CENTERS FOR MEDICARE & MEDICAID SERVICES

# Medicare & You

# 2013

## This is the official U.S. government Medicare handbook:

- ★ What's new (page 4)
- ★ What Medicare covers (page 27)

Don't forget that Open Enrollment begins and ends earlier—October 15–December 7. See page 12.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

NEW!

**Now available for e-Reader**
Visit www.medicare.gov/publications to download a digital version of this handbook to your e-Reader. You can get the same important information that's included in the printed version in an easy-to-read format that you can take anywhere you go. This new option is available for the iPad, Nook, Sony e-Reader, Kindle, and all other e-Reader devices.

**Please keep this handbook for future reference.**
Information 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.

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

# Welcome to "Medicare & You" 2013

This year's handbook is full of important information to help answer questions about your Medicare benefits, coverage options, rights, and more. Medicare is stronger than ever and we're working hard to make sure you have reliable, high-quality health care at a cost you can afford.

We're excited to continue implementing the new Medicare benefits provided to you under the 2010 Affordable Care Act. There's a lot of information about this law in the news including many new opportunities for all Americans to compare plans and get affordable health care coverage. Be assured that you'll still have access to all of your guaranteed Medicare benefits. In fact, this important piece of legislation extends the life of the Medicare program and offers you real benefits. Here are some improvements people with Medicare have seen so far because of this law:

- More than 32.5 million people received one or more preventive service at no cost, helping them find and treat health problems early.
- In 2011, 3.6 million people with Medicare received a 50% discount on brand-name prescription drugs, when they reached the Part D donut hole. That's a savings of about $600 per person.

Our goal is for you to live a healthier, prosperous, and more productive life. Providing you with high quality affordable health care and adding benefits to keep you healthy will lead us in the right direction.

If you have specific questions about Medicare, visit the newly redesigned www.medicare.gov to find the answers you need faster and more easily than ever. You also can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For personal assistance, you can turn to your local State Health Insurance Assistance Program (SHIP)—they've been helping people with Medicare for 20 years. See pages 129–132 for the phone number.

Yours in good health,

/s/

Kathleen Sebelius

Secretary

U.S. Department of
Health and Human Services

/s/

Marilyn B. Tavenner

Acting Administrator

Centers for Medicare & Medicaid
Services

# What's New & Important in 2013

## More covered preventive services

See pages 33, 35, 37, 43, and 46.

Medicare now covers depression screenings, screenings and counseling for alcohol misuse and obesity, behavioral therapy for cardiovascular disease, and more. Use the checklist on page 51 to ask your health care provider which services you need.

## Even more help in the prescription drug coverage gap

See page 86.

If you reach the coverage gap (donut hole) in your Medicare prescription drug coverage (Part D), you'll pay only 47.5% for covered brand-name drugs and 79% for generic drugs.

## Medicare health & prescription drug plans

Visit www.medicare.gov/find-a-plan 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 & Part B)

See pages 24–26 and 28–32.

Find out your Medicare costs for 2013.

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# Important Enrollment Information

## Coverage & costs change yearly

Medicare health plans and prescription drug plans can change costs and coverage each year. Always review your plan materials for the coming year to make sure your plan will meet your needs for the following year. If you're satisfied that your current plan will meet your needs for next year, you don't need to do anything.

## Open Enrollment Period

**Mark your calendar with these important dates!** In most cases, this may be the one chance you have each year to make a change to your health and prescription drug coverage.

| | |
|---|---|
| October 1–<br>October 15, 2012 | **Compare your coverage with other options.** See pages 53–56. |
| **OPEN ENROLLMENT**<br>October 15–<br>December 7, 2012 | **Change your Medicare health or prescription drug coverage for 2013.** See pages 76–77 and 82–83 for other times when you can switch your coverage. |
| January 1, 2013 | **New coverage begins if you made a change.** New costs and benefit changes also begin if you kept your existing Medicare health or prescription drug coverage and your plan made changes. |

Important!

Definitions of blue words are on pages 133–136.

Health plans and prescription drug plans can decide not to participate in Medicare for the coming year. If your plan decides to leave Medicare or stop providing coverage in your area, you'll get a letter before the start of the Open Enrollment Period. See page 104 for more information about your rights and options.

# Section 1—

# Learn How Medicare Works

## What is Medicare?

Medicare is health insurance for:

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

## What are the different parts of Medicare?

See pages 27–31.

### Medicare Part A (Hospital Insurance) helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

See pages 32–51.

### Medicare Part B (Medical Insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment
- Some preventive services

See pages 68–78.

### Medicare Part C (Medicare Advantage):

- Run by Medicare-approved private insurance companies
- Includes all benefits and services covered under Part A and Part B
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- May include extra benefits and services for an extra cost

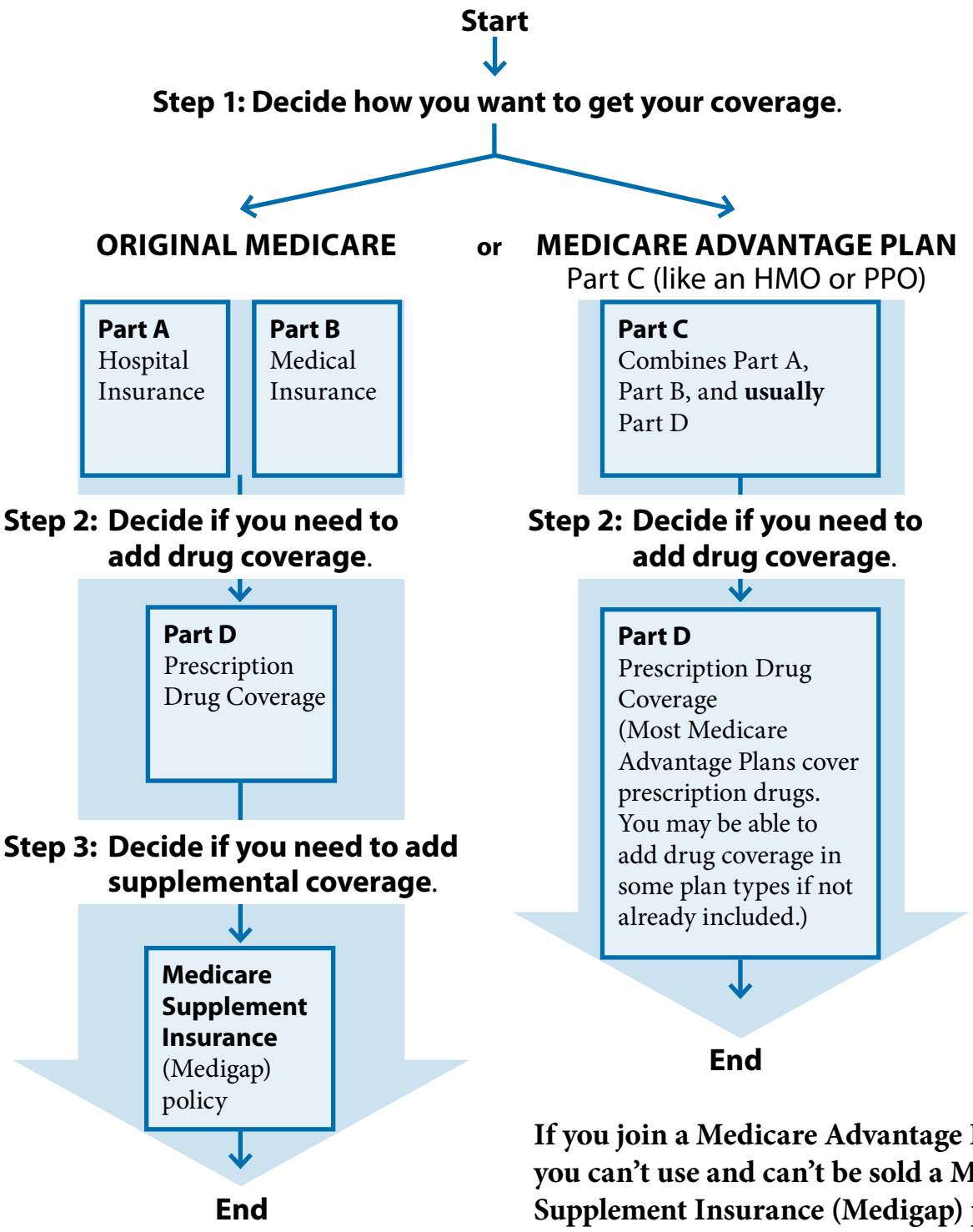
See pages 81–94.

### Medicare Part D (Medicare prescription drug coverage):

- Run by Medicare-approved private insurance companies
- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

## What are my Medicare coverage choices?

There are 2 main ways to get your Medicare coverage—Original Medicare or a Medicare Advantage Plan. Use these steps to help you decide which way to get your coverage.




**If you join a Medicare Advantage Plan, you can't use and can't be sold a Medicare Supplement Insurance (Medigap) policy.**

**See page 55 for more details about your coverage choices.**

## Where can I get my questions answered?

**1-800-MEDICARE** (1-800-633-4227)
Get general or claims-specific Medicare information. If you need help in a language other than English or Spanish, say "Agent" to talk to a customer service representative.
TTY 1-877-486-2048
www.medicare.gov

**State Health Insurance Assistance Program (SHIP)**
Get personalized Medicare counseling at no cost to you. See pages 129–132 for the phone number. Visit www.medicare.gov/contacts or call 1-800-MEDICARE to get the phone numbers of SHIPs in other states.

**Social Security**
Get a replacement Medicare card, change your address or name, find out if you're eligible for Part A and/or Part B and how to enroll, apply for Extra Help with Medicare prescription drug costs, ask questions about premiums, and report a death.
1-800-772-1213
TTY 1-800-325-0778
www.socialsecurity.gov

**Medicare Coordination of Benefits Contractor**
Find out if Medicare or your other insurance pays first, let Medicare know you have other insurance, or report changes in your insurance information.
1-800-999-1118
TTY 1-800-318-8782

**Department of Defense**
Get information about TRICARE for Life and the TRICARE Pharmacy Program.
1-866-773-0404 (TFL)
TTY 1-866-773-0405
1-877-363-1303 (Pharmacy)
TTY 1-877-540-6261
www.tricare.mil/mybenefit

**Department of Health and Human Services**

**Office for Civil Rights**

If you think you were discriminated against or if your health information privacy rights were violated.
1-800-368-1019
TTY 1-800-537-7697
www.hhs.gov/ocr

**Department of Veterans Affairs**

If you're a veteran or have served in the U.S. military.
1-800-827-1000
TTY 1-800-829-4833
www.va.gov

**Office of Personnel Management**

Get information about the Federal Employee Health Benefits Program for current and retired federal employees.
1-888-767-6738
TTY 1-800-878-5707
www.opm.gov/insure

**Railroad Retirement Board (RRB)**

If you have benefits from the RRB, call them to change your address or name, check eligibility, enroll in Medicare, replace your Medicare card, or report a death.
1-877-772-5772
TTY 1-312-751-4701
www.rrb.gov

**Quality Improvement Organization (QIO)**

Ask questions or report complaints about the quality of care for a Medicare-covered service or if you think Medicare coverage for your service is ending too soon. Visit www.medicare.gov/contacts or call 1-800-MEDICARE to get the phone number of your QIO.

Definitions of blue words are on pages 133–136.

# Section 2—

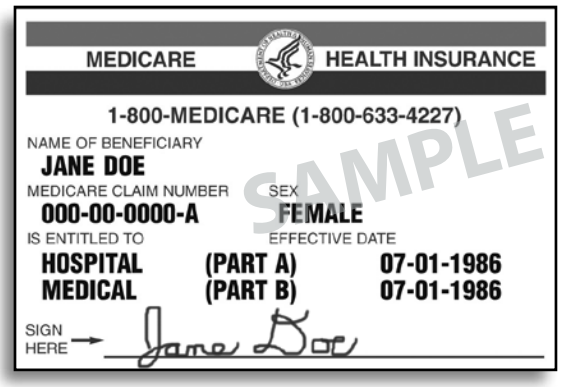
# Sign Up for Medicare

## How do I sign up for Part A & Part B?

### Some people get Part A and Part B automatically

**If you're already getting benefits from Social Security or the Railroad Retirement Board (RRB),** you'll automatically get Part A and Part B starting the first day of the month you turn 65. (If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.)

**If you're under 65 and disabled,** you'll automatically get Part A and Part B after you get disability benefits from Social Security for 24 months or certain disability benefits from the RRB for 24 months.




If you're automatically enrolled, you'll get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday or your 25th month of disability benefits. If you don't need 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. See pages 20–21 for help deciding if you need to sign up for Part B.

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

## How do I sign up for Part A & Part B? (continued)

### Some people have to sign up for Part A and/or Part B

**If you're close to 65, but not getting Social Security or Railroad Retirement Board (RRB) benefits and you want Part A and Part B, you'll need to sign up.** Contact Social Security 3 months before you turn 65. You can also apply for Part A (premium-free) and Part B (for which you pay a monthly premium) at www.socialsecurity.gov/retirement. If you worked for a railroad, contact the RRB.

**If you have End-Stage Renal Disease (ESRD),** you'll need to sign up. Visit your local Social Security office, or call Social Security at 1-800-772-1213 to find out when and how to sign up for Part A and Part B. TTY users should call 1-800-325-0778. For more information, including when your Medicare coverage will end if you're only eligible for Medicare because of permanent kidney failure, visit www.medicare.gov/publications to view the booklet "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

**Important!**

**If you live in Puerto Rico and get benefits from Social Security or the RRB,** you'll automatically get Part A the first day of the month you turn 65 or after you get disability benefits for 24 months. **However, if you want Part B, you'll need to sign up for it. If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty.** See page 25. Contact your local Social Security office or RRB for more information.

### Where can I get more information?

Call Social Security at 1-800-772-1213 for more information about your Medicare eligibility, and to sign up for Part A and/or Part B. If you worked for RRB or get RRB benefits, call the RRB at 1-877-772-5772.

Visit www.medicare.gov for general information about enrolling. You can also get personalized health insurance counseling at no cost to you from your State Health Insurance Assistance Program (SHIP). See pages 129–132 for the phone number.

Definitions of blue words are on pages 133–136.

## If I'm not automatically enrolled, when can I sign up?

If you're not eligible for premium-free Part A, you can get Part A by paying a monthly premium. See page 24. If you want Part A and/or Part B, you can sign up during the following times:

### Initial Enrollment Period

You can sign up for Part A and/or Part B during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

If you sign up for Part A and/or Part B during the first 3 months of your Initial Enrollment Period, in most cases, your coverage starts the first day of your birthday month. However, if your birthday is on the first day of the month, your coverage will start the first day of the prior month.

If you enroll in Part A and/or Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, your start date will be delayed.

Remember, if you live in Puerto Rico, you don't automatically get Part B. You must call Social Security at 1-800-772-1213 to sign up for it. TTY users should call 1-800-325-0778.

### General Enrollment Period

If you didn't sign up for Part A and/or Part B (for which you must pay premiums) when you were first eligible, you can sign up between January 1–March 31 each year. Your coverage will begin July 1. You may have to pay a higher Part A and/or Part B premium for late enrollment. See pages 24–25.

### Special Enrollment Period

If you didn't sign up for Part A and/or Part B when you were first eligible because you're covered under a group health plan based on **current employment (your own, a spouse's, or a family member's if you're disabled)**, you can sign up for Part A and/or Part B:

- Anytime you're still covered by the group health plan.
- During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first.

## If I'm not automatically enrolled, when can I sign up? (continued)

Usually, you don't pay a late enrollment penalty if you sign up during a Special Enrollment Period. This Special Enrollment Period doesn't apply to people with End-Stage Renal Disease (ESRD). See page 18. You may also qualify for a Special Enrollment Period if you're a volunteer serving in a foreign country.

**Important!**

COBRA and retiree health plans aren't considered coverage based on current employment. You're not eligible for a Special Enrollment Period when that coverage ends. To avoid paying a higher premium, make sure you sign up for Medicare when you're first eligible. See page 93 for more information about COBRA.

To learn more details about enrollment periods, visit www.medicare.gov/publications to view the fact sheet "Understanding Medicare Enrollment Periods." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

## Should I get Part B?

The following information can help you decide.

**Employer or union coverage**—If you or your spouse (or family member if you're disabled) is still working and you have health coverage through that employer or union, contact your employer or union benefits administrator to find out how your coverage works with Medicare. This includes federal or state employment, but not military service. It may be to your advantage to delay Part B enrollment.

You can sign up for Part B without penalty any time you have health coverage based on current employment. COBRA and retiree health coverage don't count as current employer coverage. See page 22 to find out how your other insurance will work with Medicare.

Once the employment ends, 3 things happen:

1. You have 8 months to sign up for Part B without a penalty. This period will run whether or not you choose COBRA. **If you choose COBRA, don't wait until your COBRA ends to enroll in Part B.** If you don't enroll in Part B during the 8 months, you may have to pay a penalty. You won't be able to enroll until the next General Enrollment Period and you'll have to wait before your coverage begins. See page 19.

Definitions of blue words are on pages 133–136.

2. You may be able to get COBRA coverage, which continues your health insurance through the employer's plan (in most cases for only 18 months) and probably at a higher cost to you.
   - If you already have COBRA coverage when you enroll in Medicare, your COBRA will probably end.
   - If you become eligible for COBRA coverage after you're already enrolled in Medicare, you must be allowed to take the COBRA coverage. It will always be secondary to Medicare (unless you have End-Stage Renal Disease (ESRD)).
3. When you sign up for Part B, your Medigap Open Enrollment Period begins. See below.

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

- You don't have to enroll in Part B to keep your TRICARE coverage while the service member is on active duty.
- Before the active-duty service member retires, you must enroll in Part B to keep TRICARE without a break in coverage.
- You can get Part B during a Special Enrollment Period if you have Medicare because you're 65 or older, or you're disabled.
- You should enroll in Part A and Part B when you're first eligible based on ESRD.

## When can I get a Medicare Supplement Insurance (Medigap) Policy?

Medicare Supplement Insurance (Medigap) policies, sold by private insurance companies, help pay some of the health care costs that Medicare doesn't cover. You have a one-time 6-month Medigap Open Enrollment Period which starts the first month you're 65 **and** enrolled in Part B. This period gives you a guaranteed right to buy any Medigap policy sold in your state regardless of your health status. Once this period starts, it can't be delayed or replaced.
See pages 64–67 for more information about Medigap.

## How does my other insurance work with Medicare?

When you have other insurance (like employer group health coverage), there are rules that decide whether Medicare or your other insurance pays first.

Use this chart to see who pays first.

| | |
|---|---|
| If you have **retiree** insurance (insurance from former employment)… | Medicare pays first. |
| If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **20 or more employees**… | Your group health plan pays first. |
| If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **less than 20 employees**… | Medicare pays first. |
| If you're under 65 and disabled, have group health plan coverage based on your or a family member's **current** employment, and the employer has **100 or more employees**… | Your group health plan pays first. |
| If you're under 65 and disabled, have group health plan coverage based on your or a family member's **current** employment, and the employer has **less than 100 employees**… | Medicare pays first. |
| If you have Medicare because of End-Stage Renal Disease (ESRD)… | Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period. |

Definitions of blue words are on pages 133–136.

**Note:** In some cases, your employer may join with other employers or unions to form a multiple employer plan. If this happens, the size of the largest employer/union determines whether Medicare pays first or second.

**Here are some important facts to remember:**

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The one that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover.
- The secondary payer (which may be Medicare) may not pay all of the uncovered costs.
- If your employer insurance is the secondary payer, you may need to enroll in Part B before your insurance will pay.

Medicare may pay second if you're in an accident or have a workers' compensation case in which other insurance covers your injury or you're suing another entity for medical expenses. In these situations you or your lawyer should tell Medicare as soon as possible. These types of insurance usually pay first for services related to each type:

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

**Medicaid and TRICARE never pay first for services that are covered by Medicare.** They only pay after Medicare, employer group health plans, and/or Medicare Supplement Insurance have paid.

For more information, visit www.medicare.gov/publications to view the booklet "Medicare and Other Health Benefits: Your Guide to Who Pays First." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

**Important!**

If you have other insurance, tell your health care provider, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Medicare's Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. You can also contact your employer or union benefits administrator. You may need to give your Medicare number to your other insurers so your bills are paid correctly and on time.

## How much does Part A coverage cost?

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

If you aren't eligible for premium-free Part A, you may be able to buy Part A if:

- You're 65 or older, and you have (or are enrolling in) Part B and meet the citizenship and residency requirements.
- You're under 65, disabled, and your premium-free Part A coverage ended because you returned to work. (If you're under 65 and disabled, you can continue to get premium-free Part A for up to 8 1/2 years after you return to work.)

**Note:** People who have to buy Part A will pay up to $441 each month in 2013.

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 pages 99–100. Call Social Security at 1-800-772–1213 for more information about the Part A premium. TTY users should call 1-800-325-0778.

### What is the Part A late enrollment penalty?

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could have had Part A, but didn't sign up.

**Example:** If you were eligible for Part A for 2 years but didn't sign up, you'll have to pay the higher premium for 4 years. Usually, you don't have to pay a penalty if you meet certain conditions that allow you to sign up for Part A during a Special Enrollment Period. See pages 19–20.

Definitions of blue words are on pages 133–136.

## How much does Part B coverage cost?

You pay the Part B premium each month. Most people will pay the standard premium amount, which is $104.90 in 2013. However, if your modified adjusted gross income as reported on your IRS tax return from 2 years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you may pay more.

Remember, if you live in Puerto Rico, you don't automatically get Part B. You must call Social Security at 1-800-772-1213 to sign up for it. TTY users should call 1-800-325-0778.

Your modified adjusted gross income is your adjusted gross income plus your tax exempt interest income. Each year, Social Security will notify you if you have to pay more than the standard premium. The amount you pay can change each year depending on your income. If you have to pay a higher amount for your Part B premium and you disagree (for example, if your income goes down), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from RRB, you should also contact Social Security. RRB doesn't make income determinations.

| If Your Yearly Income in 2011 was | | You pay |
|---|---|---|
| **File Individual Tax Return** | **File Joint Tax Return** | |
| $85,000 or less | $170,000 or less | $104.90 |
| above $85,000 up to $107,000 | above $170,000 up to $214,000 | $146.90 |
| above $107,000 up to $160,000 | above $214,000 up to $320,000 | $209.80 |
| above $160,000 up to $214,000 | above $320,000 up to $428,000 | $272.70 |
| above $214,000 | above $428,000 | $335.70 |

## How much does Part B coverage cost? (continued)

### What is the Part B late enrollment penalty?

If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it. Usually, you don't pay a late enrollment penalty if you meet certain conditions that allow you to sign up for Part B during a Special Enrollment Period. See pages 19–20.

> **Example:** Mr. Smith's Initial Enrollment Period ended September 30, 2010. He waited to sign up for Part B until the General Enrollment Period in March 2013. His Part B premium penalty is 20%. (While Mr. Smith waited a total of 30 months to sign up, this included only 2 full 12-month periods.)

**If you have limited income and resources, see pages 99–100 for information about help paying your Medicare premiums.**

### How can I pay my Part B premium?

If you get Social Security, RRB, or Civil Service benefits, your Part B premium will be deducted from your benefit payment. If you don't get these benefit payments and choose to sign up for Part B, you'll get a bill. If you choose to buy Part A, you'll always get a bill for your premium.

You can mail your premium payments to:

Medicare Premium Collection Center
P.O. Box 790355
St. Louis, Missouri 63179-0355

If you get a bill from the RRB, mail your premium payments to:

RRB
Medicare Premium Payments
P.O. Box 979024
St. Louis, Missouri 63197-9000

If you have questions about your premiums, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Definitions of blue words are on pages 133–136.

# Section 3—

# Find Out if Medicare Covers Your Test, Service, or Item

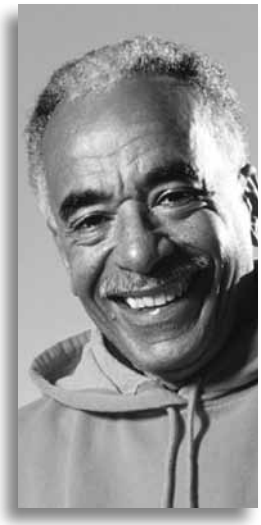
## What services does Medicare cover?

Medicare covers certain medical services and supplies in hospitals, doctors' offices, and other health care settings. Services are either covered under Part A or Part B. If you have both Part A and Part B, you can get all of the Medicare-covered services listed in this section, whether you have Original Medicare or a Medicare health plan.

## What does Part A cover?

Part A (Hospital Insurance) helps cover:

- Inpatient care in hospitals
- Inpatient care in a skilled nursing facility (not custodial or long-term care)
- Hospice care services
- Home health care services
- Inpatient care in a Religious Nonmedical Health Care Institution



You can find out if you have Part A by looking at your Medicare card. If you have Original Medicare, you'll use this card to get your Medicare-covered services. If you join a Medicare health plan, in most cases, you must use the card from the plan to get your Medicare-covered services.

## What do I pay for Part A-covered services?

Copayments, coinsurance, or deductibles may apply for each service listed in the following chart. Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get specific cost information. TTY users should call 1-877-486-2048.

**If you're in a Medicare health plan or have other insurance (like a Medicare Supplement Insurance (Medigap) policy, or employer or union coverage), your costs may be different.** Contact the plans you're interested in to find out about the costs, or visit the Medicare Plan Finder at www.medicare.gov/find-a-plan.

## Part A-covered services

| | |
|---|---|
| **Blood** | If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else. |
| **Home health services** | Medicare covers medically-necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you face-to-face before the doctor can certify that you need home health services. That doctor must order your care and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, and medical supplies for use at home. You must be homebound, which means leaving home is a major effort.<br>▪ You pay nothing for covered home health care services.<br>▪ You pay 20% of the Medicare-approved amount for durable medical equipment. See page 38. |

## Part A-covered services (continued)

| | |
|---|---|
| **Hospice care** | To qualify for hospice care, your doctor must certify that you're terminally ill and expected to live 6 months or less. If you're already getting hospice care, a hospice doctor or nurse practitioner will need to see you about 6 months after you enter hospice to certify that you're still terminally ill. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; certain durable medical equipment; and other covered services, as well as services Medicare usually doesn't cover, like spiritual and grief counseling. A Medicare-approved hospice usually gives hospice care in your home or other facility where you live, like a nursing home.<br><br>Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, like a hospice facility, hospital, or skilled nursing facility which contracts with the hospice. Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness. You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill.<br>▪ You pay nothing for hospice care.<br>▪ You pay a copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management.<br>▪ You pay 5% of the Medicare-approved amount for inpatient respite care. |

## Part A-covered services (continued)

| | |
|---|---|
| **Hospital care (inpatient)** | Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This **doesn't** include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it covers the doctor's services you get while you're in a hospital.<br>▪ You pay $1,184 and no copayment for days 1–60 each benefit period.<br>▪ You pay $296 for days 61–90 each benefit period.<br>▪ You pay $592 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime).<br>▪ You pay all costs for each day after the lifetime reserve days.<br>▪ Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.<br><br>**Note:** Staying overnight in a hospital doesn't always mean you're an inpatient. You're considered an inpatient the day a doctor formally admits you to a hospital with a doctor's order. Always ask if you're an inpatient or an outpatient since **it affects what you pay and whether you'll qualify for Part A coverage in a skilled nursing facility**. For more information, visit www.medicare.gov/publications to view the fact sheet "Are You a Hospital Inpatient or Outpatient? If You Have Medicare—Ask!" You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048. |

## Part A-covered services (continued)

| | |
|---|---|
| **Religious nonmedical health care institution (inpatient care)** | Medicare will only cover the non-medical, non-religious health care items and services (like room and board) in this type of facility if you qualify for hospital or skilled nursing facility care, but medical care isn't in agreement with your religious beliefs. Only non-medical items and services that don't require a doctor's order or prescription, like unmedicated wound dressings or use of a simple walker during your stay, are available. Medicare doesn't cover the religious portion of care. |
| **Skilled nursing facility care** | Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other medically-necessary services and supplies after a 3-day minimum medically-necessary inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day you're formally admitted with a doctor's order and doesn't include the day you're discharged. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy. Medicare **doesn't** cover long-term care or custodial care.<br>▪ You pay nothing for the first 20 days each benefit period.<br>▪ You pay $148 per day for days 21–100 each benefit period.<br>▪ You pay all costs for each day after day 100 in a benefit period. |

## What does Part B cover?

Part B (Medical Insurance) helps cover medically-necessary doctors' services, outpatient care, home health services, durable medical equipment, and other medical services. Part B also covers many preventive services. You can find out if you have Part B by looking at your Medicare card.

Pages 33–50 include a list of common Part B-covered services and general descriptions. Medicare may cover some services and tests more often than the timeframes listed if needed to diagnose a condition. To find out if Medicare covers a service not on this list, visit www.medicare.gov/coverage, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For more details about Medicare-covered services, visit www.medicare.gov/publications to view the booklet "Your Medicare Benefits." Call 1-800-MEDICARE to find out if a copy can be mailed to you.

**You'll see this apple next to the preventive services on pages 33–50.** Use the preventive services checklist on page 51 to ask your doctor or other health care provider which preventive services you should get.

## What do I pay for Part B-covered services?

The alphabetical list on the following pages gives general information about what you pay if you have Original Medicare and see doctors or other health care providers who accept assignment. You'll pay more if you see doctors or providers who don't accept assignment. **If you're in a Medicare Advantage Plan (like an HMO or PPO) or have other insurance, your costs may be different. Contact your plan or benefits administrator directly to find out about the costs.**

Definitions of blue words are on pages 133–136.

Under Original Medicare, if the Part B deductible ($147 in 2013) applies you must pay all costs until you meet the yearly Part B deductible before Medicare begins to pay its share. Then, after your deductible is met, you typically pay 20% of the Medicare-approved amount of the service, if the doctor or other health care provider accepts assignment. There's no yearly limit for what you pay out-of-pocket. Visit www.medicare.gov, or call 1-800-MEDICARE to get specific cost information.

You pay nothing for most preventive services if you get the services from a doctor or other qualified health care provider who accepts assignment. However, for some preventive services, you may have to pay a deductible, coinsurance, or both.

**Important!**

See pages 60–61 for more information about assignment.

## What does Part B cover?

| | |
|---|---|
| **Abdominal aortic aneurysm screening** | Medicare covers a one-time screening abdominal aortic aneurysm ultrasound for people at risk. You must get a referral for it as part of your one-time "Welcome to Medicare" preventive visit. See page 50. You pay nothing for the screening if the doctor or other qualified health care provider accepts assignment. |
| **Alcohol misuse counseling** NEW! | Medicare covers 1 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 practitioner must provide the counseling in a primary care setting (like a doctor's office). You pay nothing if the qualified primary care doctor or other primary care practitioner accepts assignment. |
| **Ambulance services** | Medicare 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.<br><br>In some cases, Medicare may pay for limited non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is necessary due to your medical condition. Medicare will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. |

= Preventive service

## What does Part B cover? (continued)

| | |
|---|---|
| **Ambulatory surgical centers** | Medicare covers the facility fees for approved surgical procedures in an ambulatory surgical center (facility where surgical procedures are performed, and the patient is expected to be released within 24 hours). Except for certain preventive services (for which you pay nothing), you pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you, and the Part B deductible applies. You pay all facility fees for procedures Medicare doesn't cover in ambulatory surgical centers. |
| **Blood** | If the provider gets blood from a blood bank at no charge, you won't have to pay for it or replace it. However, you'll pay a copayment for the blood processing and handling services for every unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else. |
| **Bone mass measurement (bone density)** | This test helps to see if you're at risk for broken bones. It's covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. You pay nothing for this test if the doctor or other qualified health care provider accepts assignment. |
| **Breast cancer screening (mammograms)** | Medicare covers screening mammograms to check for breast cancer once every 12 months for all women with Medicare 40 and older. Medicare covers 1 baseline mammogram for women between 35–39. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment. |
| **Cardiac rehabilitation** | Medicare covers comprehensive programs that include exercise, education, and counseling for patients who meet certain conditions. Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. You pay 20% of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you also pay the hospital a copayment. The Part B deductible applies. |

= Preventive service

## What does Part B cover? (continued)

| | |
|---|---|
| **Cardiovascular disease (behavioral therapy)** NEW! | Medicare will cover 1 visit per year with your primary care doctor in a primary care setting (like a doctor's office) 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. You pay nothing if the doctor or other qualified health care provider accepts assignment. |
| **Cardiovascular screenings** | These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. Medicare covers these screening tests every 5 years to test your cholesterol, lipid, lipoprotein, and triglyceride levels. You pay nothing for the tests, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit. |
| **Cervical and vaginal cancer screening** | Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the exam, Medicare also covers a clinical breast exam to check for breast cancer. Medicare covers these screening tests once every 24 months. Medicare covers these screening tests once every 12 months if you're at high risk for cervical or vaginal cancer or if you're of child-bearing age and had an abnormal Pap test in the past 36 months. You pay nothing if the doctor or other qualified health care provider accepts assignment. |
| **Chemotherapy** | Medicare covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting for people with cancer. For chemotherapy given in a doctor's office or freestanding clinic, you pay 20% of the Medicare-approved amount. If you get chemotherapy in a hospital outpatient setting, you pay a copayment for the treatment. For chemotherapy in a hospital inpatient setting covered under Part A, see Hospital Care (Inpatient) on page 30. |
| **Chiropractic services (limited)** | Medicare covers these services to help correct a subluxation (when 1 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.<br>**Note:** You pay all costs for any other services or tests ordered by a chiropractor (including X-rays and massage therapy). |

## What does Part B cover? (continued)

| | |
|---|---|
| **Clinical research studies** | Clinical research studies test how well different types of medical care work and if they're safe. Medicare covers some costs, like office visits and tests, in qualifying clinical research studies. You may pay 20% of the Medicare-approved amount, and the Part B deductible may apply.<br><br>**Note:** If you're in a Medicare Advantage Plan (like an HMO or PPO), some costs may be covered by Medicare and some may be covered by your plan. |
| **Colorectal cancer screenings** | Medicare covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. One or more of the following tests may be covered:<br>▪ **Fecal occult blood test**—This test is covered once every 12 months if you're 50 or older. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.<br>▪ **Flexible sigmoidoscopy**—This test is generally covered once every 48 months if you're 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.<br>▪ **Colonoscopy**—This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There is no minimum age. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment. **Note:** If a polyp or other tissue is found and removed during the colonoscopy, you may have to pay 20% of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting.<br>▪ **Barium enema**—This test is generally covered once every 48 months if you're 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy. You pay 20% of the Medicare-approved amount for the doctor services. In a hospital outpatient setting, you also pay the hospital a copayment. |

= Preventive service

## What does Part B cover? (continued)

| | |
|---|---|
| **Defibrillator (implantable automatic)** | Medicare covers these devices for some people diagnosed with heart failure. If the surgery takes place in an outpatient setting, you pay 20% of the Medicare-approved amount for the doctor's services. If you get the device as a hospital outpatient, you also pay the hospital a copayment, but no more than the Part A hospital stay deductible. The Part B deductible applies. Surgeries to implant defibrillators in a hospital inpatient setting are covered under Part A. |
| **Depression screening** NEW! | Medicare covers 1 depression screening per year. The screening must be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and referrals. You pay nothing for this test if the doctor or other qualified health care provider accepts assignment, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit. |
| **Diabetes screenings** | Medicare covers these screenings if your doctor determines you're at risk for diabetes. You may be eligible for up to 2 diabetes screenings each year. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment. |
| **Diabetes self-management training** | Medicare covers a program to help people cope with and manage diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks. You must have diabetes and a written order from your doctor or other health care provider. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. |
| **Diabetes supplies** Important! | Medicare covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Medicare only covers insulin if used with an external insulin pump. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.<br><br>**Note:** Medicare prescription drug coverage (Part D) may cover insulin, certain medical supplies used to inject insulin (like syringes), and some oral diabetic drugs.<br><br>If you live in a Durable Medical Equipment (DME) competitive bidding area (see page 38), and get your diabetes supplies by mail, the amount you pay may change starting in January 2013. From January through June 2013, you can get your supplies from any supplier. Starting in July 2013, you'll need to use a Medicare contract supplier for Medicare to pay for your mail order diabetic testing supplies. This national mail order program will help save you money. |

## What does Part B cover? (continued)

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|---|---|
| **Doctor and other health care provider services** | Medicare covers medically-necessary doctor services (including outpatient and some doctor services you get when you're a hospital inpatient) and covered preventive services. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Except for certain preventive services (for which you may pay nothing), you pay 20% of the Medicare-approved amount, and the Part B deductible applies. |
| **Durable medical equipment (DME) (like walkers)** | Medicare covers items like oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **In all areas of the country, you must get your covered equipment or supplies and replacement or repair services from a Medicare-approved supplier for Medicare to pay.**<br><br>For more information, visit www.medicare.gov/publications to view the booklet "Medicare Coverage of Durable Medical Equipment and Other Devices." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.<br><br>**DME Competitive Bidding Program: To get certain items in some areas of the country, you must use specific suppliers called "contract suppliers," or Medicare won't pay for the item and you likely will pay full price.**<br><br>**This program is effective in certain areas in these states:** California, Florida, Indiana, Kansas, Kentucky, Missouri, North Carolina, Ohio, Pennsylvania, South Carolina, and Texas. If you need durable medical equipment or supplies, visit www.medicare.gov/supplier to find Medicare-approved suppliers. If your ZIP code is in a competitive bidding area, the items included in the program are marked with an orange star. You can also call 1-800-MEDICARE.<br><br>**Important!** The program is scheduled to expand to 91 more areas around the country in July 2013. Medicare will provide more information before changes occur in those areas. |

## What does Part B cover? (continued)

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|---|---|
| **EKG (electrocardiogram) screening** | Medicare covers a one-time screening EKG if referred by your doctor or other health care provider as part of your one-time "Welcome to Medicare" preventive visit. See page 50. You pay 20% of the Medicare-approved amount. An EKG is also covered as a diagnostic test. See page 47. If you have the test at a hospital or a hospital owned clinic, you also pay the hospital a copayment. |
| **Emergency department services** | These services are covered when you have an 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 or other health care provider's services. The Part B deductible applies. However, your costs may be different if you're admitted to the hospital. |
| **Eyeglasses (limited)** | Medicare covers 1 pair of eyeglasses with standard frames (or 1 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** | Medicare covers many outpatient primary care and preventive services you get through certain community-based organizations. Generally, you pay 20% of the charges. You pay nothing for most preventive services. |
| **Flu shots** | Medicare generally covers flu shots once per flu season in the fall or winter. You pay nothing for getting the flu shot if the doctor or other qualified health care provider accepts assignment for giving the shot. |
| **Foot exams and treatment** | Medicare covers 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. In a hospital outpatient setting, you also pay the hospital a copayment. |

= Preventive service

## What does Part B cover? (continued)

| | |
|---|---|
| **Glaucoma tests** | These tests are covered once every 12 months for people at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African-American and 50 or older, or are Hispanic and 65 or older. An eye doctor who is legally allowed by the state must do the tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies for the doctor's visit. In a hospital outpatient setting, you also pay the hospital a copayment. |
| **Hearing and balance exams** | Medicare covers these exams if your doctor or other health care provider orders them to see if you need medical treatment. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.<br><br>**Note:** Medicare doesn't cover hearing aids or exams for fitting hearing aids. |
| **Hepatitis B shots** | Medicare covers these shots for people at high or medium risk for Hepatitis B. You pay nothing for the shot if the doctor or other qualified health care provider accepts assignment. |
| **HIV screening** | Medicare covers HIV (Human Immunodeficiency Virus) screenings for people at increased risk for the virus, anyone who asks for the test, and pregnant women. Medicare covers this test once every 12 months or up to 3 times during a pregnancy. You pay nothing for the HIV screening if the doctor or other qualified health care provider accepts assignment. |

= Preventive service

## What does Part B cover? (continued)

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| **Home health services** | Medicare covers medically-necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you face-to-face before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it.<br><br>Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, which means leaving home is a major effort. You pay nothing for covered home health services. For Medicare-covered durable medical equipment information, see page 38. |
| **Kidney dialysis services and supplies** | Generally, Medicare covers dialysis treatment 3 times a week if you have End-Stage Renal Disease (ESRD). This includes dialysis drugs, laboratory tests, home dialysis training, and related equipment and supplies. The dialysis facility is responsible for coordinating your dialysis services (at home or in a facility). You pay 20% of the Medicare-approved amount, and the Part B deductible applies. |
| **Kidney disease education services** | Medicare covers up to 6 sessions of kidney disease education services if you have Stage IV kidney disease, and your doctor or other health care provider refers you for the service. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. |
| **Laboratory services** | Medicare covers laboratory services including certain blood tests, urinalysis, and some screening tests. You pay nothing for these services if the doctor or other health care provider accepts assignment. |

## What does Part B cover? (continued)

| | |
|---|---|
| **Medical nutrition therapy services** | Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you have had a kidney transplant in the last 36 months, and your doctor or other health care provider refers you for the service. You pay nothing for these services if the doctor or other qualified health care provider accepts assignment. |
| **Mental health care (outpatient)** | Medicare covers mental health care services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor's or other health care provider's office or hospital outpatient department), including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist, or clinical social worker; certain treatment for substance abuse; and lab tests. Certain limits and conditions apply.<br><br>What you pay will depend on whether you're being diagnosed and monitored or whether you're getting treatment.<br>▪ For visits to a doctor or other health care provider to diagnose your condition, you pay 20% of the Medicare-approved amount.<br>▪ Generally, for outpatient treatment of your condition (like counseling or psychotherapy), you pay 35% of the Medicare-approved amount. This coinsurance amount will decrease to 20% in 2014.<br><br>The Part B deductible applies for both visits to diagnose or treat your condition.<br><br>**Note:** Inpatient mental health care is covered under Part A. See Hospital care (inpatient) on pages 30. |

## What does Part B cover? (continued)

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|---|---|
| **Obesity screening and counseling** NEW! | If you have a body mass index (BMI) 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 (like a doctor's office), where it can be coordinated with your personalized prevention plan. Talk to your primary care doctor or primary care practitioner to find out more. You pay nothing for this service if the primary care doctor or other qualified primary care practitioner accepts assignment. |
| **Occupational therapy** | Medicare covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) after an illness or accident when your doctor or other health care provider certifies you need it. There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. |
| **Outpatient hospital services** | Medicare covers many diagnostic and treatment services in participating hospital outpatient departments. Generally, you pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You may pay more for services you get in a hospital outpatient setting than you'll pay for the same care in a doctor's office. In addition to the amount you pay the doctor, you'll usually pay the hospital a copayment for each service you get in a hospital outpatient setting, except for certain preventive services for which there's no copayment. The copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies, except for certain preventive services. |
| **Outpatient medical and surgical services and supplies** | Medicare covers approved procedures like X-rays, casts, or stitches. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You generally pay the hospital a copayment for each service you get in a hospital outpatient setting. For each service, the copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies, and you pay all charges for items or services that Medicare doesn't cover. |

## What does Part B cover? (continued)

| | |
|---|---|
| **Physical therapy** | Medicare covers evaluation and treatment for injuries and diseases that change your ability to function when your doctor or other health care provider certifies your need for it. There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. |
| **Pneumococcal shot** | Medicare covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). Most people only need this shot once in their lifetime. Talk with your doctor or other health care provider to see if you should get this shot. You pay nothing if the doctor or other qualified health care provider accepts assignment for giving the shot. |
| **Prescription drugs (limited)** | Medicare covers a limited number of drugs like injections you get in a doctor's office, certain oral cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump), and under very limited circumstances, certain drugs you get in a hospital outpatient setting. You pay 20% of the Medicare-approved amount for these covered drugs and the Part B deductible applies.<br><br>If the covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay the copayment for the services. However, other types of drugs in a hospital outpatient setting (sometimes called "self-administered drugs" or drugs you would normally take on your own), aren't covered by Part B. What you pay depends on whether you have Part D or other prescription drug coverage, whether your drug plan covers the drug, and whether the hospital's pharmacy 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 that aren't covered under Part B. See page 91 for more information.<br><br>Other than the examples above, you pay 100% for most prescription drugs, unless you have Part D or other drug coverage. |

## What does Part B cover? (continued)

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|---|---|
| **Prostate cancer screenings** | Medicare covers a Prostate Specific Antigen (PSA) test and a digital rectal exam once every 12 months for men over 50 (beginning the day after your 50th birthday). You pay nothing for the PSA test if the doctor or other health care provider accepts assignment. You pay 20% of the Medicare-approved amount, and the Part B deductible applies for the digital rectal exam. In a hospital outpatient setting, you also pay the hospital a copayment. |
| **Prosthetic/ orthotic items** | Medicare covers arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a doctor or other health care provider enrolled in Medicare. For Medicare to cover your prosthetic or orthotic, you must go to a supplier that's enrolled in Medicare. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.<br><br>**Important!** DMEPOS Competitive Bidding Program: To get enteral nutrition therapy in some areas of the country, you must use specific suppliers called "contract suppliers," or Medicare won't pay and you'll likely pay full price. See page 38 for more information. |
| **Pulmonary rehabilitation** | Medicare covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral from the doctor treating this chronic respiratory disease. You pay 20% of the Medicare-approved amount if you get the service in a doctor's office. You also pay the hospital a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible applies. |
| **Rural health clinic services** | Medicare covers many outpatient primary care and preventive services in rural health clinics. Generally, you pay 20% of the charges, and the Part B deductible applies. However, you pay nothing for most preventive services. |

= Preventive service

## What does Part B cover? (continued)

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|---|---|
| **Second surgical opinions** | Medicare covers second surgical opinions 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. |
| **Sexually transmitted infections screening and counseling** NEW! | 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.<br><br>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 are provided by a primary care doctor or other primary care practitioner and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.<br><br>You pay nothing for these services if the primary care doctor or other qualified primary care practitioner accepts assignment. |
| **Speech-language pathology services** | Medicare covers evaluation and treatment given to regain and strengthen speech and language skills, including cognitive and swallowing skills, when your doctor or other health care provider certifies you need it. There may be a limit on the amount Medicare will pay for these services in a single year, and there may be certain exceptions to these limits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. |

= Preventive service

## What does Part B cover? (continued)

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|---|---|
| **Surgical dressing services** | Medicare covers these services for treatment of a surgical or surgically-treated wound. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You pay a fixed copayment for these services when you get them in a hospital outpatient setting. You pay nothing for the supplies. The Part B deductible applies. |
| **Telehealth** | Medicare covers limited medical or other health services, like office visits and consultations provided using an interactive two-way telecommunications system (like real-time audio and video) by an eligible provider who isn't at your location. These services are available in some rural areas, under certain conditions, and only if you're located at one of the following places: a doctor's office, hospital, rural health clinic, federally-qualified health center, hospital-based dialysis facility, skilled nursing facility, or community mental health center. For most of these services, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. |
| **Tests (other than lab tests)** | Medicare covers 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. If you get the test at a hospital as an outpatient, you also pay the hospital a copayment that may be more than 20% of the Medicare-approved amount, but it can't be more than the Part A hospital stay deductible. See Laboratory services on page 41 for other Part B-covered tests. |

## What does Part B cover? (continued)

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| **Tobacco use cessation counseling** | **If you use tobacco and you're diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that's affected by tobacco**, Medicare covers up to 8 face-to-face visits in a 12-month period. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.<br><br>**If you haven't been diagnosed with an illness caused or complicated by tobacco use**, Medicare coverage of tobacco use cessation counseling is considered a covered preventive service. You pay nothing for the counseling sessions if the doctor or other qualified health care provider accepts assignment. |
| **Transplants and immunosuppressive drugs** | Medicare covers doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and only in a Medicare-certified facility. Medicare covers bone marrow and cornea transplants under certain conditions.<br><br>Medicare covers immunosuppressive drugs if the transplant was eligible for Medicare payment, or an employer or union group health plan was required to pay before Medicare paid for the transplant. You must have Part A at the time of the transplant, and you must have Part B at the time you get immunosuppressive drugs. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.<br><br>If you're thinking about joining a Medicare Advantage Plan (like an HMO or PPO) 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, other health care providers, and hospitals are in the plan's network. Also, check the plan's coverage rules for prior authorization.<br><br>**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.<br><br>You pay nothing for these services if the doctor or health care provider accepts assignment. |

## What does Part B cover? (continued)

| | |
|---|---|
| **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. (the "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the U.S. 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. Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in these rare cases:<br>1. You're in the U.S. when an emergency occurs and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.<br>2. 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.<br>3. 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.<br><br>Medicare may cover medically-necessary ambulance transportation to a foreign hospital only with admission for medically-necessary covered inpatient hospital services.<br><br>You pay 20% of the Medicare-approved amount, and the Part B deductible applies. |
| **Urgently-needed care** | Medicare covers urgently-needed care to treat a sudden illness or injury that isn't a medical emergency. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment. |

## What does Part B cover? (continued)

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|---|---|
| **"Welcome to Medicare" preventive visit** | During the first 12 months that you have Part B, you can get a "Welcome to Medicare" preventive visit. This visit includes a review of your medical and social history related to your health and education and counseling about preventive services, including certain screenings, shots, and referrals for other care if needed. When you make your appointment, let your doctor's office know that you would like to schedule your "Welcome to Medicare" preventive visit.<br><br>You pay nothing for the "Welcome to Medicare" preventive visit if the doctor or other qualified health care provider accepts assignment.* |
| **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 plan to prevent disease based on your current health and risk factors. This visit is covered once every 12 months.<br><br>Your provider will ask you to fill out a short questionnaire, called a Health Risk Assessment, as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit. The questions are based on years of medical research and advice from the Centers for Disease Control and Prevention (CDC).<br><br>**Note:** Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" visit. However, you don't need to have a "Welcome to Medicare" visit before your yearly "Wellness" visit.<br><br>You pay nothing for the yearly "Wellness" visit if the doctor or other qualified health care provider accepts assignment.* |

**Important!**

*If your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under these preventive benefits, you may have to pay coinsurance, and the Part B deductible may apply.

= Preventive service

## Want to keep track of your preventive services?

Medicare now covers more preventive services to help you stay healthy. Talk with your health care provider about which of these services are right for you. Medicare coverage of preventive services can change at any time. To learn more about new services that may be available to you at no cost, visit www.medicare.gov. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

| Page | Medicare-covered preventive service | I need (yes/no) |
|---|---|---|
| 50 | "Welcome to Medicare" preventive visit (one-time) | |
| 50 | Yearly "Wellness" visit | |
| 33 | Abdominal aortic aneurysm screening | |
| 33 | Alcohol misuse counseling | |
| 34 | Bone mass measurement | |
| 34 | Breast cancer screening (mammogram) | |
| 35 | Cardiovascular disease (behavioral therapy) | |
| 35 | Cardiovascular screenings | |
| 35 | Cervical and vaginal cancer screening | |
| 36 | Colorectal cancer screenings | |
| | Fecal occult blood test | |
| | Flexible sigmoidoscopy | |
| | Colonoscopy | |
| | Barium enema | |

| Page | Medicare-covered preventive service | I need (yes/no) |
|---|---|---|
| 37 | Depression screening | |
| 37 | Diabetes screenings | |
| 37 | Diabetes self-management training | |
| 39 | Flu shots | |
| 40 | Glaucoma tests | |
| 40 | Hepatitis B shots | |
| 40 | HIV screening | |
| 42 | Medical nutrition therapy services | |
| 43 | Obesity screening and counseling | |
| 44 | Pneumococcal shot | |
| 45 | Prostate cancer screenings | |
| 46 | Sexually transmitted infections screening and counseling | |
| 48 | Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) | |

## What's NOT covered by Part A & Part B?

Medicare doesn't cover everything. If you need certain services that Medicare doesn't cover, you'll have to pay for them yourself unless:

- You have other insurance (or Medicaid) to cover the costs.
- You're in a Medicare health plan that covers these services.

Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and copayments.

Some of the items and services that Medicare doesn't cover include:

- Long-term care (also called custodial care). See pages 117–120.
- Routine dental or eye care.
- Dentures.
- Cosmetic surgery.
- Acupuncture.
- Hearing aids and exams for fitting them.

If you have Original Medicare, visit www.medicare.gov/coverage, or call 1-800-MEDICARE (1-800-633-4227) to find out if Medicare covers a service you need. TTY users should call 1-877-486-2048. If you're in a Medicare health plan, contact your plan.

If you have a question or complaint about the quality of a Medicare-covered service, call your local Quality Improvement Organization (QIO). Visit www.medicare.gov/contacts to get your QIO's phone number. You can also call 1-800-MEDICARE.

**Note:** To get Medicare-covered Part A and/or Part B services, you must be a U.S. citizen or be lawfully present in the U.S.

Definitions of blue words are on pages 133–136.

# Section 4—

# Choose Your Health & Prescription Drug Coverage

This handbook has basic information. You'll need more detailed information than this handbook provides to make an informed choice. Before making any decisions, learn as much as you can about the types of coverage available to you.

## How can I get my Medicare coverage?

You can choose different ways to get your Medicare coverage.

1. You can choose Original Medicare and if you want prescription drug coverage, you must join a Medicare Prescription Drug Plan (Part D).
2. You can choose to join a Medicare health plan, and the plan may include Medicare prescription drug coverage. In most cases, you must take the drug coverage that comes with the Medicare health plan.

If you don't join a Medicare health plan, you'll have Original Medicare. See the next page for more information about your coverage choices, and the decisions you need to make.

Each fall, you should review your health and prescription needs because your health, finances, or plan's coverage may have changed. If you decide other coverage will better meet your needs, **you can switch plans between October 15–December 7**. See pages 76–77 and 82–83. If you're satisfied with your current plan's coverage for the following year, you don't need to do anything.

## What if I need help deciding how to get my Medicare?

1. Visit the Medicare Plan Finder at www.medicare.gov/find-a-plan to find and compare plans in your area. Medicare Plan Finder lets you compare plans by plan type and find out what your estimated costs would be in each plan. Here's an example of what you may see when using this tool:

2. Get personalized counseling about choosing coverage. See pages 129–132 for the phone number of your State Health Insurance Assistance Program (SHIP).
3. Call 1-800-MEDICARE (1-800-633-4227), and say "Agent." TTY users should call 1-877-486-2048. If you need help in a language other than English or Spanish, let the customer service representative know.

## What are my Medicare coverage choices?

There are 2 main choices for how you get your Medicare coverage. Use these steps to help you decide.

**Step 1**

**Decide if you want Original Medicare or a Medicare Advantage Plan**

### Original Medicare includes Part A (Hospital Insurance) and/or Part B (Medical Insurance)

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

See pages 57–63.

**Step 2**

**Decide if you want prescription drug coverage (Part D)**

- If you want drug coverage, **you must join a Medicare Prescription Drug Plan**. You usually pay a monthly premium.
- These plans are run by private companies approved by Medicare.

See pages 81–94.

**Step 3**

**Decide if you want supplemental coverage**

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

See pages 64–67.

### Medicare Advantage Plan

(like an HMO or PPO)

**Part C includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance)**

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

See pages 68–78.

**Step 2**

**Decide if you want prescription drug coverage (Part D)**

- If you want drug coverage, and it's offered by your plan, **in most cases you must get it through your plan**.
- In some types of plans that don't offer drug coverage, you can join a Medicare Prescription Drug Plan.

See pages 74–75.

**Note:** If you join a Medicare Advantage Plan, you can't use Medicare Supplement Insurance (Medigap) to pay for out-of-pocket costs you have in the Medicare Advantage Plan. If you already have a Medicare Advantage Plan, you can't be sold a Medigap policy. You can only use a Medigap policy if you disenroll from your Medicare Advantage Plan and return to Original Medicare. See page 67.

In addition to the options listed above, you may be able to join other types of Medicare health plans. See pages 79–80. Some people may have other coverage like employer or union, Medicaid, military, or Veterans' benefits. See pages 100–101 and 93–94.

## What should I consider when choosing or changing my coverage?

| | |
|---|---|
| **Coverage** | Does the plan cover the services you need? |
| **Your other coverage** | Do you have, or are you eligible for, other types of health or prescription drug coverage (like from a former or current employer or union)? If so, read the materials from your insurer or plan, or call them to find out how the coverage works with, or is affected by, Medicare. If you have coverage through a former or current employer or union or other source, talk to your benefits administrator, insurer, or plan before making any changes to your coverage. If you drop your coverage, you may not be able to get it back. |
| **Cost** | How much are your premiums, deductibles, and other costs? How much do you pay for services like hospital stays or doctor visits? Is there a yearly limit on what you pay out-of-pocket? Your costs vary and may be different if you don't follow the coverage rules. |
| **Doctor and hospital choice** | Do your doctors and other health care providers accept the coverage? Are the doctors you want to see accepting new patients? Do you have to choose your hospital and health care providers from a network? Do you need to get referrals? |
| **Prescription drugs** | Do you need to join a Medicare drug plan? Do you already have creditable prescription drug coverage? Will you pay a penalty if you join a drug plan later? How much will you have to pay for your prescription drugs under each plan? Are your drugs covered under the plan's formulary? Are there any coverage rules that apply to your prescriptions? Is the pharmacy you use in the plan's network? |
| **Quality of care** | Are you satisfied with your medical care? The quality of care and services given by plans and other health care providers can vary. Medicare has information to help you compare how well plans and providers work to give you the best care possible. See page 124. |
| **Convenience** | Where are the doctors' offices? What are their hours? Which pharmacies can you use? Can you get your prescriptions by mail? Do the doctors use electronic health records or prescribe electronically? Can you get an electronic copy of your information by email or to store in a personal health record? See page 125. |
| **Travel** | Will you have coverage in another state or outside the U.S.? |

# Section 5—

# Get Information about Your Medicare Health Coverage Choices

## How does Original Medicare work?

Original Medicare is one of your health coverage choices as part of Medicare. You'll have Original Medicare unless you choose a Medicare health plan.

Original Medicare is coverage managed by the federal government. Generally, there's a cost for each service. See the next page for the general rules for how it works.

| | Original Medicare |
|---|---|
| **Can I get my health care from any doctor, other health care provider, or hospital?** | In most cases, yes. You can go to any doctor, other health care provider, hospital, or other facility that's enrolled in Medicare and accepting new Medicare patients. |
| **Are prescription drugs covered?** | With a few exceptions (see pages 30 and 44), most prescriptions aren't covered. You can add drug coverage by joining a Medicare Prescription Drug Plan (Part D). |
| **Do I need to choose a primary care doctor?** | No. |
| **Do I have to get a referral to see a specialist?** | In most cases no, but the specialist must be enrolled in Medicare. |
| **Should I get 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 Medicare Supplement Insurance (Medigap) policy. See pages 64–67. |
| **What else do I need to know about Original Medicare?** | ▪ You generally pay a set amount for your health care (deductible) before Medicare pays its share. Then, Medicare pays its share, and you pay your share (coinsurance/copayment) for covered services and supplies. There's no yearly limit for what you pay out-of-pocket.<br>▪ You usually pay a monthly premium for Part B. See pages 99–100 for information about help paying your Part B premium.<br>▪ You generally don't need to file Medicare claims. The law requires providers (like doctors, hospitals, skilled nursing facilities, and home health agencies) and suppliers to file your claims for the covered services and supplies you get. |

## What do I pay?

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

- Whether you have Part A and/or Part B. Most people have both.
- Whether your doctor, other health care provider, or supplier accepts "assignment."
- The type of health care you need and how often you need it.
- Whether you choose to get services or supplies Medicare doesn't cover. If you do, you pay all the costs unless you have other insurance that covers it.
- Whether you have other health insurance that works with Medicare.
- Whether you have Medicaid or get help from your state paying your Medicare costs.
- Whether you have a Medicare Supplement Insurance (Medigap) policy.
- Whether you and your doctor or other health care provider sign a private contract. See page 62.

For more information on how other insurance works with Medicare, see pages 22–23. For more information about help to cover the costs that Original Medicare doesn't cover, see pages 99–100.

## What are Medicare Summary Notices?

If you have Original Medicare, you'll get a Medicare Summary Notice (MSN) in the mail every 3 months if you get Part A and Part B-covered services. Starting in 2013, your MSN will look different. The new MSN will help to make Medicare information clearer, more accessible, and easier to understand. The notice shows all your services or supplies that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and what you may owe the provider. **This notice isn't a bill.** Read it carefully and do the following:

- If you have other insurance, check to see if it covers anything that Medicare didn't.
- Keep your receipts and bills, and compare them to your notice to be sure you got all the services, supplies, or equipment listed. See pages 112–115 for information on Medicare fraud.
- If you paid a bill before you got your notice, compare your notice with the bill to make sure you paid the right amount for your services.
- If an item or service is denied, call your doctor's or other health care provider's office to make sure they submitted the correct information. If not, the office may resubmit.

Definitions of blue words are on pages 133–136.

## What are Medicare Summary Notices? (continued)

**If you disagree with any decision made, you can file an appeal.** See pages 104–107.

If you need to change your address on your notice, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get Railroad Retirement Board (RRB) benefits, call the RRB at 1-877-772-5772.

Important!

### Check your MSN on MyMedicare.gov

You don't have to wait for your MSN to view your Medicare claims or file an appeal. Visit www.MyMedicare.gov to look at your Medicare claims or view electronic MSNs. See page 123. Your claims generally will be available for viewing within 24 hours after processing.

## What is assignment?

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

### Make sure your doctor, provider, or supplier accepts assignment

Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. Participating providers have signed an agreement to accept assignment for all Medicare-covered services.

Here's what happens if your doctor, provider, or supplier **accepts** assignment:

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

Definitions of blue words are on pages 133–136.

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

Non-participating providers haven't signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services. These providers are called "non-participating."

Here's what happens if your doctor, provider, or supplier **doesn't accept** assignment:

- You might have to pay the entire charge at the time of service. Your doctor, provider, or supplier is supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

  **Note:** In some cases, you might have to submit your own claim to Medicare using form CMS-1490S to get paid back. Visit www.medicare.gov/medicareonlineforms for the form and instructions, or call 1-800-MEDICARE.
- They can charge you more than the Medicare-approved amount, but there's a limit called "the limiting charge." The provider can only charge you up to 15% over the amount that non-participating providers are paid. Non-participating providers are paid 95% of the fee schedule amount. The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment.

**Important!**

To find out if your doctors and other health care providers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your doctor, provider, or supplier if they accept assignment.

## What are private contracts?

A "private contract" is a written agreement between you and a doctor or other health care provider who has decided **not** to provide services to anyone through Medicare. The private contract only applies to the services provided by the doctor or other provider who asked you to sign it.

### Rules for private contracts

You don't have to sign a private contract. You can always go to another provider who gives services through Medicare. If you sign a private contract with your doctor or other provider:

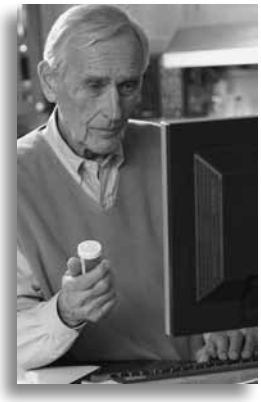
- **Medicare won't pay any amount for the services you get from this doctor or provider, even if it's a Medicare-covered service.**
- You'll have to pay the full amount of whatever this provider charges you for the services you get.
- If you have a Medicare Supplement Insurance (Medigap) policy, it won't pay anything for the services you get. Call your insurance company before you get the service if you have questions.
- Your provider must tell you if Medicare would pay for the service if you get it from another provider who accepts Medicare.
- Your provider must tell you if he or she has been excluded from Medicare.
- You can always get services not covered by Medicare if you choose to pay for them yourself.

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

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 129–132 for the phone number.

Definitions of blue words are on pages 133–136.

## Can I add drug coverage (Part D) to Original Medicare?



In Original Medicare, **if you don't already have creditable prescription drug coverage** (for example, from a current or former employer or union) and you would like Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan. These plans are available through private companies under contract with Medicare. If you don't currently have creditable prescription drug coverage, you should think about joining a Medicare Prescription Drug Plan as soon as you're eligible. **If you don't join a Medicare Prescription Drug Plan when you're first eligible and you decide to join later, you may have to pay a late enrollment penalty.** See pages 88–89 for more information.

**If you have creditable prescription drug coverage from an employer or union**, call your employer or union's benefits administrator before you make any changes to your coverage. Your employer or union plan will tell you each year if your prescription drug coverage is creditable prescription drug 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.

People with limited income and resources may qualify for Extra Help paying their Medicare prescription drug coverage costs. See pages 95–98 to find out if you qualify.

## What are Medicare Supplement Insurance (Medigap) policies?

Original Medicare pays for many, but not all, health care services and supplies. A Medicare Supplement Insurance policy, sold by private companies, can help pay some of the health care costs that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles. **Medicare Supplement Insurance policies are also called Medigap policies.**

Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then, your Medigap policy pays its share. You have to pay the premiums for a Medigap policy.

### Are Medigap policies standardized?

Every Medigap policy must follow federal and state laws designed to protect you and it must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only a "standardized" policy identified in most states by letters A–N. All policies offer the same basic benefits, but some offer additional benefits so you can choose which one meets your needs. In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

**Note:** Plans E, H, I, and J are no longer available to buy, but if you already have one of those policies, you can keep it. Contact your insurance company for more information.

### How do I compare Medigap policies?

**Different insurance companies may charge different premiums for the same exact policy.** As you shop for a policy, be sure you're comparing the same policy (for example, compare Plan A from one company with Plan A from another company).

In some states, you may be able to buy a type of Medigap policy called Medicare SELECT (a policy that requires you to use specific hospitals and, in some cases, specific doctors or other health care providers to get full coverage). If you buy a Medicare SELECT policy, you have the right to change your mind within 12 months and switch to a standard Medigap policy.

Definitions of blue words are on pages 133–136.

**The chart below shows basic information about the different benefits that Medigap policies cover. If a percentage appears, the Medigap plan covers that percentage of the benefit.**

**Note:** You'll need more details than this chart provides to compare and choose a policy. For more details, visit www.medicare.gov/publications to view the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

| | Medicare Supplement Insurance (Medigap) Plans | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefits** | **A** | **B** | **C** | **D** | **F*** | **G** | **K** | **L** | **M** | **N**** |
| Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used) | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |
| Medicare Part B coinsurance or copayment | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | 50% | 75% | **100%** | **100%** |
| Blood (first 3 pints) | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | 50% | 75% | **100%** | **100%** |
| Part A hospice care coinsurance or copayment | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | 50% | 75% | **100%** | **100%** |
| Skilled nursing facility care coinsurance | | | **100%** | **100%** | **100%** | **100%** | 50% | 75% | **100%** | **100%** |
| Medicare Part A deductible | | **100%** | **100%** | **100%** | **100%** | **100%** | 50% | 75% | 50% | **100%** |
| Medicare Part B deductible | | | **100%** | | **100%** | | | | | |
| Medicare Part B excess charges | | | | | **100%** | **100%** | | | | |
| Foreign travel emergency (up to plan limits) | | | **100%** | **100%** | **100%** | **100%** | | | **100%** | **100%** |
| | | | | | | | Out-of-pocket limit in 2013 | | | |
| | | | | | | | $4,800 | $2,400 | | |

* Plan F also offers a high-deductible plan in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,110 in 2013 before your policy pays anything.

** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

## What else should I know about Medicare Supplement Insurance (Medigap)?

### Important facts

- You must have Part A and Part B.
- You pay a monthly premium for your Medigap policy in addition to your monthly Part B premium.
- A Medigap policy only covers one person. Spouses must buy separate policies.
- You can't have prescription drug coverage in both your Medigap policy and a Medicare drug plan. See page 93.
- It's important to compare Medigap policies since the costs can vary and may go up as you get older. Some states limit Medigap premium costs.

### When to buy

- The best time to buy a Medigap policy is during your Medigap Open Enrollment Period. This 6-month period begins on the first day of the month in which you're 65 or older **and** enrolled in Part B. (Some states have additional open enrollment periods.) After this enrollment period, your option to buy a Medigap policy may be limited and it may cost more.
- If you delay enrolling in Part B because you have group health coverage based on your (or your spouse's) current employment, your Medigap Open Enrollment Period won't start until you sign up for Part B.
- Federal law doesn't require insurance companies to sell Medigap policies to people under 65. If you're under 65, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. However, some states require Medigap insurance companies to sell Medigap policies to people under 65.

### How does Medigap work with Medicare Advantage Plans?

- If you have a Medigap policy and join a Medicare Advantage Plan (like an HMO or PPO), you may want to drop your Medigap policy. Your Medigap policy **can't** be used to pay your Medicare Advantage Plan copayments, deductibles, and premiums. If you want to cancel your Medigap policy, contact your insurance company. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you won't be able to get it back.

Definitions of blue words are on pages 133–136.

- If you have a Medicare Advantage Plan, it's illegal for anyone to sell you a Medigap policy unless you're switching back to Original Medicare. If you want to switch to Original Medicare and buy a Medigap policy, find out what policies are available to you and contact your Medicare Advantage Plan to disenroll. You'll need to let the Medigap insurer know the date your plan coverage will end. If you don't intend to leave your Medicare Advantage Plan, and someone tries to sell you a Medigap policy, report it to your State Insurance Department.
- If you join a Medicare Advantage Plan for the first time, and you aren't happy with the plan, you'll have special rights to buy a Medigap policy if you return to Original Medicare within 12 months of joining.
  - —If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.
  - —If you joined a Medicare Advantage Plan when you were first eligible for Medicare, you can choose from any Medigap policy.
  - —The Medigap policy can no longer have prescription drug coverage even if you had it before, but you may be able to join a Medicare Prescription Drug Plan.

## Where can I get more information about Medicare Supplement Insurance (Medigap)?

- Visit www.medicare.gov/publications to view the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.
- Visit www.medicare.gov/medigap to find policies in your area.
- Call your State Insurance Department. Visit www.medicare.gov/contacts or call 1-800-MEDICARE to get the phone number.
- Call your State Health Insurance Assistance Program (SHIP). See pages 129–132 for the phone number.

## What are Medicare Advantage Plans (Part C)?

A Medicare Advantage Plan (like an HMO or PPO) is another Medicare health plan choice you may have as part of Medicare. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, you still have Medicare. You'll get your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare.

### Medicare Advantage Plans cover all Medicare services

In all types of Medicare Advantage Plans, you're always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care and some care in qualifying clinical research studies. Original Medicare covers hospice care and some costs for clinical research studies even if you're in a Medicare Advantage Plan.

Medicare Advantage Plans may offer extra coverage, like vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to your Part B premium, you usually pay a monthly premium for the Medicare Advantage Plan.

### Medicare Advantage Plans must follow Medicare's rules

Medicare pays a fixed amount for your care every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to doctors, facilities, or suppliers that belong to the plan for non-emergency or non-urgent care). These rules can change each year. The plan must notify you about any changes before the start of the next enrollment year.

**Important!**

### Read the information you get from your plan

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

**There are different types of Medicare Advantage Plans:**

- **Health Maintenance Organization (HMO) Plans**—In most HMOs, you can only go to doctors, other health care providers, or hospitals in the plan's network except in an emergency. You may also need to get a referral from your primary care doctor. See page 74.

- **Preferred Provider Organization (PPO) Plans**—In a PPO, you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You usually pay more if you use doctors, hospitals, and providers outside of the network. See page 74.
- **Private Fee-for-Service (PFFS) Plans**—PFFS plans are similar to Original Medicare in that you can generally go to any doctor, other health care provider, or hospital as long as they agree to treat you. The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care. See page 75.
- **Special Needs Plans (SNP)**—SNPs provide focused and specialized health care for specific groups of people, like those who have both Medicare and Medicaid, who live in a nursing home, or have certain chronic medical conditions. See page 75.
- **HMO Point-of-Service (HMOPOS) Plans**—These are HMO plans that may allow you to get some services out-of-network for a higher copayment or coinsurance.
- **Medical Savings Account (MSA) Plans**—This is a plan that combines a high deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year. For more information about MSAs, visit www.medicare.gov/publications to view the booklet "Your Guide to Medicare Medical Savings Account Plans." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

Definitions of blue words are on pages 133–136.

**Important!**

Make sure you understand how a plan works before you join. See pages 74–75 for more information about Medicare Advantage Plan types. If you want more information about a Medicare Advantage Plan, you can call any plan and request a "Summary of Benefits" (SB) document. Contact your State Health Insurance Assistance Program (SHIP) for help comparing plans. See pages 129–132 for the phone number.

## What else should I know about Medicare Advantage Plans?

### Important facts

- You have Medicare rights and protections, including the right to appeal. See pages 103–107.
- You can check with the plan before you get a service to find out if it's covered and what your costs may be.
- You must follow plan rules. It's important to check with the plan for information about your rights and responsibilities.
- If you go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan, your services may not be covered, or your costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs.
- If you join a clinical research study, some costs may be covered by Medicare and some by your plan.
- Medicare Advantage Plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care.
- Medicare Advantage Plans have a yearly cap on how much you pay for Part A and Part B services during the year. This yearly maximum out-of-pocket amount can be different between Medicare Advantage Plans and can change each year. You should consider this when you choose a plan.

### Joining & leaving

- You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease (ESRD). See page 72.
- You can only join or leave a plan at certain times during the year. See pages 76–77.
- Each year, Medicare Advantage Plans can choose to leave Medicare or make changes to the services they cover and what you pay. If the plan decides to stop participating in Medicare, you'll have to join another Medicare health plan or return to Original Medicare. See page 104.
- Medicare Advantage Plans must follow certain rules when giving you information about how to join their plan. See page 78 for more information about these rules and how to protect your personal information.

Definitions of blue words are on pages 133–136.

### Prescription drug coverage

You usually get prescription drug coverage (Part D) through the Medicare Advantage Plan. In some types of plans that don't offer drug coverage, you can join a Medicare Prescription Drug Plan. **If your Medicare Advantage Plan includes prescription drug coverage and you join a Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.**

## Who can join?

You must meet these conditions to join a Medicare Advantage Plan:

- You have Part A and Part B.
- You live in the plan's service area.
- You don't have End-Stage Renal Disease (ESRD), except as explained on page 72.

## What if I have other coverage?

Talk to your employer, union, or other 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. If you lose coverage for yourself, you may also lose coverage for your spouse and dependants. 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 if I have a Medicare Supplement Insurance Policy?

You can't use (and can't be sold) a Medicare Supplement Insurance (Medigap) policy while you're in a Medicare Advantage Plan. You can't use it to pay for any expenses (copayments, deductibles, and premiums) you have under a Medicare Advantage Plan. If you already have a Medigap policy and join a Medicare Advantage Plan, you'll probably want to drop your Medigap policy. **If you drop your Medigap policy, you may not be able to get it back.** See pages 64–67.

## What if I have End-Stage Renal Disease (ESRD)?

If you have End-Stage Renal Disease (ESRD), you can only join a Medicare Advantage Plan in certain situations:

- If you're already in a Medicare Advantage Plan when you develop ESRD, you may be able to stay in your plan or join another plan offered by the same company.
- If you're 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 plan.
- If you have an employer or union health plan or other health coverage through a company that offers Medicare Advantage Plans, you may be able to join one of their Medicare Advantage Plans.
- If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan.
- You may be able to join a Medicare Special Needs Plan (SNP) for people with ESRD if one is available in your area.

### For more information

Visit www.medicare.gov/publications to view the booklet "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

**Note:** If you have ESRD and Original Medicare, you may join a Medicare Prescription Drug Plan.

Definitions of blue words are on pages 133–136.

## What do I pay?

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

- Whether the plan charges a monthly premium.
- Whether the plan pays any of your monthly Part B premium.
- Whether the plan has a yearly deductible or any additional deductibles for certain services.
- How much you pay for each visit or service (copayments or coinsurance).
- The type of health care services you need and how often you get them.
- Whether you go to a doctor or supplier who accepts assignment (if you're in a Preferred Provider Organization, Private Fee-for-Service Plan, or Medical Savings Account Plan and you go out-of-network). See pages 60–61 for more information about assignment.
- Whether you follow the plan's rules, like using network providers.
- Whether you need extra benefits and if the plan charges for it.
- The plan's yearly limit on your out-of-pocket costs for all medical services.
- Whether you have Medicaid or get help from your state.

To learn more about your costs in specific Medicare Advantage Plans, visit www.medicare.gov/find-a-plan. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**Important!**

## Read the information you get from your plan

See page 68 for more information about the "Evidence of Coverage" (EOC) and "Annual Notice of Change" (ANOC) your plan sends you each fall.

## How do Medicare Advantage Plans work?

| | Health Maintenance Organization (HMO) Plan | Preferred Provider Organization (PPO) Plan |
|---|---|---|
| **Can I get my health care from any doctor, other health care provider, or hospital?** | No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option. | In most cases, yes. PPOs have network doctors, other health care providers, and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost. |
| **Are prescription drugs covered?** | In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join an HMO Plan that offers prescription drug coverage. | In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join a PPO Plan that offers prescription drug coverage. |
| **Do I need to choose a primary care doctor?** | In most cases, yes. | No. |
| **Do I have to get a referral to see a specialist?** | In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral. | In most cases, no. |
| **What else do I need to know about this type of plan?** | ▪ If your doctor or other health care provider leaves the plan, your plan will notify you. You can choose another doctor in the plan.<br>▪ If you get health care outside the plan's network, you may have to pay the full cost.<br>▪ It's important that you follow the plan's rules, like getting prior approval for a certain service when needed. | ▪ PPO Plans aren't the same as Original Medicare or Medigap.<br>▪ Medicare PPO Plans usually offer extra benefits than Original Medicare, but you may have to pay extra for these benefits. |

**There may be several private companies that offer different types of Medicare Advantage Plans in your area. Each plan 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 the Medicare Plan Finder at www.medicare.gov/find-a-plan, to find plans in your area. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

| Private Fee-for-Service (PFFS) Plan | Special Needs Plan (SNP) |
|---|---|
| In some cases, yes. **You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you.** Not all providers will. If you join a PFFS Plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but you may pay more. | You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). |
| Sometimes. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan (Part D) to get coverage. | Yes. All SNPs must provide Medicare prescription drug coverage (Part D). |
| No. | Generally, yes. |
| No. | In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral. |
| ▪ PFFS Plans aren't the same as Original Medicare or Medigap.<br>▪ The plan decides how much you must pay for services.<br>▪ Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before.<br>▪ Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before.<br>▪ For each service you get, make sure your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms.<br>▪ In an emergency, doctors, hospitals, and other providers must treat you. | ▪ A plan must limit membership to the following groups: 1) people who live in certain institutions (like a nursing home) or who require nursing care at home, or 2) people who are eligible for both Medicare and Medicaid, or 3) people who have specific chronic or disabling conditions (like diabetes, ESRD, HIV/AIDS, chronic heart failure, or dementia). Plans may further limit membership. You can join a SNP at any time if you're eligible.<br>▪ Plans should coordinate the services and providers you need to help you stay healthy and follow doctor's or other health care provider's orders.<br>▪ If you have Medicare and Medicaid, your plan should make sure that all of the plan doctors or other health care providers you use accept Medicaid.<br>▪ If you live in an institution, make sure that plan providers serve people where you live. |

## When can I join, switch, or drop a Medicare Advantage Plan?

- **When you first become eligible for Medicare,** you can join during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.
- **If you get Medicare due to a disability,** you can join during the 7-month period that begins 3 months before your 25th month of disability and ends 3 months after your 25th month of disability.
- **Between October 15–December 7** anyone can join, switch, or drop a Medicare Advantage Plan. Your coverage will begin on January 1, as long as the plan gets your request by December 7.

### Can I make changes to my coverage after December 7?

Between January 1–February 14, if you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare. If you switch to Original Medicare during this period, you'll have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Your coverage will begin the first day of the month after the plan gets your enrollment request.

During this period, you **can't**:

- Switch from Original Medicare to a Medicare Advantage Plan.
- Switch from one Medicare Advantage Plan to another.
- Switch from one Medicare Prescription Drug Plan to another.
- Join, switch, or drop a Medicare Medical Savings Account Plan.

### Special Enrollment Periods

In most cases, you must stay enrolled for the 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 during a Special Enrollment Period. Contact your plan if:

- You move out of your plan's service area.
- You have Medicaid.
- You qualify for Extra Help. See pages 95–98.
- You live in an institution (like a nursing home).

Definitions of blue words are on pages 133–136.

### 5-Star Special Enrollment Period

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans. A plan can get a rating between 1 and 5 stars. A 5-star rating is considered excellent. These ratings help you compare plans based on quality and performance. These ratings are updated each fall and can change each year.

You can switch to a Medicare Advantage Plan that has **5 stars for its overall plan rating** from December 8, 2012 through November 30, 2013.

- The overall plan ratings are available at www.medicare.gov/find-a-plan.
- You can only join a 5-star Medicare Advantage Plan if one is available in your area.
- You can only use this Special Enrollment Period once during the above timeframe.

Visit the Medicare Plan Finder at www.medicare.gov/find-a-plan to search for plans. For more information about overall plan ratings, visit www.medicare.gov.

**Important!**

You may lose your prescription drug coverage if you move from a Medicare Advantage Plan that has drug coverage to a 5-star Medicare Advantage Plan that doesn't. You'll have to wait until the next Open Enrollment Period to get drug coverage, and you may have to pay a late enrollment penalty. See pages 88–89.

## How do I join?

You can join a Medicare Advantage Plan by:

- Enrolling on the plan's website or on www.medicare.gov.
- Completing a paper enrollment form.
- Calling the plan.
- Calling 1-800-MEDICARE.

When you join a Medicare Advantage Plan, you'll 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.

**Important!**

### Don't give out personal information

In most cases, Medicare Advantage Plans can't:

- Call you to enroll you in a plan.
- Ask you for financial information, including credit card or bank account numbers, over the phone. Don't give your personal information to anyone who calls you to enroll in a plan.
- Call you or come to your home uninvited to sell Medicare products.

See pages 112–115 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. TTY users should call 1-877-486-2048.

## How do I switch?

Follow these steps if you're already in a Medicare Advantage Plan and want to switch:

- **To switch to a new Medicare Advantage Plan,** simply join the plan you choose during one of the enrollment periods explained on pages 76–77. You'll 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. If you don't have drug coverage, you should carefully consider Medicare prescription drug coverage (Part D). You may also want to consider a Medicare Supplement Insurance (Medigap) policy if you're eligible. See pages 64–67 for more information about buying a Medigap policy.

For more information on joining, dropping, and switching plans, visit www.medicare.gov/publications to view the fact sheet "Understanding Medicare Enrollment Periods." You can also call 1-800-MEDICARE to find out if a copy can be mailed to you.

Definitions of blue words are on pages 133–136.

## Are there other types of Medicare health plans?

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

### Medicare Cost Plans

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

- You can join even if you only have Part B.
- If you have Part A and Part B and go to a non-network provider, the services are covered under Original Medicare. You would pay the Part A and Part B coinsurance and deductibles.
- You can join anytime the plan is accepting new members.
- You can leave anytime and return to Original Medicare.
- You can either get your Medicare prescription drug coverage from the plan (if offered), or you can join a Medicare Prescription Drug Plan. **Note:** You can add or drop Medicare prescription drug coverage only at certain times. See pages 82–83.

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

For more information about Medicare Cost Plans, contact the plans you're interested in. You can also visit the Medicare Plan Finder at www.medicare.gov/find-a-plan. Your State Health Insurance Assistance Program (SHIP) can also give you more information. See pages 129–132 for the phone number.

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

PACE is a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community.

To qualify for PACE, you must meet these conditions:

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

PACE provides coverage for prescription drugs, doctor or other health care provider visits, transportation, home care, hospital visits, and even nursing home stays whenever necessary. If you have Medicaid, you won't have to pay a monthly premium for the long-term care portion of the PACE benefit. If you have Medicare but not Medicaid, you'll 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, in PACE there's never a deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.

Visit www.pace4you.org or call your State Medical Assistance (Medicaid) office to find out if you're eligible and if there's a PACE site near you. You can also visit www.medicare.gov/publications to view the fact sheet "Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)." You can call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

### Medicare Innovation Projects

Medicare develops innovative models, demonstrations, and pilot projects to test and measure the effect of potential changes in Medicare coverage, payment, and quality of care. These projects help to find new ways to improve your health care and reduce costs. Usually, they 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 project (or with your health care provider) for more information about how it works.

To find out about current Medicare models, demonstrations, and pilot projects, visit www.innovations.cms.gov. You can also call 1-800-MEDICARE.

Definitions of blue words are on pages 133–136.

# Section 6—

# Get Information about Prescription Drug Coverage

## How does Medicare prescription drug coverage (Part D) work?

Medicare offers prescription drug coverage to everyone with Medicare. Even if you don't take many prescriptions now, you should consider joining a Medicare drug plan. If you decide not to join a Medicare drug plan when you're first eligible, and you don't have other creditable prescription drug coverage, or you don't get Extra Help, you'll likely pay a late enrollment penalty if you join a plan later. See pages 88–89. To get Medicare prescription 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 specific drugs covered.

There are 2 ways to get Medicare prescription drug coverage:

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

In either case, you must live in the service area of the Medicare drug plan you want to join. **Both types of plans are called "Medicare drug plans" in this handbook.**

**Important!**

### 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. If you want to know how Medicare prescription drug coverage works with other drug coverage you may have, see pages 93–94.

## When can I join, switch, or drop a Medicare drug plan?

- **When you're first eligible for Medicare,** you can join during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.
- **If you get Medicare due to a disability,** you can join during the 7-month period that begins 3 months before your 25th month of disability benefits and ends 3 months after your 25th month of disability. You'll have another chance to join during the 7-month period that begins 3 months before the month you turn 65 and ends 3 months after the month you turn 65.
- **Between October 15–December 7, anyone can join, switch, or drop a Medicare drug plan.** The change will take effect on January 1 as long as the plan gets your request by December 7.
- **Anytime, if you qualify for Extra Help.**

### Special Enrollment Periods

You generally must stay enrolled for the calendar year. However, in certain situations like the following, you may be able to join, switch, or drop Medicare drug plans at other times:

- If you move out of your plan's service area
- If you lose other creditable prescription drug coverage
- If you live in an institution (like a nursing home)

Definitions of blue words are on pages 133–136.

### 5-Star Special Enrollment Period

You can switch to a Medicare Prescription Drug Plan that has **5 stars for its overall plan rating** from December 8, 2012 through November 30, 2013. The overall plan ratings are available at www.medicare.gov/find-a-plan. These ratings are updated each fall and can change each year. See page 77 for more information.

- You can only switch to a 5-star Medicare Prescription Drug Plan if one is available in your area.
- You can only use this Special Enrollment Period once during the above timeframe.

Visit the Medicare Plan Finder at www.medicare.gov/find-a-plan to search for plans. For more information about overall plan ratings, visit www.medicare.gov.

Call your State Health Insurance Assistance Program (SHIP) for more information. See pages 129–132 for the phone number. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

## How do I join?

You can join a Medicare drug plan by:

- Enrolling on the plan's website or on www.medicare.gov.
- Completing a paper enrollment form.
- Calling the plan.
- Calling 1-800-MEDICARE.

When you join a Medicare drug plan, you'll 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.

**Important!**

### If you have a Medicare Advantage Plan

If your Medicare Advantage Plan includes prescription drug coverage and you join a Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.

### Don't give out personal information

**In most cases, Medicare drug plans aren't allowed to call you to enroll you in a plan.** If this happens, don't give out your personal information. Call 1-800-MEDICARE (1-800-633-4227) to report a plan that does this. TTY users should call 1-877-486-2048.

## How do I switch?

You can switch to a new Medicare drug plan simply by joining another drug plan during one of the times listed on pages 82–83. **You don't need to cancel your old Medicare drug plan.** 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 with the new plan begins.

## How do I drop a Medicare drug plan?

If you want to drop your Medicare drug plan and you don't want to join a new plan, you can do so during one of the times listed on page 82. You can disenroll by calling 1-800-MEDICARE. You can also send a letter to the plan to tell them you want to disenroll. If you drop your plan and want to join another Medicare drug plan later, you have to wait for an enrollment period. You may have to pay a late enrollment penalty. See pages 88–89.

## What do I pay?

Below and continued on the next page are descriptions of what you pay in your Medicare drug plan. **Your actual drug plan costs will vary depending on the following:**

- Your prescriptions and whether they're on your plan's formulary (drug list)
- The plan you choose
- Which pharmacy you use (preferred, non preferred, out-of-network, or mail order)
- Whether you get Extra Help paying your Part D costs

Definitions of blue words are on pages 133–136.

### 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're in 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.

**Note:** Contact your drug plan (not Social Security or RRB) if you want your premium deducted from your monthly Social Security payment. If you want to stop premium deductions and get billed directly, contact your drug plan.

**Important!**

**What you pay for Part D coverage could be higher based on your income.** This includes Part D coverage you get from a Medicare Prescription Drug Plan, a Medicare Advantage Plan, a Medicare Cost Plan, or employer group Medicare Advantage Plan that includes Medicare prescription drug coverage. If your income is above a certain limit, you'll pay an extra amount in addition to your plan premium. Usually, the extra amount will be deducted from your Social Security check or billed by the RRB if you get benefits from the RRB. If you're billed the amount by Medicare or the RRB, you must pay the extra amount to Medicare or the RRB and not your plan. If you have to pay an extra amount and you disagree (for example, you have a life event that lowers your income), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

| If Your Yearly Income in 2011 was | | You pay |
|---|---|---|
| **File Individual Tax Return** | **File Joint Tax Return** | |
| $85,000 or less | $170,000 or less | Your Plan Premium |
| above $85,000 up to $107,000 | above $170,000 up to $214,000 | $11.60 + Your Plan Premium |
| above $107,000 up to $160,000 | above $214,000 up to $320,000 | $29.90 + Your Plan Premium |
| above $160,000 up to $214,000 | above $320,000 up to $428,000 | $48.30 + Your Plan Premium |
| above $214,000 | above $428,000 | $66.60 + Your Plan Premium |

### Yearly deductible

This is the amount you must pay before your drug plan begins to pay its share of your covered drugs. Some drug plans don't have a deductible.

### Copayments or coinsurance

These are the amounts you pay for your covered prescriptions after the deductible (if the plan has one). You pay your share and your drug plan pays its share for covered drugs. These amounts may vary.

### Coverage gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary limit on what the drug plan will cover for drugs. The coverage gap begins after you and your drug plan have spent a certain amount for covered drugs. In 2013, once you enter the coverage gap, you pay 47.5% of the plan's cost for covered brand-name drugs and 79% of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Not everyone will enter the coverage gap.

These items all **count** toward you getting out of the coverage gap:

- Your yearly deductible, coinsurance, and copayments
- The discount you get on covered brand-name drugs in the coverage gap
- What you pay in the coverage gap

The drug plan premium and what you pay for drugs that aren't covered **don't count** toward getting you out of the coverage gap.

Some plans offer additional coverage during the gap, like for generic drugs, but they may charge a higher monthly premium. Check with the plan first to see if your drugs would be covered during the gap.

In addition to the discount on covered brand-name prescription drugs, there will be increasing coverage for drugs in the coverage gap each year until the gap closes in 2020. For more information, visit www.medicare.gov/publications to view the fact sheet "Closing the Coverage Gap—Medicare Prescription Drugs Are Becoming More Affordable." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

### Catastrophic coverage

Once you get out of the coverage gap, you automatically get "catastrophic coverage." Catastrophic coverage assures that you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

**Note:** If you get Extra Help, you won't have some of these costs. See pages 95–98.

Definitions of blue words are on pages 133–136.

**The example below shows costs for covered drugs in 2013 for a plan that has a coverage gap.**

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2013. 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 (what you pay at the pharmacy) | 3. Coverage gap | 4. Catastrophic coverage |
| Ms. Smith pays the first $325 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 their combined amount (plus the deductible) reaches $2,970. | Once Ms. Smith and her plan have spent $2,970 for covered drugs, she's in the coverage gap. In 2013, she pays 47.5% of the plan's cost for her covered brand-name prescription drugs and 79% of the plan's cost for covered generic drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap. | Once Ms. Smith has spent $4,750 out-of-pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year. |

**Important!**

To get specific Medicare drug plan costs, call the plans you're interested in. Visit the Medicare Plan Finder at www.medicare.gov/find-a-plan to get plan contact information and to compare costs. For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP). See pages 129–132 for the phone number. You can also 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's added to your Part D premium. You may owe a late enrollment penalty if at any time after your initial enrollment period is over, there's a period of 63 or more days in a row when you don't have Part D or other creditable prescription drug coverage.

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

### 3 ways to avoid paying a penalty:

1. **Join a Medicare drug plan when you're first eligible.** You won't have to pay a penalty.
2. **Don't go 63 days or more in a row without a Medicare drug plan or other creditable coverage.** Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, the Department of Veterans Affairs, or health insurance coverage. Your plan must tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
3. **Tell your plan about any drug coverage you had if they ask about it.** When you join a Medicare drug plan, and the plan believes you went at least 63 days in a row without other creditable prescription drug coverage, the plan will send you a letter. The letter will include a form asking about any drug coverage you had. Complete the form and return it to your drug plan. If you don't tell the plan about your creditable prescription drug coverage, you may have to pay a penalty.

Definitions of blue words are on pages 133–136.

## How much more will I pay?

The cost of the late enrollment penalty depends on how long you didn't have creditable prescription drug coverage. Currently, the late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" ($31.17 in 2013) times the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $.10 and added to your monthly premium. Since the "national base beneficiary premium" may increase each year, the penalty amount may also increase each year. You may have to pay this penalty for as long as you have a Medicare drug plan.

**Example:** Mrs. Jones didn't join when she was first eligible—by May 1, 2009. She joined a Medicare drug plan with an effective date of January 1, 2013. Since Mrs. Jones didn't join when she was first eligible and went without other creditable drug coverage for 43 months (June 2009–December 2012), she will be charged a monthly penalty of $13.40 in 2012 ($31.17 X .01 = $.3117 X 43 = $13.40) in addition to her plan's monthly premium.

After you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be.

## What if I don't agree with the penalty?

If you don't agree with your late enrollment penalty, you can ask for a review or reconsideration. You'll need to fill out a reconsideration request form (that your Medicare drug plan will send you), and you'll have the chance to provide proof that supports your case, like information about previous creditable prescription drug coverage. If you need help, call your Medicare plan. You can also contact your State Health Insurance Assistance Program (SHIP). See pages 129–132 for the phone number.

## What drugs are covered?

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. Many Medicare drug plans place drugs into different "tiers" on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier. In some cases, if your drug is in a higher tier and your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) thinks you need that drug instead of a similar drug in a lower tier, you or your prescriber can ask your plan for an exception to get a lower copayment.

Contact the plan for its current formulary, or visit the plan's website. You can also visit the Medicare Plan Finder at www.medicare.gov/find-a-plan, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Your plan will notify you of any formulary changes.

**Note:** Medicare drug plans must cover all medically-necessary commercially-available vaccines, not already covered under Part B (like the shingles vaccine).

**Important!**

Each month that you fill a prescription, your drug plan mails you an "Explanation of Benefits" (EOB) notice. This notice gives you a summary of your prescription drug claims and your costs. Review your notice and check it for mistakes. Contact your plan if you have questions or find mistakes. If you suspect fraud, call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). See page 114 for more information about the MEDIC.

Definitions of blue words are on pages 133–136.

**Plans may have the following coverage rules:**

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

**If you or your prescriber believe that one of these coverage rules should be waived, you can ask for an exception.** See page 106.

**Note:** In most cases, the prescription drugs (sometimes called "self-administered drugs" or drugs you would usually take on your own) you get in an outpatient setting, like an emergency department, or during observation services, aren't covered by Part B. Your Medicare drug plan may cover these drugs under certain circumstances. You'll likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Or, if you get a bill for self-administered drugs you got in a doctor's office, call your Medicare drug plan (Part D) for more information.

Visit www.medicare.gov/publications to view the fact sheet, "How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

### Medication Therapy Management Program

If you're in a Medicare drug plan and take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a Medication Therapy Management (MTM) program. This program helps you and your doctor make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive medication review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion to have available when you talk with your health care providers. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

**Your drug plan may enroll you in this program if you meet all of the following:**

1. You have more than one chronic health condition.
2. You take several different medications.
3. Your medications have a combined cost of more than $3,144 per year. This dollar amount (which can change each year) is estimated based on your out-of-pocket costs and the costs your plan pays for the medications each calendar year. Your plan can help you find out if you may reach this dollar limit.

Visit www.medicare.gov/find-a-plan to get general information about program eligibility for your Medicare drug plan or for other plans that interest you. Contact each drug plan for specific details.

Definitions of blue words are on pages 133–136.

## How do other insurance and programs work with Part D?

The charts on the next 2 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 prescription drug coverage is creditable. **Keep the information you get**. Call your benefits administrator for more information before making any changes to your coverage. **Note:** If you join a Medicare drug plan, you, your spouse, or your dependants may lose your employer or union health coverage.

**COBRA**—A federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependant of the covered employee. As explained on pages 20–21, there may be reasons why you should take Part B instead of, or in addition to, COBRA. However, if you take COBRA and it includes creditable prescription drug coverage, you'll 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 129–132 for the phone number.

**Medicare Supplement Insurance (Medigap) policy with prescription drug coverage**—You may choose to join a Medicare drug plan because most Medigap drug coverage isn't creditable and you may pay more if you join a drug plan later. See pages 88–89. Medigap policies can no longer be sold with prescription drug coverage, but if you have drug coverage under a current Medigap policy, you can keep it. If you join a Medicare drug plan, your Medigap insurance company must remove the prescription drug coverage under your Medigap policy and adjust your premiums. Call your Medigap insurance company for more information.

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

## How does other government insurance work with Part D?

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

**Federal Employee Health Benefits (FEHB) Program**—Health coverage for current and retired federal employees and covered family members. FEHB plans usually include prescription drug coverage, so you don't need to join a Medicare drug plan. However, if you decide to join a Medicare drug plan, you can keep your FEHB plan, and your plan will let you know who pays first. For more information, visit www.opm.gov/insure or contact the Office of Personnel Management at 1-888-767-6738. TTY users should call 1-800-878-5707. You can also call your plan if you have questions.

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

**TRICARE (military health benefits)**—Health care plan for active-duty service members, retirees, and their families. **Most people with TRICARE who are entitled to Part A must have Part B to keep TRICARE prescription drug benefits**. If you have TRICARE, you don't need to join a Medicare Prescription Drug Plan. However, if you do, your Medicare drug plan pays first and TRICARE pays second. If you join a Medicare Advantage Plan (like an HMO or PPO) with prescription drug coverage, your Medicare Advantage Plan and TRICARE may coordinate their benefits if your Medicare Advantage Plan network pharmacy is also a TRICARE network pharmacy. For more information, visit www.tricare.mil/mybenefit or call the TRICARE Pharmacy Program at 1-877-363-1303. TTY users should call 1-877-540-6261.

**Indian Health Services**—Health care services for American Indians and Alaska Natives. Many Indian health facilities participate in the Medicare prescription drug program. If you get prescription drugs through an Indian health facility, you'll continue to get drugs at no cost to you and your coverage won't be interrupted. Joining a Medicare drug plan may help your Indian health facility because the drug plan pays the Indian health facility for the cost of your prescriptions. Talk to your local Indian health benefits coordinator who can help you choose a plan that meets your needs and tell you how Medicare works with the Indian health care system.

# Section 7—

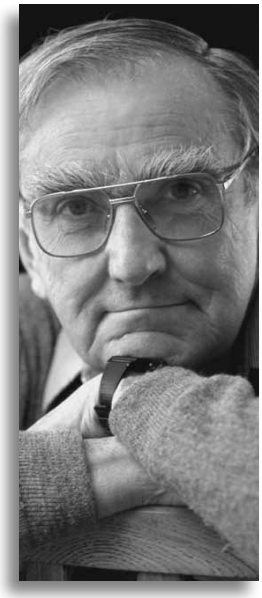
# Get Help Paying Your Health & Prescription Drug Costs

## What if I need help paying my Medicare prescription drug costs?

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

**Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs.** You may qualify for Extra Help, also called the low-income subsidy (LIS), if your yearly income and resources are below these limits in 2012:

- Single person—Income less than $16,755 and resources less than $13,070
- Married person living with a spouse and no other dependants—Income less than $22,695 and resources less than $26,120



These amounts may change in 2013. You may qualify even if you have a higher income (like if you still work, live in Alaska or Hawaii, or have dependants living with you). Resources include money in a checking or savings account, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs). Resources **don't** include your home, car, household items, burial plot, up to $1,500 for burial expenses (per person), or life insurance policies.

If you qualify for Extra Help and join a Medicare drug plan, you'll:

- Get help paying your Medicare drug plan's monthly premium, yearly deductible, coinsurance, and copayments
- Have no coverage gap
- Have no late enrollment penalty

### Extra Help paying for Medicare prescription drug coverage (continued)

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

- You have full Medicaid coverage.
- You get help from your state Medicaid program paying your Part B premiums (in a Medicare Savings Program). See pages 99–100.
- You get Supplemental Security Income (SSI) benefits.

To let you know you automatically qualify for Extra Help, Medicare will mail you a purple letter that you should keep for your records. You don't need to apply for Extra Help if you get this letter.

- If you aren't already in a Medicare drug plan, you must join one to use this Extra Help.
- If you don't join a Medicare drug plan, Medicare may enroll you in one. If Medicare enrolls you in a plan, you'll get a yellow or green letter letting you know when your coverage begins.
- Different plans cover different drugs. Check to see if the plan you're enrolled in covers the drugs you use and if you can go to the pharmacies you want. Visit www.medicare.gov/find-a-plan, or call 1-800-MEDICARE (1-800-633-4227) to compare with other plans in your area. TTY users should call 1-877-486-2048.
- If you're getting Extra Help, you can switch to another Medicare drug plan anytime. Your new coverage will be effective the first day of the next month.
- If you have Medicaid and live in certain institutions (like a nursing home) or get home and community-based services (see page 118), you pay nothing for your covered prescription drugs.

If you don't want to join a Medicare drug plan (for example, because you want only your employer or union coverage), call the plan listed in your letter, or call 1-800-MEDICARE. 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 or if your employer or union coverage is creditable prescription drug coverage, you won't have to pay a penalty if you join later.

**Important!**

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 before you join.

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

- Visit www.socialsecurity.gov/i1020 to apply online.
- Call Social Security at 1-800-772-1213 to apply for Extra Help by phone or to get a paper application. TTY users should call 1-800-325-0778.
- Visit your State Medical Assistance (Medicaid) office. Visit www.medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users should call 1-877-486-2048.

**Note:** With your consent, Social Security will forward information to the Medicaid office in your state to start an application for a Medicare Savings Program. See pages 99–100.

Drug costs in 2013 for most people who qualify will be no more than $2.65 for each generic drug and $6.60 for each brand name drug. Look on the Extra Help letters you get, or contact your plan to find out your exact costs.

To get answers to your questions about Extra Help and help choosing a drug plan, call your State Health Insurance Assistance Program (SHIP). See pages 129–132 for the phone number. You can also call 1-800-MEDICARE.

### Paying the right amount

Medicare gets information 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.

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

You can also give your plan **any** of the documents listed on the next page (also called "Best Available Evidence") as proof that you qualify for Extra Help. **Your plan must accept these documents.** Each item must show that you were eligible for Medicaid during a month after June of 2012.

Definitions of blue words are on pages 133–136.

**Paying the right amount (continued)**

| Proof you have Medicaid and live in an institution or get home and community-based services | Other proof 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<br>▪ A print-out from your state's Medicaid system showing that you lived in the institution for at least a month<br>▪ A document from your state that shows you have Medicaid and are getting home and community-based services | ▪ A copy of your Medicaid card (if you have one)<br>▪ A copy of a state document that shows you have Medicaid<br>▪ A print-out from a state electronic enrollment file or from your state's Medicaid system that shows you have Medicaid<br>▪ Any other document from your state that shows you have Medicaid |

If you aren't already enrolled in a Medicare drug plan and paid for prescriptions since you qualified for Extra Help, you may be able to get back part of what you paid. **Keep your receipts**, and call Medicare's Limited Income Newly Eligible Transition (NET) Program at 1-800-783-1307 for more information. TTY users should call 1-877-801-0369.

For more information, visit www.medicare.gov/publications to view the fact sheet "If You Get Extra Help, Make Sure You're Paying the Right Amount." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

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

Definitions of blue words are on pages 133–136.

## What if I need help paying my Medicare health care costs?

### Medicare Savings Programs

If you have limited income and resources, you may be able to get help from your state to pay your Medicare costs if you meet certain conditions.

There are 4 kinds of Medicare Savings Programs:

1. **Qualified Medicare Beneficiary (QMB) Program**—Helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments.
2. **Specified Low-Income Medicare Beneficiary (SLMB) Program**—Helps pay Part B premiums only.
3. **Qualifying Individual (QI) Program**—Helps pay Part B premiums only. You must apply every year for QI benefits and the applications are granted on a first-come first-served basis.
4. **Qualified Disabled and Working Individuals (QDWI) Program**—Helps pay Part A premiums only. You may qualify for this program if you have a disability and are working.

**Important!**

The names of these programs and how they work may vary by state. Medicare Savings Programs aren't available in Puerto Rico and the U.S. Virgin Islands.

### How do I qualify?

In most cases, to qualify for a Medicare Savings Program, you must have:

- Part A
- Monthly income less than $1,277 and resources less than $6,940—one person
- Monthly income less than $1,723 and resources less than $10,410—married and living together

**Note:** These amounts may change each year. Many states figure your income and resources differently, so you may qualify in your state even if your income or resources are higher than the amounts listed above. If you have income from working, you may qualify for benefits even if your income is higher than the limits above. Resources include money in a checking or savings account, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs). Resources **don't** include your home, car, burial plot, burial expenses up to your state's limit, furniture, or other household items. Some states don't have any limits on resources.

## Medicare Savings Programs (continued)

### For more information

- Call or visit your State Medical Assistance (Medicaid) office, and ask for information on Medicare Savings Programs. Call if you think you qualify for any of these programs, even if you aren't sure. To get the phone number for your state, visit www.medicare.gov/contacts. You can also call 1-800-MEDICARE (1-800-633-4227), and say "Medicaid." TTY users should call 1-877-486-2048.
- Visit www.medicare.gov/publications to view the brochure "Get Help With Your Medicare Costs: Getting Started." You can also call 1-800-MEDICARE to find out if a copy can be mailed to you.
- Contact your State Health Insurance Assistance Program (SHIP). See pages 129–132 for the phone number.

## Medicaid

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

### What does Medicaid cover?

- If you have Medicare and full Medicaid coverage, most of your health care costs are covered. You can get your Medicare coverage through Original Medicare or a Medicare Advantage Plan (like an HMO or PPO).
- If you have Medicare and full Medicaid, Medicare covers your Part D prescription drugs. Medicaid may still cover some drugs and other care that Medicare doesn't cover.
- People with Medicaid may get coverage for services that Medicare doesn't fully cover, like nursing home care and personal care services.

Definitions of blue words are on pages 133–136.

**How do I qualify?**

- Medicaid programs vary from state to state. They may also have different names, like "Medical Assistance" or "Medi-Cal."
- Each state has different income and resource requirements.
- 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. Visit www.medicare.gov/contacts. You can also call 1-800-MEDICARE (1-800-633-4227), and say "Medicaid" to get the phone number for your State Medical Assistance (Medicaid) office. TTY users should call 1-877-486-2048.

NEW!

**Demonstration plans for people who have both Medicare and Medicaid**

Medicare is working with several states and health plans to create demonstration plans for certain people who have both Medicare and Medicaid, referred to as Medicare-Medicaid Plans. These plans will be available in mid 2013 and will include all your Medicare and Medicaid benefits, including drug coverage. If you're interested in joining a Medicare-Medicaid Plan, visit www.medicare.gov/find-a-plan to find out if one is available in your area. Contact your State Medical Assistance (Medicaid) Office or 1-800-MEDICARE for more information.

### State Pharmacy Assistance Programs (SPAPs)

Many states have SPAPs that help certain people pay for prescription drugs based on financial need, age, or medical condition. Each SPAP makes its own rules on how to provide drug coverage to its members. To find out if there's an SPAP in your state and how it works, call your State Health Insurance Assistance Program (SHIP). See pages 129–132 for the phone number.

### Pharmaceutical Assistance Programs (also called Patient Assistance Programs)

Many major drug manufacturers offer assistance programs for people with Medicare drug coverage who meet certain requirements. Visit www.medicare.gov/pap/index.asp to learn more about Pharmaceutical Assistance Programs.

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

PACE is a Medicare and Medicaid program offered in many states that allows people who need a nursing home-level of care to remain in the community. See page 80 for more information.

### Supplemental Security Income (SSI) Benefits

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

You can visit www.socialsecurity.gov, and use the "Benefit Eligibility Screening Tool" to find out if you're 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. **Note:** People who live in Puerto Rico, the U.S. Virgin Islands, Guam, or American Samoa can't get SSI.

### Programs for people who live in the U.S. territories

There are programs in Puerto Rico, the U.S. 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 learn more, or call 1-800-MEDICARE (1-800-633-4227) and say "Medicaid" for more information. TTY users should call 1-877-486-2048.

### Children's Health Insurance Program (CHIP)

Do you have children or grandchildren who need health insurance? CHIP provides low-cost health insurance coverage to children in families who earn too much income to qualify for Medicaid, but not enough to buy private health insurance. Each state has its own program, with its own eligibility rules. Visit www.insurekidsnow.gov or call 1-877-KIDS-NOW (1-877-543-7669) for more information about CHIP in your state.

# Section 8—

# Know Your Rights & How to Protect Yourself from Fraud

## What are my Medicare rights?

No matter how you get your Medicare, you have certain rights and protections. All people with Medicare have the right to:

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

Definitions of blue words are on pages 133–136.

## What if my plan stops participating in Medicare?

Medicare health and prescription drug plans can decide not to participate in Medicare for the coming year. Plans that choose to leave Medicare entirely or in certain areas are "non-renewing." In these cases, your coverage under the plan will end after December 31. The plan will send you a letter about your options before Open Enrollment. You can always choose another plan effective January 1 if you do so between October 15–December 7. If your plan is non-renewing for the next year, you'll also have a special right to join another Medicare plan until February 28, 2013.

If you want to continue to have Medicare prescription drug coverage (Part D) or a Medicare Advantage Plan (like an HMO or PPO), without any interruption in coverage, you'll need to join a new plan by December 31. If you don't join a new Medicare Advantage Plan by December 31, you'll continue to have Medicare coverage through Original Medicare on January 1, but if you don't join a Part D plan by that date, you won't have Medicare drug coverage.

- Generally, if you're in a Medicare health plan, you'll automatically return to Original Medicare if you don't choose to join another Medicare health plan. You'll also have the right to buy certain Medigap policies within 63 days after your plan coverage ends. If you return to Original Medicare, you can also join a Medicare Prescription Drug Plan.
- If you're in a Medicare drug plan, you'll have the right to join another Medicare drug plan or a Medicare health plan with drug coverage. If you don't join a new plan, you won't have Part D.

## What's an appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision by Medicare or your Medicare plan. For example, you can appeal if Medicare or your plan denies:

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

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

Definitions of blue words are on pages 133–136.

If you decide to file an appeal, you can ask your doctor or other health care provider or supplier for any information that may help your case. Keep a copy of everything you send to Medicare as part of your appeal.

## How do I file an appeal?

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

### If you have Original Medicare

1. Get the "Medicare Summary Notice" (MSN) that shows the item or service you're appealing. Your MSN is the notice you get every 3 months that lists all the services billed to Medicare and tells you if Medicare paid for the services. See pages 59–60.
2. Circle the item(s) you disagree with on the MSN, and write an explanation of why you disagree with the decision on the MSN or on a separate piece of paper and attach it to the MSN.
3. Include your name, phone number, and Medicare number on the MSN and sign it. Keep a copy for your records.
4. Send the MSN, or a copy, to the company that handles bills for Medicare listed on the MSN. You can include any other additional information you have about your appeal. Or you can use CMS Form 20027, and file it with the Medicare contractor at the address listed on the notice. To view or print this form, visit www.cms.gov/cmsforms/downloads/cms20027.pdf, or call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.
5. You must file the appeal within 120 days of the date you get the MSN in the mail.

You'll generally get a decision from the Medicare contractor within 60 days after they get your request. If Medicare will cover the item(s) or service(s), it will be listed on your next MSN.

### If you have a Medicare health plan

Learn how to file an appeal by looking at the materials your plan sends you, calling your plan, or visiting www.medicare.gov/publications to view the booklet "Medicare Appeals." You can also call 1-800-MEDICARE to find out if a copy can be mailed to you.

In some cases, you can file a fast appeal. See materials from your plan and page 107.

### If you have a Medicare Prescription Drug Plan

You have the right to do all of the following (even before you buy a certain 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 benefits, including whether a certain drug is covered, whether you've met the requirements to get a requested drug, how much you pay for a drug, and whether to make an exception to a plan rule when you request it.
- Ask for an exception if you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes you need a drug that isn't on your plan's formulary.
- Ask for an exception if you or your prescriber believes that a coverage rule (like prior authorization) should be waived.
- Ask for an exception if you think you should pay less for a higher tier (more expensive) drug because you or your prescriber believes you can't take any of the lower tier (less expensive) drugs for the same condition.

### How do I ask for a coverage determination?

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

You or your prescriber may make a standard request by phone or in writing, if you're asking for prescription drug benefits you haven't gotten yet. If you're asking to get paid back for prescription drugs you already bought, your plan can require you or your prescriber to make the standard request in writing.

You or your prescriber can call or write your plan for an expedited (fast) request. Your request will be expedited if you haven't gotten the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting.

**Important!**

If you're requesting an exception, your prescriber must provide a statement explaining the medical reason why the exception should be approved.

### How can I get help filing an appeal?

For more information about the different levels of appeals in a Medicare drug plan, visit www.medicare.gov/publications to view the booklet "Medicare Appeals." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP). See pages 129–132 for the phone number.

## What are my rights if I think my services are ending too soon?

If you're 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 can ask for a fast appeal. Your provider will give you a notice before your services end that will tell you how to ask for a fast appeal. You should read this notice carefully. If you don't get this notice, ask your provider for it.

### How do I ask for a fast appeal?

With a fast appeal, an independent reviewer, called a Quality Improvement Organization (QIO), will decide if your services should continue.

Definitions of blue words are on pages 133–136.

- Ask your doctor or other health care provider for any information that may help your case if you decide to file a fast appeal.
- Call your QIO to request a fast appeal no later than the time shown on the notice you get from your provider. Use the phone number for your QIO listed on your notice to request your appeal.
- If you miss the deadline, you still have appeal rights:
  - —If you have Original Medicare, call your QIO.
  - —If you're in a Medicare health plan, read your notice carefully and follow the instructions for filing an appeal with your plan. You can also call your plan.

**Important!**

Visit www.medicare.gov/contacts or call 1-800-MEDICARE to get the phone number for the QIO in your state.

## What's an Advance Beneficiary Notice of Noncoverage (ABN)?

If you have Original Medicare, your doctor, other health care provider, or supplier may give you a notice called an "Advance Beneficiary Notice of Noncoverage" (ABN). This notice says Medicare probably (or certainly) won't pay for some services in certain situations.

### What happens if I get an ABN?

- You'll 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're agreeing to pay if Medicare doesn't.
- You'll be asked to sign the ABN to say that you've read and understood it.
- Doctors, other health care providers, and suppliers don't have to (but still may) give you an ABN for services that Medicare never covers. See page 52.
- 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 claim to Medicare or another insurer. If Medicare denies payment, you can still file an appeal. However, you'll have to pay for the items or services if Medicare determines that the items or services aren't covered (and no other insurer is responsible for payment).

### Can I get an ABN for other reasons?

- You may get a Home Health ABN for other reasons, like when your doctor or other health care provider makes changes to or reduces your home health care.
- You may get a Skilled Nursing Facility ABN when the facility believes Medicare will no longer cover your stay or other items and services.

Definitions of blue words are on pages 133–136.

### What if I didn't get an ABN?

- If your provider was required to give you an ABN but didn't, in most cases your provider must pay you back what you paid for the item or service.

For more information if you're in a Medicare plan, call your plan to find out if a service or item will be covered.

Visit www.medicare.gov/publications to view the booklet "Medicare Appeals." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

## How does Medicare use my personal information?

Medicare protects the privacy of your health information. The next 2 pages describe how your information may be used and given out by law 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 payment information 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:

- Where allowed by federal law to state and other federal agencies that need Medicare data for their program operations (like to make sure Medicare is making proper payments or to coordinate benefits between programs)
- To your health care providers so they know what other treatments you've gotten and to coordinate your care (for example, for programs to ensure the delivery of quality health care)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like fraud and abuse investigations)
- For judicial and administrative proceedings (like in response to a court order)
- For law enforcement purposes (like providing limited information to locate a missing person)
- For research studies, including surveys, that meet all privacy law requirements (like 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

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

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

- See and get a copy of your personal medical information held by Medicare.
- Have your personal medical information amended if you believe that it is wrong or if information is missing, and Medicare agrees. If Medicare disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from Medicare. The listing won't cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for Medicare operations, or that was given out for law enforcement purposes if it would likely get in the way of these 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/privacy.

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'll 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.**

## How can I protect myself from identity theft?

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, credit card, or bank account numbers. Guard your card. Protect your Medicare number. Keep this information safe.

**Only give personal information, like your Medicare number, to doctors, other health care providers, and plans approved by Medicare; any insurer who pays benefits on your behalf; and to trusted 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.

If you suspect identity theft, or feel like you gave your personal information to someone you shouldn't have, call your local police department and the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338. TTY users should call 1-866-653-4261. Visit www.ftc.gov/idtheft to learn more about identity theft.

## How can I protect myself & Medicare from 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 fraud happens when Medicare is billed for services or supplies you never got. Medicare fraud costs Medicare a lot of money each year.

Definitions of blue words are on pages 133–136.

### Check your statements for mistakes

When you get health care services, record the dates on a calendar and save the receipts and statements you get from providers to check for mistakes. If you think you see an error or are billed for services you didn't get, do the following to find out what was billed:

- Check your "Medicare Summary Notice" (MSN) if you have Original Medicare to see if the service was billed to Medicare. If you're in a Medicare plan, check the statements you get from your plan.
- If you know the health care provider or supplier, call and ask for an itemized statement. They should give this to you within 30 days.
- Visit www.MyMedicare.gov to view your Medicare claims if you have Original Medicare. Your claims are generally available online within 24 hours after processing. The sooner you see and report errors, the sooner we can stop fraud. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**If you've contacted the provider and you suspect that Medicare is being charged for a service or supply that you didn't get, or you don't know the provider on the claim, call 1-800-MEDICARE.**

For more information on protecting yourself from Medicare fraud and tips for spotting and reporting fraud, visit www.stopmedicarefraud.gov, or contact your local SMP Program. See page 114.

You can also visit www.oig.hhs.gov or call the fraud hotline of the Department of Health and Human Services Office of the Inspector General at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950.

### Plans must follow rules

Important!

Medicare plans must follow certain rules when marketing their plans and getting your enrollment information. They can't ask you for credit card or banking information over the phone or via email, unless you're already a member of that plan. Medicare plans can't enroll you into a plan over the phone unless you call them and ask to enroll.

**Call 1-800-MEDICARE (1-800-633-4227) to report any plans that:**

- Ask for your personal information over the phone
- Call to enroll you in a plan
- Use false information to mislead you

You can also call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). The MEDIC helps prevent inappropriate activity and fights fraud, waste, and abuse in Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) Programs.

For more information on the rules that Medicare plans must follow, visit www.medicare.gov/publications to view the booklet "Protecting Medicare and You from Fraud." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

## Reporting suspected Medicaid fraud

You can report Medicaid fraud to your State Medical Assistance (Medicaid) office. Visit www.cms.gov/fraudabuseforconsumers to learn more. Medicaid fraud can also be reported to the OIG National Fraud hotline at 1-800-HHS-TIPS (1-800-447-8477).

## What is the Senior Medicare Patrol (SMP) Program ?

The SMP Program educates and empowers people with Medicare to take an active role in detecting and preventing health care fraud and abuse. The SMP Program not only protects people with Medicare, it also helps preserve Medicare. There's an SMP Program in every state, the District of Columbia, Guam, the U.S. Virgin Islands, and Puerto Rico. Contact your local SMP Program to get personalized counseling and to find out about community events in your area. For more information or to find your local SMP Program, visit www.smpresource.org, or call 1-877-808-2468. You can also call 1-800-MEDICARE.

Definitions of blue words are on pages 133–136.

## Fighting fraud can pay

You may get a reward if you meet certain conditions. For more information, visit www.stopmedicarefraud.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

## Investigating fraud takes time

Medicare takes all reports of suspected fraud seriously. When you report fraud, you may not hear of an outcome right away. It takes time to investigate your report and build a case.

## Am I 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 at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

## What is the Medicare Beneficiary Ombudsman?

An "ombudsman" is a person who reviews complaints and helps resolve them. The Medicare Beneficiary Ombudsman makes sure information about the following is available to all people with Medicare:

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

The Ombudsman reviews the concerns raised by people with Medicare through 1-800-MEDICARE and through your State Health Insurance Assistance Program (SHIP).

Visit www.medicare.gov/ombudsman/resources.asp for information on inquiries and complaints, activities of the Ombudsman, and what people with Medicare need to know.

## What is the Long-term Care Ombudsman?

Residents of long-term care facilities (like nursing homes, assisted living, and board and care homes) also have access to a long-term care ombudsman. These ombudsmen provide information about how to find a facility, how to get quality care, and can help you with complaints.

The long-term care ombudsman is funded by the Older Americans Act and is available to any long-term care facility resident. For more information, visit www.ltcombudsman.org. You can also call the ElderCare Locator at 1-800-677-1116 to get the phone number for your local ombudsman program office.

Definitions of blue words are on pages 133–136.

# Section 9—

# Plan Ahead for Long-Term Care

## How do I plan for long-term care?

Long-term care includes medical and non-medical care for people who have a chronic illness or disability. Non-medical care includes non-skilled personal care assistance, like help with everyday activities, including dressing, bathing, and using the bathroom. At least 70% of people over 65 will need long-term care services at some point. **Medicare and most health insurance plans, including Medicare Supplement Insurance (Medigap) policies, don't pay for this type of care, also called "custodial care."** Long-term care can be provided at home, in the community, in an assisted living facility, or in a nursing home. It's important to start planning for long-term care now to maintain your independence and to make sure you get the care you may need in the future.

## How do I pay for long-term care?

**Long-term care insurance**—This type of private insurance can help pay for many types of long-term care, including both skilled and non-skilled (custodial) care. Long-term care insurance policies 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 Federal Long-Term Care Insurance Program at 1-800-582-3337. TTY users should call 1-800-843-3557.

**Personal resources**—You can use your own resources 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.

**Other private options**—Besides long-term care insurance and personal resources, you may choose to pay for long-term care through a trust or annuity. The best option for you depends on your age, health status, risk of needing long-term care, and your personal financial situation. Visit www.longtermcare.gov for more information about your options.

**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.

If you're already eligible for Medicaid, you or your family members may be able to get help with the costs of services that help you stay in your home instead of moving to a nursing home. Examples of home and community-based services include homemaker services, personal care, and respite care. For more information, contact your State Medical Assistance (Medicaid) office. Visit www.medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227), and say "Medicaid" to get the phone number. TTY users should call 1-877-486-2048. See page 100 for more information about Medicaid.

Definitions of blue words are on pages 133–136.

**Veterans' benefits**—The Department of Veterans Affairs (VA) may provide long-term care for service-related disabilities or for certain eligible veterans. The VA also has a Housebound and an Aid and Attendance Allowance Program that provides cash grants to eligible disabled veterans and surviving spouses instead of formally-provided homemaker, personal care, and other services needed for help at home. For more information, visit www.va.gov, or call the VA at 1-800-827-1000.

**Programs of All-inclusive Care for the Elderly (PACE)**—PACE is a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community. See page 80 for more information.

## Long-term care contacts

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

- Visit www.medicare.gov/ltcplanning. You can visit www.medicare.gov/nhcompare to compare nursing homes or www.medicare.gov/hhcompare to compare home health agencies in your area.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.longtermcare.gov to learn more about planning for long-term care.
- Call your State Insurance Department to get information about long-term care insurance. Call 1-800-MEDICARE to get the phone number.
- Call your State Health Insurance Assistance Program (SHIP). See pages 129–132 for the phone 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, a public service of the U.S. Administration on Aging, at www.eldercare.gov to find your local Aging and Disability Resource Center (ADRC). You can also call 1-800-677-1116. ADRCs offer a full range of long-term care services and support in a single, coordinated program.

## What are advance directives?

Advance directives are legal documents that allow you to put in writing what kind of health care you would want or name someone who can speak for you if you were too ill to speak for yourself.

These legal documents help ensure your wishes are followed, but it's important to talk to your family, friends, and health care providers about your wishes. You should also make sure that your family, friends, and health care providers have copies of your legal documents. It's better to think about these important decisions and have plans in place before you're ill or a crisis strikes.

**Advance directives most often include:**

- **A health care proxy** (sometimes called a "durable power of attorney for health care"). This is used to name the person you want to make health care decisions for you if you aren't able to make them yourself.
- **A living will.** This is another way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened.
- **After-death wishes.** These may include choices like organ and tissue donation.

Each state has its own laws for creating advance directives. Some states may allow you to combine your advance directives in one document.

**What if I already have advance directives?**

Take time now to review them to be sure you're still satisfied with your decisions and the person you identify in 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.

For more information, contact your health care provider, an attorney, your local Area Agency on Aging, your state health department, or visit www.eldercare.gov.

Definitions of blue words are on pages 133–136.

# Section 10—

# Get More Information

## Where can I get personalized help?

**1-800-MEDICARE (1-800-633-4227)**

**TTY users call 1-877-486-2048**

**Get information 24 hours a day, including weekends**

- Speak clearly, have your Medicare card in front of you, and be ready to provide your Medicare number. This helps reduce the amount of time you may wait to speak to a customer service representative. It also allows us to play messages that may specifically impact your coverage and may help us get you to a representative more quickly.
- To enter your Medicare number, speak the numbers and letter(s) clearly one at a time. Or, enter your Medicare number on the phone keypad. Use the star key to indicate any place there may be a letter. For example, if your Medicare number is 000-00-0000A, you would enter 0-0-0-0-0- 0-0-0-0-*. The voice system will then ask you for that letter.
- Use 1 or 2 words to briefly say what you're calling about.

**Tip: You can say "Agent" at anytime to talk to a customer service representative.**

If you need help in a language other than English or Spanish, let the customer service representative know.

## Where can I get personalized help? (continued)

**Important!**

If you want someone to be able to call 1-800-MEDICARE on your behalf, you need to let Medicare know in writing. You can fill out a "Medicare Authorization to Disclose Personal Health Information" form so Medicare can give your personal health information to someone other than you. You can do this by visiting www.medicare.gov/medicareonlineforms or by calling 1-800-MEDICARE (1-800-633-4227) to get a copy of the form. TTY users should call 1-877-486-2048. You may want to do this now in case you become unable to do it later.

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

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

If you want to get only one copy in future, call 1-800-MEDICARE, and say "Agent." If you get RRB benefits, call 1-877-772-5772.

## What are State Health Insurance Assistance Programs (SHIPs)?

SHIPs are state programs that get money from the federal government to give local health insurance counseling to people with Medicare. SHIPs aren't connected to any insurance company or health plan. SHIP volunteers work hard to help you with the following Medicare questions or concerns:

- Your Medicare rights
- Billing problems
- Complaints about your medical care or treatment
- Plan choices
- How Medicare works with other insurance

**See pages 129–132 for the phone number of your local SHIP. If you would like to become a volunteer SHIP counselor, contact the SHIP in your state to learn more.**

Definitions of blue words are on pages 133–136.

## Where can I find Medicare information online?

### Need general information about Medicare?

**Visit www.medicare.gov**

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

### Need personalized Medicare information?

**Register at www.MyMedicare.gov**

- Complete your "Initial Enrollment Questionnaire" so your claims can get paid correctly.
- Manage your personal information (like medical conditions, allergies, and implanted devices).
- Sign up to get this handbook electronically. You won't get a printed copy if you choose to get it electronically.
- 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 Part B deductible status.
- View and order copies of your "Medicare Summary Notice."
- Get access to your personal health information by using Medicare's "Blue Button."

### Need help finding other health insurance options?

**Visit www.healthcare.gov**

- Take control of your health care with new information and resources that will help you access quality and affordable health coverage.
- Find public and private health coverage options tailored to your needs in a single easy-to-use tool.

## How do I 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 and safety of medical care and services given by most Medicare plans and health care providers. Medicare also has information about the experiences of people with the care and services they get.

Compare the quality of care (how well plans and providers work to give you the best care possible) 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 129–132 for the phone number.

When you, a family member, friend, or SHIP counselor visit www.medicare.gov, under "Resource Locator," select:

- "Hospital Compare"
- "Nursing Home Compare"
- "Home Health Compare"
- "Dialysis Facility Compare"
- "Physician Compare"
- "Medicare Plan Finder"

These search tools on www.medicare.gov give you a "snapshot" of the quality of care and services some plans and providers give. Medicare Plan Finder and Nursing Home Compare both feature a star rating system to help you compare plans and quality of care measures that are important to you. Find out more about the quality of care and services by:

- Asking what your plan or provider does to ensure and improve the quality of care and services. Each plan and health care provider should have someone you can talk to about quality.
- Asking your doctor or other health care provider what he or she thinks about the quality of care or services the plan or other providers give. You can also talk to your doctor or other health care provider about Medicare's information on quality of care and services.

Definitions of blue words are on pages 133–136.

## What's Medicare doing to better coordinate my care?

Medicare continues to look for ways to better coordinate your care and to make sure that you get the best health care possible. Health information technology (also called Health IT) and improved ways to deliver your care can help manage your health information, improve how you communicate with your health care providers, and improve the quality and coordination of your health care. These tools also reduce paperwork, medical errors, and health care costs.

Here are examples of how your **health care providers** can better coordinate your care:

**Electronic Health Records (EHRs)**—A record that your doctor, other health care provider, medical office staff, or a hospital keeps on a computer about your health care or treatments.

- EHRs can help lower the chances of medical errors, eliminate duplicate tests, and may improve your overall quality of care.
- Your doctor's EHR may be able to link to a hospital, lab, pharmacy, or other doctors, so the people who care for you can have a more complete picture of your health. You also have the right to get a copy of your health information for your own personal use and to make sure the information is complete and accurate.

**Electronic prescribing**—An electronic way for your prescribers (your doctor or other health care provider who is legally allowed to write prescriptions) to send your prescriptions directly to your pharmacy. Electronic prescribing can save you money, time, and help keep you safe.

- You don't have to drop off and wait for your prescription. Your prescription may be ready when you arrive.
- Prescribers can check which drugs your insurance covers and may be able to prescribe a drug that costs you less.
- Electronic prescriptions are easier for the pharmacist to read than handwritten prescriptions. This means there's less chance that you'll get the wrong drug or dose.
- Prescribers can be alerted to potential drug interactions, allergies, and other warnings.

**Accountable Care Organizations (ACOs)**—An ACO is a group of doctors and other health care providers who agree to work together with Medicare to give you the best possible care by making sure they have the most up-to-date information about you. ACOs are designed to help your providers work together more closely to give you a more coordinated patient-centered experience.

If you have Original Medicare and your doctor has decided to participate in an ACO, you'll be notified, either in person or by letter, that your doctor is participating in an ACO and that the ACO may request your personal health information to better coordinate your care. The notice will allow you to decline having your claims information shared with the ACO. Your Medicare benefits, services, and protections won't change, and you still have the right to use any doctor or hospital that accepts Medicare at any time, the same way you do now.

Definitions of blue words are on pages 133–136.

For more information, visit www.medicare.gov/acos.html or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

## Can I manage my health information online?

Here's what **you** can do to help manage your health information:

**Personal Health Records (PHRs)**—A record with information about your health that you or someone helping you keeps on a computer for easy reference.

- These tools can help you manage your health information from anywhere you have Internet access.
- With a PHR, you can keep track of health information, like the date of your last yearly "Wellness" visit, major illnesses, operations, allergies, or a list of your prescriptions.
- PHRs are often offered by providers, health plans, and private companies. Some are free, while others charge fees.
- When you use a PHR, make sure that it's on a secure website. With a secure website, you usually have to create a unique user ID and password, and the information you type is encrypted (put in code) so other people can't read it.
- Read the PHR's notice of privacy practices. It should tell you how the PHR is protecting your information and how it may use or disclose your information.

**Important!**

There are federal and state laws that protect the privacy and security of your information. PHRs that aren't sponsored or maintained by health plans or health care providers may not have to follow federal or state laws that protect the privacy of your health information.

## Are there other ways to get Medicare information?

### Publications

Visit www.medicare.gov/publications to view, print, or download copies of booklets, brochures, or fact sheets on different Medicare topics. You can search by keyword (like "rights" or "mental health"), or select "View All 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. Some publications are also available as podcasts that you can download and listen to.

### Videos

Visit www.YouTube.com/cmshhsgov to see videos covering different health care topics on Medicare's YouTube channel.

### Messages/Tweets

Follow official Medicare information at @CMSGov and the Children's Health Insurance Program at @IKNGov.

### Blogs

Visit http://blog.medicare.gov/feed/ or http://blog.cms.gov/feed/ for up-to-date news and activity information from our websites.

**Important!**

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

## Are resources available for caregivers?

Yes, Medicare has resources to help you get the information you need. To find out more:

- Visit "Ask Medicare" at www.medicare.gov/caregivers to help someone you care for choose a drug plan, compare nursing homes, get help with billing, and more.
- Sign up for the bi-monthly "Ask Medicare" electronic newsletter (e-Newsletter) when you go to www.medicare.gov/caregivers. The e-Newsletter has the latest information including important dates, Medicare changes, and resources in your community.
- Visit the Eldercare Locator, a public service of the U.S. Administration on Aging, at www.eldercare.gov, or call 1-800-677-1116 to find caregiver support services in your area.

## State Health Insurance Assistance Programs (SHIPs)

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

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# Section 11—Definitions

**Assignment**—An agreement by your doctor, other health care provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

**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're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

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

**Copayment**—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or 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's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

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

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

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

**Demonstrations**—Special projects, sometimes called "pilot programs" or "research studies," that test changes in Medicare coverage, payment, and quality of care. They usually operate for a limited time, for a specific group of people, and in specific areas.

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

**Formulary**—A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

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

**Institution**—For the purposes of this publication, an institution is a facility that provides short-term or long-term care, such as a nursing home, skilled nursing facility (SNF), or rehabilitation hospital. Private residences, such as an assisted living facility or group home, aren't considered institutions for this purpose.

**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.

**Long-term care**—A variety of services that help people with their medical and non-medical needs over a period of time. Long-term care can be provided at home, in the community, or in various other types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.

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

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

**Medicare-approved amount**—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

**Medicare health plan**—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and in some cases, plans available under Demonstration/Pilot Projects. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans that can be offered by public or private entities, and that provide Part D and other benefits in addition to Part A and Part B benefits.

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

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

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

**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.

**Primary care practitioner**—A doctor who has a primary specialty in family medicine, internal medicine, geriatric medicine, or pediatric medicine; or a nurse practitioner, clinical nurse specialist, or physician assistant.

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

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

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

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

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

## 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 at 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 129–132 for the phone 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.

Medicare cares about what you think. If you have general comments about this handbook, email us at medicareandyou@cms.hhs.gov. We can't respond to every comment, but we'll consider your feedback when writing future versions.

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- Available in Spanish, Braille, Audio CD, Large Print (English and Spanish). Also available as a podcast and e-book. Visit www.medicare.gov/publications for more information.
- 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 al 1-800-MEDICARE (1-800-633-4227).
Los usuarios de TTY deberán llamar al 1-877-486-2048.

If you need help in a language other than English or Spanish, call 1-800-MEDICARE and say "Agent." Then tell the customer service representative the language you need.

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

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