicare or Medicaid or both to join PACE. Call your State Medical Assistance (Medicaid) office to find out if you are eligible and if there is a PACE site near you. For more information, you can also visit www.medicare.gov/Publications/Pubs/pdf/11341.pdf to view the fact sheet, "Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)."

See pages 100–102 for more information about PACE and long-term care.

Medicare Prescription Drug Coverage (Part D)

Medicare offers prescription drug coverage (Part D) to everyone with Medicare. To get Medicare drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered.

Blue words in the text are defined on pages 115–118.

There are two ways to get Medicare prescription drug coverage:

1. **Medicare Prescription Drug Plans.** These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
2. **Medicare Advantage Plans (like an HMO or PPO) or other Medicare health plans that offer Medicare prescription drug coverage.** You get all of your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs."

Both types of plans are called "Medicare drug plans" in this section.

Why Join a Medicare Drug Plan?

Even if you don't take a lot of prescription drugs now, you should still consider joining a Medicare drug plan. See page 43 for a list of things to consider when choosing a plan. If you decide not to join a Medicare drug plan when you are first eligible, and you don't have other creditable prescription drug coverage (also called creditable coverage), you will likely pay a late enrollment penalty (higher premiums) if you join later. See page 67 for more information on creditable coverage and the late enrollment penalty.

Note: Discount cards, doctor samples, free clinics, drug discount Web sites, and manufacturer's pharmacy assistance programs aren't considered prescription drug coverage and aren't creditable coverage.

If you have limited income and resources, you may qualify for Extra Help from Medicare to pay for prescription drug coverage. You may also be able to get help from your state. See pages 78–84.

Who Can Get Medicare Drug Coverage?

To join a Medicare Prescription Drug Plan, you must have Medicare Part A and/or Part B. If you would like to get prescription drug coverage through a Medicare Advantage Plan, you must have Part A **and** Part B. You must also live in the service area of the Medicare drug plan you want to join.

If you have employer or union coverage, call your benefits administrator before you make any changes, or before you sign up for any other coverage. If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union **drug** coverage without also dropping your employer or union **health** (doctor and hospital) coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependants.

When Can You Join, Switch, or Drop a Medicare Drug Plan?

You can join, switch, or drop a Medicare drug plan at these times:

- When you are first eligible for Medicare (the 7-month period that begins 3 months before the month you turn age 65, includes the month you turn age 65, and ends 3 months after the month you turn age 65).
- If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of disability. You will have another chance to join 3 months before the month you turn age 65 to 3 months after the month you turn age 65.
- Between November 15–December 31 each year. Your coverage will begin on January 1 of the following year, as long as the plan gets your enrollment request by December 31.
- Between January 1–March 31 of each year if you already have Medicare prescription drug coverage.
- Anytime, if you qualify for Extra Help or if you have both Medicare and Medicaid.

In most cases, you must stay enrolled for that calendar year starting the date your coverage begins. However, in certain situations, you may be able to join, switch, or drop Medicare drug plans during a special enrollment period (like if you move out of the service area, lose other creditable prescription drug coverage, or live in an institution).

When Can You Join, Switch, or Drop a Medicare Drug Plan? (continued)

Call your State Health Insurance Assistance Program (SHIP) for more information. See pages 110–113 for the telephone number. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How Do You Join?

Once you choose a Medicare drug plan, you may be able to join by completing a paper application, calling the plan, or enrolling on the plan's Web site or on www.medicare.gov. You can also enroll by calling 1-800-MEDICARE. **Medicare drug plans aren't allowed to call you to enroll you in a plan. Call 1-800-MEDICARE to report a plan that does this.**

Blue words in the text are defined on pages 115–118.

Contact the plan to find out how you can join. When you join a Medicare drug plan, you will have to provide your Medicare number and the date your Part A or Part B coverage started. This information is on your Medicare card. **Visit www.medicare.gov, or call 1-800-MEDICARE for a list of the Medicare plans in your area.**

How Do You Switch?

Depending on your circumstances, you can switch to a new Medicare drug plan simply by joining another drug plan during one of the times listed on page 63. **You don't need to cancel your old Medicare drug plan or send them anything.** Your old Medicare drug plan coverage will end when your new drug plan begins. You should get a letter from your new Medicare drug plan telling you when your coverage begins.

After you join a Medicare drug plan, the plan will mail you membership materials, including a card to use when you get your prescriptions filled.

Note: If your Medicare Prescription Drug Plan decides not to participate in Medicare or stops providing service in your area, your plan will send you a letter about your options. You will have the opportunity to join a different Medicare Prescription Drug Plan. If you have a Medicare Advantage Plan with prescription drug coverage, see page 59 for more information.

What You Pay

Exact coverage and costs are different for each Medicare drug plan, but all plans must provide at least a standard level of coverage set by Medicare.

Below and continued on the next page are descriptions of the payments you make throughout the year in a Medicare drug plan. After the descriptions is an example of what someone may pay in a Medicare drug plan. **Your actual drug plan costs will vary** depending on the prescriptions you use, the plan you choose, whether you go to a pharmacy in your plan's network, whether your drugs are on your plan's formulary, and whether you qualify for Extra Help paying your Part D costs.

- **Monthly premium**—Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. If you belong to a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium may include an amount for prescription drug coverage.
- **Yearly deductible**—Amount you pay for your prescriptions before your plan begins to pay. Some drug plans don't have a deductible.
- **Copayments or coinsurance**—Amounts you pay at the pharmacy for your covered prescriptions after the deductible. You pay your share, and your drug plan pays its share for covered drugs.
- **Coverage gap**—Most Medicare drug plans have a coverage gap. This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Your yearly deductible, your coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan's premium or what you pay for drugs that aren't on your plan's formulary.

There are plans that offer some coverage during the gap, like for generic drugs. However, plans with gap coverage may charge a higher monthly premium. Check with the drug plan first to see if your drugs would be covered during the gap.

For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP). See pages 110–113 for the telephone number. You can also visit www.medicare.gov and select "Compare Medicare Prescription Drug Plans."

What You Pay (continued)

Catastrophic coverage—Once you reach your plan's out-of-pocket limit during the coverage gap, you automatically get "catastrophic coverage." Catastrophic coverage assures that once you have spent up to your plan's out-of-pocket limit for covered drugs, you only pay a small coinsurance amount or copayment for the drug for the rest of the year.

Note: If you get Extra Help paying your drug costs, you won't have a coverage gap and will pay only a small or no copayment once you reach catastrophic coverage. See pages 78–81.

The example below shows costs for covered drugs in 2010 for a plan that has a coverage gap.

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2010. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions.

Monthly Premium—Ms. Smith pays a monthly premium throughout the year.			
1. Yearly Deductible →	2. Copayment or Coinsurance →	3. Coverage Gap →	4. Catastrophic Coverage
Ms. Smith pays the first $310 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until what they **both** pay (plus the deductible) reaches $2,830.	Once Ms. Smith and her plan have spent $2,830 for covered drugs, she is in the coverage gap. She will have to pay **all of her drug costs** until **she** has spent $4,550.	Once Ms. Smith has spent $4,550 out-of-pocket for the year, her coverage gap ends. Now she only pays a small copayment for each drug until the end of the year.

Call the plans you're interested in to get specific Medicare drug plan costs. You can also visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What is the Part D Late Enrollment Penalty?

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a late enrollment penalty if one of the following is true:

- You didn't join a Medicare drug plan when you were first eligible for Medicare, and you didn't have other creditable prescription drug coverage.
- You had a break in your Medicare prescription drug coverage or other creditable coverage of at least 63 days in a row.

Blue words in the text are defined on pages 115–118.

Note: If you get Extra Help, you don't pay a late enrollment penalty.

Here are a few ways to avoid paying a penalty:

- **Join a Medicare drug plan when you're first eligible.** You won't have to pay a penalty, even if you've never had prescription drug coverage before.
- **Don't go for more than 63 days in a row without a Medicare drug plan or other creditable coverage.** Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, or the Department of Veterans Affairs. Your plan will tell you each year if your drug coverage is creditable coverage. Keep this information, because you may need it if you join a Medicare drug plan later.
- **Let your Medicare drug plan know if you had other creditable coverage.** When you join a plan, you may get a letter asking if you have creditable coverage. Complete the form they send you. If you don't tell the plan about your creditable coverage, you may have to pay a penalty.

How Much More Will You Pay?

When you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be. To estimate your penalty amount, count the number of full months that you didn't have creditable coverage after you were eligible to join a Medicare drug plan. If you multiply this number by the "1% penalty calculation" which is $.32 in 2010, you can estimate the amount that will be added each month to your Medicare drug plan's premium for the current year. This penalty amount may increase every year.

If You Don't Agree With Your Penalty

If you don't agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You will need to fill out a reconsideration request form (that your drug plan will send you), and you will have the chance to provide proof that supports your case such as information about previous prescription drug coverage.

Important Drug Coverage Rules

The following information can help answer common questions as you begin to use your coverage.

To Fill a Prescription Before You Get Your Membership Card

Within 2 weeks after your plan gets your completed application, you will get a letter from the plan letting you know they got your information. You should get a welcome package with your membership card within 5 weeks or sooner. If you need to go to the pharmacy before your membership card arrives, you can use any of the following as proof of membership in your Medicare drug plan:

- A letter from the plan
- An enrollment confirmation number that you got from the plan, the plan name, and telephone number

You should also bring your Medicare and/or Medicaid card, proof of any other prescription drug coverage, and a photo ID. If you qualify for Extra Help, see page 80 for more information about what you can use as proof of Extra Help. If you don't have any of the items listed above, and your pharmacist can't get your drug plan information any other way, you may have to pay out-of-pocket for your prescriptions. **If you do, save the receipts and contact your plan to get money back.**

If you want to know how Medicare prescription drug coverage works with other drug coverage you may have, see pages 71–72.

Once you consider your options and choose a plan, join early to give the plan time to mail your membership card, acknowledgement letter, and welcome package before your coverage becomes effective. This way, even if you go to the pharmacy on your first day of coverage, you can get your prescriptions filled without delay. If you don't get these items, call your plan.

Important Drug Coverage Rules (continued)

Plans may have the following coverage rules:

- Prior authorization—You and/or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) must contact the drug plan before you can fill certain prescriptions. Your prescriber may need to show that the drug is medically necessary for the plan to cover it.
- Quantity limits—Limits on how much medication you can get at a time.
- Step therapy—You must try one or more similar, lower cost drugs before the plan will cover the prescribed drug.

Blue words in the text are defined on pages 115–118.

If your prescriber believes that one of these coverage rules should be waived, you can ask for an exception. See pages 90–91.

What Are "Tiers"?

Many Medicare drug plans place drugs into different "tiers." Drugs in each tier have a different cost. For example, a drug in a lower tier will cost you less than a drug in a higher tier. In some cases, if your drug is on a higher tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can file an exception and ask your plan for a lower copayment.

Note: Medicare drug plans must cover all commercially-available vaccines (like the shingles vaccine) when medically necessary to prevent illness except for vaccines that are covered under Part B. Information about a plan's list of covered drugs (called a formulary) isn't included in this handbook because each plan has its own formulary. Formularies can change. Contact the plan for its current formulary, or visit the plan's Web site. You can also visit www.medicare.gov and select "Compare Medicare Prescription Drug Plans."

In most cases the prescription drugs you get in an outpatient setting like an emergency room (sometimes called "self-administered drugs") aren't covered by Part B. Your Medicare drug plan may cover these drugs **under certain circumstances**. You will likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Call your plan for more information. You can also visit www.medicare.gov/Publications/Pubs/pdf/11333.pdf to view the fact sheet, "How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings."

Important Drug Coverage Rules (continued)

Ways to Pay Your Premium

You have choices in the way you pay your Medicare drug plan premium. Depending on your plan and your situation, you may be able to pay your Medicare drug plan premium in one of four ways:

1. **Deducted** from your checking or savings account.
2. **Charged** to a credit or debit card.
3. **Billed** to you each month directly by the plan. Some plans bill in advance for coverage the next month. **Send your payment to the plan (not Medicare). Contact your plan for the payment address.**
4. **Deducted from your monthly Social Security payment.** Contact your drug plan (not Social Security) to ask for this payment option. With this option, your first deductions usually take 3 months to start, and 3 months of premiums will likely be collected at one time. You may also see a delay in premiums being withheld if you switch or leave plans.

For more information about your Medicare drug plan premium or ways to pay for it, contact your drug plan.

Use the following resources to get more information about Medicare prescription drug coverage:

- Contact the plans you are interested in.
- Visit www.medicare.gov/pdphome.asp to get general information, view publications, and compare plans in your area.
- Call 1-800-MEDICARE (1-800-633-4227), and say "Drug Coverage." TTY users should call 1-877-486-2048.
- Contact your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling. See pages 110–113 for the telephone number.

Other Private Insurance

The charts on the next two pages provide information about how other insurance you have works with, or is affected by, Medicare prescription drug coverage (Part D).

Employer or Union Health Coverage—Health coverage from your, your spouse's, or other family member's current or former employer or union. If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your drug coverage is creditable. **Keep the information you get.** Call your benefits administrator for more information before making any changes to your coverage.

COBRA—A Federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. As explained on page 24, there may be reasons why you should take Part B instead of COBRA. However, if you take COBRA and it includes creditable prescription drug coverage, you will have a special enrollment period to join a Medicare drug plan without paying a penalty when the COBRA coverage ends. Talk with your State Health Insurance Assistance Program (SHIP) to see if COBRA is a good choice for you. See pages 110–113 for the telephone number.

Medigap (Medicare Supplement Insurance) Policy with Prescription Drug Coverage—Medigap policies can no longer be sold with prescription drug coverage, but if you have drug coverage under a current Medigap policy, you can keep it. However, it may be to your advantage to join a Medicare drug plan because most Medigap drug coverage isn't creditable. If you join a Medicare drug plan, your Medigap insurance company must remove the prescription drug coverage under your Medigap policy and adjust your premiums. Call your Medigap insurance company for more information.

Note: Keep any creditable coverage information you get from your plan. You may need it if you decide to join a Medicare drug plan later. Don't send creditable coverage letters/certificates to Medicare.

Other Government Insurance

Federal Employee Health Benefits Program (FEHBP)—Health coverage for current and retired Federal employees and covered family members. If you join a Medicare drug plan, you can keep your FEHBP plan, and your plan will let you know who pays first. For more information, contact the Office of Personnel Management at 1-888-767-6738, or visit www.opm.gov/insure. TTY users should call 1-800-878-5707. You can also call your plan if you have questions.

Veterans' Benefits—Health coverage for veterans and people who have served in the U.S. military. You may be able to get prescription drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a Medicare drug plan, but if you do, you can't use both types of coverage for the same prescription. For more information, call the VA at 1-800-827-1000, or visit www.va.gov. TTY users should call 1-800-829-4833.

TRICARE (Military Health Benefits)—Health care plan for active-duty service members, retirees, and their families. Most people with TRICARE who are entitled to Part A **must** have Part B to keep TRICARE prescription drug benefits. If you have TRICARE, you aren't required to join a Medicare Prescription Drug Plan. If you do, your Medicare drug plan pays first, and TRICARE pays second. If you join a Medicare Advantage Plan with prescription drug coverage, TRICARE won't pay for your prescription drugs. For more information, call the TRICARE pharmacy contractor at 1-877-363-8779, or visit www.tricare.mil. TTY users should call 1-877-540-6261.

Indian Health Services—Health care for people who are American Indian/Alaska Native through an Indian health care provider. If you get prescription drugs through an Indian health pharmacy, you pay nothing and your coverage won't be interrupted. Joining a Medicare drug plan may help your Indian health provider with costs, because the drug plan pays part of the cost of your prescriptions. Talk to your benefits coordinator who can help you choose a plan that meets your needs and tell you how Medicare works with your health care system.

Note: The types of insurance listed on this page are all considered creditable prescription drug coverage. If you have one of these types of insurance, in most cases, it will be to your advantage to keep your current coverage.

Who Pays First When You Have Other Insurance?

When you have other insurance (like employer group health coverage), there are rules that decide whether Medicare or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage.

If your other coverage is from an employer or union group health plan, these rules apply:

- If you are **retired**, Medicare pays first.
- If your group health plan coverage is based on your or a family member's **current employment**, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you are under age 65 and disabled, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you are over age 65 and still working, your plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because you have ESRD, your plan pays first for the first 30 months you have Medicare.

The following types of coverage usually pay first:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Medicare's Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. You may need to give your Medicare number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Medigap (Medicare Supplement Insurance) Policies

Blue words in the text are defined on pages 115–118.

Original Medicare pays for many, but not all, health care services and supplies. A Medigap policy, sold by private insurance companies, can help pay some of the health care costs ("gaps") that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles. Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, both plans will pay their share of Medicare-approved amounts for covered health care costs. Medicare doesn't pay any of the costs for a Medigap policy.

Every Medigap policy must follow Federal and state laws designed to protect you, and it must be clearly identified as "Medicare Supplement Insurance." Medigap insurance companies can sell you only a "standardized" Medigap policy identified in most states by letters, Plans A through N. All plans offer the same basic benefits but some offer additional benefits, so you can choose which one meets your needs.

Note: In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

NEW: Starting June 1, 2010, the types of Medigap Plans that you can buy will change:

1. There will be two new Medigap Plans offered—Plans M and N.
2. Plans E, H, I, and J will no longer be available to buy. If you already have or you buy Plan E, H, I, or J before June 1, 2010, you can keep that plan. Contact your plan for more information.

Insurance companies may charge different premiums for exactly the same Medigap coverage. As you shop for a Medigap policy, be sure you are comparing the same Medigap policy (for example, compare Plan A from one company with Plan A from another company).

In some states, you may be able to buy another type of Medigap policy called Medicare SELECT (a Medigap policy that requires you to use specific hospitals and, in some cases, specific doctors to get full coverage).

If You Want to Buy a Medigap Policy

- Generally, you must have Part A and Part B to buy a Medigap policy.
- You pay a monthly premium for your Medigap policy to the private insurer, and you pay your monthly Part B premium. See page 119.
- A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, you must each buy separate policies.
- It's important to compare Medigap policies since the costs can vary and may go up as you get older. Some states limit Medigap costs.
- The best time to buy a Medigap policy is during the 6-month period that begins on the first day of the month in which you are both age 65 or older and enrolled in Part B. (Some states have additional open enrollment periods.) After this initial enrollment period, your option to buy a Medigap policy may be limited.
- If you are under age 65, you may have additional rights to buy a Medigap policy, depending on the laws in your state.
- If you have a Medigap policy and join a Medicare Advantage Plan (like an HMO or PPO), you may want to consider dropping your Medigap policy. You can continue to pay your Medigap premium, but your policy **can't** be used to pay your Medicare Advantage Plan copayments and deductibles.
- If you want to drop your Medigap policy, you must contact your insurance company to cancel the policy.
- If you already have a Medicare Advantage Plan, it's illegal for anyone to sell you a Medigap policy unless you are switching back to Original Medicare.
- If you join a Medicare health plan for the first time, and you aren't happy with the plan, you will have special rights to buy a Medigap policy if you return to Original Medicare within 12 months of joining.
  - If you had a Medigap policy before you joined, you may be able to get the same plan back if the company still sells it.
  - The Medigap policy can no longer have prescription drug coverage even if you had it before, but you may be able to join a Medicare Prescription Drug Plan.
  - If you joined a Medicare health plan when you were first eligible for Medicare, you can choose from any policy.
- If you buy a Medicare SELECT policy you also have rights to change your mind within 12 months and switch to a standard Medigap policy.
- You can't have drug coverage in both your Medigap policy and a Medicare drug plan. See page 71.

Blue words in the text are defined on pages 115–118.

For more information about Medigap policies

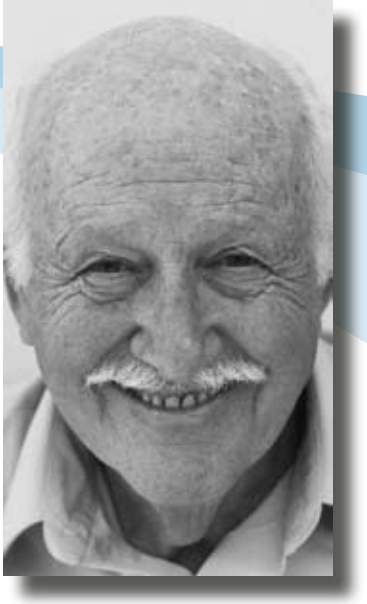
- Visit www.medicare.gov/Publications/Pubs/pdf/02110.pdf to view the booklet, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."
- Call your State Insurance Department to get more information. Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number. TTY users should call 1-877-486-2048.

To find and compare Medigap policies

- Visit www.medicare.gov, and select, "Compare Medicare Health Plans and Medigap Policies in Your Area."
- Call 1-800-MEDICARE.
- Call your State Health Insurance Assistance Program (SHIP). See pages 110–113 for the telephone number.

SECTION 3

Programs for People with Limited Income and Resources



There are Federal and state programs available for people with limited income and resources. These programs may help you save on your health care and prescription drug costs or provide extra income.

Section 3 includes information about the following:

Extra Help Paying for Medicare Prescription Drug Coverage (Part D) 78–81

Medicaid 82

State Pharmacy Assistance Programs (SPAPs) 82

Programs of All-inclusive Care for the Elderly (PACE) 82

Medicare Savings Programs 83

Supplemental Security Income (SSI) Benefits 84

Programs for People Who Live in the U.S. Territories 84

Keep all information you get from Medicare, Social Security, your Medicare health or prescription drug plan, Medigap insurer, or employer or union. This may include notices of award or denial, Annual Notices of Change, notices of creditable prescription drug coverage, or Medicare Summary Notices. You may need these documents to apply for the programs explained in this section. Also keep copies of any applications you submit.

Programs for People with Limited Income and Resources

If you have limited income and resources, you might qualify for help to pay for some health care and prescription drug costs.

The U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Commonwealth of Northern Mariana Islands provide their residents help with Medicare drug costs. This help isn't the same as the Extra Help described below. See page 84 for more information.

Extra Help Paying for Medicare Prescription Drug Coverage (Part D)

You may qualify for Extra Help, also called the low-income subsidy (LIS) from Medicare to pay prescription drug costs if your yearly income and resources are below the following limits in 2009:

- Single person—Income less than $16,245 and resources less than $12,510
- Married person living with a spouse and no other dependents—Income less than $21,855 and resources less than $25,010

These amounts will change in 2010. You may qualify even if you have a higher income (like if you still work, or if you live in Alaska or Hawaii, or have dependents living with you). Resources include money in a checking or savings account, stocks, and bonds. Resources **don't** include your home, car, household items, burial plot, up to $1,500 for burial expenses (per person), or life insurance policies.

Blue words in the text are defined on pages 115–118.

If you qualify for Extra Help and join a Medicare drug plan, you will get the following:

- Help paying your Medicare drug plan's monthly premium. Depending on your income and resources and your drug plan's premium, you may pay a reduced premium or no premium for a basic plan. For an enhanced drug plan (a plan that may cover more drugs and generally has a higher monthly premium), you must pay more for the extra coverage.
- Help paying any yearly deductible.
- Help paying coinsurance and copayments for prescription drugs that are on your plan's formulary (list of covered drugs). You generally pay all costs for drugs that aren't on your plan's formulary unless you are granted an exception. See page 90.
- No coverage gap.
- No late enrollment penalty.

Extra Help Paying for Medicare Prescription Drug Coverage (Part D) (continued)

You **automatically** qualify for Extra Help if you have Medicare and meet one of these conditions:

- You have full Medicaid coverage.
- You get help from your state Medicaid program paying your Part B premiums (belong to a Medicare Savings Program).
- You get Supplemental Security Income (SSI) benefits.

Medicare will mail you a purple letter to let you know you automatically qualify for Extra Help. You don't need to apply for Extra Help if you get this letter.

- Keep the letter for your records.
- If you aren't already in a plan, you must join a Medicare drug plan to get this Extra Help.
- If you don't join a drug plan, Medicare may enroll you in one. If Medicare enrolls you in a plan, Medicare will send you a yellow or green letter letting you know when your coverage begins.
- Different plans cover different drugs. Check to see if the plan you are enrolled in covers the drugs you use and if you can go to the pharmacies you want. Compare with other plans in your area.
- If you're getting Extra Help, you can switch to another Medicare drug plan anytime. Your coverage will be effective the first day of the next month.
- In most cases, you will pay only a small amount for each covered prescription.
- If you have Medicaid, Medicare will provide you with prescription drug coverage instead of Medicaid. Medicaid may still cover some drugs that Medicare prescription drug coverage doesn't cover. Medicaid may still cover other care that Medicare doesn't cover.
- If you have Medicaid and live in certain institutions (like a nursing home), you pay nothing for your covered prescription drugs.

If you qualify, your drug costs in 2010 will be no more than $2.50 for each generic drug and $6.30 for each brand-name drug. Look on the Extra Help letters you get, or contact your plan to find out your exact costs.

Extra Help Paying for Medicare Prescription Drug Coverage (Part D) (continued)

If you don't want to join a Medicare drug plan (for example, because you want to keep your employer or union coverage instead), call 1-800-MEDICARE (1-800-633-4227) or the plan listed in your letter. TTY users should call 1-877-486-2048. Tell them you don't want to be in a Medicare drug plan (you want to "opt out"). If you continue to qualify for Extra Help, you won't have to pay a penalty if you join later. See page 67.

Blue words in the text are defined on pages 115–118.

If you didn't automatically qualify for Extra Help, you can apply:

- Call Social Security at 1-800-772-1213 to apply by phone or to get a paper application. TTY users should call 1-800-325-0778.
- Visit www.socialsecurity.gov to apply online.
- Apply at your State Medical Assistance (Medicaid) office. Call 1-800-MEDICARE, and say "Medicaid" to get the telephone number, or visit www.medicare.gov.

Note: You can apply for Extra Help at any time.

To get answers to your questions about Extra Help, call your State Health Insurance Assistance Program (SHIP). See pages 110–113 for the telephone number. You can also call 1-800-MEDICARE.

If you **apply and qualify** for Extra Help, you must join a Medicare drug plan to get this help. If you don't join a drug plan, Medicare may enroll you in one. If Medicare enrolls you in a plan, Medicare will send you a green letter letting you know when your coverage begins. Check to see if the plan you are enrolled in covers the drugs you use and if you can go to the pharmacies you want. If not, you can switch plans at anytime.

If you have employer or union coverage and you join a Medicare drug plan, you may lose your employer or union coverage even if you qualify for Extra Help. Call your employer's benefits administrator for more information before you join.

Medicare gets data from your state or Social Security that tells whether you qualify for Extra Help. If Medicare doesn't have the right information, you may be paying the wrong amount for your prescription drug coverage.

Extra Help Paying for Medicare Prescription Drug Coverage (Part D) (continued)

Paying the Right Amount

If you automatically qualify, you can show your drug plan the purple letter and the yellow or green letter you got from Medicare as proof that you qualify. If you applied for Extra Help, you can show your "Notice of Award" from Social Security as proof that you qualify.

You can also give your plan any of the following documents (also called "Best Available Evidence") as proof that you qualify for extra help. Your plan must accept these documents. Each item listed below must show that you were eligible for Medicaid during a month after June of 2009.

Other Proof You Have Medicaid	Proof You Have Medicaid and Live in an Institution
▪ A copy of your Medicaid card ▪ A copy of a state document that shows you have Medicaid ▪ A print-out from a state electronic enrollment file or screen print from your state's Medicaid systems that shows you have Medicaid ▪ Any other document from your state that shows you have Medicaid	▪ A bill from the institution (like a nursing home) or a copy of a state document showing Medicaid payment to the institution for at least a month ▪ A screen print from your state's Medicaid systems showing that you lived in the institution for at least a month

Call your drug plan to find out how you can provide them with this information. If you think you qualify for Extra Help because you have Medicaid, but you don't have proof, ask your drug plan for help. They must help you.

If you paid for prescriptions since you qualified for Extra Help, your plan should pay you back some of these costs. Keep the receipts, and call your plan for more information.

If your drug plan doesn't correct a problem to help you pay the right amount, doesn't respond to your request for help, or takes longer than expected to get back to you, call 1-800-MEDICARE (1-800-633-4227) to file a complaint. TTY users should call 1-877-486-2048.

Medicaid

Medicaid is a joint Federal and state program that helps pay medical costs if you have limited income and resources and meet other eligibility requirements. Some people qualify for both Medicare and Medicaid (these people are also called "dual-eligibles").

- If you have Medicare and full Medicaid coverage, most of your health care costs are covered. You have the option of Original Medicare or a Medicare Advantage Plan (like an HMO or PPO).
- Medicaid programs vary from state to state. They may also be called by different names, such as "Medical Assistance" or "Medi-Cal."
- People with Medicaid may get coverage for services that Medicare doesn't fully cover, such as nursing home and home health care.
- Each state has different Medicaid eligibility income and resource limits and other eligibility requirements.
- In some states, you may need to apply for Medicare to be eligible for Medicaid.
- Call your State Medical Assistance (Medicaid) office for more information and to see if you qualify. Call 1-800-MEDICARE (1-800-633-4227) and say "Medicaid" to get the telephone number for your State Medical Assistance (Medicaid) office. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.

Blue words in the text are defined on pages 115–118.

State Pharmacy Assistance Programs (SPAPs)

Many states have State Pharmacy Assistance Programs (SPAPs) that help certain people pay for prescription drugs based on financial need, age, or medical condition. Each SPAP makes its own rules about how to provide drug coverage to its members. Depending on your state, the SPAP will help you in different ways. To find out about the SPAP in your state, call your State Health Insurance Assistance Program (SHIP). See pages 110–113 for the telephone number.

Programs of All-inclusive Care for the Elderly (PACE)

PACE combines medical, social, and long-term care services, and prescription drug coverage for frail elderly and disabled people. This program allows people who need a nursing home-level of care to remain in the community. See page 101 for more information.

Medicare Savings Programs (Help With Medicare Costs)

States have programs that pay Medicare premiums and, in some cases, may also pay Part A and Part B deductibles and coinsurance. These programs help people with Medicare save money each year.

To qualify for a Medicare Savings Program, you must meet all of these conditions:

- Have Part A
- Single person—Have monthly income less than $1,239 and resources less than $8,100
- Married and living together—Have monthly income less than $1,660 and resources less than $12,910

Note: These amounts may change each year. Many states figure your income and resources differently or may not have limits at all, so you may qualify in your state even if your income is higher. Resources include money in a checking or savings account, stocks, and bonds. Resources don't include your home, car, burial plot, up to $1,500 for burial expenses (per person), furniture, or other household items.

For More Information

- Call or visit your State Medical Assistance (Medicaid) office, and ask for information on Medicare Savings Programs. The names of these programs and how they work may vary by state. Call if you think you qualify for any of these programs, even if you aren't sure.
- Call 1-800-MEDICARE (1-800-633-4227), and say "Medicaid" to get the telephone number for your state. TTY users should call 1-877-486-2048.
- Visit www.medicare.gov/Publications/Pubs/pdf/10126.pdf to view the brochure, "Get Help With Your Medicare Costs: Getting Started."
- Contact your State Health Insurance Assistance Program (SHIP) for free health insurance counseling. See pages 110–113 for the telephone number.

Supplemental Security Income (SSI) Benefits

SSI is a monthly amount paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits provide cash to meet basic needs for food, clothing, and shelter. SSI benefits aren't the same as Social Security benefits.

Blue words in the text are defined on pages 115–118.

To get SSI benefits, you must also meet these conditions:

- Be a resident of the U.S. (includes the Northern Mariana Islands, but not the territories listed below).
- Not be out of the country for a full calendar month or more than 30 consecutive days.
- Be either a U.S. citizen or national, or in one of certain categories of eligible non–citizens. People who live in Puerto Rico, the Virgin Islands, Guam, or American Samoa generally can't get SSI. You can visit www.socialsecurity.gov, and use the "Benefit Eligibility Screening Tool" to find out if you may be eligible for SSI or other benefits. Call Social Security at 1-800-772-1213, or contact your local Social Security office for more information. TTY users should call 1-800-325-0778.

Programs for People Who Live in the U.S. Territories

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules, or call 1-800-MEDICARE (1-800-633-4227) and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.

Children's Health Insurance Program

Do you have children or grandchildren who need health insurance? A new bill signed into law in 2009 extends health insurance coverage to millions of uninsured children.

Each state has its own program, with its own eligibility rules. In many states, uninsured children 18 years old and younger, whose families earn up to $44,500 a year (for a family of four) are eligible for free or low-cost health insurance that pays for doctor visits, dental care, prescription drugs, hospitalizations, and much more. Call 1-877-KIDS-NOW (1-877-543-7669), or visit www.insurekidsnow.gov for more information about the Children's Health Insurance Program.

SECTION 4

Protecting Yourself and Medicare

You can protect yourself and Medicare by understanding your rights (including your right to appeal) and knowing how to identify and report fraud.

Section 4 includes information about the following:

Medicare Rights and Appeals Information 86–88

Advance Beneficiary Notices (ABNs) 89

Appeals (Medicare Drug Plans) 90–91

How Medicare Uses Your Personal Information 92–93

Protecting Yourself From Fraud and Identity Theft 94–95

Senior Medicare Patrol (SMP) 95

Billing Fraud 96–97

How Medicare Protects You 97

Medicare's Beneficiary Ombudsman 98

Your Medicare Rights

No matter what type of Medicare coverage you have, you have certain guaranteed rights. As a person with Medicare, you have the right to all of the following:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Have access to doctors, specialists, and hospitals
- Have your questions about Medicare answered
- Learn about all of your treatment choices and participate in treatment decisions
- Get information in a way you understand from Medicare, health care providers, and, under certain circumstances, contractors
- Get emergency care when and where you need it
- Get a decision about health care payment or services, or prescription drug coverage
- Get a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage
- File complaints (sometimes called grievances), including complaints about the quality of your care
- Have your personal and health information kept private

What Is an Appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare or your Medicare plan. You can appeal if Medicare or your plan denies one of the following:

- A request for a health care service, supply, or prescription that you think you should be able to get
- A request for payment for health care services or supplies or a prescription drug you already got that was denied
- A request to change the amount you must pay for a prescription drug

You can also appeal if Medicare or your plan stops **providing or paying for all or part of** an item or service you think you still need.

If you decide to file an appeal, ask your doctor or other health care provider or supplier for any information that may help your case.

How to File an Appeal

How you file an appeal depends on the type of Medicare coverage you have:

- If you have a Medicare health plan, look at your plan materials, call your plan, or visit www.medicare.gov/Publications/Pubs/pdf/10112.pdf to view the booklet, "Your Medicare Rights and Protections."
- If you have a Medicare Prescription Drug Plan, look at your plan materials, call your plan, or look on pages 90–91 to learn how to file an appeal.
- If you have Original Medicare, do the following to file an appeal:
    1. Get the Medicare Summary Notice (MSN) that shows the item or service you are appealing. Your MSN is the statement you get every 3 months that lists all the services billed to Medicare and tells you if Medicare paid for the services.
    2. Circle the item(s) you disagree with on the MSN, and write an explanation on the MSN of why you disagree.
    3. Sign, write your telephone number, and provide your Medicare number on the MSN. Keep a copy for your records.
    4. Send the MSN, or a copy, to the Medicare contractor's address listed on the MSN. You can also send any additional information you may have about your appeal.
    5. You must file the appeal within 120 days of the date you get the MSN. If you want to file an appeal, make sure you read your MSN carefully, and follow the instructions. You can also use CMS Form 20027 and file it with the Medicare contractor at the address listed on the MSN. Visit www.cms.hhs.gov/cmsforms/downloads/CMS20027.pdf to view or print this form.

You can also file a fast appeal in some cases. See page 88.

Find Out if Medicare or Your Plan Was Billed For the Services You Got

Check with your health care provider or supplier to see if they submitted the bill to Medicare or your plan. Do the following to find out what was billed:

- Ask your health care provider or supplier for an itemized statement. They should give this to you within 30 days.
- Check your MSN if you have Original Medicare to see if the service was billed to Medicare. If you are in a Medicare plan, check with your plan.
- Visit www.MyMedicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to view your Medicare claims. TTY users should call 1-877-486-2048.

Blue words in the text are defined on pages 115–118.

Your Right to a Fast Appeal

If you are getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your Medicare-covered services are ending too soon, you have the right to a fast appeal (also called an "expedited review" or an "immediate appeal"). Your provider will give you a notice at least 2 days before your services end that will tell you how to ask for a fast appeal. If you don't get this notice, ask your provider for it. With a fast appeal, an independent reviewer, called a Quality Improvement Organization (QIO), will decide if your services should continue.

- You may ask your doctor for any information that may help your case if you decide to file a fast appeal.
- You must call your local QIO to request a fast appeal no later than noon on the day before your notice says your coverage will end.
- The number for the QIO in your state should be on your notice. You can also call 1-800-MEDICARE (1-800-633-4227) to get the telephone number, or visit www.medicare.gov. TTY users should call 1-877-486-2048.
- If you miss the deadline, you still have appeal rights:
  - If you have Original Medicare, call your local QIO.
  - If you are in a Medicare health plan, call your plan. Look in your plan materials to get the telephone number.

Contact your State Health Insurance Assistance Program (SHIP) if you need help filing an appeal. See pages 110–113 for the telephone number.

Blue words in the text are defined on pages 115–118.

Advance Beneficiary Notice (ABN)

If you have Original Medicare, your health care provider or supplier may give you a notice called an "Advance Beneficiary Notice" (ABN).

- This notice says Medicare probably (or certainly) won't pay for some services in certain situations.
- You will be asked to choose whether to get the items or services listed on the ABN.
- If you choose to get the items or services listed on the ABN, you will have to pay if Medicare doesn't.
- You will be asked to sign the ABN to say that you have read and understood the notice.
- An ABN isn't an official denial of coverage by Medicare. You could choose to get the items listed on the ABN and still ask your health care provider or supplier to submit the bill to Medicare or another insurer. If Medicare denies payment, you can still file an appeal. However, you will have to pay for the items or services on appeal if Medicare determines that the items or services aren't covered (and no other insurer is responsible for payment).
- You may also get an ABN for other reasons, such as when your doctor or health care provider reduces your home health care.
- If you should have received an ABN but didn't, in most cases your provider should refund you for what you paid for the item or service. However, you still must pay any copayments and/or deductibles that apply.

If you are in a Medicare plan, call your plan to find out if a service or item will be covered.

For more information about ABNs, visit www.medicare.gov/Publications/Pubs/pdf/10112.pdf to view the booklet, "Your Medicare Rights and Protections," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Appealing Your Medicare Drug Plan's Decisions

If you have Medicare prescription drug coverage (Part D), you have the right to do all of the following (even before you buy a particular drug):

- Get a written explanation (called a "coverage determination") from your Medicare drug plan. A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your prescription drug benefits, including whether a particular drug is covered, whether you have met all the requirements for getting a requested drug, how much you're required to pay for a drug, and whether to make an exception to a plan rule when you request it.
- Ask your drug plan for an exception if you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes you need a drug that isn't on your drug plan's list of covered drugs.
- Ask for an exception if you or your prescriber believes that a coverage rule (such as prior authorization) should be waived.
- Ask for an exception if you think you should pay less for a higher tier drug because you or your prescriber believes you can't take any of the lower tier drugs for the same condition.

You or your prescriber must contact your plan to ask for a coverage determination or an exception. If your network pharmacy can't fill a prescription as written, the pharmacist will show you a notice that explains how to contact your Medicare drug plan so you can make your request. If the pharmacist doesn't show you this notice, ask to see it.

A standard request for a coverage determination or exception must be made in writing unless your plan accepts requests by phone. You or your prescriber can call or write your plan for an expedited (fast) request. Your request will be expedited if you haven't received the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting. **If you are requesting an exception, your prescriber must provide a statement explaining the medical reason why similar drugs covered by your plan won't work or may be harmful to you.**

Appealing Your Medicare Drug Plan's Decisions (continued)

Once your Medicare drug plan gets your request for a coverage determination or your prescriber's statement, the Medicare drug plan has 72 hours (for a standard request) or 24 hours (for an expedited request) to notify you of its decision. If the drug plan doesn't give you a prompt decision, and you can show that the delay would affect your health, the plan's failure to act is considered a coverage determination.

If you disagree with your Medicare drug plan's coverage determination or exception decision, you can appeal. There are five levels of appeals available to you. The first level is appealing through your plan.

Appealing Your Drug Plan's Coverage Determination Decision

- You, your representative, or your prescriber can appeal your drug plan's coverage determination decision.
- The appeal request must be made within 60 days of the drug plan's decision.
- A standard request must be made in writing, unless your Medicare drug plan accepts requests by phone.
- You, your representative, or your prescriber can call or write your plan for an expedited request.
- The Medicare drug plan has 7 days (for a standard request) or 72 hours (for an expedited request) from the date it gets your request to notify you of its decision. You may have additional appeal rights if you don't agree with the plan's decision.
- You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP). See pages 110–113 for the telephone number.

Blue words in the text are defined on pages 115–118.

If your plan doesn't respond to your request for a coverage determination, an exception, or an appeal, you can file a complaint. Call your plan or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

After you appeal through your plan, you will get a notice explaining the next level of appeal. If you disagree with the plan's decision, you can ask for an independent review of your case.

For more information about your rights and the different levels of appeals, visit www.medicare.gov/Publications/Pubs/pdf/10112.pdf to view the booklet, "Your Medicare Rights and Protections," or call 1-800-MEDICARE.

How Medicare Uses Your Personal Information

You have the right to have your personal and health information kept private. The next two pages describe how your information may be used and given out and explain how you can get this information.

Notice of Privacy Practices for Original Medicare

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, Medicare is required to protect the privacy of your personal medical information. Medicare is also required to give you this notice to tell you how Medicare may use and give out ("disclose") your personal medical information held by Medicare.

Medicare must use and give out your personal medical information to provide information to the following:

- To you or someone who has the legal right to act for you (your personal representative)
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected
- Where required by law

Medicare has the right to use and give out your personal medical information to pay for your health care and to operate the Medicare Program. Examples include the following:

- Companies that pay bills for Medicare use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), or to prepare your Medicare Summary Notice.
- Medicare may use your personal medical information to make sure you and other people with Medicare get quality health care, to provide customer service to you, to resolve any complaints you have, or to contact you about research studies.

Medicare may use or give out your personal medical information for the following purposes under limited circumstances:

- To State and other Federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/State Medicaid programs)
- For public health activities (such as reporting disease outbreaks)
- For government health care oversight activities (such as fraud and abuse investigations)
- For judicial and administrative proceedings (such as in response to a court order)
- For law enforcement purposes (such as providing limited information to locate a missing person)
- For research studies, including surveys, that meet all privacy law requirements (such as research related to the prevention of disease or disability)
- To avoid a serious and imminent threat to health or safety
- To contact you about new or changed coverage under Medicare
- To create a collection of information that can no longer be traced back to you

How Medicare Uses Your Personal Information (continued)

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in this notice. You may take back ("revoke") your written permission anytime, except to the extent that Medicare has already acted based on your permission.

By law, you have the right to take these actions:

- See and get a copy of your personal medical information held by Medicare.
- Have your personal medical information amended if you believe that it is wrong or if information is missing, and Medicare agrees. If Medicare disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from Medicare. The listing won't cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for Medicare operations, or that was given out for law enforcement purposes.
- Ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare Program. Please note that Medicare may not be able to agree to your request.
- Get a separate paper copy of this notice.

Visit www.medicare.gov for more information on the following:

- Exercising your rights set out in this notice.
- Filing a complaint, if you believe Original Medicare has violated these privacy rights. Filing a complaint won't affect your coverage under Medicare.

You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. Ask to speak to a customer service representative about Medicare's privacy notice. TTY users should call 1-877-486-2048.

You may file a complaint with the Secretary of the Department of Health and Human Services. Call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr/hipaa.

By law, Medicare is required to follow the terms in this privacy notice. Medicare has the right to change the way your personal medical information is used and given out. If Medicare makes any changes to the way your personal medical information is used and given out, you will get a new notice by mail within 60 days of the change.

The Notice of Privacy Practices for Original Medicare became effective April 14, 2003.

Protect Yourself from Fraud and Identity Theft

Identity theft is a serious crime. Identity theft happens when someone uses your personal information without your consent to commit fraud or other crimes. Personal information includes things like your name and your Social Security, Medicare, or credit card numbers. Don't be a victim of identity theft. Guard against identity theft by taking action to protect yourself.

Keep your personal information safe. You have control over when you provide and who you allow to have your personal information. Generally, no one should call you or come to your home uninvited to get you to join a Medicare plan. Don't give your personal information to someone who does this. **Only give personal information like your Medicare number to doctors, other health care providers, and plans approved by Medicare; any insurer who pays benefits on your behalf; and to people in the community who work with Medicare, like your State Health Insurance Assistance Program (SHIP) or Social Security.** Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a provider is approved by Medicare. TTY users should call 1-877-486-2048.

Blue words in the text are defined on pages 115–118.

Medicare plans can't ask you for credit card or banking information over the telephone, unless you are already a member of that plan. In most cases, Medicare plans can't call you to ask you to join a plan; instead, you must call them.
Call 1-800-MEDICARE to report any plans that ask for your personal information over the telephone or that call to enroll you in a plan. You can also call the Medicare Drug Integrity Contractor at 1-877-7SAFERX (1-877-772-3379).

Protect Yourself from Fraud and Identity Theft (continued)

If you think someone is using your personal information without your consent, call your local police department and the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338 to make a report. TTY users should call 1-866-653-4261. For more information about identity theft or to file a complaint online, visit www.consumer.gov/idtheft.

The SMP Program Can Help You

The SMP (formerly known as the Senior Medicare Patrol) Program educates and empowers people with Medicare to take an active role in detecting and preventing health care fraud and abuse. There is an SMP Program in every state, the District of Columbia, Guam, the U.S. Virgin Islands, and Puerto Rico. For more information or to find your local SMP Program, visit www.smpresource.org, or call your State Health Insurance Assistance Program (SHIP) to get the telephone number. See pages 110–113 for the SHIP telephone number.

Protect Yourself and Medicare from Billing Fraud

Blue words in the text are defined on pages 115–118.

Most doctors, pharmacists, plans, and other health care providers who work with Medicare are honest. Unfortunately, there may be some who are dishonest. Medicare is working with other government agencies to protect you and Medicare. Medicare fraud happens when Medicare is billed for services or supplies you never got. Medicare fraud costs Medicare a lot of money each year. You pay for it with higher premiums.

Remember these tips to help prevent billing fraud:

- Ask questions! You have the right to know everything about your health care including the costs billed to Medicare.
- Educate yourself about Medicare. Know your rights and what a provider can and can't bill to Medicare.
- Be wary of providers who tell you that the item or service isn't usually covered, but they "know how to bill Medicare" so Medicare will pay.

If you believe a Medicare plan or provider has used false information to mislead you, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

When you get health care services, record the dates on a calendar and save the receipts you get from providers. Use the calendar and receipts to check for mistakes on statements you get. These include the Medicare Summary Notice if you have Original Medicare, or similar statements that list the services you got or prescriptions you filled.

If you suspect billing fraud, here's what you can do:

1. Contact your health care provider to be sure the bill is correct.
2. Call 1-800-MEDICARE.
3. Call the fraud hotline of the HHS Office of Inspector General at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950. You can also email HHSTips@oig.hhs.gov.
4. Call the Medicare Drug Integrity Contractor at 1-877-7SAFERX (1-877-772-3379) if you are in a Medicare Advantage Plan or a Medicare Prescription Drug Plan.

Fighting Fraud Can Pay

You may get a reward of up to $1,000 if you meet **all** these conditions:

- You report suspected Medicare fraud.
- The Inspector General's Office reviews your suspicion.
- The suspected fraud you report isn't already being investigated.
- Your report leads directly to the recovery of at least $100 of Medicare money.

For more information, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Note: For your protection, your full Medicare number is no longer printed on your Medicare Summary Notice. The first 5 digits of your number are replaced with "Xs."

How Medicare Protects You

Medicare works with other government agencies to protect Medicare from fraud and to protect you from identity theft. With help from honest health care providers, suppliers, law enforcement, and citizens like you, Medicare is improving its ability to prevent fraud and identity theft. Some dishonest health care providers have been removed from Medicare, and some have gone to jail. These actions are saving money for taxpayers and protecting Medicare for the future. Below and on the next page are other ways Medicare is working to protect you.

You Are Protected from Discrimination

Every company or agency that works with Medicare must obey the law. You can't be treated differently because of your race, color, national origin, disability, age, religion, or sex. If you think that you haven't been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights toll-free at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

The Medicare Beneficiary Ombudsman

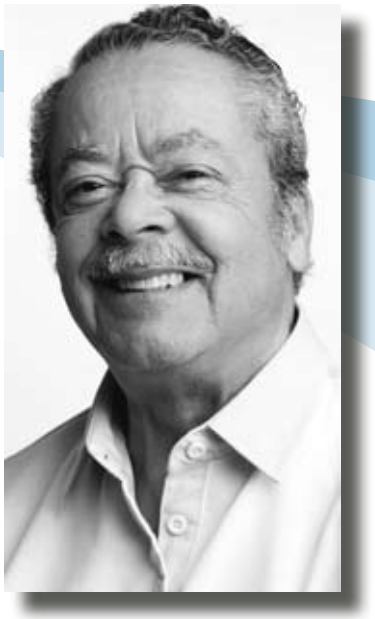
An "ombudsman" is a person who reviews issues and helps to resolve them. The Medicare Beneficiary Ombudsman shares information with the Secretary of Health and Human Services, Congress, and other organizations about what works well and what doesn't work well in Medicare. The Ombudsman helps improve the quality of the services and care you get from Medicare by reporting problems and making recommendations.

The Ombudsman makes sure information about the following is available to all people with Medicare:

- Your Medicare coverage
- Information to help you make good health care decisions
- Your Medicare rights and protections
- How you can get issues resolved

The Ombudsman reviews the concerns raised by people with Medicare through 1-800-MEDICARE (1-800-633-4227) and through your State Health Insurance Assistance Program (SHIP). For more information about the Medicare Beneficiary Ombudsman, visit www.medicare.gov, and select "Ombudsman."

SECTION 5



Planning Ahead

This section gives you information to help you plan ahead to make important health care choices. Your family, friends, and partners in your community may be an important part of helping you manage and plan for your future health care. Whether it's helping you plan for long-term care or keeping a copy of your advance directives, be sure to ask for any help you may need from people you trust.

Section 5 includes information about the following:

Plan for Long-term Care 100–102
Advance Directives (like a living will) 103–104

Plan for Long-term Care

Blue words in the text are defined on pages 115–118.

Long-term care is a variety of services including medical and non-medical care for people who have a chronic illness or disability. Non-medical care includes non-skilled personal care assistance, such as help with everyday activities like dressing, bathing, and using the bathroom. **Medicare and most health insurance plans, including Medigap (Medicare Supplement Insurance) policies don't pay for this type of care, also called "custodial care."** Medicare only pays for medically-necessary skilled nursing facility or home health care if you meet certain conditions. Long-term care can be provided at home, in the community, in assisted living, or in a nursing home.

Paying for Long-term Care

Long-term Care Insurance—This type of private insurance policy can help pay for many types of long-term care, including both skilled and non-skilled (custodial) care. Long-term care insurance can vary widely. Some policies may cover only nursing home care. Others may include coverage for a range of services like adult day care, assisted living, medical equipment, and informal home care.

Note: Long-term care insurance doesn't replace your Medicare coverage.

Your current or former employer or union may offer long-term care insurance. Current and retired Federal employees, active and retired members of the uniformed services, and their qualified relatives can apply for coverage under the Federal Long-term Care Insurance Program. If you have questions, visit www.opm.gov/insure/ltc, or call the Office of Personnel Management at 1-888-767-6738. TTY users should call 1-800-878-5707.

Personal Resources—You can use your savings to pay for long-term care. Some insurance companies let you use your life insurance policy to pay for long-term care. Ask your insurance agent how this works.

Paying for Long-term Care (continued)

Medicaid—Medicaid is a joint Federal and state program that pays for certain health services for people with limited income and resources. If you qualify, you may be able to get help to pay for nursing home care or other health care costs. See page 82 for more information about Medicaid.

Home and Community-based Services Programs—If you are already eligible for Medicaid (or, in some states, would be eligible for Medicaid coverage in a nursing home), you may be able to get help with the costs of services that help you stay in your home instead of moving to a nursing home. Examples include homemaker services, personal care, and respite care. For more information, visit the Eldercare Locator at www.eldercare.gov, or call 1-800-677-1116 (weekdays 9:00 a.m. to 8:00 p.m. Eastern Time) for your local Area Agency on Aging telephone number.

Programs of All-inclusive Care for the Elderly (PACE)—PACE is a Medicare and Medicaid program that allows people who otherwise need a nursing home-level of care to remain in the community. PACE was created as a way to provide you, your family, caregivers, and your health care providers flexibility to meet your health care needs and to help you continue living in the community.

PACE provides all the care and services covered by Medicare and Medicaid, as authorized by a team of health professionals, as well as additional medically-necessary care and services not covered by Medicare and Medicaid. PACE provides coverage for prescription drugs, doctor visits, transportation, home care, check-ups, hospital visits, and even nursing home stays whenever necessary.

For more information about PACE, visit www.medicare.gov/Publications/Pubs/pdf/11341.pdf to view the fact sheet, "Quick Facts About Programs of All-inclusive Care for the Elderly."

Paying for Long-term Care (continued)

Long-term Care Resources

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

- Visit www.medicare.gov, and select "Plan for Your Long-term Care Needs."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.longtermcare.gov to learn more about planning for long-term care.
- Call your State Insurance Department to get information about long-term care insurance. Call 1-800-MEDICARE to get the telephone number.
- Call the National Association of Insurance Commissioners at 1-866-470-6242 to get a copy of "A Shopper's Guide to Long-term Care Insurance."
- Visit the Eldercare Locator at www.eldercare.gov to find your local Aging and Disability Resource Center. You can also call 1-800-677-1116.

Blue words in the text are defined on pages 115–118.

Advance Directives

Advance directives are **legal** documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself. Advance directives most often include the following:

- A health care proxy (durable power of attorney)
- A living will
- After-death wishes

Talking with your family, friends, and health care providers about your wishes is important, but these legal documents ensure your wishes are followed. It's better to think about these important decisions before you are ill or a crisis strikes.

A health care proxy (sometimes called a durable power of attorney for health care) is used to name the person you wish to make health care decisions for you if you aren't able to make them yourself. Having a health care proxy is important because if you suddenly aren't able to make your own health care decisions, someone you trust will be able to make these decisions for you.

A living will is another way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened. Dialysis for kidney failure, a breathing machine if you can't breathe on your own, CPR (cardiopulmonary resuscitation) if your heart and breathing stop, or tube feeding if you can no longer eat are examples of medical treatment you can choose to accept or refuse.

In some states, advance directives can also include after-death wishes. This may include choices such as organ and tissue donation.

Advance Directives (continued)

If you already have advance directives, take time now to review them to be sure you are still satisfied with your decisions and your health care proxy is still willing and able to carry out your plans. Find out how to cancel or update them in your state if they no longer reflect your wishes. **Make sure to give your new advance directives to your doctors, proxy, and family members.**

Each state has its own laws for creating advance directives. For more information, contact your health care provider, an attorney, your local Area Agency on Aging, or your state health department.

Tips

1. Keep the original copies of your advance directives where they are easily found.
2. Give the person you've named as your health care proxy, and other concerned family members or friends, a copy of your advance directives.
3. Give your doctor a copy of your advance directives for your medical record. Provide a copy to any hospital or nursing home you stay in.
4. Carry a card in your wallet that states you have advance directives.

SECTION 6

For More Information

(Phone, Web sites, Publications)

Medicare has free information sources to help you with your Medicare and related questions.

Section 6 includes information about the following:

1-800-MEDICARE 106

www.MyMedicare.gov (for your personal Medicare information) 107

www.medicare.gov (for general information) 107

Quality of plans and providers 108

Medicare publications 109

If you have a question or complaint about the quality of a Medicare-covered service, call your local Quality Improvement Organization (QIO). Call 1-800-MEDICARE (1-800-633-4227) to get your QIO's telephone number. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.

1-800-MEDICARE (1-800-633-4227)
TTY Users 1-877-486-2048.

Get Information 24 Hours a Day, Including Weekends.

- Speak clearly, and have your Medicare card in front of you. You'll be asked for your Medicare number to reduce the amount of time it takes to speak to an agent. You can either say your Medicare number or enter the numbers using your telephone keypad.
- **Say "AGENT" at any time to talk to a customer service representative, or use this chart.** If you need help in a language other than English or Spanish, let the customer service representative know the language.

If you are calling about…	Say …
Medicare prescription drug coverage	"Drug Coverage"
Claim or billing issues, or appeals	"Claims" or "Billing"
Preventive services	"Preventive Services"
Help paying health or prescription drug costs	"Limited Income"
Forms or publications	"Publications"
Telephone numbers for your State Medical Assistance (Medicaid) office	"Medicaid"
Outpatient doctor's care	"Doctor Service"
Hospital visit or emergency room care	"Hospital Stay"
Equipment or supplies like oxygen, wheelchairs, walkers, or diabetic supplies	"Medical Supplies"
Information about your Part B deductible	"Deductible"
Nursing Home Services	"Nursing Home"

People who get benefits from the RRB should call 1-800-833-4455 with questions about Part B services and bills.

Note: If you want Medicare to give your personal health information to someone other than you, you need to let Medicare know in writing. You can fill out a "Medicare Authorization to Disclose Personal Health Information" form. You can do this by visiting www.medicare.gov or by calling 1-800-MEDICARE to get a copy of the form.

Go Online to Get the Information You Need

Need Personalized Information?

Register at www.MyMedicare.gov, Medicare's secure online service for accessing your personal Medicare information:

- Complete your Initial Enrollment Questionnaire so your bills get paid correctly.
- Track your health care claims.
- Check your Part B deductible status.
- View your eligibility information.
- Track the preventive services you can get.
- Find a Medicare health or prescription drug plan.
- Keep your Medicare information in one convenient place.
- Sign up to get your "Medicare & You" handbook electronically.

Need General Information about Medicare?

Visit www.medicare.gov:

- Get detailed information about the Medicare health and prescription drug plans in your area, including what they cost and what services they provide.
- Find doctors or other health care providers and suppliers who participate in Medicare.
- See what Medicare covers, including preventive services.
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, home health agencies, and dialysis facilities.
- Look up helpful Web sites and telephone numbers.
- View Medicare publications.

If you don't have a computer, your local library or senior center may be able to help you look up this information. You can also call your State Health Insurance Assistance Program (SHIP). See pages 110–113 for the telephone number.

Compare the Quality of Plans and Providers

You can't always plan ahead when you need health care, but when you can, take time to compare. Medicare collects information about the quality of care and services given by most Medicare plans and other health care providers and information about the experiences of people with the care and services they get.

Now you can compare the quality of care and services given by health and prescription drug plans, or health care providers nationwide by visiting www.medicare.gov or by calling your State Health Insurance Assistance Program (SHIP). See pages 110–113 for the telephone number.

When you, a family member, friend, or SHIP counselor visit Medicare's Web site, select one of the following:

- "Compare Health Plans and Medigap Policies"
- "Compare Medicare Prescription Drug Plans"
- "Compare Dialysis Facilities"
- "Compare Home Health Agencies"
- "Compare Hospitals"
- "Compare Nursing Homes"

These search tools on www.medicare.gov give you a "snapshot" of the quality of care and services some plans and providers give. Find out more about the quality of care and services by doing the following:

- Ask what your plan or provider does to ensure and improve the quality of care and services. Every plan and health care provider should have someone you can talk to about quality.
- Ask your doctor what he or she thinks about the quality of care or services the plan or other health care provider gives. Talk to your doctor about Medicare's information on the quality of care and services that plans and providers give.

Medicare Publications

To read, print, or download copies of booklets, brochures, or fact sheets on the topics listed below or to see what's available, visit www.medicare.gov and select "Find a Medicare Publication." You can search by keyword (such as "rights" or "mental health"), or select "View All Medicare Publications."

If the publication you want has a check box after "Order Publication," you can have a printed copy mailed to you. You can also call 1-800-MEDICARE (1-800-633-4227), and say "Publications" to find out if a printed copy can be mailed to you. TTY users should call 1-877-486-2048.

Search for free booklets on Medicare topics like the following:

- Ambulance coverage
- Choosing a nursing home
- Comparing plans and health care providers
- Coverage outside the U.S.
- Fighting fraud
- Home health care
- Hospice care
- Hospital quality
- Kidney dialysis and transplant services
- Medicare Advantage Plan options
- Medicare prescription drug coverage, including Extra Help
- Mental health care
- Preventive services
- Rights and protections
- Skilled nursing facility care

Blue words in the text are defined on pages 115–118.

ask Medicare

Do you help someone with Medicare?

Medicare has two new resources to help you get the information you need.

- Visit "Ask Medicare" at www.medicare.gov/caregivers to help your loved one choose a drug plan, compare nursing homes, get help with billing, and more!
- Sign up for the free bi-monthly "Ask Medicare" electronic newsletter (e-Newsletter) when you go to the site mentioned above. The e-Newsletter has the latest information including important dates, Medicare changes, and resources in your community.

State Health Insurance Assistance Program (SHIP):

For help with questions about appeals, buying other insurance, choosing a health plan, buying a Medigap policy, and Medicare rights and protections.

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Notes

Definitions

Benefit Period—The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Creditable Prescription Drug Coverage—Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Critical Access Hospital—A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Custodial Care—Nonskilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Extra Help—A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Inpatient Rehabilitation Facility—A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Institution—A facility that provides short-term or long-term care, such as a nursing home, skilled nursing facility (SNF), or rehabilitation hospital. Private residences, such as an assisted living facility, or group home are not considered institutions for this purpose.

Lifetime Reserve Days—In Original Medicare, these are additional days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-Term Care Hospital—Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Medically Necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare-approved Amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare Health Plan—A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term is used throughout this handbook to include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Plan—Refers to any way other than Original Medicare that you can get your Medicare health or prescription drug coverage. This term includes all Medicare health plans and Medicare Prescription Drug Plans.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Doctor—Your primary care doctor is the doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Quality Improvement Organization (QIO)—A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to people with Medicare.

Referral—A written order from your primary care doctor for you to see a specialist or to get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Service Area—A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Facility (SNF) Care—Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include, physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

TTY—A teletypewriter (TTY) is a communication device used by people who are deaf, hard-of-hearing, or have a severe speech impairment. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

Medicare Costs

Your Monthly Premiums for Medicare

Part A (Hospital Insurance) Monthly Premium

Most people don't pay a Part A premium because they paid Medicare taxes while working.

In 2010, you pay up to $461 each month if you don't get premium-free Part A. If you pay a late enrollment penalty, this amount is higher.

Part B (Medical Insurance) Monthly Premium (See page 21.)

If Your Yearly Income in 2008 was		You Pay
File Individual Tax Return	File Joint Tax Return	
$85,000 or below	$170,000 or below	$110.50*
$85,001–$107,000	$170,001–$214,000	$154.70
$107,001–$160,000	$214,001–$320,000	$221.00
$160,001–$214,000	$320,001–$428,000	$287.30
above $214,000	above $428,000	$353.60

* Most people will continue to pay the 2009 Part B premium of $96.40 in 2010. If you have questions about your Part B premium, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Note: If you don't get Social Security, RRB, or Civil Service benefit payments and choose to sign up for Part B, you will get a bill. If you choose to buy Part A, you will always get a bill for your premium. You can mail your premium payments to the Medicare Premium Collection Center, P.O. Box 790355, St. Louis, MO 63179-0355. If you get a bill from the RRB, mail your premium payments to RRB, Medicare Premium Payments, P.O. Box 9024, St. Louis, MO 63197-9024.

Part C and Part D (Medicare Health and Prescription Drug Plan) Monthly Premium

Contact the plans you're interested in for the actual plan premium. You also pay the Part B premium (and Part A if you don't get it premium-free).

What you pay if you have Original Medicare

Part A Costs for Covered Services and Items

Blood	In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated.
Home Health Care	**You pay:** ▪ $0 for home health care services ▪ 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	**You pay:** ▪ $0 for hospice care ▪ A copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management ▪ 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest) Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).
Hospital Stay	**In 2010, you pay:** ▪ $1,100 deductible and no coinsurance for days 1–60 each benefit period ▪ $275 per day for days 61–90 each benefit period ▪ $550 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime) ▪ All costs for each day after the lifetime reserve days ▪ Inpatient mental health care in a psychiatric hospital limited to 190 days in a lifetime See "Medical and Other Services" on page 121 for what you pay for doctor services while you are a hospital inpatient.
Skilled Nursing Facility Stay	**In 2010, you pay:** ▪ $0 for the first 20 days each benefit period ▪ $137.50 per day for days 21–100 each benefit period ▪ All costs for each day after day 100 in a benefit period

Note: If you are in a Medicare Advantage Plan, costs vary by plan and may be either higher or lower than those noted above. Check with your plan.

What you pay if you have Original Medicare (continued)

Part B Costs for Covered Services and Items

Part B Deductible	**In 2010, you pay** the first $155 yearly for Part B-covered services or items.
Blood	In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. However, you will pay a copayment for the blood processing and handling services for every unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else. You pay a copayment for additional units of blood you get as an outpatient (after the first 3), and the Part B deductible applies.
Clinical Laboratory Services	**You pay** $0 for Medicare-approved services.
Home Health Services	**You pay** $0 for Medicare-approved services. You pay 20% of the Medicare-approved amount for durable medical equipment.
Medical and Other Services	**You pay** 20% of the Medicare-approved amount for most doctor services (including most doctor services while you are a hospital inpatient), outpatient therapy*, most preventive services, and durable medical equipment.
Mental Health Services	**You pay** 45% of the Medicare-approved amount for most outpatient mental health care.
Other Covered Services	**You pay** copayment or coinsurance amounts.
Outpatient Hospital Services	**You pay** a coinsurance or copayment amount that varies by service for each individual outpatient hospital service. No copayment for a single service can be more than the amount of the inpatient hospital deductible.

*In 2010, there may be limits on physical therapy, occupational therapy, and speech-language pathology services. If so, there may be exceptions to these limits.

Note: All Medicare Advantage Plans must cover these services. Costs vary by plan and may be either higher or lower than those noted above. Check with your plan.

Part C and Part D (Medicare Health and Prescription Drug Plans) Costs for Covered Services and Supplies

Cost information for the Medicare plans in your area is available by visiting www.medicare.gov. You can also contact the plan, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also call your State Health Insurance Assistance Program (SHIP). See pages 110–113 for the telephone number. Medicare Advantage Plans (like an HMO or PPO) must cover all Part A and Part B-covered services and supplies. Check your plan's materials for actual amounts.

The figures below are used to estimate the Part D late enrollment penalty. The national base beneficiary premium amount can change each year. For more information about estimating your penalty amount, see page 67.

	2010
Part D National Base Beneficiary Premium	$31.94
1% Penalty Calculation	$.32

Medicare cares about what you think. If you have general comments about this handbook, call 1-800-MEDICARE or email us at medicareandyou@cms.hhs.gov. We won't be able to respond to your comments about the handbook, but we will consider your feedback when writing future versions.

Using Computers to Manage Your Health Information

You can help manage your health information and improve how you communicate with your doctors and other health care providers by using a computer. Computers can also help you get and share access to your health information like never before. This technology (also called Health Information Technology or Health IT) reduces paperwork, medical errors, and health care costs and can also help improve your quality of care.

Electronic Health Records (EHRs)—An EHR is a record with important information about your health and treatment (like lab reports) that are maintained and used by **your doctor**, your doctor's staff, or a hospital.

- EHRs can help all of your providers have the same information about your conditions, treatments, tests, and prescriptions.
- EHRs can help lower the chances of medical errors and can help improve your overall quality of care.

Personal Health Records (PHRs)—A PHR is a record with information about your health that **you** maintain and keep for easy reference.

- These easy-to-use online tools can help you manage your health information from anywhere you have internet access.
- With a PHR, you can keep track of health information, like the date of your last physical, major illnesses, operations, allergies, or a list of your medicines.
- PHRs are often offered by providers, health plans, and private companies. Some are free, while others charge a monthly or annual fee.

Visit www.medicare.gov/phr to learn more.

Electronic Prescribing (E-Prescribing)—A way for your prescribers (your doctor or other health care provider who is legally allowed to write prescriptions) to send your prescriptions to your pharmacy using a secure computer.

- E-prescribing lets your prescribers send secure electronic prescriptions directly to your pharmacy, instead of writing prescriptions on paper.
- E-prescribing helps to avoid harmful drug interactions and allows your prescriber to see what drugs your plan offers, including lower-cost generics.

Ask your prescribers if they e-prescribe.

There are strict rules about protecting the privacy and security of electronic information. When you use a secure Web site, you usually have to create a unique user ID and password, and the information you type is encrypted (put in code) so other people can't read it. More work is being done to make sure that this new technology is even more secure.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

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National Medicare Handbook

- Also available in Spanish, Braille, Audiotape, and Large Print (English and Spanish).
- Suspect fraud? Call the Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950.
- New address? Call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

- ¿Necesita usted una copia de este manual en Español? Llame GRATIS al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deberán llamar al 1-877-486-2048.

www.medicare.gov
1-800-MEDICARE (1-800-633-4227)
TTY 1-877-486-2048

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