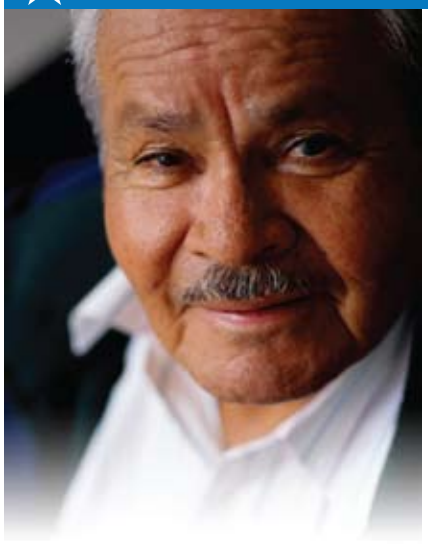
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare & You 2009



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

- ★ What's new
- ★ 2009 Medicare costs
- ★ What Medicare covers
- ★ Health and prescription drug plans
- ★ Your Medicare rights
- ★ Fraud and identity theft

Welcome to Medicare & You 2009

Medicare's goal is to make it easy for you to get the highest quality health care at the most affordable price. Medicare is transforming itself from a program which simply pays the bills to a program which actively supports a high quality health care system.

What do we mean by a **high quality** health care system? It's a system that does the following:

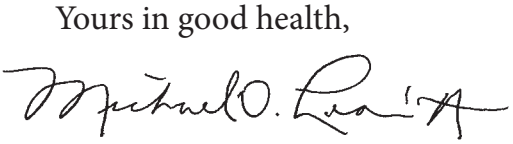
- Rewards providers for quality and efficiency
- Uses objective standards to determine quality and efficiency
- Communicates using an interconnected, computerized health information network, so providers can get a comprehensive view of the patient securely and without delay
- Offers consumers complete, objective, easily accessible information, so they can make solid decisions about their own health care based on quality and price

Medicare shares quality information about providers in your area at www.medicare.gov.

In addition, this "Medicare & You" handbook is another way Medicare is working to make sure you have reliable information to help you make good health care decisions.

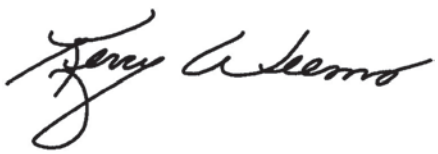
Throughout this handbook, we have information about how you can get the most out of your Medicare, including Medicare health and prescription drug plan choices and coverage, how to protect yourself and Medicare from fraud, background on advance directives, and resources for detailed information and personalized help. This information is up-to-date between January 1, 2009–December 31, 2009. You will get a new handbook every fall to help you compare coverage and learn new and important information.

Yours in good health,



Michael O. Leavitt

Secretary
Department of Health and Human Services



Kerry N. Weems

Acting Administrator
Centers for Medicare & Medicaid Services

Are You Getting the Most Out of Medicare?

Use this checklist to find out.

- ❑ Review how your current coverage will change and compare it to other coverage options for next year to see if there's a better choice for you. See page 44.
- ❑ Remember that you can only join, switch, or drop Medicare plans at certain times. See pages 11, 59, and 65.
- ❑ If you have other health insurance, find out how it works with Medicare. See pages 72–74.
- ❑ Call your State Health Insurance Assistance Program (SHIP) for free help with your Medicare questions. See pages 111–114 for the telephone number.
- ❑ Ask your doctor or other health care provider which preventive services (like screenings, shots, and tests) you should get. Take the checklist on page 39 to your next visit.
- ❑ Find out if you qualify for help paying your Medicare health and prescription drug costs. See pages 77–84.
- ❑ Protect yourself from identity theft and fraud. See pages 94–97.
- ❑ Visit www.MyMedicare.gov to access your personalized Medicare information. Help save tax dollars by choosing to access future "Medicare & You" handbooks electronically.
- ❑ **If you are new to Medicare**, use the www.MyMedicare.gov password and instructions Medicare mailed to you. Fill out your Initial Enrollment Questionnaire (IEQ) online or the IEQ that was mailed to you, so Medicare can process your bills correctly. See page 109. If you have questions about the IEQ or to complete it over the telephone, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.
- ❑ **If you are new to Medicare**, get a one-time "Welcome to Medicare" physical exam. See "physical exam" on page 33 to see what's covered and what you pay.

Important Information about This Handbook

Please keep this handbook for future reference. Changes may occur after printing. 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.

This box lets you know that blue words in the text are defined on pages 115–118.

Did your household get more than one copy of "Medicare & You?" If you would like to get only one copy in the future, call 1-800-MEDICARE.

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

The term "Medicare health plan" 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).

This symbol highlights important information.

Contents

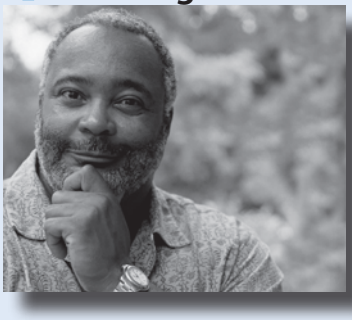
Medicare & You 2009

Continued ⇨

11 What's new?

15 What's covered? What's not?

41 Coverage choices



Contents (continued)

78 Need "extra help" with costs?

94 Fraud and identity theft

119 2009 Medicare costs

Index

A Quick Way to Find What You Need

The page number in **bold** provides the most detailed information.

The page number in **bold** provides the most detailed information.

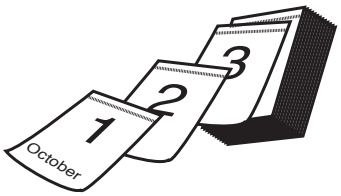
The page number in **bold** provides the most detailed information.

The page number in **bold** provides the most detailed information.

Medicare Basics

What's New and Important in 2009?

- **One-Time "Welcome to Medicare" physical exam**—More time and lower cost. See page 33.
- **Fraud and Identity Theft**—Protect yourself and Medicare. See pages 94–97.
- **Planning Ahead**—Plan for your current and future health care needs. See pages 99–106.
- **New Technology**—Electronic and Personal Health Records. See page 101.
- **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)**—The amounts you will pay in 2009 are on pages 119–121.
- **Electronic Handbook**—Choose to get future "Medicare & You" handbooks electronically. See page 122.



Plan Coverage and Costs Change Yearly.

Mark your calendar with these important dates!

October 2008: Prepare and Compare

Your health, finances, or coverage may have changed in the last year. Look at the cost, coverage, quality, and convenience your current Medicare health or prescription drug coverage will offer in 2009, and compare it with other available coverage options to see if there's a better choice for you.

November 15, 2008–December 31, 2008: Stay or Switch

You can switch your Medicare health or prescription drug coverage for 2009 during this period.

January 1, 2009: 2009 Coverage and Costs Begin

New coverage begins if you made a change between November 15, 2008–December 31, 2008. New costs and coverage changes also begin if you keep your current coverage.

Note: There may be other times when you can change your Medicare health or prescription drug coverage. See pages 59 and 65.

What Is Medicare?

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and 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 if you meet certain conditions. 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 and outpatient care
- Helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse

See pages 21–37.

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

- A health coverage choice run by private companies approved by Medicare
- Includes Part A, Part B, and usually other coverage including prescription drugs

See the next page.

Medicare Part D (Prescription Drug Coverage)

- 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 63–71.

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 Part B coverage.
- 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 coverage. See pages 75–76.

Medicare Advantage Plans (like an HMO or PPO) (See pages 50–60.)

- Run by private companies approved by 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 for an extra cost. **Costs 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 a Medigap policy.

Other Medicare Health Plans (See pages 61–62 and 103–104.)

- 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).
- Some plans provide Part A and Part B coverage, and some also provide prescription drug coverage (Part D).

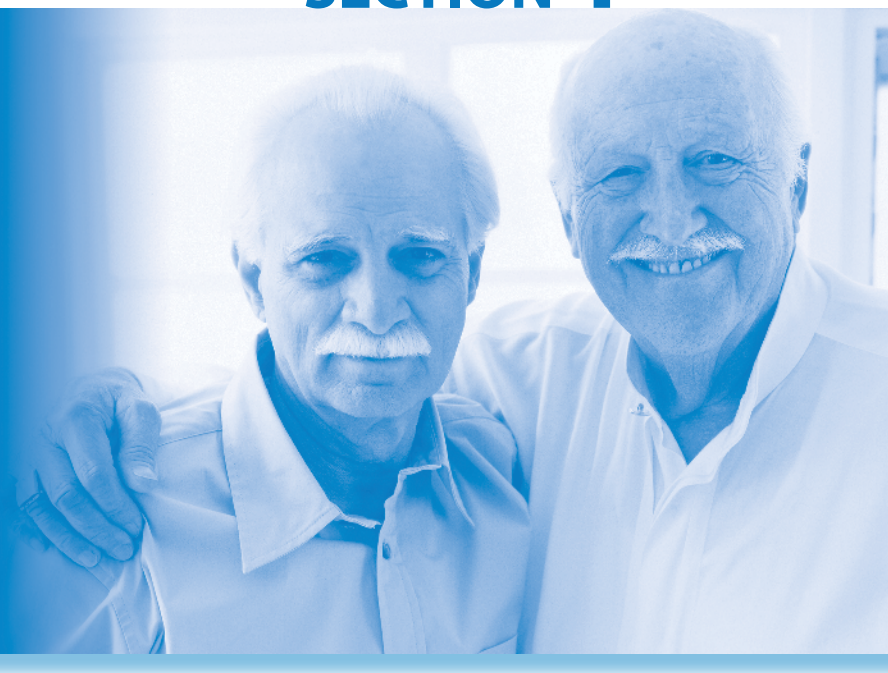
Note: You might also have health and/or prescription drug coverage from a former or current employer or union. See pages 72–73.

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. See page 108.	1-800-633-4227 TTY 1-877-486-2048
State Health Insurance Assistance Program (SHIP) To get free personalized health insurance counseling, including help making health care decisions, information on programs for people with limited income and resources, and help with claims, billing, and appeals.	**See pages 111–114.**
Social Security To get a replacement 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, 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.	1-800-999-1118 TTY 1-800-318-8782
Department of Defense To get information about TRICARE. To get information about TRICARE for Life.	 1-888-363-5433 1-866-773-0404 TTY 1-866-773-0405
Department of Health and Human Services **Office of Inspector General** If you suspect fraud, see pages 94–97. **Office for Civil Rights** If you think you've been treated unfairly, see page 97.	 1-800-447-8477 TTY 1-800-377-4950 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, enroll in Medicare, replace your Medicare card, and report a death.	Local RRB office or 1-800-808-0772 After January 1, 2009, call 1-877-772-5772.
Quality Improvement Organization (QIO) To ask questions or report complaints about the quality of care for a Medicare-covered service.	1-800-MEDICARE to get the telephone number for your QIO.

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



Medicare is here to help you stay healthy. We're committed to providing you with information that can help you make informed health care decisions. This section explains what Medicare covers.

Section 1 includes information about the following:

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 the full range of Medicare-covered services listed here, no matter what type of Medicare coverage you choose.

A list of the services covered by Part A is on pages 19–20.
A list of the services covered by Part B is on pages 26–37.

What Is Part A (Hospital Insurance)?

Part A helps cover the following:

- Inpatient care in hospitals (includes critical access hospitals and inpatient rehabilitation facilities)
- Inpatient stays 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 (facility that provides non-medical, non-religious health care items and services to people who need hospital or skilled nursing facility care but for whom that care wouldn't be in agreement with their religious beliefs)

See pages 17–18 for the conditions you must meet to get Part A-covered services.

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 the citizenship or residency requirements and you are age 65 or older or you are under age 65, disabled, and your premium-free Part A coverage ended because you returned to work.

Note: The 2009 premium amount for people who buy Part A is up to $443 each month.

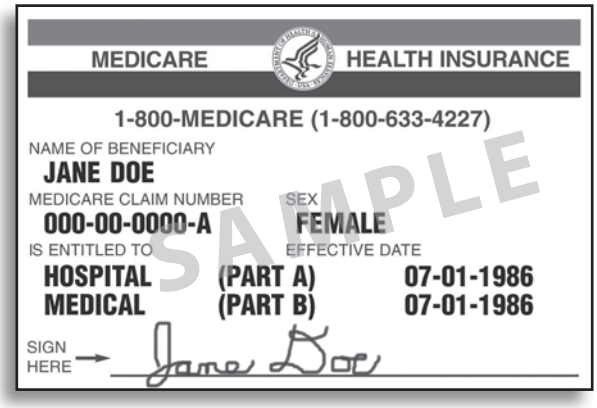
Blue words in the text are defined on pages 115–118.

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.

See pages 94–97 to find out about protecting yourself from identity theft and fraud.

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 RRB, visit www.rrb.gov and select, "Benefit Online Services," or call your local RRB office. After January 1, 2009, call the RRB toll-free at 1-877-772-5772.

When Can You Sign Up for Part A?

Many People Automatically Get Part A

If you get benefits from Social Security or the 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.

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

Some People Need to Sign up for Part A

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. You will need to sign up even if you are eligible for premium-free Part A. 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 have End-Stage Renal Disease (ESRD), you can sign up for Part A by visiting your local Social Security office or by calling Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. To get more information on how to enroll in Medicare if you have ESRD, visit www.medicare.gov/Publications/Pubs/pdf/10128.pdf to view the booklet, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services."

If you aren't eligible for premium-free Part A, you can buy it during the following times:

- **Initial Enrollment Period**—When you first become eligible for Medicare (3 months before you turn age 65 to 3 months after the month you turn age 65).
- **General Enrollment Period**—Between January 1–March 31 each year.
- **Special Enrollment Period**—If you or your spouse (or family member if you are disabled) is working and has group health plan coverage through the employer or union. See page 23.
- **Special Enrollment Period for International Volunteers**—If you are serving as a volunteer in a foreign country. See page 23.

If you don't buy Part A when you are first eligible, the monthly premium may go up 10% unless 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 your local RRB office or 1-800-808-0772. After January 1, 2009, call the RRB toll-free at 1-877-772-5772.

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

Part A-Covered Services

Blood	If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 pints of blood you get in a calendar year or have the blood donated. 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.
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. Care must be ordered by a doctor and provided by a Medicare-certified home health agency. 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 takes a lot of effort. Part A covers the cost of the first 100 home health visits following a hospital stay.
Hospice Care	For people with a terminal illness who are expected to live 6 months or less (as certified by a doctor). Coverage may include drugs (for pain relief and symptom management), medical, nursing, social services, and other covered services as well as services not usually covered by Medicare (like grief counseling). Hospice care is usually given in your home (or other facility like a nursing home) by a Medicare-approved hospice. Medicare covers some short-term inpatient stays (for pain and symptom management that requires an inpatient stay) in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility. Medicare also covers inpatient respite care (care given to a hospice patient so that the usual caregiver can rest). You can stay in a Medicare-approved facility up to 5 days each time you get respite care. Medicare may 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.

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 (see page 27), and mental health care. This **doesn't** include private-duty nursing, a television or telephone in your room, or personal care items like razors or slipper socks. It also doesn't include a private room, unless medically necessary. The doctor services you get while you are in a hospital are covered under Part B. See page 30. For emergency room services, also see page 30.
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) for up to 100 days in a benefit period. To get 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. See pages 102–104.

See page 120 for specific costs and other information about these services.

What Is Part B (Medical Insurance)?

Part B helps cover medically-necessary services like doctors' services, outpatient care, 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. See the sample card on page 17.

How Much Does Part B Cost?

You pay the Part B premium each month. Most people will pay the standard premium amount, which is $96.40 in 2009. However, your monthly premium will be higher if you meet the following conditions:

- You are single (file an individual tax return), and your yearly modified adjusted gross income is more than $85,000 (in 2009).
- You are married (file a joint tax return), and your yearly modified adjusted gross income is more than $170,000 (in 2009).

The 2009 Part B premium amounts are on page 119.

Your modified adjusted gross income is your adjusted gross (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, call Social Security.

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

You also pay a Part B deductible each year before Medicare starts to pay its share. In 2009, the deductible amount is $135.

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

What Is the Part B Late Enrollment Penalty?

If you don't sign up for Part B when you are first eligible, 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. If you delay taking Part B because you or your spouse (or a family member, if you are disabled) is working and has group health plan coverage based on current employment, you may not have to pay the higher premium. See page 23 ("Special Enrollment Period") for more information.

When Can You Sign Up for Part B?

If you get benefits from Social Security or the RRB, you will automatically get Part B starting the first day of the month you turn age 65. 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.

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

If you have ESRD, you can sign up for Part B when you sign up for Part A. (See page 18 to find out how to get 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 period that begins 3 months before the month of your 65th birthday and ends 3 months after the month of your 65th birthday).

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

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. The cost of your Part B will go up 10% for each full 12-month period you could have had Part B but didn't sign up for it, unless you qualify for a special enrollment period (see below). You may have to pay this late enrollment penalty as long as you have Part B.
- **Special Enrollment Period**—If you wait to sign up for Part B because you or your spouse is working and has group health plan coverage based on that work, or if you are disabled and you or a family member is working and has group health plan coverage based on that work. You can sign up for Part B any time while you have group health plan coverage based on current employment or during the 8-month period that begins the month the employment ends, or the group health plan coverage ends, whichever happens first.
- **Special Enrollment Period for International Volunteers**—If you waited to enroll in Part B because you had health insurance while volunteering in a foreign country. You can sign up during the 6-month period that begins the month you are no longer volunteering outside the United States, or the sponsoring organization is no longer tax exempt, or you no longer have health coverage outside the U.S., whichever comes first.

Usually, you don't pay a late enrollment penalty if you sign up for Part B during a special enrollment period.

Call Social Security at 1-800-772-1213 for more information about your Medicare eligibility and to enroll in Part B. TTY users should call 1-800-325-0778. If you get RRB benefits, call your local RRB office or 1-800-808-0772. After January 1, 2009, call the RRB toll-free 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 111–114 for the telephone number.

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

Part B and TRICARE Coverage

If you have Medicare and you also have TRICARE coverage (for active-duty military or retirees and their families), you will need to contact TRICARE to find out what you need to do if you want to keep TRICARE. For example, you may have to buy Part B if you or your spouse is no longer active duty.

See page 73 for more information about TRICARE.

Note: If you are in a Medicare Advantage Plan or choose to join a plan, tell the plan you have TRICARE.

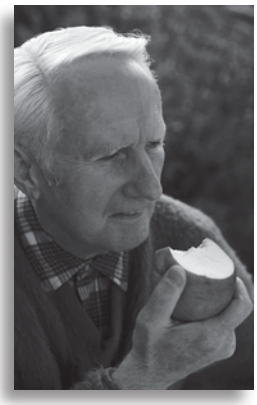
Part B and Group Health Plan Coverage from an Employer or Union

Your Part B enrollment rights can be affected if you have coverage through an employer (including FEHBP) or union, and you or your spouse is still working.

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 only lasts for 8 months after your employment ends. This period will run whether or not you elect COBRA, so if you wait until your COBRA ends, your special enrollment period will probably be over.
3. If you sign up for Part B, it will also start 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 also can't be delayed or repeated. See pages 75–76.

Part B-Covered Services



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

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

Pages 26–37 include an alphabetical list of common services covered by Medicare Part B. To find out if Medicare covers a service that's not included on this list, visit www.medicare.gov and select, "Find Out What Medicare Covers." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You will see this symbol next to preventive services.

Your doctor or other health care provider can help you better understand the preventive services Medicare covers and will tell you which services you need.

What You Pay for Medicare Part B-Covered Services

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

Costs for Part B services vary depending on whether you have Original Medicare or are in a Medicare health plan. The charts on pages 26–38 give general information about what you must pay if you have Original Medicare. You generally have to pay for the doctor's visit, even if there is no cost for the service itself. 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, 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 82–84.

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 from those shown on pages 26–37. For more information about the different costs, contact the plans you are interested in.

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" on page 33. 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 the same day). You pay 20% of the Medicare-approved amount (except for 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	If the provider has to buy blood for you, you must either pay the provider costs for the first 3 pints of blood you get in a calendar year or have the blood donated. 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. You pay 20% of the Medicare-approved amount for additional pints of blood you get as an outpatient, 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 prevent 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	Including 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. Medicare covers some costs, like doctor visits and tests, in qualifying clinical research studies. Clinical research studies help doctors and researchers see if the new care works and if it's safe. 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

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 generally you 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 for those not at high risk, 120 months after a previous screening colonoscopy. 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 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, 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.

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 training 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 page 33. 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 ordered by your doctor for use in the home. Some items must first be rented. 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. For more information, visit www.medicare.gov/Publications/Pubs/pdf/11045.pdf to view "Medicare Coverage of Durable Medical Equipment and Other Devices."
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	For people with diabetes to check for diabetic retinopathy once every 12 months. 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.
Federally-Qualified Health Center Services	Provides a broad range of outpatient primary care and preventive services. You pay 20% of the Medicare-approved amount.
Flu Shots	Helps prevent influenza or flu virus. This is 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 (see page 47) for giving the shot.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

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. This is covered once every 12 months for people at high risk for glaucoma. You are considered high risk for glaucoma if you have diabetes, or a family history of glaucoma, or are African-American and age 50 or older, or are Hispanic and age 65 or older. Tests must be done by an eye doctor who is legally authorized by the state. 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. Hearing aids and exams for fitting hearing aids aren't covered. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
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 lowers your resistance to infection. Other factors may increase your risk for Hepatitis B, so check with your doctor about your risk. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Home Health Services	Limited to medically-necessary part-time or intermittent skilled nursing care or physical therapy, or speech-language pathology, or a continuing need for occupational therapy. Must be ordered by a doctor and provided by a Medicare-certified home health agency. 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 takes a lot of 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.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Kidney Dialysis Services and Supplies	For people with ESRD. Dialysis is covered 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.
Mammograms (screening)	A type of X-ray to check women for breast cancer before they or their doctor may be able to find it. Screening mammograms are covered once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between age 35 and 39. You pay 20% of the Medicare-approved amount.
Medical Nutrition Therapy Services	Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, 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. For doctor or other health care provider visits to diagnose, or to monitor or change your prescription, you pay 20% of the Medicare-approved amount. For outpatient treatment of your mental health condition (such as therapy), you pay 50% of the Medicare-approved amount. The Part B deductible applies. 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. See page 120 for more information about inpatient mental health care.
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. In 2009, 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 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 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. **New:** Starting January 1, 2009, 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, and the Part B deductible no longer applies. **Important:** In 2008, you had to get the physical exam within the first 6 months you had Part B, and the Part B deductible applied.
Physical Therapy	Evaluation and treatment for injuries and diseases that change your ability to function when your doctor certifies your need for it. In 2009, 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.
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 (see page 47) for giving the shot.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

Practitioner Services (Non-doctor)	Such as services provided by physician assistants and nurse practitioners. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Prescription Drugs (limited)	Includes a limited number of prescription drugs such as those you get in a hospital outpatient department under certain circumstances, injected drugs you get in a doctor's office, certain oral cancer drugs, and drugs used with some types of durable medical equipment (like a nebulizer or infusion pump). You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **Note:** Other than the examples above, under Part B, you pay 100% for most prescription drugs, unless you have Part D or other drug coverage. For more information, see pages 63–71.
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. No cost to you for the PSA test.
Prosthetic/ Orthotic Items	Including arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); 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 ordered by a doctor. 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	Provides a broad range of 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.
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.

Part B deductible and coinsurance amounts are on page 121.

Part B-Covered Services

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. In 2009, 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, and the Part B deductible applies.
Telemedicine	Medical or other health services given to a patient using a communications system (like a computer, telephone, or television) by a provider in a location different from the patient's. Available in some rural areas, under certain conditions and only in a provider's office, a hospital, or a federally-qualified 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 as a hospital outpatient, you pay a specified copayment that may be more than 20% of the Medicare-approved amount but 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. Bone marrow and cornea transplants are covered 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 entitled to Part B at the time you get immunosuppressive drugs, and the transplant must have been performed in a Medicare-certified facility. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. If you are thinking of 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. **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)	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?

Items and services that Medicare doesn't cover include, **but aren't limited to**, the following:

- Acupuncture.
- Chiropractic services (except as listed on page 27).
- Cosmetic surgery.
- Custodial care, except when you also get skilled nursing care in a skilled nursing facility, at home, or as part of hospice care.
- Deductibles, coinsurance, or copayments when you get certain health care services. See pages 120–121 for these amounts. People with limited income and resources may get help paying these costs. See pages 82–84.
- Dental care and dentures (with a few exceptions).
- Eye exams (routine), eye refractions (exam that measures how well you see at specific distances), and eyeglasses (except as listed on page 30).
- Foot care (routine), like cutting corns or calluses (with few exceptions). See page 31.
- Hearing aids and exams for the purpose of fitting a hearing aid.
- Hearing tests that haven't been ordered by your doctor.
- Laboratory tests (screening), except those listed on pages 26–35.
- Long-term care. See pages 102–104.
- Orthopedic shoes (with few exceptions). See page 29 under Diabetes Supplies.
- Physical exams (routine or yearly). Medicare will cover a one-time physical exam. See page 33.
- Prescription drugs (with few exceptions). See page 34. See pages 63–71 for information about Medicare prescription drug coverage (Part D).
- Shots to prevent illness, except as listed on pages 30, 31, and 33. Part D must cover all commercially-available vaccines (like the shingles vaccine) except those covered by Part B.
- Surgical procedures given in ambulatory surgical centers that aren't included on Medicare's list of ambulatory surgical center covered procedures.
- Syringes or insulin. Insulin used with an insulin pump is covered by Part B. Syringes or insulin may be covered by Part D.
- Travel (health care while you're traveling outside the United States, except as listed on page 37).

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

Preventive Services Checklist

Take this checklist to your doctor or other health care provider, and ask which preventive services are right for you. Look on pages 25–34 for more details about the costs, how often, and whether you meet the conditions to get these services. Write down any notes (like the date you get the service).

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

Visit www.MyMedicare.gov to keep track of your preventive services. See page 109.

Notes

Decide How to Get Your Medicare

You have choices about 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:

This handbook has basic information. You may need more detailed information than this handbook provides to make a choice. See page 42 to find out how to get personalized health insurance counseling.

Your Medicare Choices

You can choose different ways to get your Medicare coverage, Original Medicare or a Medicare Advantage Plan (like an HMO or PPO). If you choose Original Medicare and you want drug coverage, you can join a Medicare Prescription Drug Plan. 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 page 43 for more information about your coverage choices and the decisions you need to make.

Each year you should review your health and prescription needs because your health, finances, or coverage may have changed. If you decide other coverage will better meet your needs, you can switch plans during certain times. See pages 59 and 65.

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 counseling about choosing coverage. See pages 111–114 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.

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

Use These Steps to Help You Decide

Step 1

Decide if You Want

Original Medicare	OR a	Medicare Advantage Plan (like an HMO or PPO)
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 pay deductibles and coinsurance. ▪ You usually pay a monthly premium for Part B. See pages 45–49.		**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. ▪ You usually pay a monthly premium (in addition to your Part B premium) and a copayment for covered services. ▪ Costs, extra coverage, and rules vary by plan. See pages 50–60.

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 63–71.		▪ If you want this coverage, in most cases you must get it through your Medicare Advantage Plan. ▪ Most Medicare Advantage Plans include prescription drug coverage (Part D), usually for an extra cost. See pages 54–56.

Step 3

Decide If You Want Supplemental Coverage

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

See pages 75–76.

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 any expenses you have under the Medicare Advantage Plan. If you already have a Medicare Advantage Plan, you can't be sold a Medigap policy. See page 57.

In addition to Original Medicare or a Medicare Advantage Plan, you may be able to join other types of Medicare health plans (see pages 61–62). 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 72–73).

Things to Consider When Choosing or Changing Your Coverage

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

- **Coverage**—When choosing between Original Medicare and a Medicare health plan, does the plan provide extra coverage you want that Original Medicare doesn't cover?
- **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, talk to your benefits administrator, insurer, or plan before making any changes to your coverage.
- **Cost**—How much are your premiums and deductibles? How much do you pay for services like hospital stays or doctor visits? 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 they accepting new patients? If you are considering a Medicare health plan, do you have to choose your hospital and health care providers from a network? Do you need a referral to see a specialist?
- **Prescription drugs**—What are your drug needs? Do you need to join a Medicare drug plan? What will your prescription drugs cost under each plan? Are your drugs covered under the plan's formulary (drug list)? Formularies can change.
- **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 100.
- **Convenience**—Where are the doctors' offices? What are their hours? Which pharmacies can you use? Can you get your prescriptions by mail?
- **Travel**—Do you spend part of each year in another state? Will the plan cover you there?

Your Medicare plan will send you an Evidence of Coverage (EOC) and Annual Notice of Change (ANOC) 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.

Original Medicare

Original Medicare is one of your health coverage choices as part of Medicare. You will have Original Medicare unless you choose to join a Medicare health plan.

How Does Original Medicare Work?

Under Original Medicare, you have your choice of doctors and hospitals. You don't need a referral. You pay a separate amount for each service. Here are the general rules for how it works:

	Original Medicare
Are prescription drugs covered?	Only in limited situations like when you are a hospital inpatient. See pages 20 and 34. You can add comprehensive drug coverage by joining a Medicare Prescription Drug Plan. See pages 63–71.
Do I need to choose a primary care doctor?	No.
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.
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. See pages 75–76.
What else do I need to know about Original Medicare?	▪ Each year, you generally must 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) for covered services and supplies. See pages 120–121 to find out what you pay. ▪ If you have Part A, you can generally get the Part A-covered services listed on pages 19–20. ▪ If you have Part B, you can generally get the services listed on pages 26–37. You usually pay a monthly premium for Part B. See page 119. ▪ You generally don't need to file Medicare claims. Providers (like doctors, hospitals, skilled nursing facilities, and home health agencies) and suppliers are required by law to file Medicare claims for the covered services and supplies you get.

Original Medicare Payment Information

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 were 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, you should 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.
- 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.

MSNs are mailed every 3 months. If you are due a refund check from Medicare, 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 your local RRB office or 1-800-808-0772. After January 1, 2009, call 1-877-772-5772.

Visit www.MyMedicare.gov to track your Medicare claims.
See page 109.

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 page 47.
- How often you need health care.
- What type of health care you need.
- 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. See pages 82–83.

See pages 75–84 for more information about help to cover the costs that Original Medicare doesn't cover.

"Assignment" in Original Medicare

Assignment is an agreement between you, Medicare, and doctors, other health care providers, or suppliers. When you "assign" a claim, Medicare will pay the doctor, provider, or supplier directly for the services you get.

Remember the following if your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less.
- Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. In some cases they must accept assignment, like when they have a participation agreement with Medicare and give you Medicare-covered services.
- If a doctor, provider, or supplier accepts assignment, they agree to only charge you the Medicare deductible or coinsurance amount and wait for Medicare to pay its share.
- All doctors, providers, and suppliers that give you Medicare-covered services have to submit your claim to Medicare directly. They can't charge you for submitting the claim.

Remember the following 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 for these services, you should contact the company that handles bills for Medicare for your state to file a complaint. Look on your MSN for the telephone number. In the meantime, 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.

To find doctors and suppliers who accept assignment, 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.

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

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 through Medicare. The private contract only applies to the services provided by the doctor who asked you to sign it. You can't be asked to sign a private contract in an emergency situation or when you need urgent care. You don't have to sign a private contract with a doctor. You can go to another doctor who will provide services through Medicare. If you sign a private contract with your doctor, remember these rules:

- Medicare won't pay **any** amount for the services you get from this doctor.
- You will have to pay whatever this doctor or provider charges you for the services you get.
- If you have a Medigap (Medicare Supplement Insurance) policy, it won't pay anything for this service. Call your Medigap insurance company before you get the service if you have questions.
- Your doctor must tell you if Medicare would pay for the service 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 are always free to get non-covered services on your own if you choose to pay for the service yourself. See page 38 for a list of services and items that Medicare doesn't cover.

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 111–114 for the telephone number.

See pages 85–98 for information about your appeal rights and how to protect yourself and Medicare from fraud.

Adding Medicare Prescription Drug Coverage (Part D)

If you have Original Medicare and you want Medicare drug coverage, you must join a Medicare Prescription Drug Plan. These plans are available through private companies that work with Medicare to provide prescription drug coverage. See pages 63–71 for more details about Medicare 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.

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

Help Paying for a Medicare Drug Plan

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."

Medicare Advantage Plans (Part C)

Medicare Advantage Plans are health plan options (like an HMO or PPO) approved by Medicare and offered by private companies. These plans are part of Medicare and are sometimes called "Part C" or "MA Plans." 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. **Medicare Advantage Plans provide your Medicare health coverage and usually Medicare drug coverage. They aren't supplemental insurance.**

Not all Medicare Advantage Plans work the same way, so find out the plan's rules before joining. See the chart that starts on page 54 for an outline of these various plans' rules. In all plan types, you are always covered for emergency and urgent care.

Medicare Advantage Plans include the following:

- Preferred Provider Organization (PPO) Plans. See page 54.
- Health Maintenance Organization (HMO) Plans. See page 54.
- Private Fee-for-Service (PFFS) Plans. See page 55.
- Medical Savings Account (MSA) Plans. See page 55.
- Special Needs Plans (SNP). See page 56.

Note: There are other types of Medicare Advantage Plans that may be available; however, they are less common. Provider Sponsored Organizations (PSOs) are plans run by a provider or group of providers. In a PSO, you usually get your health care from the providers who are a part of the plan. Religious Fraternal Benefit (RFB) Plans are offered to members of certain religious groups. RFBs can be any plan type, including an HMO or PPO.

Medicare Advantage Plans (Part C) (continued)

Medicare Advantage Plans provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. This means they must cover at least all of the services that Original Medicare covers. However, each Medicare Advantage Plan can charge different out-of-pocket costs. These are usually copayments but can also be coinsurance and deductibles. It's important to call any plan before joining to find out the plan's rules, what your costs will be, and to make sure the plan meets your needs.

Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (usually for an extra cost). You may need a referral to see specialists. Some Medicare Advantage Plans have provider networks. In some cases this means you can only see doctors who belong to the plan or go to certain hospitals to get covered services (other than for emergency or urgently needed care or medically-necessary dialysis).

In some plans, if you see a doctor or other provider who doesn't contract or participate with the plan, your services may not be covered at all, or your costs will likely be higher. You should check with your doctors or hospital to find out if they accept the plan.

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. Contact the plans you're interested in to find out about the service area. 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.
- You don't have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) except as explained on page 58.

Note: In most cases, you can join a Medicare Advantage Plan only at certain times during the year. See page 59.

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

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. See page 58.
- You can only join a plan during one of the periods listed on page 59. In most cases, you are enrolled in a plan for a year.
- If you see a doctor who 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.
- You usually get prescription drug coverage (Part D) through the plan. **In most cases, 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. It won't cover your Medicare Advantage Plan deductibles, copayment, or coinsurance.

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

See pages 85–97 for information about your appeal rights and how to protect yourself and Medicare from fraud.

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. Medicare Advantage Plans charge one combined premium for Part A and Part B health coverage, Medicare prescription drug coverage (Part D) (if offered), and extra coverage (if offered).
- Whether the plan pays any of the monthly Part B premium (see "Saving on Your Part B Premium" below).
- 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.

To learn more about your costs in specific Medicare Advantage Plans, contact the plans you are interested in to get more details.

Saving on Your Part B Premium

There are two ways to save on your Part B premium:

- A few Medicare Advantage Plans may pay all or part of your Part B premium. You still get all Part A and Part B-covered services.
- You can also call your State Medical Assistance (Medicaid) office if you have limited income and resources to see if you can get help paying your Part B premium costs. See page 83.

Saving on Your Part D Premium

Your Medicare Advantage Plan's premium may include the premium for Medicare prescription drug coverage (Part D). Some plans may pay all or part of the premium for prescription drug coverage. Plans decide each year whether to offer this help, so read the plan materials carefully.

If you have limited income and resources, you may be able to get "extra help" paying for your Part D premium and other prescription drug coverage costs. See pages 78–81.

How Do Medicare Advantage Plans Work?

	Preferred Provider Organization (PPO) Plan	Health Maintenance Organization (HMO) Plan
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want drug coverage, you must join a PPO Plan that offers prescription drug coverage.	In most cases, yes. Ask the plan. If you want drug coverage, you must enroll in an HMO Plan that offers prescription drug coverage.
Do I need to choose a primary care doctor?	No.	In most cases, yes.
Can I get my health care from any doctor or hospital?	Yes. PPOs have network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.	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). If the plan offers Point-of-Service, you can go out-of-network for certain services for a higher cost.
Do I have to get a referral to see a specialist?	No.	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.
What else do I need to know about this type of plan?	▪ There are two types of PPOs—Regional PPOs and Local PPOs. ▪ Regional PPOs must limit your out-of-pocket costs for Medicare-covered services. This limit varies by 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 when needed.

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
Are prescription drugs covered?	Sometimes. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan to get drug 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.
Can I get my health care from any doctor or hospital?	In most cases, yes. **You can go to any Medicare-approved doctor or hospital if they agree to treat you. Not all providers will accept the plan's payment terms or agree to treat you.**	Yes. Some plans may have preferred doctors and hospitals you could go to for a lower cost.
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 it will pay doctors and hospitals and how much you must pay for services. ▪ Doctors, hospitals, and other providers may decide on a case-by-case basis not to treat you. ▪ Before you join a PFFS Plan, make sure you find doctors, hospitals, and other types of providers who agree to treat you and accept the PFFS Plan's payment terms.	▪ 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 usually 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 deductible, your plan will cover your Medicare-covered services. ▪ Any money left in your account at the end of the year remains in your account along with the deposit for next year.

How Do Medicare Advantage Plans Work? (continued)

	Special Needs Plan (SNP)
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.
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.
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?	▪ SNPs serve people who either 1) live in certain institutions (like a nursing home) or who require nursing care at home, or 2) are eligible for both Medicare and Medicaid, or 3) have one or more specific chronic or disabling conditions (like diabetes, congestive heart failure, a mental health condition, or HIV/AIDS). ▪ A plan may limit plan membership to people in one of these groups or further limit membership within these groups. It may also enroll a limited number of other people. ▪ 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, 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. ▪ You may be disenrolled if you no longer meet the plan's membership requirements, like if you lose Medicaid or leave a nursing home. If you are disenrolled, you will be returned to Original Medicare and will have 3 months to join another Medicare health or prescription drug plan.

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)

Can You Join a Medicare Advantage Plan if You Have Employer or Union Coverage?

Talk to your employer or union 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.

What Happens if You Drop Your Medigap (Medicare Supplement Insurance) Policy When You Join a Medicare Advantage Plan?

- In most cases, if you drop your Medigap policy, you won't be able to get it back.
- **However, you may have special Medigap protections if this is the first time you have done either of the following:**
  - — Joined a Medicare Advantage Plan or other Medicare health plan
  - — Bought a Medicare SELECT policy (a Medigap policy that requires you to use specific hospitals and, in some cases, specific doctors to get full coverage)
- These protections give you a right to get your old Medigap policy back or buy a new one if you choose to leave your Medicare health plan or drop your Medicare SELECT policy within the first year. See page 76. In either case, the new Medigap policy can't include prescription drug coverage.
- However, you may be able to join a Medicare Prescription Drug Plan if you join a Medicare Advantage Plan and leave it within the first year.
- Check with your State Health Insurance Assistance Program (SHIP) to see if your state offers other rights to buy Medigap policies. See pages 111–114 for the telephone number.

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

How Do Medicare Advantage Plans Work? (continued)

Special Rules for People with End-Stage Renal Disease (ESRD)

If you have ESRD (permanent kidney failure requiring dialysis or a kidney transplant) and you have 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 it 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 offered by 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, as long as the plan you choose is accepting new members.

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 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."

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 (3 months before you turn age 65 to 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.
- Between November 15–December 31 each year. Your coverage will begin on January 1 of the following year.
- Between January 1–March 31 of each year. However, you can't join or switch to a plan with prescription drug coverage during this time unless you already have Medicare prescription drug coverage (Part D). You also can't drop a plan with prescription drug coverage or join, switch, or drop a Medicare Medical Savings Account Plan during this period.

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"
- If you live in an institution

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

You can call your State Health Insurance Assistance Program (SHIP) for more information. See pages 111–114 for the telephone number.

What Happens If Your Medicare Advantage Plan Leaves Medicare?

If your plan leaves Medicare, it 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 a Medigap policy. See pages 75–76.

How Do You Join a Medicare Advantage Plan?

Once you choose a Medicare Advantage Plan, you may be able to join by completing a paper application, calling the plan, or enrolling online. 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 Medicare Advantage Plans?

If you are already in a Medicare Advantage Plan and want to switch during one of the times listed on page 59, this is what you need to do:

- To switch to a new Medicare Advantage Plan, simply join the plan you choose during a period listed on page 59. 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.

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.

Other Medicare Health Plans

Some people who have or are eligible for Medicare get their coverage from other types of Medicare health plans, or from other government or private insurance.

Some types of Medicare 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. You should know the following 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 any time the plan is accepting new members.
- You can leave any time 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 111–114 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. You can also 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 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 nursing home-level care.
- At the time you join, you are able to live safely in the community with the help of PACE services.

PACE is only available in states that have chosen it as an optional Medicaid benefit. 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 103–104 for more information about PACE and long-term care.

Medicare Prescription Drug Coverage (Part D)

Medicare offers prescription drug coverage (Part D) for 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. If you want Medicare drug coverage, you need to choose a plan that works with your health coverage.

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, including 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.

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

Even if you don't take a lot of prescription drugs now, you should still consider joining a Medicare drug plan. See page 44 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, you will likely pay a late enrollment penalty (higher premiums) if you choose to join later. See page 68 for more information on creditable coverage.

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

If you have limited income and resources, you may qualify for "extra help" from Medicare paying for prescription drug coverage. You may also be able to get help from your state. See pages 78–81.

How Do Medicare Drug Plans Work?

Who Can Get Medicare Drug Coverage?

To join a Medicare Prescription Drug Plan, you must have Medicare Part A and/or Part B. To join a Medicare Advantage Plan (like an HMO or PPO), 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.

Choosing Medicare Prescription Drug Coverage (Part D)

Joining a Medicare drug plan when you are first eligible means you won't have to pay a late enrollment penalty. Every year (between November 15–December 31), you can switch to a different Medicare drug plan if your plan coverage is changing or your needs change. When you join or switch to a new Medicare drug plan, your coverage generally begins on January 1 of the following year. **See page 68 for important information about the late enrollment penalty.**

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. When you use the card, you may have to pay a copayment, coinsurance, and/or deductible charged by the plan.

Note: The Medicare drug plan you join will release your personal information to Medicare and other plans as necessary for treatment, payment, and health care operations. Medicare may release your personal information for research and other purposes. See pages 92–93 to find out more about how Medicare can use your personal information.

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

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 first become eligible for Medicare.
- Between November 15–December 31 each year. Your coverage will begin on January 1 of the following year.

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, live in an institution, or qualify for "extra help").

Call your State Health Insurance Assistance Program (SHIP) for more information. See pages 111–114 for the telephone number.

How Do You Join a Medicare Drug Plan?

Once you choose a Medicare drug plan, you may be able to join by completing a paper application, calling the plan, or enrolling online. **Medicare drug plans aren't allowed to call you to enroll you in a plan.** See pages 94–97 for more information about how to protect yourself from fraud.

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 (1-800-633-4227) for a list of the Medicare plans in your area. TTY users should call 1-877-486-2048.**

How Do You Switch Your Medicare Drug Plan?

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 above. **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.

How Much Does Medicare Drug Coverage Cost?

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

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

Below and continued on page 67 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 plan. **Your actual drug plan costs will vary** depending on the drugs you use, the plan you choose, whether you go to a pharmacy in your plan's network, 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 charge no deductible.

- **Copayments or coinsurance**—Amounts you pay for your prescriptions after the deductible. You pay your share, and your plan pays its share for covered drugs.
- **Coverage gap**—Most Medicare drug plans have a coverage gap. This means that after you and your plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your drugs up to a 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.

  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 plan first to see if your drugs would be covered during the gap.

How Much Does Medicare Drug Coverage Cost? (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 a copayment 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 a small or no copayment once you reach catastrophic coverage. See pages 78–81.

  The example below shows the costs for covered drugs in 2009 for a plan that has a coverage gap.

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2009. 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 $295 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** pay (plus the deductible) reaches $2,700.	Once Ms. Smith and her plan have spent $2,700 for covered drugs, she is in the coverage gap. She will have to pay **all of her drug costs** until **she** has spent $4,350.	Once Ms. Smith has spent $4,350 out-of-pocket for the year, her coverage gap ends. Now she only pays a small copayment (like $6) 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 (for as long as you have Medicare drug coverage) if **all** of the following are true:

- You don't join a Medicare drug plan when you're first eligible.
- You don't have other creditable prescription drug coverage.
- You later decide to join a Medicare drug plan.

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 without a Medicare drug plan or other creditable coverage.** Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. (You should get a notice every year telling you whether the drug coverage you have is creditable coverage. Keep this notice, because you may need it if you join a Medicare drug plan later.)
- **Let your Medicare drug plan know if you have other creditable coverage.** Watch carefully for a letter from your plan asking if you have creditable coverage and complete the form they give you if you do. If you don't tell the plan about your creditable coverage, you may have to pay a penalty.

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

How Much Will Your Part D Late Enrollment Penalty Be?

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 $.30 (the "1% penalty calculation" number on page 122), 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.

Important Drug Coverage Rules

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

What If You Need to Fill a Prescription Before You Get Your Medicare Drug Plan Membership Card?

About a week after you join a plan, you will get a letter from the plan letting you know they got your information. Three to 5 weeks later, you should get a welcome package with your membership card. 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 81 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 72–73.

Enroll early in the month 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.

Important Drug Coverage Rules (continued)

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

Plans may have the following coverage rules:

- Prior authorization—You and/or your doctor must contact the plan before you can fill certain prescriptions. Your doctor may need to show that the drug is medically necessary for it to be covered.
- Quantity limits—Limits how many pills you can get at a time.
- Step therapy—You must try one or more similar, lower cost drugs before the plan will cover the drug your doctor prescribed.

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

What Are "Tiers" or "Categories" on a Medicare Drug Plan's Formulary?

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 doctor 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. See pages 90–91.

Note: 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 website.

In most cases the prescription drugs you get in an outpatient setting like an emergency room 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 plan. Call your plan for more information.

Important Drug Coverage Rules (continued)

What Are the Ways to Pay Your Medicare Drug Plan 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.)
4. **Deducted from your Social Security payment.** Contact your plan (not Social Security) to ask for this payment option. With this option, your first deductions usually take 2 months to start, and 2 months of premiums will likely be collected at one time.

For more information about your Medicare drug plan premium or ways to pay for it, contact your 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 find plans in your area.
- Call 1-800-MEDICARE (1-800-633-4227) and say, "Drug Coverage." TTY users should call 1-877-486-2048.

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 notices you get. Call your benefits administrator for more information.

COBRA—A Federal statute 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 111–114 for the telephone number.

Medigap (Medicare Supplement Insurance) Policy with Prescription Drug Coverage—If you have prescription drug coverage under a current Medigap policy, the issuer of the policy will notify you each year to let you know if the coverage is creditable. Most Medigap coverage isn't creditable. You can't join a Medicare drug plan and keep the prescription drug coverage in your Medigap policy. If you join, your Medigap insurance company must remove the prescription drug coverage under your Medigap policy and reduce your premiums. Call your Medigap insurance company for more information.

Note: Keep any creditable coverage notice you get. **You may need it if you decide to join a Medicare drug plan later.**

Other Government Insurance

Federal Employee Health Benefits Program (FEHBP)—Health coverage for current and retired Federal employees and covered family members. Prescription drug coverage under FEHBP is considered creditable, and, in most cases, it will be to your advantage to keep your current coverage. If you join a Medicare drug plan, you can keep your FEHBP plan, and your plans 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 VA program. This coverage is considered creditable. You may join a Medicare drug plan, but if you do, you can't use both types of coverage at the same time. In most cases, it will be to your advantage to keep your current coverage. For more information, call the U.S. Department of Veterans Affairs (VA) at 1-800-827-1000, or visit www.va.gov. TTY users should call 1-800-829-4833.

Military Benefits (TRICARE)—Health care program for active-duty service members, retirees, and their families. All people with TRICARE are eligible for TRICARE pharmacy benefits. Most people keep their TRICARE pharmacy benefits because they are considered creditable prescription drug coverage. You may also add Medicare prescription drug coverage. If you do, your Medicare drug plan pays first and TRICARE pays second. In most cases, it will be to your advantage to keep your current coverage. For more information, call the contractor that handles TRICARE claims at 1-866-773-0404, or visit www.tricare.osd.mil. TTY users should call 1-866-773-0405.

Indian Health Services—Health care for people who are American Indian/Alaska Native through an Indian health care provider. If you get health care from one of these providers, you have creditable prescription drug coverage. 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. For more information, contact your local health care provider to find out how Medicare works with your health care system.

How Your Bills Get Paid If You Have Other Health Insurance

When you have other insurance, 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 it covers any of the 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 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 ESRD:
  - — If you are under age 65 and disabled, your plan pays first if your employer has 100 or more employees.
  - — If you are over age 65 and still working, your plan pays first if your employer has 20 or more employees.
- If you have Medicare because you have ESRD, in all cases your plan pays first for the first 30 months you have Medicare.

The following types of coverage always pay first:

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

If you have other insurance, tell your doctor, hospital, and pharmacy so your bills get paid correctly. 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.

Medigap (Medicare Supplement Insurance) Policies

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 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 (A through L). Each standardized Medigap policy must offer the same basic coverage, no matter which insurance company sells it. Cost is usually the only difference between Medigap policies sold by different insurance companies.

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

What Do You Need to Know If You Want to Buy a Medigap Policy?

- Generally, you must have Parts A and 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 each must buy separate Medigap policies.
- It's important to compare Medigap policies since the costs can vary and may go up as you get older. (Prices may be limited by state law.)

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

What Do You Need to Know If You Want to Buy a Medigap Policy? (continued)

- 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), your Medigap policy **can't** be used to pay your Medicare Advantage Plan copayments and deductibles.
- 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 Advantage Plan for the first time, and you aren't happy with the plan, you have the right to return to Original Medicare within the first 12 months of joining. If you joined when you were first eligible for Medicare, you can choose from any Medigap policy. If you had a Medigap policy before, you can get the same plan back (without any prescription drug coverage) if the company still sells it.
- You can't have drug coverage in both your Medigap policy and a Medicare drug plan. See page 72.

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." You can also 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 Medigap policies, visit www.medicare.gov and select, "Compare Medicare Health Plans and Medigap Policies in Your Area." You can also call 1-800-MEDICARE or your State Health Insurance Assistance Program (SHIP). See pages 111–114 for the telephone number.

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:

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

Help 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)

What is this program?

You may qualify for "extra help" (also called the low-income subsidy) from Medicare to pay prescription drug costs if your yearly income and resources are below the following limits in 2008:

- Income less than $15,600 and resources less than $11,990—Single person
- Income less than $21,000 and resources less than $23,970—Married person living with a spouse and no other dependents

These amounts will change in 2009. You may qualify if you have a higher income (like if you still work or if you live in Alaska or Hawaii). 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.

If you qualify for "extra help" in 2009, and you 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 plan's premium, you may pay a reduced premium or no premium for a basic plan. For an enhanced 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.
- No coverage gap. See pages 66–67.

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

"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. See page 82.
- You get help from your state Medicaid program paying your Part B premiums (belong to a Medicare Savings Program). See page 83.
- You get Supplemental Security Income (SSI) benefits. See page 84.

What happens if you automatically qualify for "extra help?"

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 will 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.
- You can switch to another Medicare drug plan at any time. 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. However, some drugs that aren't covered by Medicare prescription drug coverage may still be covered by Medicaid. Medicaid may still cover other care that Medicare doesn't cover.
- If you have Medicaid and live in certain institutions (like a nursing home or long-term care hospital), you may pay nothing for your covered prescription drugs.

The exact amount you pay depends on the level of "extra help" you get. Look on the "extra help" letters you get, or contact your plan to find out your exact premium, deductible, and coinsurance or copayment amounts.

"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 68.

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 their telephone number, or visit www.medicare.gov.

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

To get answers to your questions about "extra help" paying for your prescription drug costs, call your State Health Insurance Assistance Program (SHIP). See pages 111–114 for the telephone number.

If you apply and qualify for "extra help," you must join a Medicare drug plan to get this "extra help." If you don't join a drug plan, Medicare will 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 any time.

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)

If you think you qualify for "extra help," what can you do to make sure you pay the right amount?

If you automatically qualify, you should have received a purple, yellow, or green letter from Medicare you can show to your plan 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 as proof that you qualify for "extra help." Each item listed below must show that you were eligible for Medicaid during a month after June of 2008.

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 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 plan for help.

If you paid for prescriptions since you qualified for "extra help," you may be able to get back some of these costs. Keep the receipts, and call your plan for more information.

If your plan doesn't correct a problem to help you pay the right amount for your prescriptions, you can file a complaint with your plan. You can also 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. 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 whether you have Original Medicare or are in 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 aren't fully covered by Medicare, such as nursing home and home health care.
- Each state may have different Medicaid eligibility income and resource limits.
- In some states, you may need 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 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 111–114 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 nursing home-level care to remain in the community. See pages 103–104 for more information.

Medicare Savings Programs (Help from Medicaid to Pay Medicare Premiums)

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.
- Have monthly income less than $1,190 and resources less than $4,000—Single person.
- Have monthly income less than $1,595 and resources less than $6,000—Married and living together.

Note: These amounts may change each year. If you live in Alaska or Hawaii, income limits are slightly higher. Many states figure your income and resources differently, so you may be eligible 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 for more information. The names of these programs may vary by state, so ask for information on Medicare Savings Programs. Call if you think you qualify for any of these programs, even if you aren't sure.
- Visit www.medicare.gov/Publications/Pubs/pdf/10126.pdf to view the brochure "If You Need Help Paying Medicare Costs, There Are Programs That Can Help You."
- 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.
- Contact your State Health Insurance Assistance Program (SHIP) for free health insurance counseling. See pages 111–114 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.

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

- Be a resident of the U.S. or the Northern Mariana Islands.
- 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.

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

Programs for People Who Live in the U.S. Territories of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa

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.

Free or low cost health insurance is available in your state for uninsured children under age 19. Call 1-877-KIDS-NOW (1-877-543-7669) for more information about the State Children's Health Insurance Program.

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:

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
- 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, its providers, and contractors under certain circumstances
- 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 of (appeal) 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 or a prescription drug you already got
- A request to change the amount you must pay for a prescription drug

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

If you decide to file an appeal, ask your doctor, 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 Advantage Plan or a Medicare Prescription Drug Plan, look at your plan materials, call your plan, or visit www.medicare.gov to learn how to file an appeal.
- If you have Original Medicare, you can file an appeal by following the instructions below:
    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) on the MSN you disagree with, 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. You may want to make a copy to keep 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.

If you have Original Medicare or are in a Medicare Advantage Plan, 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

You can find out what was billed in one of the following ways:

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

Your Right to a Fast Appeal in Original Medicare and a Medicare Advantage Plan

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 may have the right to a fast appeal (also called an "expedited review" or an "immediate appeal"). Your provider will give you a notice that will tell you how to ask for a fast appeal. If you don't get this notice, ask for one. If you ask for this fast appeal, an independent reviewer will decide if your services should continue.

- Ask your doctor for any information that may help your case if you decide to file a fast appeal.
- Contact your State Health Insurance Assistance Program (SHIP) if you need help filing an appeal. See pages 111–114 for the telephone number. You can also call your local Quality Improvement Organization (QIO). Call 1-800-MEDICARE (1-800-633-4227) to get their telephone number. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.
- If you miss the timeframe for filing a fast appeal, find out if you have other appeal rights:
  - — If you have Original Medicare, call your local Quality Improvement Organization (QIO).
  - — If you are in a Medicare Advantage Plan (like an HMO or PPO), call your plan. Look in your plan materials to get the telephone number.

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

What Is an 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 payment is denied, you can still file an appeal.
- You can ask the company that handles bills for Medicare for a prior determination of coverage to find out if Medicare will cover the item or service in your situation. This information is only available for a limited number of services and items.
- You may also get an ABN for other reasons, such as when your doctor reduces your home health care.

If you are in a Medicare Advantage Plan (like an HMO or PPO) or Medicare Prescription Drug 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." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Can You Appeal 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 if you haven't bought 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 drug coverage, 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 doctor 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 doctor 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 non-preferred drug because you or your doctor believes you can't take any of the preferred drugs for the same condition.

You or your doctor 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 doctor can call or write your plan for an expedited (fast) request. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be at risk by waiting. **If you are requesting an exception, your prescribing doctor must provide a statement explaining the medical reason why similar drugs covered by your plan won't work or may be harmful to you.**

Can You Appeal Your Medicare Drug Plan's Decisions? (continued)

Once your Medicare drug plan gets your request for a coverage determination or your doctor'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 to be a coverage determination.

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

If You Want to Appeal Your Drug Plan's Coverage Determination Decision

- You have 60 days from the date of the drug plan's decision to request an appeal.
- A standard request must be made in writing, unless your Medicare drug plan accepts requests by phone.
- You or your doctor 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 111–114 for the telephone number.

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." You can also call 1-800-MEDICARE.

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

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 at any time, 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 selling Medicare products. Don't give your personal information to someone who does this. **Only give personal information to doctors, other providers, and plans approved by Medicare, 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 enroll in 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.**

Note: Medicare demonstrations or pilot programs are allowed to call you to see if you want to enroll. See page 62 for more information about demonstrations and pilot programs.

Protect Yourself from Fraud and Identity Theft (continued)

If you think someone is using your personal information, you can call any of these numbers:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- 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 send an email to HHSTips@oig.hhs.gov.
- 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, visit www.consumer.gov/idtheft.

The SMP (Senior Medicare Patrol) Program Can Help You

The SMP Program educates and empowers people with Medicare to take an active role in detecting and preventing health care fraud and abuse. There is a SMP Program in every state, the District of Columbia, Guam, U.S. Virgin Islands, and Puerto Rico. For more information or to find your local SMP Program, visit www.smpresource.org.

Protect Yourself and Medicare from Billing Fraud

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.

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

The following are examples of possible Medicare fraud:

- A health care provider bills Medicare for services you never got.
- A supplier bills Medicare for equipment different than what they provided to you.
- Someone uses another person's Medicare card to get medical care, supplies, or equipment.
- Someone bills Medicare for home medical equipment after it has been returned.
- A company offers a Medicare drug plan that hasn't been approved by Medicare.
- A company uses false information to mislead you into joining a Medicare plan.

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

When you get health care services, you may want to save the receipts you get from providers. Use your 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 Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950. You can also send an email to HHSTips@oig.hhs.gov.

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 for your state, or call toll-free 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.

How Does the Medicare Beneficiary Ombudsman Help You?

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

- 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 you raise through 1-800-MEDICARE (1-800-633-4227) and through your State Health Insurance Assistance Program (SHIP). TTY users should call 1-877-486-2048. For more information about the Medicare Beneficiary Ombudsman, visit www.medicare.gov and select, "Ombudsman."

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

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 compare plans 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:

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.

Learn How to 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 how satisfied people are 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 111–114 for the telephone number.

When you, a family member, friend, or SHIP counselor visit Medicare's website, 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 these 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 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 about the quality of plans and providers.

Learn About Electronic and Personal Health Records

One way to take an active role in your health is to learn about the new technology that may be used to handle your health records. Two types of health records that are stored electronically are 1) **Electronic Health Records** which are records that your doctor, your doctor's staff, or a hospital keeps with information about your health and medical treatment (like lab reports), primarily for your doctor's or your hospital's use and 2) **Personal Health Records** which are records you keep or control with health information you want to keep track of.

Electronic Health Records

Many health care providers, like doctors, nurses, hospitals, and equipment suppliers are starting to keep your information in a computer instead of writing the information in a paper chart. These computer records are called Electronic Health Records (EHRs).

Medicare supports doctors and hospitals using this technology. Over time, EHRs will help your providers have the same knowledge about your conditions, treatments, tests, and prescriptions, which lowers the chances of medical errors and can help improve your overall quality of care.

The Federal and state governments already have strict rules about protecting the privacy and security of electronic information. More work is being done to make sure that this new technology will be even more secure. You have a right to see and get a copy of your medical records, even when your information is in an EHR.

Personal Health Records

Personal Health Records (PHRs) are electronic records of your health information that you create and control. You can keep track of your health information, like the date of your last physical and test results, major illnesses, allergies, or a list of your medicines online. PHRs help you stay involved with your health care services. Sometimes health plans, health care providers, or private companies offer ways for you to create and keep PHRs.

If you decide not to keep track of your health information online with a PHR, you should still try to keep your information in one place.

Visit www.medicare.gov for more information on EHRs and PHRs.

Plan for Long-Term Care

What is Long-Term Care?

Long-term care is a variety of services including medical and non-medical care for people who have a chronic illness or disability. Long-term care can be provided at home, in the community, in assisted living, or in a nursing home. Most long-term care is non-skilled personal care assistance, such as help with everyday activities like dressing, bathing, and using the bathroom.

Does Medicare pay for long-term care?

Medicare and most health insurance plans, including Medigap (Medicare Supplement Insurance) policies don't pay for this type of care, called "custodial care." Medicare only pays for medically-necessary skilled nursing facility or home health care if you meet certain conditions. See page 20.

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

How can you pay 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.

Plan for Long-Term Care (continued)

How can you pay 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 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 going to a nursing home. Examples include homemaker services, personal care, and respite care. For more information, visit www.eldercare.gov. You can also call the Eldercare Locator at 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 nursing home-level of care to remain in the community. PACE was created as a way to provide you, your family, caregivers, and professional 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 care, transportation, home care, check-ups, hospital visits, and even nursing home stays whenever necessary.

Plan for Long-Term Care (continued)

How can you pay for long-term care? (continued)

Programs of All-Inclusive Care for the Elderly (PACE) (continued)

With PACE, your inability to pay will never keep you from getting the care you need. If you have Medicare, all Medicare-covered services are paid by Medicare. If you have Medicare and Medicaid, you will either have a small monthly payment or pay nothing for the long-term care portion of the PACE benefit. If you don't have Medicaid, you will be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, with PACE, there is never a deductible or copayment for any drug, service, or care approved by the PACE team of health professionals.

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 and to get a free copy of the Own Your Future Planning Kit.
- 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.

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

Have Your Voice Heard Through 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 living will
- A health care proxy (durable power of attorney)
- After-death wishes

Talking to 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 living will 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 breath 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.

A health care proxy (sometimes called a durable power of attorney for health care) is another way to make sure your voice is heard. You use it 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.

Advance directives can also include after-death wishes such as organ and tissue donation.

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 office on aging, or your state health department.

Have Your Voice Heard Through Advance Directives (continued)

Tips

1. Keep your original advance directives where it's 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.

For More Information

(Phone, Websites, 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 (1-800-633-4227)
TTY Users Should Call 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.
- **Say "agent" at any time to talk to a customer service representative, or use this chart.**

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"
"Extra help" paying health or prescription drug costs	"Limited Income"
Forms or Handbooks	"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.

Get the Information You Need Online

Need Personalized Information?

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

- Complete your Initial Enrollment Questionnaire.
- Track your health care claims.
- Check your Part B deductible status.
- View your eligibility information.
- Track the preventive services you can get.
- Find your Medicare health or prescription drug plan, or search for a new one.
- Keep your Medicare information in one convenient place.
- Sign up to get your "Medicare & You" handbook electronically (see page 122).

"Using www.MyMedicare.gov is easy! I keep up with my Medicare claims, get copies of my Medicare Summary Notices, and track which Medicare-covered preventive services I can get."

Need General Information about Medicare?

Visit www.medicare.gov

- See what Medicare health and prescription drug plans are in your area.
- Find doctors 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 nursing homes, hospitals, home health agencies, plans, and dialysis facilities.
- Look up helpful telephone numbers for your area.
- View Medicare publications.

If you don't have a computer, your local library or senior center may be able to help you look at this information. You can also call your State Health Insurance Assistance Program (SHIP). See pages 111–114 for the telephone number.

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:

- Preventive services
- Hospice care
- Home health care
- Medicare prescription drug coverage, including "extra help"
- Medicare Advantage Plans including Medicare MSAs and Medicare Private Fee-for-Service Plans
- Choosing a nursing home
- Hospital quality
- Comparing plans and health care providers
- Mental health care
- Kidney dialysis and transplant services
- Skilled nursing facility care
- Fighting fraud
- Rights and protections
- Coverage outside the U.S.

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

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

Definitions

Section 7 includes definitions of words used throughout this handbook.

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 to 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.

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.

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 meets Medicare's definition of a long-term care facility, such as a nursing facility or skilled nursing facility, not including assisted or adult living facilities, or residential homes.

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. See page 120 for the amount you will pay in 2009.

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

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 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—This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (such as help with activities of daily living, like bathing and dressing) can't qualify you for Medicare coverage in a skilled nursing facility if that's the only care you need. However, if you qualify for coverage based on your need for skilled nursing care or rehabilitation, Medicare will cover all of your care needs in the facility, including help with activities of daily living.

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.

2009 Medicare Costs

Your 2009 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.

You pay up to $443* each month if you don't get premium-free Part A.

Part B (Medical Insurance) Monthly Premium

If Your Yearly Income Is		You Pay
File Individual Tax Return	File Joint Tax Return	
$85,000 or below	$170,000 or below	$96.40*
$85,001–$107,000	$170,001–$214,000	$134.90*
$107,001–$160,000	$214,001–$320,000	$192.70*
$160,001–$213,000	$320,001–$426,000	$250.50*
above $213,000	above $426,000	$308.30*

Note: If you get a monthly benefit payment from Social Security, the RRB, or the Civil Service, you must have your Part B premiums deducted from your monthly benefit payment. If you don't get any of these 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 Premiums

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), or an amount for your Part D coverage is added to your Part C premium. See page 53 to find out how to save on your Part B premium.

*If you pay a late enrollment penalty, this amount is higher.

What you pay in 2009 if you have Original Medicare

Part A Costs for Covered Services and Items

Blood	If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 pints of blood you get in a calendar year or have the blood donated. 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.
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	You pay: ▪ $1,068 deductible and no coinsurance for days 1–60 each benefit period ▪ $267 per day for days 61–90 each benefit period ▪ $534 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	You pay: ▪ $0 for the first 20 days each benefit period ▪ $133.50 per day for days 21–100 each benefit period ▪ All costs for each day after day 100 in a benefit period

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

What you pay in 2009 if you have Original Medicare (continued)

Part B Costs for Covered Services and Items

Part B Deductible	You pay the first $135 yearly for Part B-covered services or items.
Blood	If the provider has to buy blood for you, you must either pay the provider costs for the first 3 pints of blood you get in a calendar year or have the blood donated. 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. You pay 20% of the Medicare-approved amount for additional pints of blood you get as an outpatient, 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 50% 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 Part A hospital deductible ($1,068 in 2009).

*In 2009, 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 but may be either higher or lower than those noted above. Check with your plan.

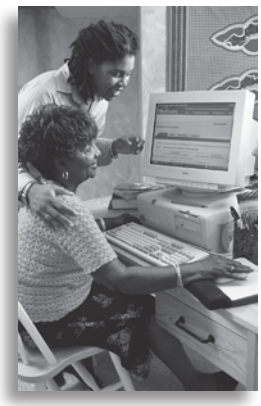
Part C and Part D (Medicare Health and Prescription Drug Plans) Costs for Covered Services and Supplies

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 111–114 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 determine 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 68.

	2009
Part D National Base Beneficiary Premium	$30.36
1% Penalty Calculation	$.30

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.



Choose to Get Future Handbooks Electronically.

Save tax dollars by signing up to access your future "Medicare & You" handbooks electronically (also called the eHandbook). Visit www.MyMedicare.gov to request the 2010 and future eHandbooks. We'll send you an email next October when the new eHandbook is available. You won't get a copy of your handbook in the mail if you choose to get it electronically.

Notes

Tips To Help Prevent Medicare Fraud

DOs

DO protect your Medicare Number (on your Medicare card). Treat your Medicare card like it is a credit card. Don't ever give it out except to your doctor or other Medicare provider. Never give your Medicare or Medicaid number in exchange for free medical equipment or any other free offer. Dishonest providers will use your numbers to get payment for services they never delivered.

DO remember that nothing is ever "free." Don't accept offers of money or gifts for free medical care.

DO ask questions! You have a right to know everything about your medical care including the costs billed to Medicare.

DO educate yourself about Medicare. Know your rights and know what a provider can and can't bill to Medicare.

DO use a calendar to record all of your doctor's appointments and what tests or X-rays you get. Then check your Medicare statements carefully to make sure you got each service listed and that all the details are correct.

DO be cautious of any provider or plan representative who says he has been approved by the Federal government.

DO 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.

DO make sure you understand how a plan works before you join.

Tips To Help Prevent Medicare Fraud

DO always check your pills before you leave the pharmacy to be sure you got the full amount. If you don't get your full prescription, report the problem to the pharmacist.

DO report suspected instances of fraud. See pages 88–89 to find out who to call.

DO review your Medicare payment notice for errors. The payment notice shows what services or supplies were billed to Medicare, what Medicare paid, and what you owe. Make sure Medicare wasn't billed for health care services or medical supplies and equipment you didn't get. If you spend time in a hospital, make sure the admission date, discharge date, and diagnosis on your bill are correct.

DON'Ts

DON'T allow anyone, except your doctor or other Medicare providers, to review your medical records or recommend services.

DON'T contact your doctor to request a service that you don't need. Don't let anyone persuade you to see a doctor for care or services you don't need.

DON'T accept medical supplies from a door-to-door salesman. If someone comes to your door claiming to be from Medicare or Medicaid, remember that Medicare and Medicaid don't send representatives to your home.

DON'T be influenced by certain media advertising about your health. Many television and radio ads don't have your best interest at heart.

This page intentionally left blank.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use, $300

CMS Publication No. 10050
September 2008

National Medicare Handbook

- Also available in Spanish, Braille, Audiotape, 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.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

10% Recycled paper