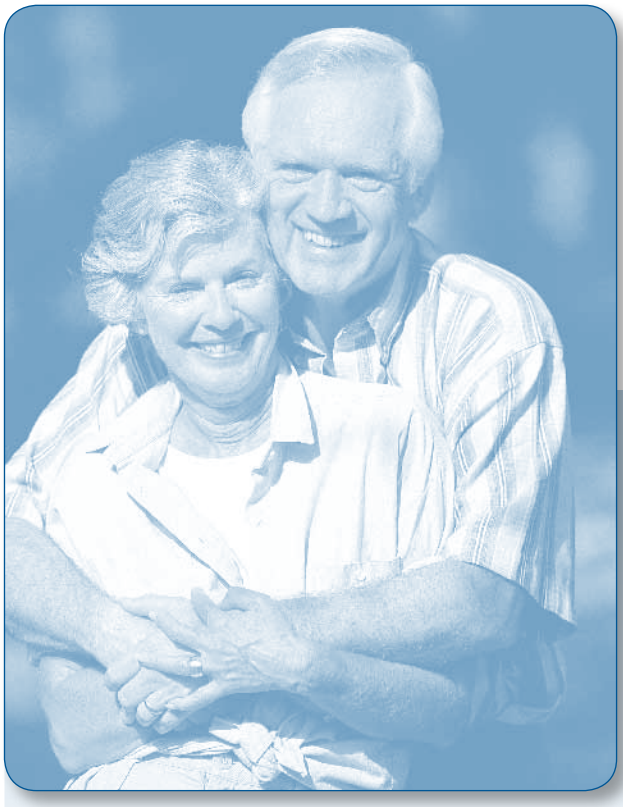
YOUR MEDICARE BENEFITS



This official government guide has important information about:

- The services and supplies Original Medicare covers
- How much you pay
- Where to get more information

CENTERS FOR MEDICARE & MEDICAID SERVICES

ABOUT THIS BOOK

This booklet explains which health care services and supplies Medicare covers, and how to get those benefits through Original Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). It includes:

- What specific benefits you can get and when
- How much Medicare pays for each service and how much you pay
- How to get help with any questions you may have

The 2010 Affordable Care Act makes many improvements to Medicare, including added benefits and more coverage. Medicare is stronger than ever. You now have access to benefits to help maintain and improve your health, like the "Welcome to Medicare" preventive visit and a yearly "Wellness" visit to discuss your health and health care needs. You can also choose from thousands of health care providers and hospitals across the country.

The health care law has made Medicare drug coverage more affordable with the gradual closing of the coverage gap (also called the "donut hole"). If you reach the Part D coverage gap, you'll get a 50% discount on covered brand-name drugs and some coverage for generic drugs in the gap.

If you have a question about an item or service that isn't listed in this booklet, visit www.medicare.gov and select "Find Out if Medicare Covers Your Test, Item, or Service." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

There are other Medicare booklets available with more detailed information on many of the items and services mentioned in this booklet. "Your Medicare Benefits" lists many, but not all, of the items and services that Medicare covers.

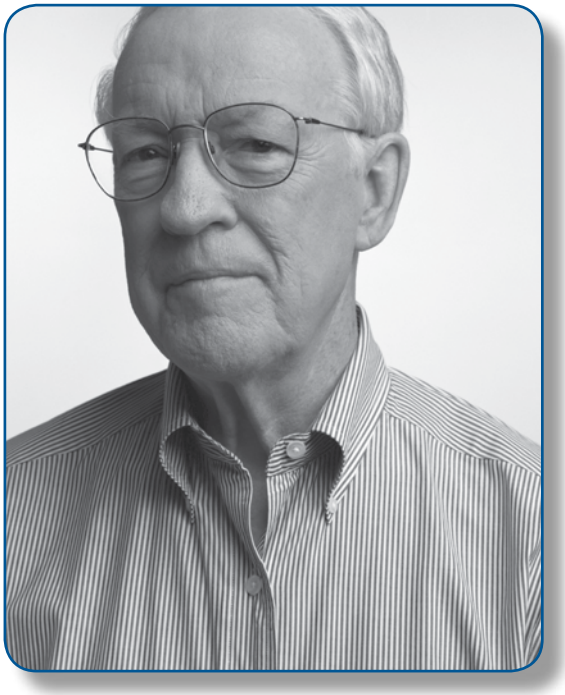
For a list of specific publications, see pages 51–52.

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

TABLE OF CONTENTS

The information in this booklet was correct when it was printed. Changes may occur after printing. Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users should call 1-877-486-2048.

Notes



SECTION 1

List of Topics

An alphabetical list of what's in this guide

SECTION 2

What Original Medicare Covers

The information starting on the next page explains:

- Services and supplies covered by Original Medicare
- Conditions and limits for coverage
- How much you pay

As you read this booklet, keep these 2 points in mind:

1. Unless otherwise noted, in 2012, you pay a yearly $140 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.
2. Depending on the service or supply, actual amounts you pay may be higher if doctors, other health care providers, or suppliers don't accept assignment.

> **Assignment** is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the amount Medicare approves for the service as payment in full, and not to bill you for any more than the Medicare deductible and coinsurance.

Doctors that don't accept assignment may charge you more than the Medicare-approved amount for a service, but they can't charge more than 15% over the Medicare fee schedule amount. This is called "the limiting charge." The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment.

The information about services and supplies listed in these charts applies to all people with Original Medicare. If you have a Medicare Advantage Plan (like an HMO or PPO) or another Medicare health plan, you have the same basic benefits, but the rules vary by plan. Some services and supplies may not be listed because the coverage depends on where you live. To find out more, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Preventive Services

There's a picture of an apple next to each preventive service that Medicare covers. Talk with your doctor about which preventive services are right for you.

Blue words are defined on pages 55–57.

Abdominal Aortic Aneurysm Screening

Medicare Part B (Medical Insurance) covers a one-time screening ultrasound for people at risk. You're considered at risk if you have a family history of abdominal aortic aneurysms, or you're a man 65 to 75 and have smoked at least 100 cigarettes in your lifetime. Medicare only covers this screening if you get a referral for it from your doctor as a result of your "Welcome to Medicare" preventive visit. See page 40.

In 2012, you pay NOTHING. You pay $0 for this screening. There's no coinsurance, copayment, or deductible if the doctor accepts assignment.

Acupuncture

Medicare doesn't cover acupuncture.

Alcohol Misuse Screenings & Counseling

Part B covers one alcohol misuse screening per year for adults with Medicare (including pregnant women) who use alcohol, but don't meet the medical criteria for alcohol dependency. If your primary care doctor or other primary care practitioner determines you're misusing alcohol, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling). A qualified primary care doctor or other primary care provider must provide the counseling in a primary care setting.

In 2012, you pay NOTHING. You pay $0 for this screening. There's no coinsurance, copayment, or deductible if the doctor accepts assignment.

Ambulance Services

Part B covers ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically-necessary services, and transportation in any other vehicle could endanger your health. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide.

In some cases, Medicare may pay for limited non-emergency ambulance transportation if you have a statement from your doctor saying that ambulance transportation is medically necessary. Medicare will only cover ambulance services (ground or air) to the nearest appropriate medical facility that's able to give you the care you need.

In 2012, YOU pay 20% of the Medicare-approved amount, and the Part B deductible **does** apply. All ambulance suppliers must accept assignment.

Ambulatory Surgical Centers

Medicare Part B covers the facility fees for services, in connection with covered surgical procedures provided in an ambulatory surgical center.

In 2012, YOU pay 20% of the Medicare-approved amount, except for certain preventive services for which you pay nothing. The Part B deductible **does** apply. You pay all facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.

Anesthesia

Medicare Part A (Hospital Insurance) covers anesthesia services provided by a hospital for an inpatient. Part B covers anesthesia services provided by a hospital for an outpatient or by a freestanding ambulatory surgical center for a patient.

In 2012, YOU pay 20% of the Medicare-approved amount for the anesthesia services provided by a doctor or certified registered nurse anesthetist.
The anesthesia service must be associated with the underlying medical or surgical service, and you may have to pay a copayment.

Artificial Limbs & Eyes

Part B covers artificial limbs and eyes when ordered by a doctor.

In 2012, YOU pay 20% of the Medicare-approved amount.

B

Blood

Part A covers blood you get as a hospital inpatient. Part B covers blood you get as a hospital outpatient.

In 2012, YOU pay either the provider customary charges for the first 3 units of blood you get in a calendar year, or you must arrange (with limited exceptions) to have the blood replaced (donated by you or someone else) if the provider has to buy blood for you. In general, if the provider doesn't have to pay the blood bank for the blood, you won't have to pay for it or arrange for it to be replaced.

Blood Processing & Handling

Hospitals generally charge for blood processing and handling, whether the blood is donated or purchased. Part A covers this service for an inpatient. Part B covers this service for an outpatient.

In 2012, YOU pay a copayment for blood processing and handling services for each unit of blood you get as a hospital outpatient.

Bone Mass Measurement (Bone Density)

Medicare Part B covers bone mass measurement ordered by a doctor or other qualified provider if you meet one or more of the following conditions:

Women

- You're at clinical risk for osteoporosis, based on your medical history and other findings.

Men & Women

- Your X-rays show possible osteoporosis, osteopenia, or vertebrae fractures.
- You're on prednisone or steroid-type drugs or are planning to begin such treatment.
- You've been diagnosed with primary hyperparathyroidism.
- You're being monitored to see if your osteoporosis drug therapy is working.

The test is covered once every 24 months for qualified individuals and more often if medically necessary.

In 2012, you pay NOTHING. You pay $0 for this test if the doctor accepts assignment, and the Part B deductible doesn't apply.

Braces (arm, leg, back, & neck)

Part B covers arm, leg, back, and neck braces.

In 2012, YOU pay 20% of the Medicare-approved amount.

Breast Prostheses

Part B covers external breast prostheses (including a post-surgical bra) after a mastectomy. Medicare Part A covers surgically implanted breast prostheses after a mastectomy if the surgery takes place in an inpatient setting, and Part B covers the surgery if it takes place in an outpatient setting.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services and the external breast prostheses. For surgeries to implant breast prostheses in a hospital inpatient setting covered under Part A, see Hospital Care (Inpatient) on page 30. For surgeries to implant breast prostheses in a hospital outpatient setting covered under Part B, see Outpatient Hospital Services on page 34.

Canes/Crutches

Medicare Part B covers canes and crutches. Medicare doesn't cover white canes for the blind. For more information, see Durable Medical Equipment on pages 22–23.

In 2012, YOU pay 20% of the Medicare-approved amount.

Cardiac Rehabilitation Program

Part B covers comprehensive programs that include exercise, education, and counseling for patients whose doctor referred them and who had any of the following:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris (chest pain)
- A heart valve repair or replacement
- An angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a device used to keep an artery open)
- A heart or heart-lung transplant

Part B also covers intensive cardiac rehabilitation (ICR) programs that, like cardiac rehabilitation (CR) programs, include exercise, education, and counseling for patients whose doctor referred them and who had any of the conditions listed above. ICR programs are typically more rigorous or more intense than CR programs. These programs may be provided in a hospital outpatient setting (including a critical access hospital) or in a doctor's office.

In 2012, YOU pay 20% of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you pay the hospital a copayment. The Part B deductible does apply.

Cardiovascular Disease (Behavior Therapy)

Medicare covers one visit per year with your primary care doctor in a primary care doctor's office or primary care clinic to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.

In 2012, you pay NOTHING. You pay $0 if the doctor or health care provider accepts assignment.

Cardiovascular Screenings

Part B covers screening tests for cholesterol, lipid, and triglyceride levels every 5 years, to help you prevent a heart attack or stroke.

In 2012, you pay NOTHING. You pay $0 for this test, and the Part B deductible doesn't apply. You generally pay 20% of the Medicare-approved amount for the doctor's visit.

Chemotherapy

Medicare Part A covers chemotherapy for cancer patients who are hospital inpatients. Medicare Part B covers chemotherapy for hospital outpatients or patients in a doctor's office or freestanding clinic.

In 2012, YOU pay a copayment for chemotherapy covered under Part B in a hospital outpatient setting. For chemotherapy given in a doctor's office or freestanding clinic, you pay 20% of the Medicare-approved amount. For chemotherapy in the hospital inpatient setting covered under Part A, see Hospital Care (Inpatient) on page 30.

Chiropractic Services

Part B covers manipulation of the spine if medically necessary to correct a subluxation (when one or more of the bones of your spine move out of position) when provided by a chiropractor or other qualified provider.

In 2012, YOU pay 20% of the Medicare-approved amount, and the Part B deductible does apply. You pay all costs for any additional services or tests ordered by a chiropractor.

Clinical Research Studies

Clinical research studies test different types of medical care, like how well a cancer drug works. These studies help doctors and researchers see if a new treatment works and if it's safe. Part A and/or Part B covers some costs, like doctor visits and tests, in a qualifying clinical research study.

In 2012, YOU pay the part of the payment that you would normally pay for covered services. The Part B deductible may apply.

Colorectal Cancer Screening

Part B covers several types of colorectal cancer screening tests to help find precancerous growths or find cancer early, when treatment is most effective. All people 50 or older with Medicare are covered. However, there's no minimum age for having a colonoscopy. One or more of the following tests may be covered:

Barium Enema: When this test is used instead of a flexible sigmoidoscopy or colonoscopy, Medicare covers the test once every 48 months for people 50 or older and once every 24 months for people at high risk for colorectal cancer.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you also pay a copayment. The Part B deductible doesn't apply. If this screening test results in the biopsy of a lesion or growth the same day, you may have to pay coinsurance or a copayment, but the Part B deductible doesn't apply.

Colorectal Cancer Screening (continued)

Colonoscopy: Medicare covers this test once every 24 months if you're at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, Medicare covers the test once every 120 months, or 48 months after a screening flexible sigmoidoscopy.

In 2012, you pay NOTHING. You pay $0 for this test. There's no coinsurance, copayment, or deductible if the doctor accepts assignment. There's no minimum age.

If a screening test results in the biopsy or removal of a lesion or growth during the same visit, the procedure is considered diagnostic, and you may have to pay coinsurance or a copayment, but the Part B deductible doesn't apply.

Fecal Occult Blood Test: Medicare covers this lab test once every 12 months for people 50 or older.

In 2012, you pay NOTHING. You pay $0 for this test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit. The Part B deductible doesn't apply for the test.

Flexible Sigmoidoscopy: Medicare covers this test once every 48 months for most people 50 or older. For those not at high risk, Medicare covers this test 120 months after a previous screening colonoscopy.

In 2012, you pay NOTHING. You pay $0 for this test if the doctor accepts assignment, and the Part B deductible doesn't apply.

If a screening test results in the biopsy or removal of a lesion or growth during the same visit, the procedure is considered diagnostic and you may have to pay coinsurance or a copayment, but the Part B deductible doesn't apply.

Commode Chairs

Part B covers commode chairs that your doctor orders for use in your home if you're confined to your bedroom. For more information, see Durable Medical Equipment on pages 22–23.

In 2012, YOU pay 20% of the Medicare-approved amount.

Cosmetic Surgery

Medicare generally doesn't cover cosmetic surgery unless it's needed because of accidental injury or to improve the function of a malformed body part. Medicare covers breast reconstruction if you had a mastectomy because of breast cancer.

Custodial Care (help with activities of daily living, like bathing, dressing, using the bathroom, and eating)

Medicare doesn't cover custodial care when it's the only kind of care you need. Care is considered custodial when it helps you with activities of daily living or personal needs and could be done safely and reasonably by people without professional skills or training.

D

Defibrillator (Implantable Automatic)

Medicare Part A or Part B covers defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services. You pay a copayment, but no more than the Part A inpatient hospital deductible, if you get the defibrillator as a hospital outpatient. For surgeries to implant defibrillators in the hospital inpatient setting covered under Part A, see Hospital Care (Inpatient) on page 30. The Part B deductible **does** apply.

Dental Services

Medicare doesn't cover routine dental care or most dental procedures or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. Part A will pay for certain dental services that you get when you're in a hospital. Part A can pay for hospital stays if you need to have emergency or complicated dental procedures, even though the dental care isn't covered.

Depression Screenings

Part B covers one depression screening per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.

In 2012, you pay NOTHING. You pay $0 for this screening. There's no coinsurance, copayment, or deductible if the doctor accepts assignment.

Diabetes Screenings

Medicare Part B covers tests to check for diabetes. These tests are available if you have any of the following risk factors:

- High blood pressure (hypertension)
- History of abnormal cholesterol and triglyceride levels (dyslipidemia)
- Obesity
- A history of high blood sugar (glucose)

Medicare also covers these tests if 2 or more of the following apply to you:

- Age 65 or older
- Overweight
- Family history of diabetes (parents, brothers, sisters)
- A history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds

Based on the results of these tests, you may be eligible for up to 2 diabetes screenings each year.

In 2012, you pay NOTHING. You pay $0 for this test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit. The Part B deductible doesn't apply.

Diabetes Services & Supplies

Part B covers some diabetes supplies, including these:

- Blood sugar (glucose) test strips
- Blood glucose testing monitors
- Lancet devices and lancets
- Glucose control solutions for checking test strip and monitor accuracy

There may be limits on how much or how often you get these supplies. For more information, see Durable Medical Equipment on pages 22–23.

In 2012, YOU pay 20% of the Medicare-approved amount, and the Part B deductible does apply.

Diabetes Services & Supplies (continued)

Insulin: Medicare Part B doesn't cover insulin (unless used with an insulin pump), insulin pens, syringes, needles, alcohol swabs, or gauze. Medicare Part D (Medicare prescription drug coverage) may cover insulin and certain medical supplies used to inject insulin, such as syringes, gauze, and alcohol swabs. If you use an external insulin pump, insulin and the pump may be covered as durable medical equipment. See Durable Medical Equipment on pages 22–23.

In 2012, YOU pay 100% for insulin (unless used with an insulin pump, then you pay 20% of the Medicare-approved amount) and 100% for syringes and needles, unless you have Part D.

Therapeutic Shoes or Inserts: Part B covers therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. The shoes and inserts must be prescribed by a podiatrist (foot doctor) or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, or pedorthist. Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year. Shoe modifications may be substituted for inserts. Medicare covers the fitting of the shoes or inserts for the shoes.

In 2012, YOU pay 20% of the Medicare-approved amount.

Medicare also covers these diabetes services:

Diabetes Self-Management Training: Part B covers diabetes outpatient self-management training to teach you to manage your diabetes. It includes education about how to monitor your blood sugar, diet, exercise, and insulin. If you've been diagnosed with diabetes, Medicare may cover up to 10 hours of initial diabetes self-management training. You may also qualify for up to 2 hours of follow-up training each year if the following conditions are met:

- It's provided in a group of 2 to 20 people.*
- It lasts for at least 30 minutes.
- It takes place in a calendar year after the year you got your initial training.
- Your doctor or a qualified provider ordered it as part of your plan of care.

* Some exceptions apply if no group session is available or if your doctor or qualified provider says you have special needs that prevent you from participating in group training.

In 2012, YOU pay 20% of the Medicare-approved amount, and the Part B deductible does apply.

Diabetes Services & Supplies (continued)

Medicare also covers these diabetes services:

Yearly Eye Exam: Medicare Part B covers a yearly eye exam for diabetic retinopathy by an eye doctor who is legally allowed to do the test in your state.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you pay a copayment.

Foot Exam: Part B covers a foot exam every 6 months for people with diabetic peripheral neuropathy and loss of protective sensations, as long as you haven't seen a foot care professional for another reason between visits.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you pay a copayment.

Glaucoma Tests: See page 25.

Medical Nutrition Therapy Services: See page 33.

Diagnostic Tests, X-rays, & Clinical Laboratory Services

Part B covers diagnostic tests, like CT scans, MRIs, EKGs, and X-rays, when your doctor or health care provider orders them as part of treating a medical problem. Medicare also covers medically-necessary clinical diagnostic laboratory services provided by certified laboratories enrolled in Medicare, and ordered by your treating doctor or practitioner. Diagnostic tests and lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare also covers some preventive tests and screenings to help prevent, find, or manage a medical problem. For more information, see Preventive Services on page 39.

In 2012, YOU pay 20% of the Medicare-approved amount for covered diagnostic tests and X-rays done in a doctor's office or in an independent testing facility. You pay a copayment for diagnostic tests and X-rays done in the hospital outpatient setting. You pay $0 for Medicare-covered clinical diagnostic laboratory services, and the Part B deductible doesn't apply.

Dialysis (Kidney) Services & Supplies

Medicare covers many kidney dialysis services and supplies for people with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). All kidney dialysis services and supplies used to provide an outpatient maintenance dialysis treatment are provided (directly or under arrangement) and billed by your dialysis facility.

Inpatient Dialysis Treatments: Medicare Part A covers dialysis if you're admitted to the hospital for special care. See Hospital Care (Inpatient) on page 30.

Outpatient Maintenance Dialysis Treatments: Part B covers a variety of dialysis services if you get routine maintenance dialysis from a Medicare-certified dialysis facility. For example, Part B covers ESRD-related laboratory tests and medications (like erythropoiesis stimulating agents), but excludes certain ESRD-related medications that only have an oral form of administration (drugs taken by mouth that only come in capsule, tablet, or liquid forms), which are covered only under Medicare Part D.

In 2012, YOU pay 20% of the Medicare-approved amount.

Training for Home Dialysis: Part B covers training if you're a candidate for home dialysis. Part B covers training conducted during the course of your regular treatments for you and the person helping you with your home dialysis treatments.

The training must be conducted by a dialysis facility that has been certified by Medicare to provide home dialysis training.

The cost of home training is included as part of the outpatient maintenance dialysis treatment. **In 2012, YOU pay** 20% of the Medicare-approved amount for the outpatient maintenance dialysis treatment. Only dialysis facilities can bill Medicare for providing (directly or under arrangement) home dialysis training.

Home Dialysis Support Services: Part B covers home dialysis support services provided by your dialysis facility. Home dialysis support services can include periodic visits by trained dialysis workers to check on your home dialysis, to help in dialysis emergencies when needed, and to check your dialysis equipment and hemodialysis water supply.

The cost of home dialysis support services is included as part of the outpatient maintenance dialysis treatment. **In 2012, YOU pay** 20% of the Medicare-approved amount for the outpatient maintenance dialysis treatment. Only dialysis facilities can bill Medicare for providing (directly or under arrangement) home dialysis support services.

Dialysis (Kidney) Services & Supplies (continued)

Home Dialysis Equipment & Supplies: Medicare Part B covers all kidney dialysis equipment and supplies including alcohol, wipes, dialysis machines, sterile drapes, rubber gloves, and scissors.

The cost of home dialysis equipment and supplies is included as part of the outpatient maintenance dialysis treatment. **In 2012, YOU pay** 20% of the Medicare-approved amount for the outpatient maintenance dialysis treatment. Only dialysis facilities can bill Medicare for providing (directly or under arrangement) home dialysis equipment and supplies.

Certain Drugs for Home Dialysis: Part B covers heparin, the antidote for heparin (when medically necessary), and topical anesthetics. Part B also covers erythropoiesis stimulating agents (ESAs), such as epoetin alfa or darbepoetin alfa, to treat anemia related to your ESRD.

The costs of home dialysis drugs and biologicals are included as part of the outpatient maintenance dialysis treatment (with the exception of ESRD-related medications that only have an oral form of administration, which are covered only under Medicare Part D). **In 2012, YOU pay** 20% of the Medicare-approved amount for the outpatient maintenance dialysis treatment. Only dialysis facilities can bill Medicare for payment for providing (directly or under arrangement) home dialysis drugs and biologicals.

Doctor's Services

Part B covers medically-necessary services or covered preventive services you get from your doctor in his or her office, a hospital, a skilled nursing facility, your home, or other settings.

In 2012, YOU pay 20% of the Medicare-approved amount, except for certain preventive services for which you pay nothing. Medicare covers yearly "Wellness" visits, and a one-time "Welcome to Medicare" preventive visit. See page 40. Medicare covers some preventive tests and screenings. See Preventive Services on page 39.

Drugs

See Prescription Drugs (Outpatient) on pages 37–38.

Durable Medical Equipment (DME)

Medicare Part B covers durable medical equipment (DME) that your doctor prescribes for use in your home. Only your doctor can prescribe medical equipment for you. Durable medical equipment meets the following criteria:

- Durable (long lasting)
- Used for a medical reason
- Not usually useful to someone who isn't sick or injured
- Used in your home

In certain circumstances, the DME that Medicare covers includes, but isn't limited to:

- Air-fluidized beds
- Blood sugar monitors and diabetic testing strips
- Canes (however, white canes for the blind aren't covered)
- Commode chairs
- Crutches
- Home oxygen equipment and supplies
- Hospital beds
- Infusion pumps (and some medicines used in infusion pumps if considered reasonable and necessary)
- Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary)
- Patient lifts (to lift patient from bed or wheelchair by hydraulic operation)
- Suction pumps
- Traction equipment
- Walkers
- Wheelchairs

Make sure your doctor or supplier is enrolled in Medicare. Doctors and other suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If your doctor or supplier isn't enrolled, Medicare won't pay the claim submitted by your doctor or supplier. It's also important to ask your supplier if it participates in Medicare before you get DME. If the supplier is a participating supplier, it must accept assignment (that is, they're limited to charging you only the Medicare-approved amount). If the supplier is enrolled in Medicare but isn't "participating," it may choose not to accept assignment (so there would be no limit on the amount they can charge you). To find suppliers who accept assignment, visit www.medicare.gov/supplier, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Durable Medical Equipment (DME) (continued)

In 2012, YOU pay 20% of the Medicare-approved amount for DME, and the Part B deductible does apply.

Note: Medicare pays for different kinds of DME in different ways: some equipment is rented, other equipment may be purchased, and you may choose to rent or buy some equipment. If a DME supplier doesn't accept assignment, Medicare doesn't limit how much the supplier can charge you. You also may have to pay the entire bill (your share and Medicare's share) at the time you get the DME.

Medicare has started a new program called "DME competitive bidding" to help save you and Medicare money, and ensure that you get quality equipment, supplies, and services. This program also helps limit fraud and abuse. **Because of this new program, in some areas of the country if you need certain items or equipment, you must use specific competitive bidding suppliers. If you don't use these suppliers, Medicare won't pay for the item or equipment and you likely will have to pay the full price. It's important to check whether you're affected by this new program to ensure Medicare payment and avoid any disruption of service**.

The program is currently in effect in certain areas of the following states: California, Florida, Indiana, Kansas, Kentucky, Missouri, North Carolina, Ohio, Pennsylvania, South Carolina, and Texas. More areas will be added in 2013.

In these areas you'll need to use specific suppliers for Medicare to pay for:

- Oxygen, oxygen equipment, and supplies
- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories (Group 2 only)
- Mail-order diabetes supplies
- Enteral nutrients, equipment, and supplies
- Hospital beds and related accessories
- Continuous Positive Airway Pressure (CPAP) devices, Respiratory Assist Devices (RADs), and related supplies and accessories
- Walkers and related accessories
- Support surfaces including certain mattresses and overlays (Miami, Fort Lauderdale, and Pompano Beach, Florida only)

The program will expand to additional areas in the future.

EKG Screening

Medicare Part B covers a one-time screening electrocardiogram (EKG) if you get a referral from your doctor for it as a result of your one-time "Welcome to Medicare" preventive visit. See Preventive Visits on page 40. An EKG is also covered as a diagnostic test. See page 19.

In 2012, YOU pay 20% of the Medicare-approved amount. If you have the test at a hospital or a hospital-owned clinic, you also pay the hospital a copayment.

Emergency Department Services

Part B covers emergency department services. Emergency services may be covered in foreign countries only in rare circumstances. For more information, see Travel on page 47. A medical emergency is when you believe that you have an injury or illness that requires immediate medical attention to prevent a disability or death.

In 2012, YOU pay a copayment for each emergency department visit and a copayment for each hospital service. You also pay 20% of the Medicare-approved amount for the doctor's services, and the Part B deductible does apply. If you're admitted to the same hospital for a related condition within 3 days of your emergency department visit, you don't pay the copayment because your visit is part of your inpatient stay.

Equipment

See Durable Medical Equipment on pages 22–23.

Eye Exams

Medicare doesn't cover routine eye exams (refractions) for eyeglasses or contact lenses. Medicare covers some preventive and diagnostic eye exams:

- See Yearly Eye Exam under Diabetes Services & Supplies on page 19.
- See Glaucoma Tests on page 25.
- See Macular Degeneration on page 31.

Eyeglasses/Contact Lenses

Generally, Medicare doesn't cover eyeglasses or contact lenses. However, **following cataract surgery with an implanted intraocular lens**, Part B helps pay for corrective lenses (eyeglasses or contact lenses).

In 2012, YOU pay 100% for non-covered services, including most eyeglasses or contact lenses. You pay 20% of the Medicare-approved amount for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens, and the Part B deductible does apply. You pay any additional cost for upgraded frames.

Eye Refractions

Eye refractions are eye exams. Medicare doesn't cover routine eye refractions for eyeglasses/contacts. See Eye Exams.

F

Flu Shots

Medicare Part B normally covers one flu shot per flu season in the fall or winter.

In 2012, you pay NOTHING. You pay $0 for a flu shot, and the Part B deductible doesn't apply. If you get your flu shot from a doctor who doesn't accept assignment, you may have to pay coinsurance for the doctor's services, but not for the shot itself.

Foot Care

Part B covers podiatrist (foot doctor) services for medically-necessary treatment of foot injuries or diseases (like hammer toe, bunion deformities, and heel spurs), but it doesn't cover routine foot care. See Therapeutic Shoes (on page 18) and Foot Exam under Diabetes Services and Supplies (on page 19).

In 2012, YOU pay 100% for routine foot care, in most cases. You pay 20% of the Medicare-approved amount for medically-necessary treatment provided by a doctor, and the Part B deductible does apply. In a hospital outpatient setting, you also pay a copayment for medically-necessary treatment.

G

Glaucoma Tests

Part B covers a glaucoma test once every 12 months for people at high risk for glaucoma. This includes people with diabetes, people with a family history of glaucoma, African Americans 50 or older, and Hispanic Americans 65 or older. The screening must be done or supervised by an eye doctor who is legally allowed to do this test in your state.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services, and the Part B deductible does apply for the doctor's visit. In a hospital outpatient setting, you also pay a copayment.

Health Education/Wellness Programs

Medicare generally doesn't cover health education and wellness programs. However, Medicare does cover medical nutrition therapy for people with diabetes or kidney disease and diabetes education for people with diabetes (see page 18), counseling to stop smoking and tobacco use (see page 45), alcohol misuse counseling (see page 10), depression screenings (see page 16), a one-time "Welcome to Medicare" preventive visit (see page 40), and yearly "Wellness" visits (see page 40).

Hearing & Balance Exams/Hearing Aids

Medicare Part B covers diagnostic hearing and balance exams if your doctor orders these tests to see if you need medical treatment. Medicare doesn't cover routine hearing exams, hearing aids, or exams for fitting hearing aids.

In 2012, YOU pay 100% for routine exams and hearing aids. You also pay 20% of the Medicare-approved amount for the doctor's services for covered exams, and the Part B deductible does apply. In a hospital outpatient setting, you pay a copayment.

Hepatitis B Shots

Part B covers this shot for people at high or medium risk for Hepatitis B. Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), or certain conditions that lower your resistance to infection. Other factors may also increase your risk for Hepatitis B. Check with your doctor to see if you're at high or medium risk for Hepatitis B.

In 2012, you pay NOTHING. You pay $0 for a Hepatitis B shot if the doctor accepts assignment, and the Part B deductible doesn't apply. If you get your Hepatitis B shot from a doctor who doesn't accept assignment, you may have to pay coinsurance for the doctor's services, but not for the shot itself.

HIV Screening

Part B covers HIV screening for people with Medicare who ask for the test, who are pregnant, and who have an increased risk for the infection. Medicare covers this test once every 12 months or up to 3 times during a pregnancy.

In 2012, you pay NOTHING. You pay $0 for the test, and the Part B deductible doesn't apply, but you generally pay 20% of the Medicare-approved amount for the doctor's visit.

Home Health Services

You can use your home health benefits under Medicare Part A and/or Part B if you meet all the following conditions:

- You must be under the care of a doctor, and you must be getting services under a plan of care established and reviewed regularly by a doctor.
- You must need, and a doctor must certify that you need, one or more of the following:
  - Intermittent skilled nursing care (other than just drawing blood)
  - Physical therapy
  - Speech-language pathology services
  - Continued occupational therapy
- The home health agency caring for you must be Medicare-certified.
- You must be homebound, and a doctor must certify that you're homebound. To be homebound means the following:
  - Leaving your home isn't recommended because of your condition.
  - Your condition keeps you from leaving home without help (like using a wheelchair or walker, needing special transportation, or getting help from another person).
  - Leaving home takes a considerable and taxing effort.

A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care.

Note: Home health services may also include medical social services, part-time or intermittent home health aide services, medical supplies for use at home, durable medical equipment (see pages 22–23), or an injectable osteoporosis drug.

In 2012, you pay NOTHING. You pay $0 for all covered home health visits. You pay 20% of the Medicare-approved amount for Medicare-covered medical equipment.

Home Health Services (continued)

Osteoporosis Drugs for Women

Medicare Part A and Part B help pay for an injectable drug for osteoporosis in women who are eligible for Part B, meet the criteria for Medicare home health services, and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. You must also be certified by a doctor as unable to learn or unable to give yourself the drug by injection, and that family and/or caregivers are unable or unwilling to give the drug by injection. Medicare covers the visit by a home health nurse to give the drug.

In 2012, YOU pay 20% of the Medicare-approved amount for the cost of the drug. You pay $0 for the home health nurse visit to give the drug.

Hospice Care

Medicare Part A covers hospice care if you meet **all** of the following conditions:

- You're eligible for Part A.
- Your doctor certifies that you're terminally ill and are expected to live less than 6 months.*
- You accept palliative care (for comfort) instead of care to cure your illness.
- You sign a statement choosing hospice care instead of routine Medicare-covered benefits for your terminal illness.

Medicare will still pay for covered benefits for any health problems that aren't related to your terminal illness.

* In a Medicare-approved hospice, nurse practitioners aren't permitted to certify the patient's terminal diagnosis, but after a doctor certifies the diagnosis, the nurse practitioner can serve in place of an attending doctor. You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill.

Hospice Care (continued)

Hospice care is usually given in your home. It includes the following services when your doctor includes them in the plan of care for palliative care (for comfort) for the terminal illness and related conditions:

- Doctor and nursing services
- Social work services
- Counseling services
- Hospice aide or homemaker services
- Physical, occupational, or speech language pathology therapy services
- Drugs and medications for pain or other symptoms
- Medical supplies and durable medical equipment
- Short-term inpatient care for symptom relief or for respite care*
- Any other services normally covered by Medicare to provide palliative care for the terminal illness and related conditions

*Respite care is inpatient care given to a hospice patient so that the usual caregiver can rest. You can stay in a Medicare-approved facility, such as a hospice facility, hospital, or nursing home, up to 5 days each time you get respite care.

In 2012, you pay NOTHING. You pay $0 for hospice care. You may need to pay a copayment of up to $5 per prescription for outpatient prescription drugs for symptom control or pain relief. 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). If your attending doctor isn't employed by the hospice, you pay your usual Medicare Part B deductible and copayment for his or her services.

If the hospice staff determines that you need short-term inpatient care in a hospice facility, hospital, or nursing home, or if your caregiver needs a short period of rest (see page 42), Medicare covers the costs for room and board.

Hospital Bed

See Durable Medical Equipment on pages 22–23.

Hospital Care (Inpatient)

For Outpatient Hospital Services, see page 34.

Medicare Part A covers inpatient hospital care when **all** of the following are true:

- A doctor makes an official order which says you need inpatient hospital care to treat your illness or injury
- You need the kind of care that can be given only in a hospital.
- The hospital accepts Medicare.
- The Utilization Review Committee of the hospital approves your stay while you're in the hospital.

Medicare-covered hospital services include the following: a semi-private room, meals, general nursing, drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in critical access hospitals and inpatient mental health care. See page 32. This doesn't include private-duty nursing, a television or a telephone in your room, and personal care items, like razors or slipper socks. It also doesn't include a private room, unless medically necessary.

If you have Medicare Part B, it covers the doctor's services you get while you're in the hospital.

In 2012, YOU pay the following for each benefit period:

- Days 1–60: $1,156 deductible.
- Days 61–90: $289 coinsurance each day.
- Days 91 and beyond: $578 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- Beyond lifetime reserve days: all costs.
- Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

You pay for private-duty nursing, a television, or a phone in your room. You pay for a private room unless it's medically necessary. For more information about benefit periods and lifetime reserve days, see page 56.

K

Kidney (Dialysis)

See Dialysis on pages 20–21.

Kidney Disease Education

Medicare covers up to 6 sessions of kidney disease education services if you have Stage IV chronic kidney disease that will require dialysis or a kidney transplant, if your doctor refers you for the service, and when the service is given by a doctor, certain qualified non-doctor provider, or a rural provider. Kidney disease education teaches you how to take the best possible care of your kidneys and gives you information you need to make informed decisions about your care.

In 2012, YOU pay 20% of the Medicare-approved amount per session if you get the service from a doctor or other qualified health care provider, and the Part B deductible does apply.

L

Laboratory Services (Clinical)

Medicare Part B covers medically-necessary clinical diagnostic laboratory services that are ordered by your treating doctor or practitioner. Services include certain blood tests, urinalysis, some screening tests, and more. They must be provided by a laboratory that meets Medicare requirements. For more information, see Diagnostic Tests on page 19.

In 2012, you pay NOTHING. You pay $0 for Medicare-approved covered clinical diagnostic laboratory services, and the Part B deductible doesn't apply.

M

Macular Degeneration

Part B covers certain diagnoses and treatment of diseases and conditions of the eye for some patients with age-related macular degeneration (AMD), like lucentis, avastin, pegaptanib, and ocular photodynamic therapy with verteporfin (Visudyne®).

In 2012, YOU pay 20% of the Medicare-approved amount for the drug and the doctor's services. In a hospital outpatient setting, you pay a copayment.

Mammograms

Part B covers a screening mammogram once every 12 months (11 full months must have passed since the last screening) for all women with Medicare who are 40 or older. You can also get one baseline mammogram between 35–39.

In 2012, you pay NOTHING. You pay $0 for the screening test if the doctor accepts assignment, and the Part B deductible doesn't apply.

Part B also covers diagnostic mammograms when medically necessary.
In 2012, YOU pay 20% of the Medicare-approved amount.

Medical Nutrition Therapy Services

See Nutrition Therapy Services (Medical) on page 33.

Mental Health Care

Medicare Part A and Part B cover mental health services in a variety of settings.

Inpatient Mental Health Care: Part A covers inpatient mental health care services. These services can be given in hospitals, including specialized psychiatric units, or in specialized psychiatric hospitals. Medicare helps pay for inpatient mental health services in the same way it pays for all other inpatient hospital care.

Note: If you're in a specialty psychiatric hospital, Medicare only helps pay for a total of 190 days of inpatient care during your lifetime.

Outpatient Mental Health Care: Part B covers mental health services on an outpatient basis when provided by a doctor, clinical psychologist, clinical social worker, nurse practitioner, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient setting. What you pay will depend on whether you're being diagnosed and monitored, or whether you're getting treatment.

In 2012, YOU pay 20% of the Medicare-approved amount for visits to a doctor or other health care provider to **diagnose** your condition or to **monitor** or change your prescriptions. The Part B deductible does apply.

In 2012, YOU pay 40% of the Medicare-approved amount for outpatient **treatment** of your condition (such as counseling or psychotherapy) in a doctor's office setting. This coinsurance amount will decrease to 35% in 2013, and in 2014, you'll pay only 20% of the Medicare-approved amount for these services. In a hospital outpatient setting, you pay a copayment.

Partial Hospitalization: Part B covers partial hospitalization in some cases. It's a structured program of outpatient active psychiatric treatment that is more intense than the care you get in your doctor's or therapist's office. To be eligible for a partial hospitalization program, a doctor must certify that you would otherwise need inpatient treatment.

In 2012, YOU pay a percentage of the Medicare-approved amount for each service you get from a qualified provider (as described above in Outpatient Mental Health Care). You also pay a copayment for each day of service when provided in a hospital outpatient setting or community mental health center.

N

Non-Doctor Services

Medicare Part B covers certain services provided by certain health care professionals who aren't doctors, like clinical social workers, nurse practitioners, and physician assistants.

In 2012, YOU pay 20% of the Medicare-approved amount, except for certain preventive services and certain outpatient mental health treatment services as noted on page 32. The Part B deductible **does** apply.

Nursing Home Care

Most nursing home care is custodial care, like help with bathing or dressing. Medicare doesn't cover custodial care if that's the only care you need. However, if it's medically necessary for you to have skilled care (like changing sterile dressings), Medicare Part A can pay for care given in a certified skilled nursing facility if you meet all of the applicable coverage requirements. See Skilled Nursing Facility Care on pages 43–45.

Nutrition Therapy Services (Medical)

Part B covers medical nutrition therapy services, when ordered by a doctor, for people with kidney disease (but who aren't on dialysis), for people who've had a kidney transplant, or for people with diabetes. A registered dietitian or Medicare-approved nutrition professional can give these services. Services may include nutritional assessment, one-on-one counseling, and therapy through an interactive telecommunications system. If you get dialysis in a dialysis facility, Medicare covers medical nutrition therapy as part of your overall dialysis care. See Diabetes Services & Supplies on pages 17–19.

In 2012, you pay NOTHING. You pay $0 for these services if the doctor accepts assignment, and the Part B deductible doesn't apply.

O

Obesity Screening & Counseling

If you have a body mass index of 30 or more, Medicare covers intensive counseling to help you lose weight. This counseling may be covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan.

In 2012, you pay NOTHING. You pay $0 for this service if the primary care practitioner accepts assignment.

Observation Services

See Outpatient Hospital Services on page 34.

Occupational Therapy

See Physical Therapy/Occupational Therapy/Speech-Language Pathology on page 36.

Orthotics & Artificial Limbs

Medicare Part B covers artificial limbs and eyes, as well as arm, leg, back, and neck braces. Medicare doesn't pay for orthopedic shoes unless they're a necessary part of the leg brace. See Diabetes Services and Supplies (Therapeutic Shoes) on page 18. You must go to a supplier that's enrolled in Medicare for Medicare to cover your orthotics.

In 2012, YOU pay 20% of the Medicare-approved amount.

Ostomy Supplies

Part B covers ostomy supplies for people who have had a colostomy, ileostomy, or urinary ostomy. Medicare covers the amount of supplies your doctor says you need, based on your condition.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services and supplies.

Outpatient Hospital Services

Part B covers medically-necessary services you get as an outpatient from a Medicare-participating hospital for diagnosis or treatment of an illness or injury. Covered outpatient hospital services include:

- Emergency or observation services which may include an overnight stay in the hospital, or services in an outpatient clinic, including same-day surgery
- Laboratory tests billed by the hospital
- Mental health care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it (see Mental Health Care on page 32)
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Screenings and preventive services
- Certain drugs and biologicals that you wouldn't usually give yourself

In 2012, YOU generally pay 20% of the Medicare-approved amount for the doctor's services. For all other services, you also generally pay a copayment for each service you get in an outpatient hospital setting. However, for some screenings and preventive services, these charges and the Part B deductible don't apply.

Oxygen Therapy

Part B covers the rental of oxygen equipment. If you own your own equipment, Medicare will help pay for oxygen contents and supplies for the delivery of oxygen when **all** of the conditions below are met:

- Your doctor says you have a severe lung disease or you're not getting enough oxygen.
- Your health might improve with oxygen therapy.
- Your arterial blood gas level falls within a certain range.
- Other alternative measures have failed.

Under the above conditions Medicare helps pay for the following:

- Systems for furnishing oxygen
- Containers that store oxygen
- Tubing and related supplies for the delivery of oxygen and oxygen contents

In 2012, YOU pay 20% of the Medicare-approved amount.

Pap Test/Pelvic Exam (Screening)

Part B covers Pap tests and pelvic exams (and a clinical breast exam) for all women once every 24 months. Medicare covers this test and exam once every 12 months if you're at high risk for cervical or vaginal cancer, or if you're of childbearing age and have had an abnormal Pap test in the past 36 months.

In 2012, you pay NOTHING. You pay $0 for the lab Pap test, and the Part B deductible doesn't apply. You also pay $0 for the Pap test specimen collection and pelvic and breast exams if the doctor accepts assignment, and the Part B deductible doesn't apply.

Physical Therapy/Occupational Therapy/Speech-Language Pathology Services

Medicare Part B helps pay for medically-necessary outpatient physical and occupational therapy, and speech-language pathology services, when both of these conditions are met:

- Your doctor or therapist sets up the plan of treatment.
- Your doctor periodically certifies the plan.

You can get outpatient physical therapy/occupational therapy/speech-language pathology services from a participating hospital, hospice, skilled nursing facility, home health agency, rehabilitation agency, or comprehensive outpatient rehabilitation facility. Also, you can get services from a participating doctor, clinical nurse specialist, physician assistant, nurse practitioner, physical therapist, occupational therapist, or speech-language pathologist in private practice, in his or her office, or in your home. In 2012, there are limits on coverage of physical therapy, occupational therapy, and speech-language pathology services provided by most outpatient providers. However, you may qualify for an exception to these limits. There are no limits on outpatient therapy received in an outpatient department of a hospital or critical access hospital.

In 2012, YOU pay 20% of the Medicare-approved amount, and the Part B deductible does apply.

Pneumococcal Shot

Part B covers a pneumococcal shot to help prevent pneumococcal infections (like certain types of pneumonia). Most people only need this preventive shot once in their lifetime. Talk with your doctor to see if you need this shot.

In 2012, you pay NOTHING. You pay $0 for a pneumococcal shot, and the Part B deductible doesn't apply. If your doctor doesn't accept assignment, you may have to pay cost sharing for the doctor's services, but not for the shot itself.

Prescription Drugs (Outpatient) Limited Coverage

Medicare Part B covers a limited number of outpatient prescription drugs, and only under limited conditions. Drugs not covered under Part B may be covered under Medicare Part D. Generally, these are drugs you wouldn't usually give to yourself, like those you get at a doctor's office or hospital outpatient setting. Doctors and pharmacies must accept assignment for Part B drugs, so you should never be asked to pay more than the coinsurance or copayment for the drug itself.

Examples of drugs covered by Part B:

- **Infused Drugs:** Medicare covers drugs infused through an item of durable medical equipment, like an infusion pump or nebulizer.
- **Some Antigens:** Medicare will help pay for antigens if they're prepared by a provider and given by a properly instructed person (who could be the patient) under appropriate supervision.
- **Injectable Osteoporosis Drugs:** Medicare helps pay for an injectable drug for osteoporosis for certain women with Medicare. See note for women with osteoporosis under Home Health Services on page 28.
- **Erythropoiesis–Stimulating Agents:** Medicare will help pay for erythropoietin by injection if you have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) or need this drug to treat anemia related to certain other conditions.
- **Blood Clotting Factors:** If you have hemophilia, Medicare will help pay for clotting factors you give yourself by injection.
- **Injectable Drugs:** Medicare covers most injectable drugs given by a licensed medical provider.
- **Immunosuppressive Drugs:** Medicare covers immunosuppressive drug therapy if you received an organ or tissue transplant for which Medicare made payments.

Note: Medicare Prescription Drug Plans may cover immunosuppressive drugs, even if Medicare didn't pay for the transplant. Part D may cover other immunosuppressive drugs that aren't covered by Part B.

Prescription Drugs (Outpatient) Limited Coverage (continued)

- **Oral Cancer Drugs:** Medicare will help pay for some cancer drugs you take by mouth if the same drug is available in injectable form or is a prodrug. Currently, Medicare covers these cancer drugs you take by mouth:
  - Capecitabine (Xeloda®)
  - Melphalan (Alkeran®)
  - Busulfan (Myleran®)
  - Temozolomide (Temodar®)
  - Cyclophosphamide
  - Topotecan (Hycamtin®)
  - Etoposide
  - Methotrexate (Trexall®)
  - Fludarabine Phosphate (Oforta®)

This list of cancer drugs is subject to change because Medicare may cover new cancer drugs as they become available.

- **Oral Anti-Nausea Drugs:** Medicare will help pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered immediately before, at, or within 48 hours of chemotherapy, and must be used as a full therapeutic replacement for the intravenous anti-nausea drugs that would otherwise be given.

In 2012, YOU pay 20% of the Medicare-approved amount for covered Medicare Part B prescription drugs that you get in a doctor's office or pharmacy, and the Part B deductible does apply. In a hospital outpatient setting, you pay a copayment. However, if you get drugs that aren't covered under Part B in a hospital outpatient setting, you pay 100% for the drugs unless you have Medicare Part D or other prescription drug coverage. In that case, what you pay depends on whether your drug plan covers the drug, and whether the hospital is in your drug plan's network. Contact your prescription drug plan to find out what you pay for drugs you get in a hospital outpatient setting.

Preventive Services

Medicare Part B covers the following preventive and screening services:

- Abdominal Aortic Aneurysm Screening on page 10
- Alcohol Misuse Screenings and Counseling on page 10
- Bone Mass Measurement on page 12
- Cardiovascular Screenings on page 13
- Colorectal Cancer Screening on pages 14–15
- Depression Screenings on page 16
- Diabetes Screenings on page 17
- Diabetes Self-Management Training on page 18
- Glaucoma Tests on page 25
- HIV Screening on page 26
- Mammogram (screenings) on page 31
- Medical Nutrition Therapy Services on page 33
- Obesity Screening and Counseling on page 33
- Pap Test/Pelvic Exam (screening) on page 35
- Prostate Cancer Screening on page 41
- Shots, including:
  - Flu Shots on page 25
  - Hepatitis B Shots on page 26
  - Pneumococcal Shots on page 36
- Smoking Cessation Counseling on page 45
- "Welcome to Medicare" Preventive Visit on page 40
- Yearly "Wellness" Visit on page 40

Preventive Visits

Medicare covers 2 types of routine preventive visits: one when you're new to Medicare and 1 each year after that.

"Welcome to Medicare" Preventive Visit

Medicare Part B covers a one-time "Welcome to Medicare" preventive visit, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.

Important: You must have the preventive visit within the first 12 months you have Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.

In 2012, you pay NOTHING. You pay $0 for the visit if the doctor accepts assignment. The Part B deductible doesn't apply.

Yearly "Wellness" Visit

If you've had Part B for longer than 12 months, you can get a yearly wellness visit to develop or update a personalized prevention plan based on your current health and risk factors.

In 2012, you pay NOTHING. You pay $0 for this visit if the doctor accepts assignment, and the Part B deductible doesn't apply. This visit is covered once every 12 months.

Note: Your first yearly "Wellness" visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" preventive visit to be covered for yearly "Wellness" visits after you've had Part B for 12 months.

Prostate Cancer Screenings

Medicare Part B covers prostate cancer screening tests once every 12 months for men with Medicare who are age 50 or older. Coverage begins the day after your 50th birthday. Covered tests include:

Digital Rectal Exam

In 2012, YOU pay 20% of the Medicare-approved amount for the digital rectal exam and for the doctor's services related to the exam. The Part B deductible does apply for the digital rectal exam. In a hospital outpatient setting, you pay a copayment.

Prostate Specific Antigen (PSA) Test

In 2012, you pay NOTHING. You pay $0 for the PSA test, and the Part B deductible doesn't apply.

Prosthetic Devices

Part B covers prosthetic devices needed to replace an internal body part or function, provided on a doctor's prescription. These include Medicare-approved corrective lenses needed after a cataract operation (see Eyeglasses/Contact Lenses on page 24), ostomy bags and certain related supplies (see Ostomy Supplies on page 34), and breast prostheses (including a surgical bra) after a mastectomy (see Breast Prostheses on page 12). You must go to a supplier that's enrolled in Medicare for Medicare to pay for your device. Medicare Part A or Part B covers surgically implanted prosthetic devices depending on whether the surgery takes place in an inpatient or outpatient setting.

In 2012, YOU pay 20% of the Medicare-approved amount for external prosthetic devices, and the Part B deductible **does** apply. For surgeries to implant prosthetic devices in a hospital inpatient setting covered under Part A, see Hospital Care (Inpatient) on page 30. For surgeries to implant prosthetic devices in a hospital outpatient setting covered under Part B, see Outpatient Hospital Services on page 34.

Pulmonary Rehabilitation Program

Medicare covers a comprehensive program of pulmonary rehabilitation if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral for pulmonary rehabilitation from the doctor treating your chronic respiratory disease. These services are intended to help you breathe better, make you stronger, and be able to live more independently. These services may be provided in doctors' offices or a hospital outpatient setting that offers pulmonary rehabilitation programs.

In 2012, YOU pay 20% of the Medicare-approved amount if you get the service in a doctor's office. You also pay a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible does apply.

R

Radiation Therapy

Medicare Part A covers radiation therapy for patients who are hospital inpatients. Medicare Part B covers this therapy for outpatients or patients in freestanding clinics.

In 2012, YOU pay the deductible and coinsurance (if applicable) as an inpatient.

In 2012, YOU pay a set copayment as an outpatient.

In 2012, YOU pay 20% of the Medicare-approved amount for the therapy at a freestanding facility.

Religious Nonmedical Health Care Institution (RNHCI)

Medicare doesn't cover the religious portion of Religious Nonmedical Health Care Institution (RNHCI) care. However, Part A covers inpatient nonreligious nonmedical care when the following conditions are met:

- The RNHCI has agreed and is currently certified to participate in Medicare.
- The Utilization Review Committee agrees that you would require hospital or skilled nursing facility care if it weren't for your religious beliefs.
- You have a written election on file with Medicare indicating that your need for RNHCI care is based on your religious beliefs. The election must also indicate that if you decide to accept standard medical care, you will cancel the election and may have to wait 1–5 years (depending on how many times you may have previously revoked your election) to be eligible for a new election to get RNHCI services. Please note that you're always able to get medically-necessary Part A services.

In 2012, for each benefit period **YOU pay**:

- Days 1–60: $1,156 deductible
- Days 61–90: $289 coinsurance each day
- Days 91–150: $578 coinsurance each day
- Beyond 150 days: all costs

For information about benefit periods and lifetime reserve days, see page 56.

Respite Care (Inpatient)

Part A covers respite care for hospice patients. Respite care is inpatient care given to a hospice patient so that the usual caregiver can rest. See Hospice Care on pages 28–29.

In 2012, YOU pay 5% of the Medicare-approved amount.

Rural Health Clinic & Federally-Qualified Health Center Services

Medicare Part B covers a broad range of outpatient primary care services.

In 2012, YOU generally pay 20% of the Medicare-approved amount. For services in a Rural Health Clinic, the Part B deductible **does** apply. There's no deductible for services in a Federally-Qualified Health Center.

Second Surgical Opinions

Part B covers a second opinion in some cases for surgery that isn't an emergency. A second opinion is when another doctor gives his or her view about your health problem and how it should be treated. Medicare also will help pay for a third opinion if the first and second opinions are different.

In 2012, YOU pay 20% of the Medicare-approved amount, and the Part B deductible **does** apply.

Sexually Transmitted Infections Screening & Counseling

Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis and/or Hepatitis B. These screenings are covered for people with Medicare who are pregnant and/or for certain people who are at increased risk for an STI when the tests are ordered by a primary care doctor or other primary care practitioner. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Medicare also covers up to 2 individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care doctor or other primary care practitioner and take place in a primary care doctor's office or primary care clinic. Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

In 2012, YOU pay $0 if the primary care doctor or primary care practitioner accepts assignment.

Shots (Vaccinations)

Medicare covers:

- **Flu Shots** on page 25
- **Hepatitis B Shots** on page 26
- **Pneumococcal Shots** on page 36

Skilled Nursing Facility (SNF) Care

Medicare Part A covers skilled care in a skilled nursing facility (SNF) under certain conditions for a limited time. Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Medicare covers certain skilled care services needed daily on a short-term basis (up to 100 days).

In 2012, YOU pay the following for each benefit period (following at least a 3-day covered inpatient hospital stay for a related illness or injury):

- Days 1–20: $0 each day
- Days 21–100: up to $144.50 each day
- Beyond 100 days: 100% of all costs

There's a limit of 100 days of Part A SNF coverage in each benefit period.

Medicare will cover SNF care if **all** these conditions are met:

1. You have Medicare Part A and have days left in your benefit period to use.
2. You have a qualifying inpatient hospital stay. This means an inpatient hospital stay of 3 consecutive days or more, including the day you're admitted to the hospital, but not including the day you leave the hospital.

   Note: Time that you spend in a hospital as an outpatient before you're admitted doesn't count toward the 3 inpatient hospital days you need to have a qualifying inpatient hospital stay for SNF benefit purposes. Observation services aren't counted as part of the qualifying inpatient hospital stay.

   You must enter the SNF within a short time (generally 30 days) of leaving the hospital and require skilled services related to your hospital stay. See item 5, below. After you leave the SNF, if you re-enter the same or another SNF within 30 days, you don't need another 3-day qualifying inpatient hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days.
3. Your doctor has decided that you need daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If you're in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just 5 or 6 days a week, as long as you need and get the therapy services each day they're offered.

Skilled Nursing Facility (SNF) Care (continued)

4. You get these skilled services in a SNF that's certified by Medicare.
5. You need these skilled services for a medical condition that was either of the following:
   - A hospital-related medical condition (any condition that was treated during your qualifying 3-day inpatient hospital stay, even if it wasn't the reason you were admitted to the hospital).
   - A condition that started while you were getting care in the SNF for a hospital-related medical condition. For example, if while you're getting SNF care for a stroke that was also treated during your qualifying 3-day inpatient hospital stay, you develop an infection that requires IV antibiotics, Medicare will cover your SNF care for treating the infection (as long as you also meet the conditions listed in items 1–4).

While you're in a non-covered stay in the Medicare-certified part of the facility, your Medicare Part B therapy services (physical therapy, occupational therapy, and speech-language pathology) must be billed by the facility. No other therapy service may be billed by another setting, such as an outpatient hospital setting.

Speech-Language Pathology

See Physical Therapy/Occupational Therapy/Speech-Language Pathology on page 36.

Supplies (you use at home)

Part B generally doesn't cover common medical supplies like bandages and gauze. Medicare covers some diabetes and dialysis supplies. See Diabetes Services and Supplies on pages 17–19 and Dialysis (Kidney) Services and Supplies on pages 20–21. For items like walkers, oxygen, and wheelchairs, see Durable Medical Equipment on pages 22–23.

In 2012, YOU pay 100% for most common medical supplies you use at home.

Surgical Dressing Services

Medicare Part B covers medically-necessary treatment of a surgical or surgically-treated wound.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services. You pay a copayment for these services when you get them in a hospital outpatient setting. You pay nothing for the supplies. The Part B deductible **does** apply.

Telehealth

Part B covers certain telehealth services, like office visits and consultations that are provided using an interactive 2-way telecommunications system (like real-time audio and video) by an eligible provider who is at a location different than the patient. Telehealth is available in some rural areas, under certain conditions, and only if the patient is located at one of the following places: a doctor's office, hospital, critical access hospital, rural health clinic, federally-qualified health center, hospital-based or critical access hospital-based dialysis facility, skilled nursing facility, or community mental health center.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services.

Therapeutic Shoes

See Diabetes Services and Supplies (Therapeutic Shoes) on page 18.

Tobacco Use Cessation Counseling (counseling to stop smoking or using tobacco products)

If you haven't yet been diagnosed with an illness caused or complicated by tobacco use, Medicare coverage of smoking and tobacco use cessation counseling is considered a covered preventive service.

In 2012, you pay NOTHING. You pay $0 for the counseling sessions, and the Part B deductible doesn't apply.

If you've been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that's affected by tobacco, Medicare Part B covers up to 8 face-to-face smoking and tobacco use cessation counseling visits in a 12-month period.

In 2012, YOU pay 20% of the Medicare-approved amount for the doctor's services, and the Part B deductible does apply. In a hospital outpatient setting, you pay a copayment.

Transplants (Doctor Services)

Part B covers doctor services for certain organ transplants. See Transplants (Facility Charges) on the next page.

In 2012, YOU pay 20% of the Medicare-approved amount for doctor services, and the Part B deductible does apply.

Transplants (Facility Charges)

Medicare Part A covers transplants of the heart, lung, kidney, pancreas, intestine, and liver under certain conditions and only at Medicare-approved facilities. Medicare only approves facilities for kidney, heart, liver, lung, intestine, and some pancreas transplants. Part B covers cornea and bone marrow transplants. Bone marrow and cornea transplants aren't limited to approved facilities. Transplant coverage includes necessary tests, labs, and exams before surgery. It also includes immunosuppressive drugs (under certain conditions), follow-up care for you, and procurement of organs and tissues. Medicare pays for the costs for a living donor for a kidney transplant.

In 2012, YOU pay various amounts. For inpatient transplants, see Hospital Care (Inpatient) on page 30.

Transportation (Routine)

Medicare doesn't cover transportation to get routine health care. For more information, see Ambulance Services on page 10.

Travel (health care needed when traveling outside the United States)

Medicare generally doesn't cover health care while you're traveling outside the U.S. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States. There are some exceptions. In some cases, Medicare Part B may pay for services that you get while on board a ship within the territorial waters adjoining the land areas of the United States. In rare cases, Medicare Part A may pay for inpatient hospital services that you get in a foreign country under the following circumstances:

- You're in the U.S. when a medical emergency occurs, and the foreign hospital is closer than the nearest U.S. hospital that can treat the emergency.
- You're 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.
- 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.

Medicare also pays for medically-necessary doctor and ambulance services you get in a foreign country as part of a covered inpatient hospital stay.

In 2012, YOU pay 20% of the approved amount for the situations described above, and the Part B deductible does apply.

U

Urgently-Needed Care

Part B covers this care to treat a sudden illness or injury that isn't a medical emergency.

In 2012, YOU pay 20% of the Medicare-approved amount, and the Part B deductible **does** apply.

W

Walker/Wheelchair

Medicare Part B covers power-operated vehicles (scooters), walkers, and wheelchairs as durable medical equipment that your doctor prescribes for use in your home. For more information, see Durable Medical Equipment on pages 22–23.

Power Wheelchair: You must have a face-to-face examination and a written prescription from a doctor or other treating provider before Medicare helps pay for a power wheelchair.

In 2012, YOU pay 20% of the Medicare-approved amount.

X

X-rays

Medicare Part B covers medically-necessary diagnostic X-rays that are ordered by your treating doctor. For more information, see Diagnostic Tests on page 19.

In 2012, YOU pay 20% of the Medicare-approved amount. In a hospital outpatient setting, you pay a copayment.

SECTION 3

For More Information

Visit MyMedicare.gov for personalized information

Register at www.MyMedicare.gov, Medicare's secure online service for accessing your personal Medicare information. You can use this Web site to:

- Complete your "Initial Enrollment Questionnaire" so your bills can get paid correctly.
- Manage your personal information (like medical conditions, allergies, and implanted devices).
- Manage your personal drug list and pharmacy information.
- Search for, add to, and manage a list of your favorite providers and access quality information about them.
- Track Original Medicare claims and your Medicare Part B deductible status.
- Order copies of your "Medicare Summary Notice."

Visit www.medicare.gov for general information about Medicare

You can use this Web site to:

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

Call 1-800-MEDICARE for answers to your Medicare questions

The 1-800-MEDICARE (1-800-633-4227) helpline has a speech-automated system to make it easier for you to get the information you need 24 hours a day, including weekends. TTY users should call 1-877-486-2048.

The system will ask you questions to direct your call automatically. Speak clearly, call from a quiet area, and have your Medicare card in front of you. If you need help, you can say "Agent" at any time to talk to a customer service representative. If you need help in a language other than English or Spanish, say "Agent."

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 online by visiting www.medicare.gov/medicareonlineforms, or by calling 1-800-MEDICARE to get a copy of the form.

Free Publications about Medicare & related topics

Health care decisions are important. Medicare provides information to help you make informed decisions. Detailed booklets and fact sheets are available on various Medicare topics. Here's how to get free publications:

- View or print electronic copies on www.medicare.gov/publications to:
  - Search by keyword (such as "rights" or "mental health").
  - Select "View All Publications."
  - See below for links to specific publications on many topics mentioned in this booklet.
- Order printed copies to be mailed to you:
  - Visit www.medicare.gov/publications. If the publication you want has a check box after "Order Publication," you can order it.
  - Call 1-800-MEDICARE (1-800-633-4227). Say "Publications" to find out if a copy is available. TTY users should call 1-877-486-2048.

Visit www.medicare.gov/publications to view the following publications:

Ambulance coverage "Medicare Coverage of Ambulance Services"

Appeals "Medicare Appeals"

Comparing health care providers

- "Guide to Choosing a Nursing Home"
- "Guide to Choosing a Hospital"

Coverage outside the U.S. (Travel) "Medicare Coverage Outside the United States"

Diabetes "Medicare Coverage of Diabetes Supplies & Services"

Durable medical equipment (DME) "Medicare Coverage of Durable Medical Equipment and Other Devices"

Free Publications about Medicare and Related Topics (continued)

Home health care "Medicare and Home Health Care"

Hospice care "Medicare Hospice Benefits"

Hospital care "Are You a Hospital Inpatient or Outpatient? If You Have Medicare—Ask!"

Kidney dialysis & transplant services "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services"

Medicare prescription drug coverage "Your Guide to Medicare Prescription Drug Coverage"

Mental health care "Medicare & Your Mental Health Benefits"

Preventive services "Your Guide to Medicare's Preventive Services"

Rights & protections "Medicare Rights and Protections"

Skilled nursing care "Medicare Coverage of Skilled Nursing Facility Care"

Do you help someone with Medicare?

Medicare has resources to help you get the information you need:

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

Other important contacts

Below are phone numbers for organizations that provide nationwide services.

State Health Insurance Assistance Program (SHIP)–Call for 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.	Visit www.medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) for your SHIP's phone number. TTY users should call 1-877-486-2048.
Social Security–Call for a replacement Medicare card; to report address or name changes; for information about Medicare Part A and/or Part B eligibility, entitlement, and enrollment; to apply for Extra Help with Medicare prescription drug costs; and to report a death.	1-800-772-1213. TTY 1-800-325-0778.
Coordination of Benefits Contractor–Call for information on whether Medicare or your other insurance pays first.	1-800-999-1118. TTY 1-800-318-8782.
Department of Defense–Call for questions about TRICARE for Life.	1-866-773-0404. TTY 1-866-773-0405.
Department of Health and Human Services Office of Inspector General–Call if you suspect billing fraud.	1-800-447-8477. TTY 1-800-377-4950.
Office for Civil Rights–Call if you think you were discriminated against or if your health information privacy rights were violated.	1-800-368-1019. TTY 1-800-537-7697.
Department of Veterans Affairs–Call if you're a veteran or have served in the U.S. military.	1-800-827-1000. TTY 1-800-829-4833.
Railroad Retirement Board (RRB)–Call if you get RRB benefits and have questions about benefits, address or name changes, or death notifications; or to enroll in Medicare or to replace your Medicare card.	Call your local RRB office or 1-877-772-5772. TTY 1-312-751-4701.

Notes

SECTION 4

Definitions

Ambulatory surgical center—A facility where simpler surgeries are performed for patients who aren't expected to need more than 24 hours of care.

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

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

You can also appeal if you're already getting coverage and Medicare or your plan stops paying.

Assignment—An agreement by your doctor to be paid directly by Medicare, to accept the amount Medicare approves for the service as payment in full, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period—Your hospital and skilled nursing facility (SNF) stays are measured in benefit days and benefit periods. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in an SNF for 60 days in a row.

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, hospital outpatient 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.

Critical access hospital—A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas and is designated as a critical access hospital by Medicare.

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.

Lifetime reserve days —In Original Medicare, these are additional days that Medicare will pay for when you're 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 ($578 in 2012).

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

Medicare-approved amount —In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges.

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

Medicare Prescription Drug Plan (Part D)—A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

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

Prodrug—An oral form of a drug that when ingested breaks down into the same active ingredient found in the injectable form of the drug.

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

Religious Nonmedical Health Care Institution (RNHCI)—A facility that provides nonmedical health care items and services to people who need hospital or skilled nursing facility care, but for whom that care would be inconsistent with their religious beliefs.

Important Information about this guide

The information, phone numbers, and Web Sites in this guide were correct at the time of printing. Changes may occur after printing. To get the most up-to-date information and Medicare phone numbers, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
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Your Medicare Benefits

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

¿ Necesita usted una copia en español?

Llame GRATIS al 1-800-MEDICARE (1-800-633-4227).