Large Print Edition

Medicare & You 2021

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

Centers for Medicare & Medicaid Services

What's new?

Coronavirus disease 2019 (COVID-19)

Medicare is committed to getting you the information you need on COVID-19. For the most up-to-date information on coverage and benefits, visit **Medicare.gov** or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Lower out-of-pocket costs for insulin

If you join a Medicare drug plan that participates in the "Part D Senior Savings Model," you could save hundreds of dollars each year in out-of-pocket costs for insulin. See page 210.

Medicare Advantage & End-Stage Renal Disease (ESRD)

If you have ESRD, you can join a **Medicare Advantage Plan** during Open Enrollment (October 15 – December 7, 2020). Your plan coverage will start January 1, 2021. See page 145.

Acupuncture for back pain

Medicare now covers up to 12 acupuncture visits in 90 days for chronic low back pain. See page 58.

Telehealth & other virtual services

Telehealth benefits allow you to get medical or health services that generally occur in-person (like office visits and consultations) from a doctor or other health care provider who's located elsewhere using real-time interactive audio and video technology (see page 112). Medicare also covers certain virtual services, like E-visits (see page 87) and Virtual check-ins (see page 118).

Get help with your Medicare coverage choices

Visit **Medicare.gov/plan-compare** to shop for and compare health and drug plans that meet your needs. You can also enter your drugs to get more accurate costs for plans in your area.

Compare health care providers & services

Visit **Medicare.gov** to find and compare doctors, hospitals, nursing homes, and other health care services near you. You can now get contact information, quality ratings, and other information in a centralized place.

Important!

This year it's more important than ever to get a **flu shot** to protect your health and your family's. See page 88.

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Get started

If you're new to Medicare:

- **Learn about your Medicare coverage options.** There are 2 main ways to get your Medicare coverage — Original Medicare (Part A and Part B) and Medicare Advantage. See the next few pages to learn more.
- **Find out how and when you can sign up.** If you don't have Medicare Part A or Part B, see Section 1, starting on page 21. If you don't have Medicare drug coverage (Part D), see Section 6, starting on page 185. There may be penalties if you don't sign up when you're first eligible.
- **If you have other health insurance,** see pages 33 – 35 to find out how your other insurance works with Medicare.

If you already have Medicare:

- **Review your Medicare health and drug coverage** and make changes if it no longer meets your needs, or if you could lower your out-of-pocket costs. You don't need to sign up for Medicare each year, but you should still review your options.

- **Mark your calendar with these important dates!** This may be the only chance you have each year to change your coverage.
  - **October 1, 2020: Start comparing your current coverage with other options.** You may be able to save money or get extra benefits. Visit **Medicare.gov/plan-compare**.
  - **October 15 to December 7, 2020: Change your Medicare health or drug coverage for 2021, if you decide to.** This includes changing to Original Medicare, or joining or changing a **Medicare Advantage Plan.**
  - **January 1, 2021: New coverage begins if you made a change.** If you kept your existing coverage and your plan's costs or benefits changed, those changes also start on this date.
  - **January 1 to March 31, 2021:** If you're in a Medicare Advantage Plan, you can change to a different Medicare Advantage Plan or switch to Original Medicare (and join a separate Medicare drug plan) once during this time. Any changes you make will be effective the first of the month after the plan gets your request. See page 144.

See pages 8 – 17 for an overview of your Medicare options.

What are the parts of Medicare?

Part A (Hospital Insurance)

Helps cover:

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

See pages 44 – 53.

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Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many **preventive services** (like screenings, shots or vaccines, and yearly "Wellness" visits)

See pages 54 – 121.

Part D (Drug coverage)

- Helps cover the cost of prescription drugs (including many recommended shots or vaccines).
- Plans that offer Medicare drug coverage are run by private insurance companies that follow rules set by Medicare.

See pages 185 – 216.

Your Medicare options

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- If you want drug coverage, you can join a separate Medicare drug plan (Part D).
- To help pay your out-of-pocket costs in Original Medicare (like your 20% **coinsurance**), you can also shop for and buy supplemental coverage.
- Can use any doctor or hospital that takes Medicare, anywhere in the U.S.

See Section 3 (starting on page 127) to learn more about Original Medicare.

Medicare Advantage (also known as Part C)

- Medicare Advantage is an “all in one” alternative to Original Medicare. These “bundled” plans include Part A, Part B, and usually Part D.
- Plans may have lower out-of-pocket costs than Original Medicare.
- In many cases, you’ll need to use doctors who are in the plan’s network.
- Most plans offer extra benefits that Original Medicare doesn’t cover—like vision, hearing, dental, and more.

See Section 4 (starting on page 137) to learn more about Medicare Advantage.

At a glance: Original Medicare vs. Medicare Advantage

Doctor & hospital choice

Original Medicare

- You can go to **any doctor or hospital that takes Medicare, anywhere in the U.S.**
- In most cases, you **don't need** a **referral** to see a specialist.

Medicare Advantage

- In many cases, you'll need to use **doctors and other providers who are in the plan's network and service area** for the lowest costs. Some plans won't cover services from providers outside the plan's network and service area.
- You **may need** to get a referral to see a specialist.

Cost

Original Medicare

- For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your **deductible**. This is called your **coinsurance**.
- You **pay a premium (monthly payment) for Part B**. If you choose to join a Medicare drug plan (Part D), you'll pay that premium separately.
- There's **no yearly limit** on what you pay out of pocket, unless you have supplemental coverage—like Medicare Supplement Insurance (Medigap).
- You **can get** Medigap to help pay your remaining out-of-pocket costs (like your 20% coinsurance). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage

- **Out-of-pocket costs vary**—plans may have lower out-of-pocket costs for certain services.
- You may **pay the plan's premium** in addition to the monthly **Part B premium**. (Most plans include drug coverage (Part D).) Plans may have a $0 premium or may help pay all or part of your Part B premiums.
- Plans have a **yearly limit** on what you pay out of pocket for services Medicare Part A and Part B covers. Once you reach your plan's limit, you'll pay nothing for services Part A and Part B covers for the rest of the year.
- You **can't buy and don't need** Medigap.

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Coverage

Original Medicare

- Original Medicare covers most **medically necessary** services and supplies in hospitals, doctors' offices, and other health care settings. Original Medicare doesn't cover some benefits like eye exams, most dental care, and routine exams (see page 122).
- You can join a **separate Medicare drug plan (Part D)** to get drug coverage.
- In most cases, you don't have to get a service or supply approved ahead of time for Original Medicare to cover it.

Medicare Advantage

- Plans must cover all of the medically necessary services that Original Medicare covers. Most plans offer **extra benefits that Original Medicare doesn't cover**—like some vision, hearing, dental, routine exams, and more. Plans can now cover more of these benefits (see page 137).
- **Drug coverage (Part D) is included in most plans.** In most types of **Medicare Advantage Plans**, you don't need to join a separate Medicare drug plan.
- In some cases, you have to get a service or supply approved ahead of time for the plan to cover it.

Travel

Original Medicare

- Original Medicare generally **doesn't cover care outside the U.S.** You may be able to buy a Medicare Supplement Insurance (Medigap) policy that covers care outside the U.S.

Medicare Advantage

- Plans generally **don't cover care outside the U.S.**

This book explains these topics in more detail:

- **Original Medicare:** See Section 3 (starting on page 127).
- **Medicare Advantage:** See Section 4 (starting on page 137).
- **Medicare drug coverage (Part D):** See Section 6 (starting on page 185).

Get the most out of Medicare

Get help choosing the coverage option that's right for you:

- Get free, personalized counseling from your State Health Insurance Assistance Program (SHIP)—see pages 288 – 294 for the phone number.
- Call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.
- Find and compare health and drug plans at **Medicare.gov/plan-compare**.

Get the most value out of your health care

We want to make sure you have the information you need to make the best decisions about your health care. This includes giving you access to accurate cost estimates and quality information up front, so you can compare and choose the providers and services that give you the most value.

Get free help with your Medicare questions

For general Medicare questions, visit **Medicare.gov**, or call 1 800 633 - 4227. See pages 269 – 294 to learn about other resources.

Get preventive services

Medicare covers many **preventive services** at no cost to you. Ask your doctor or other health care provider which preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits) you need. See pages 57 – 121 to learn more about which preventive services Medicare covers.

Get mental health & substance use disorder services

Medicare covers certain screenings, services, and programs that aid in the treatment and recovery of mental health and substance use disorders:

- **Alcohol misuse screening:** See page 60.
- **Behavioral health integration services (to manage conditions like depression or anxiety):** See page 63.
- **Counseling to prevent tobacco use & tobacco-caused disease:** See page 76.
- **Depression screening:** See page 77.
- **Mental health care:** See page 99.
- **Opioid use disorder treatment services:** See page 101.
- **Screening, Brief Intervention, & Referral to Treatment:** See page 108.

- **Telehealth:** See page 112.
- **Medication (coverage rules):** See pages 204 – 209.
- **Prescription safety checks:** See page 205.
- **Drug management programs:** See page 206.
- **Important tips if you're prescribed opioids:** See page 207.

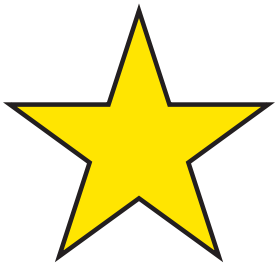
Get help paying for health care

See Section 7 (starting on page 219) to find out if you may qualify for help paying your health and drug costs.

Go paperless

Help save tax dollars and paper by switching to the electronic version of this handbook. You'll stop getting a paper copy each fall. Visit **Medicare.gov/gopaperless**, or log into your Medicare account online at **MyMedicare.gov** to switch to the electronic handbook. See page 270 for details.

Notes



Section 1: Signing up for Medicare

Who gets 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 have a disability, you'll automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months.

> If you live in Puerto Rico, you don't automatically get Part B. You must sign up for it. See page 24 for more information.

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 Social Security disability benefits begin.

Underlined words are defined on pages 295 – 302.

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 25th month of disability benefits. You don't need to pay a **premium** for Part A (sometimes called "premium-free Part A"). If you don't want Part B, let us know before the coverage start date on your Medicare card. If you do nothing, you'll keep Part B and will have to pay Part B premiums through your Social Security benefits. **If you choose not to keep Part B but decide you want it later, you may have to wait to enroll and pay a penalty for as long as you have Part B** (see page 37).

Note: If you need to replace your card because it's damaged or lost, log into your secure Medicare account online at **MyMedicare.gov** to print an official copy of your Medicare card. You can also use this account to manage your personal and other coverage information (like your drug list and claims status). If you don't have an account, visit **MyMedicare.gov** to create one. See page 273 for more information about **MyMedicare.gov**. If you need to replace your card because you think that someone else is using your number, call us at 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Who has 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, you'll need to sign up for Medicare. Contact Social Security 3 months before you turn 65. You can also apply for Part A and Part B at **socialsecurity.gov/benefits/medicare**. If you worked for a railroad, contact the RRB.

In most cases, if you don't sign up for Part B when you're first eligible, you may have a delay in getting Medicare coverage in the future (in some cases over a year), and **you may have to pay a late enrollment penalty for as long as you have Part B.** See page 37.

If you have End-Stage Renal Disease (ESRD) and you want Medicare, you'll need to sign up. Contact Social Security to find out when and how to sign up for Part A and Part B. For more information, visit **Medicare.gov/publications** to view the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

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 by completing an "Application for Enrollment in Part B Form" (CMS-40B). **Visit Medicare.gov/forms-help-resources/medicare-forms to get Form CMS-40B in English or Spanish.** 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 Part B** (see page 37).

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. TTY users can call 1 800 325 - 0778. If you worked for a railroad or get RRB benefits, call the RRB at 1 877 772 - 5772. TTY users can call 1 312 751 - 4701.

You can also get free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). See pages 288 – 294 for the phone number.

Once you're enrolled in Medicare you're not done yet.

People get coverage in different ways. You'll need to review all of your Medicare coverage options and find what best meets your needs. See pages 10 – 16 for more information.

If I didn't get enrolled in Part A and Part B automatically, when can I sign up?

If you didn't get automatically enrolled in **premium**-free Part A (for example, because you're still working and not yet getting Social Security or Railroad Retirement Board (RRB) benefits), you can sign up for premium-free Part A (if you're eligible) any time during or after your Initial Enrollment Period begins.

If you're eligible for **premium-free Part A**, you can enroll in Part A anytime after you're first eligible for Medicare. Your Part A coverage will go back (retroactively) 6 months from when you sign up, but no earlier than the first month you're eligible for Medicare. You can only sign up for Part B during the periods listed below.

Important!

Remember, in most cases, if you don't sign up for Part A (if you have to buy it) and Part B when you're first eligible, your enrollment may be delayed and you may have to pay a late enrollment penalty (see page 37).

What are the Part A and Part B sign up periods?

You can only sign up for Part B (or Part A if you have to buy it) during these enrollment periods.

Initial Enrollment Period

You can first 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 begins 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 and are paying for Part A and/or Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, the start date for your Part B coverage will be delayed.

Special Enrollment Period

After your Initial Enrollment Period is over, you may have a chance to sign up for Medicare during a Special Enrollment Period. If you didn't sign up for Part B (or Part A if you have to buy it) when you were first eligible because you have group health plan coverage based on current employment (your own, a spouse's, or a family member's—if you have a disability), 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

Usually, you don't pay a late enrollment penalty if you sign up during a Special Enrollment Period. This period doesn't apply if you're eligible for Medicare based on End-Stage Renal Disease (ESRD), or you're still in your Initial Enrollment Period.

Note: If you have a disability, and the group health plan coverage is based on a family member's current employment (other than a spouse), the employer offering the group health plan must have 100 or more employees for you to get a Special Enrollment Period.

Important!

COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, retiree health plans, VA coverage, and individual health coverage (like through the Health Insurance Marketplace) aren't considered coverage based on current employment. You aren't eligible for a Special Enrollment Period to sign up for Medicare when that coverage ends. To avoid paying a higher **premium**, make sure you sign up for Medicare when you're first eligible. See page 212 for more information about COBRA coverage.

General Enrollment Period

If you didn't sign up for Part A (if you have to buy it) and/or Part B (for which you must pay premiums) during your Initial Enrollment Period, and you don't qualify for a Special Enrollment Period, you can sign up during the General Enrollment Period between January 1 – March 31 each year. **Your coverage won't start until July 1 of that year, and you may have to pay a higher Part A and/or Part B premium for late enrollment.** See pages 35 – 38.

If you're not sure if you qualify for a Special Enrollment Period, or to learn more about enrollment periods, visit **Medicare.gov**, or call 1 800 633 - 4227. TTY users can call 1 877-486-2048.

Should I get Part B?

This information can help you decide if you should get Part B based on the type of health coverage you may have.

Employer or union coverage

If you or your spouse (or family member if you have a disability) **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 (see page 33). This includes federal or state employment and active-duty military service. It might be to your advantage to delay Part B enrollment.

Coverage based on current employment doesn't include:

- COBRA
- Retiree coverage
- VA coverage
- Individual health coverage (like through the Health Insurance Marketplace)

TRICARE

If you have TRICARE (health care program for active-duty and retired service members and their families), **you generally must enroll in Part A and Part B when you're first eligible to keep your TRICARE coverage.** However, if you're an active-duty service member or an active-duty family member, you don't have to enroll in Part B to keep your TRICARE coverage. For more information, contact TRICARE (see page 216).

If you have CHAMPVA coverage, you must enroll in Part A and Part B to keep it. Call 1 800 733 - 8387 for more information about CHAMPVA.

Medicaid

If you have Medicaid and don't have Part B, Medicaid may help you enroll. Medicare will pay first, and Medicaid will pay second. Medicaid may be able to help pay your Medicare out-of-pocket costs (like **premiums**, **deductibles**, **coinsurance**, and **copayments**).

Health Insurance Marketplace

Even if you have Marketplace coverage, you should enroll in Medicare when you're first eligible to avoid the risk of a delay in Medicare coverage and the possibility of a Medicare late enrollment penalty.

Here are some important points to consider if you have Marketplace coverage:

- You need to terminate (end) your Marketplace coverage in a timely manner to avoid an overlap in coverage.
- Once you're considered eligible for or enrolled in Part A, you won't qualify for help from the Marketplace to pay your Marketplace plan **premiums** or other medical costs. If you continue to get help to pay your Marketplace plan premiums after you have Medicare, you may have to pay back the help you got when you file your taxes.

Visit **HealthCare.gov** to connect to the Marketplace in your state and learn more. To find out how to end your Marketplace plan or Marketplace savings when your Medicare coverage begins, visit **HealthCare.gov/medicare/changing-from-marketplace-to-medicare**. You can also call the Marketplace Call Center at 1 800 318 - 2596. TTY users can call 1 855 889 - 4325.

Health Savings Accounts (HSA)

You can't contribute to your HSA once your Medicare coverage begins. However, you may use money that's already in your HSA after you enroll in Medicare to help pay for premiums (if you're billed directly), **deductibles**, **coinsurance**, or **copayments**. If you or your employer contribute to your HSA after your Medicare coverage begins, you may have to pay a tax penalty. If you'd like to continue contributing to your employer-sponsored HSA without penalty after you turn 65, you shouldn't apply for Medicare, Social Security, or Railroad Retirement Board (RRB) benefits.

To avoid a tax penalty, you should stop contributing to your HSA at least 6 months before you apply for Medicare. Remember, premium-free Part A coverage begins 6 months before the month you apply for Medicare (or Social Security/RRB benefits), but no earlier than the month you turn 65.

Compare tip

A Medicare Medical Savings Account (MSA) plan might be an option if you'd like to continue to get health benefits through a plan that's similar to an HSA plan. See page 153 for more information.

How does my other insurance work with Medicare?

When you have other insurance and Medicare, there are rules for whether Medicare or your other insurance pays first.

- If you have **retiree** insurance (insurance from your or your spouse's 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 **fewer than 20 employees**… Medicare pays first.
- If you're under 65 and have a disability, 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 have a disability, have group health plan coverage based on your or a family member's **current** employment, and the employer has **fewer than 100 employees**… Medicare pays first.

- If you have group health plan coverage based on your or a family member's employment, and you're eligible for 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.
- If you have Medicaid... Medicare pays first.

Here are some important facts to remember about how other insurance works with Medicare-covered services:

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

Visit **Medicare.gov/publications** to view the booklet, "Medicare and Other Health Benefits: Your Guide to Who Pays First." You can also call 1 800 633 - 4227 for more information. TTY users can call 1 877 486 - 2048.

Important!

If you have other insurance or changes to your insurance, you need to let Medicare know by calling Medicare's Benefits Coordination & Recovery Center at 1 855 798 - 2627. TTY users can call 1 855 797 - 2627.

If you have Part A, you may get a "Health Coverage" form (IRS Form 1095-B) from Medicare. This form verifies that you had health coverage in the past year. Keep the form for your records. Not everyone will get this form. If you don't get Form 1095-B, don't worry, you don't need to have it to file your taxes.

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 for a certain amount of time. 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.

People who buy Part A will pay a premium of either $252 or up to $458 each month in 2020* depending on how long they or their spouse worked and paid Medicare taxes. If you think you need help paying your Part A premium, see pages 226 – 230.

*The **2021** Part A premium amounts weren't available at the time of printing. To get the most up-to-date cost information, visit **Medicare.gov** later this fall.

In most cases, if you choose to **buy** Part A, you must also have Part B and pay monthly premiums for both. If you choose NOT to buy Part A, you can still buy Part B.

What's 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 a 10% higher premium for 4 years.

How much does Part B coverage cost?

The standard Part B **premium** amount in 2020* is $144.60. Most people pay the standard Part B premium amount.

*The **2021** Part B premium amount wasn't available at the time of printing. To get the most up-to-date cost information, visit **Medicare.gov** later this fall.

If your modified adjusted gross income is above a certain amount, you may pay an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium.

To determine if you'll pay the IRMAA, Medicare uses the modified adjusted gross income reported on your IRS tax return from 2 years ago.

Note: You may also pay an extra amount for your drug coverage (Part D) premium if your modified adjusted gross income is above a certain amount (see page 193).

If you have to pay an extra amount and you disagree (for example, your income is lower due to a life event), visit **socialsecurity.gov** or call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778.

What's the Part B late enrollment penalty?

Important!

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 Part B. Your monthly Part B premium may go up 10% for each 12 month-period that you could've had Part B, but didn't sign up. If you're allowed to sign up for Part B during a Special Enrollment Period, you usually don't pay a late enrollment penalty (see page 27).

Example: Mr. Smith's Initial Enrollment Period ended December 2017. He waited to sign up for Part B until March 2020 during the General Enrollment Period. His coverage begins July 1, 2020. His Part B premium penalty is 20%, and he'll have to pay this penalty for as long as he has Part B. (Even though Mr. Smith wasn't covered a total of 27 months, this included only 2 full 12-month periods.)

Shopping tip

To learn how to get help with Medicare costs, see Section 7 (starting on page 219).

How can I pay my Part B premium?

If you get Social Security or Railroad Retirement Board (RRB) benefits, your Part B premium will be deducted from your benefit payment.

If you're a federal retiree with an annuity from the Office of Personnel Management and not entitled to RRB or Social Security benefits, you may request to have your Part B premiums deducted from your annuity. Call 1 800 633 - 4227 to make your request. TTY users can call 1 877 486 - 2048.

If you don't get these benefit payments, you'll get a bill. If you choose to buy Part A, you'll always get a bill for your **premium**. There are 4 ways to pay these bills:

1. **Pay online by credit card, debit card, savings or checking account.** To do this, log into your secure Medicare account (or create an account) online at **MyMedicare.gov**. Paying online is a more secure and faster way to make your payment without sending your personal information in the mail. You'll get a confirmation number when you make your payment.
2. **Pay directly from your savings or checking account through your bank's Online Bill Payment services.** Ask your bank if it allows customers to pay bills online—not all banks offer this service and some may charge a fee. You'll need to give your bank this information:
   - **Your Medicare Number:** It's important that you use the exact number on your red, white, and blue Medicare card, but without the dashes.
   - **Payee name:** CMS Medicare Insurance
   - **Payee address:**
     Medicare Premium Collection Center
     PO Box 790355
     St. Louis, MO 63179-0355

3. **Sign up for Medicare Easy Pay.** This is a free service that automatically deducts your premium payments from your savings or checking account each month. Visit **Medicare.gov** and search for "Easy Pay," or call 1 800 633 - 4227 to find out how to sign up. TTY users can call 1 877 486 - 2048.
4. **Mail your payment to Medicare.** You can pay by check, money order, credit card, or debit card. Write your Medicare Number on your payment, and fill out your payment coupon. Mail your payment and coupon to:
   Medicare Premium Collection Center
   PO Box 790355
   St. Louis, MO 63179-0355

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

RRB Medicare Premium Payments
PO Box 979024
St. Louis, MO 63197-9000

If you have questions about your premiums, call 1 800 633 - 4227. If you need to change your address on your bill, call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778. If your bills are from the RRB, call 1 877 772 - 5772. TTY users can call 1 312 751 - 4701.

If you'd like more information about paying your Medicare premiums, visit **Medicare.gov**.

Important!

Need help paying your Part B premium? See pages 226 – 230.

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Notes

Section 2: Find out if Medicare covers your test, item, or service

What services does Medicare cover?

Medicare Part A and Part B cover certain medical services and supplies in hospitals, doctors' offices, and other health care settings. Medicare Part D covers prescription drugs.

Your red, white, and blue Medicare card shows whether you have Part A (listed as HOSPITAL), Part B (listed as MEDICAL), or both, and the date your coverage begins. If you have Original Medicare, you'll use it to get your Medicare-covered services. If you join a **Medicare Advantage Plan** or other **Medicare health plan**, in most cases, you'll use your plan's card to get your Medicare-covered services.

You can get all of the Medicare-covered services in this section if you have both Part A and Part B.

Underlined words are defined on pages 295 – 302.

What does Part A cover?

Part A (Hospital Insurance) helps cover:

- Inpatient care in a hospital
- Inpatient care in a skilled nursing facility **(not custodial or long-term care)**
- Hospice care
- Home health care
- Inpatient care in a religious non-medical health care institution

See pages 46 – 53 for a list of common services Part A covers and general descriptions.

Shopping tip

Find out what's covered on your mobile device

To get Medicare coverage information, download Medicare's free "What's covered" mobile app on the App Store or Google Play.

What do I pay for services Part A covers?

Copayments, **coinsurance**, or **deductibles** may apply for each service listed on the following pages. Visit **Medicare.gov** later this fall to find out how much you'll pay in 2021.

If you're in a Medicare Advantage Plan or have other insurance (like Medigap, Medicaid, or employer or union coverage), your copayments, coinsurance, or deductibles may be different. Visit **Medicare.gov/plan-compare** or contact the plans you're interested in to find out about costs. Or, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

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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 someone else donate the blood.

Home health services

Part A and/or Part B covers home health benefits. See page 94 for more information.

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Hospice care

To qualify for hospice care, a hospice doctor and your doctor (if you have one) must certify that you're terminally ill, meaning you have a life expectancy of 6 months or less. When you agree to hospice care, you're agreeing to comfort care (palliative care) instead of care to cure your illness. You also must sign a statement choosing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions. Coverage includes:

- All items and services needed for pain relief and symptom management
- Medical, nursing, and social services
- Drugs for pain management
- Durable medical equipment for pain relief and symptom management
- Aide and homemaker services
- Other covered services you need to manage your pain and other symptoms, as well as spiritual and grief counseling for you and your family.

Medicare-certified hospice care is usually given in your home or other facility where you live, like a nursing home.

Medicare won't pay room and board for your care in a facility unless the hospice medical team decides you need short-term inpatient care to manage pain and other symptoms. This care must be in a Medicare-approved facility, like a hospice facility, hospital, or skilled nursing facility that 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 (family member or friend) can rest. You can stay up to 5 days each time you get respite care.

After 6 months, you can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies (at a face-to-face meeting) that you're still terminally ill.

You pay:

- Nothing for hospice care.
- A **copayment** of up to $5 per prescription for outpatient drugs for pain and symptom management.
- Five-percent of the **Medicare-approved amount** for inpatient respite care.

Original Medicare will be billed for your hospice care, even if you're in a **Medicare Advantage Plan**.

Inpatient hospital care

Medicare covers semi-private rooms, meals, general nursing, drugs (including methadone to treat an opioid use disorder), and other hospital services and supplies as part of your inpatient treatment. This includes care you get in acute care hospitals, **critical access hospitals**, **inpatient rehabilitation facilities**, **long-term care hospitals**, psychiatric care in inpatient psychiatric facilities, and inpatient care for a qualifying clinical research study. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), personal care items (razors or slipper socks), and a private room, unless **medically necessary**.

If you also have Part B, it generally covers 80% of the Medicare-approved amount for doctor's services you get while you're in a hospital.

You pay:

- A **deductible** and no **coinsurance** for days 1 – 60 of each **benefit period**.
- A coinsurance amount per day for days 61 – 90 of each benefit period.
- A coinsurance amount per "**lifetime reserve day**" after day 90 of each benefit period (up to 60 days over your lifetime).
- All costs for each day after you use all the lifetime reserve days.

You can only get inpatient psychiatric care in a freestanding psychiatric hospital 190 days in a lifetime.

Note: Starting January 1, 2021, hospitals are required to make public the standard charges for all of their items and services (including charges negotiated by Medicare Advantage Plans) to help you make more informed decisions about your care.

Am I an inpatient or outpatient?

Whether you're an inpatient or an outpatient affects how much you pay for hospital services and if you qualify for Part A skilled nursing facility coverage.

- You're an inpatient when the hospital formally admits you with a doctor's order.
- You're an outpatient if you're getting emergency or observation services, lab tests, or X-rays, without a formal inpatient admission (even if you spend the night in the hospital).

Each day you have to stay, you or your caregiver should always ask the hospital and/or your doctor, or a hospital social worker or patient advocate if you're an inpatient or outpatient.

Sometimes doctors will keep you as an outpatient for observation services while they decide whether to admit you as an inpatient or release (discharge) you. If you're under observation more than 24 hours, you must get a "Medicare Outpatient Observation Notice" (also called "MOON"). This notice tells you why you're an outpatient (in a hospital or **critical access hospital**) getting observation services, and how it affects what you pay in the hospital and for care after you leave.

Religious non-medical health care institution (inpatient care)

If you qualify for inpatient hospital or **skilled nursing facility care** in these facilities, Medicare will only cover inpatient, non-religious, non-medical items and services like room and board, and items or services that don't need a doctor's order or prescription (like unmedicated wound dressings or use of a simple walker). Medicare doesn't cover the religious portion of this type of care.

Skilled nursing facility care

Medicare covers semi-private rooms, meals, skilled nursing and therapy services, and other **medically necessary** services and supplies in a skilled nursing facility. Medicare only covers these services after a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. If you're in a **Medicare Advantage Plan**, you may not need a 3-day hospital stay. Check with your plan. (**Note:** You may not need a 3-day minimum inpatient hospital stay if your doctor participates in an Accountable Care Organization (or in an entity participating in another type of Medicare initiative) approved for a Skilled Nursing Facility 3-Day Rule Waiver. See page 281.)

You may get skilled nursing or therapy care coverage if it's necessary to improve or maintain your current condition. If the facility decides to discharge you based solely on a lack of improvement, and not because you no longer require skilled nursing or therapy care, you can appeal. See page 244 for your rights when you think you're being discharged too soon.

To qualify for skilled nursing facility care coverage, your doctor must certify that you need daily skilled care (like intravenous fluids/medications or physical therapy) which, as a practical matter, you can only get as a skilled nursing facility inpatient. Medicare doesn't cover long-term care (see page 123) or **custodial care**.

You pay:

- Nothing for the first 20 days of each **benefit period**.
- A **coinsurance** amount per day for days 21 – 100 of each benefit period.
- All costs for each day after day 100 in a benefit period.

What does Part B cover?

Medicare Part B (Medical Insurance) helps cover **medically necessary** doctor's services, outpatient care, home health services, durable medical equipment, mental health services, and other medical services. Part B also covers many **preventive services**. See pages 57 – 121 for 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 or treat a condition. To find out if Medicare covers a service not on this list, visit **Medicare.gov/coverage**, or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Shopping tip

Find out what's covered on your mobile device

You can also download Medicare's free "What's covered" mobile app on the App Store or Google Play to get Medicare coverage information.

What do I pay for services Part B covers?

The list of covered services (in alphabetical order 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** (see page 133). You'll pay more if you see doctors or providers who don't accept assignment. **If you're in a Medicare Advantage Plan or have other insurance (like Medigap, Medicaid, or employer or union coverage), your copayments, coinsurance, or deductibles may be different.**

Under Original Medicare, if the Part B deductible ($198 in 2020) applies, you must pay all costs (up to the **Medicare-approved amount**) until you meet the yearly Part B deductible. Visit **Medicare.gov** later this fall to get the 2021 Part B deductible. After you meet your deductible, Medicare begins to pay its share and 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 on what you pay out-of-pocket.** There may be limits on supplemental coverage you may have, like Medigap, Medicaid, or employer or union coverage.

You pay nothing for most covered 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. These costs may also apply if you get a preventive service in the same visit as a non-preventive service.

Compare tip

Medicare Advantage Plans have a yearly limit on what you pay out-of-pocket for medical services. See pages 147 – 149 to learn more and to find out what affects your Medicare Advantage Plan costs.

Part B-covered services

Abdominal aortic aneurysm screening — This is a preventive service.

Medicare covers a one-time abdominal aortic aneurysm screening ultrasound for people at risk (only with a **referral** from your doctor or other qualified health care provider). You pay nothing for the screening if the doctor or other qualified health care practitioner accepts **assignment**.

Note: If you have a family history of abdominal aortic aneurysms, or you're a man 65 – 75 who smoked at least 100 cigarettes in your lifetime, you're considered at risk.

Acupuncture for back pain

Medicare covers up to 12 acupuncture visits in 90 days for chronic low back pain defined as:

- Lasting 12 weeks or longer
- Having no known cause (not related to cancer that has spread, inflammatory, or infectious disease)
- Pain not associated with surgery or pregnancy

Medicare covers an additional 8 sessions if you show improvement. If your doctor decides your chronic low back pain isn't improving or is getting worse, then Medicare won't cover your treatments. No more than 20 acupuncture treatments can be given yearly.

Note: Medicare doesn't cover acupuncture for any condition other than chronic low back pain.

Advance care planning

Medicare covers voluntary advance care planning as part of the yearly "Wellness" visit (see page 120). This is planning for care you would want to get if you become unable to speak for yourself. You can talk about an advance directive with your health care provider, and they can help you fill out the forms, if you want to. An advance directive is an important legal document that records your wishes about medical treatment at a future time, if you're not able to make decisions about your care. Consider carefully who you want to speak for you and what directions you want to give. You shouldn't feel forced to go against your values and preferences, and you have the right to carry out your plans without discrimination based on your age or disability. You can update your advance directive at any time. You pay nothing if it's provided as part of the yearly "Wellness" visit and the doctor or other qualified health care provider accepts assignment.

Note: Medicare may also cover this service as part of your medical treatment. When advance care planning isn't part of your yearly "Wellness" visit, the Part B **deductible** and **coinsurance** apply.

Need help with your advance directive? Visit the Eldercare Locator at **eldercare.acl.gov** to find help in your community.

Alcohol misuse screening & counseling — This is a preventive service.

Medicare covers one alcohol misuse screening per year for adults with Medicare (including pregnant women) who use alcohol, but don't meet the medical criteria for alcohol dependency. If your health care provider 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). You must get counseling in a primary care setting (like a doctor's office). You pay nothing if the doctor or other qualified health care provider 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.

In some cases, Medicare may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is medically necessary. For example, someone with End-Stage Renal Disease (ESRD) may need a medically necessary ambulance transport to a facility.

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.

Ambulatory surgical centers

Medicare covers the facility service fees related to approved surgical procedures provided 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 if the doctor or other health care provider accepts assignment), you usually pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you. The Part B deductible applies. You pay all of the facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.

Shopping tip

Visit **Medicare.gov/procedure-price-lookup** to get cost estimates for ambulatory surgical center outpatient procedures.

Behavioral health integration services

If you have a behavioral health condition (like depression, anxiety, or another mental health condition), Medicare may pay your provider to help manage that condition if they offer the Psychiatric Collaborative Care Model. This model is a set of integrated behavioral health services, including care management support that may include:

- Care planning for behavioral health conditions
- Ongoing assessment of your condition
- Medication support
- Counseling
- Other treatment your provider recommends

Your health care provider will ask you to sign an agreement for you to get this set of services on a monthly basis. You pay a monthly fee, and the Part B **deductible** and **coinsurance** apply.

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 each unit of blood you get. 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 you or someone else can donate the blood.

Bone mass measurement (bone density) — This is a preventive service.

This test helps to see if you're at risk for broken bones. Medicare covers it 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 (mammogram) — This is a preventive service.

Medicare covers a mammogram screening to check for breast cancer once every 12 months for all women with Medicare who are 40 and older. Medicare covers one baseline mammogram for women between 35 – 39. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

Note: Part B also covers diagnostic mammograms more frequently than once a year when medically necessary. You pay 20% of the **Medicare-approved amount** for diagnostic mammograms. The Part B deductible applies.

- End of Page

Cardiac rehabilitation

Medicare covers comprehensive programs that include exercise, education, and counseling for patients who meet at least one of these conditions:

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

Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. Medicare covers services in a doctor's office or hospital outpatient setting. You pay 20% of the Medicare-approved amount if you get the services in a doctor's office, and a **copayment** in a hospital outpatient setting. The Part B **deductible** applies.

Cardiovascular disease (behavioral therapy) — This is a preventive service.

Medicare will cover one visit per year with a **primary care doctor** or other qualified provider in a primary care setting (like a doctor's office) to help lower your risk for cardiovascular disease. During this visit, the doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to help you eat well. You pay nothing if the doctor or other qualified health care provider accepts **assignment**.

Cardiovascular disease screenings — This is a preventive service.

These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. Medicare covers these screening tests once every 5 years to test your cholesterol, lipid, lipoprotein, and triglyceride levels. You pay nothing for the tests if the doctor or other qualified health care provider accepts assignment.

Cervical & vaginal cancer screenings — This is a preventive service.

Part B covers Pap tests and pelvic exams to check for cervical and vaginal cancers. Medicare also covers a clinical breast exam to check for breast cancer as part of the pelvic exam. 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.

Part B also covers Human Papillomavirus (HPV) tests (when received with a Pap test) once every 5 years if you're 30 – 65 without HPV symptoms.

You pay nothing for the lab Pap test, the lab HPV with Pap test, the Pap test specimen collection, and pelvic and breast exams 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. You pay a **copayment** for chemotherapy in a hospital outpatient setting.

You pay 20% of the **Medicare-approved amount** for chemotherapy in a doctor's office or freestanding clinic. The Part B **deductible** applies.

For chemotherapy in an inpatient hospital setting covered under Part A, see Inpatient hospital care on pages 49 – 51.

- End of Page

Chiropractic services (limited coverage)

Medicare covers manipulation of the spine if **medically necessary** to correct a subluxation (when one or more of the bones of your spine move out of position) when a chiropractor or other qualified provider does the procedure. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

Note: Medicare doesn't cover other services or tests ordered by a chiropractor, including X-rays, massage therapy and acupuncture (except for low back pain). If you think your chiropractor is billing for services that Medicare doesn't cover, you can call 1 800 633 - 4277 to report the suspected Medicare fraud. TTY users can call 1 877 486 - 2048.

Chronic care management services

If you have 2 or more serious chronic conditions (like arthritis and diabetes) that you expect to last at least a year, Medicare may pay for a provider's help to manage those conditions. This includes a comprehensive care plan that lists your health problems and goals, other providers, medications, community services you have and need, and other health information. It also explains the care you need and how it will be coordinated.

Once you agree to get this service, your provider will prepare the care plan, help you with medication management, provide 24/7 access for urgent care management needs, give you support when you go from one health care setting to another, review your medicines and how you take them, and help you with other chronic care needs. You pay a monthly fee, and the Part B deductible and **coinsurance** apply. For more information, visit **Medicare.gov/coverage/chronic-care-management-services**.

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. The Part B deductible may apply.

Note: If you're in a **Medicare Advantage Plan**, Original Medicare may cover some costs along with your Medicare Advantage Plan.

Colorectal cancer screenings — This is a preventive service.

Medicare covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. One or more of these screening tests may be covered:

- **Multi-target stool DNA test:** Medicare covers this at home lab test generally once every 3 years. To be eligible you must:
  - Be between 50 – 85.
  - Show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test.
  - Be at average risk for developing colorectal cancer, meaning you:
    - Have no personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
    - Have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

You pay nothing for the test if the doctor or other qualified health care provider accepts **assignment**.

- **Fecal occult blood test:** Medicare covers this test 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.
- **Flexible sigmoidoscopy:** Medicare covers this test generally 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.
- **Colonoscopy:** Medicare covers this test generally once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There's no minimum age. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

  Note: If your doctor finds and removes a polyp or other tissue 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. The Part B **deductible** doesn't apply.

- **Barium enema:** Medicare covers this test generally once every 48 months if you're 50 or older (high risk every 24 months) when your doctor uses it instead of a flexible sigmoidoscopy or colonoscopy. You pay 20% of the Medicare-approved amount for doctor services. In a hospital outpatient setting, you also pay the hospital a copayment. The Part B deductible doesn't apply.

Continuous Positive Airway Pressure (CPAP) therapy

Medicare may cover a 3-month trial of CPAP therapy if you've been diagnosed with obstructive sleep apnea. Medicare may cover it longer if you meet with your doctor, generally in person, and your doctor documents in your medical record that the CPAP therapy is helping you.

You pay 20% of the **Medicare-approved amount** for rental of the machine and purchase of related accessories (like masks and tubing). The Part B **deductible** applies. Medicare pays the supplier to rent the machine for 13 months if you've been using it without interruption. After you've rented the machine for 13 months, you own it.

Note: Medicare may cover rental or a replacement CPAP machine and/or CPAP accessories if you had a CPAP machine before you got Medicare, and you meet certain requirements.

Counseling to prevent tobacco use & tobacco-caused disease — This is a preventive service.

Medicare covers up to 8 face-to-face visits in a 12-month period. Medicare covers all people with Medicare who use tobacco. You pay nothing for the counseling sessions if the doctor or other qualified health care provider accepts **assignment**.

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 a **copayment**. In most cases, the copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies. Part A covers surgeries to implant defibrillators in an inpatient hospital setting. See Inpatient hospital care on pages 49 – 51.

Depression screening — This is a preventive service.

Medicare covers one 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 screening if the doctor or other qualified health care provider accepts assignment.

Diabetes Prevention Program — This is a preventive service.

Medicare covers a once-per-lifetime health behavior change program to help you prevent type 2 diabetes. The program begins with weekly core sessions in a group setting over a 6-month period. In these sessions, you'll get:

- Training to make realistic, lasting behavior changes around diet and exercise.
- Tips on how to get more exercise.
- Strategies to control your weight.
- A specially trained coach to help keep you motivated.
- Support from people with similar goals and challenges.

Once you complete the core sessions, you'll get:

- 6 monthly follow-up sessions to help you maintain healthy habits.
- An additional 12 monthly ongoing maintenance sessions if you meet certain weight loss and attendance goals.

To be eligible, you must have:

- Medicare Part B (or a **Medicare Advantage Plan**).
- A hemoglobin A1c test result between 5.7% and 6.4%, a fasting plasma glucose of 110-125mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test) within 12 months prior to attending the first core session.
- A body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian).
- Never been diagnosed with type 1 or type 2 diabetes, or End-Stage Renal Disease (ESRD).
- Never participated in the Medicare Diabetes Prevention Program.

You pay nothing for these services if eligible. Visit **Medicare.gov/contacts** to see if there's a Medicare Diabetes Prevention Program supplier in your area.

Diabetes screenings — This is a preventive service.

Medicare covers up to 2 glucose laboratory test screenings (with and without a carbohydrate challenge) each year if your doctor determines you're at risk for developing diabetes. You pay nothing for the test if your doctor or other qualified health care provider accepts **assignment**.

Diabetes self-management training — This is a preventive service.

Medicare covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medicine, and reducing risks. Some patients may also be eligible for medical nutrition therapy training. You must have diabetes and a written order from your doctor or other qualified health care provider who's treating your diabetes. You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies.

Diabetes equipment & supplies & therapeutic shoes

Medicare covers meters that measure blood glucose (also called sugar) and related supplies, including test strips, lancets, lancet holders, and control solutions. Medicare also covers tubing, insertion sets, and insulin for patients using insulin pumps, and sensors for patients using continuous glucose monitors. In addition, Medicare covers one pair of extra-depth or custom shoes and inserts per year for people with specific diabetes-related foot problems. You pay 20% of the Medicare-approved amount if your supplier accepts assignment. The Part B deductible applies.

Note: Medicare drug coverage (Part D) may cover insulin, certain medical supplies used to inject insulin (like syringes), disposable pumps, and some oral diabetes drugs. Check with your plan for more information.

Doctor & other health care provider services

Medicare covers **medically necessary** doctor services (including outpatient services and some inpatient hospital doctor services) and covered **preventive services**. Medicare also covers services you get from other health care providers, like physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical social workers, physical therapists, and clinical psychologists. Except for certain preventive services (for which you may pay nothing if your doctor or other provider accepts **assignment**), you pay 20% of the Medicare-approved amount for most services. The Part B **deductible** applies.

Drugs (limited)

Medicare Part B covers a limited number of drugs like injections you get in a doctor's office, certain oral anti-cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump), immunosuppressant drugs (see page 115), and, under very limited circumstances, certain drugs you get in a hospital outpatient setting. For some drugs used with an external infusion pump, Medicare may also cover services (like nursing visits) under the home infusion therapy benefit (see page 95). Part B also covers some injectable or implantable drugs to treat opioid use disorder when a provider administers it in a doctor's office or a hospital as an outpatient (you won't have to pay any **copayments** for these services if you get them from a Medicare enrolled opioid treatment program, see page 101). You pay 20% of the **Medicare-approved amount** for these covered drugs, and the Part B deductible applies.

If the covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay a copayment for the services. However, Part B doesn't cover other types of drugs in a hospital outpatient setting (sometimes called "self-administered drugs" or drugs you'd normally take on your own). What you pay depends on whether you have Medicare drug coverage or other drug coverage, whether your drug plan covers the drug, and whether the hospital's pharmacy is in your drug plan's network. Contact your drug plan to find out what you pay for drugs you get in a hospital outpatient setting that Part B doesn't cover.

Other than the examples above, you pay 100% for most drugs, unless you have Medicare drug coverage or other drug coverage. See pages 185 – 217 for more information about Medicare drug coverage.

Durable medical equipment (DME)

Medicare covers items like oxygen and oxygen equipment, wheelchairs, walkers, and hospital beds when a Medicare-enrolled doctor or other health care provider orders for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Make sure your doctors and DME suppliers are enrolled in Medicare. It's important to ask your suppliers if they participate in Medicare before you get DME. If suppliers are participating suppliers, they must accept assignment (which means, they can charge you only the **coinsurance** and Part B deductible for the **Medicare-approved amount**). If suppliers aren't participating and don't accept assignment, there's no limit on the amount they can charge you. Medicare won't pay claims for doctors or suppliers who aren't enrolled in Medicare.

Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program: If you live in or visit a competitive bidding area and need a DMEPOS item that's included in the DMEPOS Competitive Bidding Program, you generally must use specific suppliers called "contract suppliers," if you want Medicare to help pay for the item. Contract suppliers are required to provide the item to you and accept **assignment** as a term of their contract with Medicare.

Visit **Medicare.gov/supplierdirectory** to see if you live in or are visiting a competitive bidding area, or to find suppliers who accept assignment. You can also call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. You can also call 1 800 633 - 4227 if you're having problems with your DME supplier, or you need to file a complaint.

Visit **Medicare.gov/publications** to view the booklet, "Medicare Coverage of Durable Medical Equipment and Other Devices."

EKG or ECG (electrocardiogram) screening

Medicare covers a one-time EKG/ECG screening if your doctor or other health care provider refers you as part of your one-time "Welcome to Medicare" visit (see page 119). You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies. Medicare also covers an EKG/ECG as a diagnostic test (see page 113). You also pay a **copayment** if you have the test at a hospital or a hospital-owned clinic.

Emergency department services

Medicare covers these services when you have an injury, a sudden illness, or an illness that quickly gets much worse. You pay a **copayment** for each hospital emergency department visit, and 20% of the Medicare-approved amount for doctor or other health care provider services. The Part B deductible applies. If your doctor admits you to the same hospital as an inpatient, your costs may be different.

E-visits

Medicare covers E-visits to allow you to talk with your doctor using an online patient portal without going to the doctor's office. Providers who can offer these services include doctors, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech language pathologists, licensed clinical social workers, and clinical psychologists.

You must talk to your doctor or other provider to start these types of services.

Eyeglasses (after cataract surgery)

Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after each cataract surgery that implants an intraocular lens. You pay 20% of the **Medicare-approved amount**, and the Part B deductible applies.

Note: Medicare will only pay for contact lenses or eyeglasses provided by a Medicare-enrolled supplier, whether you or your provider submits the claim.

Federally Qualified Health Center services

Federally Qualified Health Center services provide many outpatient primary care and preventive health services. There's no **deductible**, and generally, you're responsible for paying 20% of the charges. You pay nothing for most **preventive services**. All Federally Qualified Health Centers offer discounts if your income is limited. Visit **findahealthcenter.hrsa.gov** to find a health center near you.

Flu shots — This is a preventive service.

Medicare covers one flu shot (or vaccine) per flu season. You pay nothing for the flu shot if the doctor or other qualified health care provider accepts **assignment** for giving the shot.

Foot exams & treatment

Medicare covers yearly foot exams if you have diabetes-related lower leg nerve damage that can increase the risk of limb loss. This may include treatment for foot ulcers and calluses, and toenail management, based on exam results. You pay 20% of the **Medicare-approved amount**, and the Part B deductible applies. You also pay a **copayment** in a hospital outpatient setting.

Glaucoma tests — This is a preventive service.

Medicare covers these tests 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's legally allowed by the state must do the tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. You also pay a copayment in a hospital outpatient setting.

Hearing & 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. You also pay a copayment in a hospital outpatient setting.

Note: Original Medicare doesn't cover hearing aids or exams for fitting hearing aids.

Hepatitis B shots — This is a preventive service.

Medicare covers these shots (or vaccines) for people at medium or high risk for Hepatitis B. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, if you live with someone who has Hepatitis B, or if you're a health care worker and have frequent contact with blood or body fluids. Check with your doctor to see if you're at medium or high risk for Hepatitis B. You pay nothing for the shot if the doctor or other qualified health care provider accepts assignment.

Hepatitis B Virus infection screening — This is a preventive service.

Medicare covers this screening if you meet one of these conditions:

- You're at high risk for Hepatitis B Virus infection.
- You're pregnant.

Medicare will only cover this screening if your primary care provider orders it.

Medicare covers Hepatitis B Virus infection screenings:

- Yearly only for those with continued high risk who don't get a Hepatitis B shot.
- For pregnant women:
  - At the first prenatal visit for each pregnancy.
  - At the time of delivery for those with new or continued risk factors.
  - At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative Hepatitis B Virus screening results.

You pay nothing for the screening test if the doctor or other qualified health care provider accepts **assignment**.

Hepatitis C screening test — This is a preventive service.

Medicare covers one Hepatitis C screening test if you meet one of these conditions:

- You're at high risk because you have a current or past history of illicit injection drug use.
- You had a blood transfusion before 1992.
- You were born between 1945 – 1965.

Medicare also covers yearly repeat screenings for certain people at high risk.

Medicare will only cover a Hepatitis C screening tests if your health care provider orders one. You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment.

HIV (Human Immunodeficiency Virus) screening — This is a preventive service.

Medicare covers HIV screenings once every 12 months if you're:

- Between 15 – 65.
- Younger than 15 or older than 65, and at increased risk.

Medicare also covers this test 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.

Home health services

Medicare covers home health services under Part A and/or Part B. Medicare covers **medically necessary** part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, or continued occupational therapy services. A doctor, or other health care provider, must see you face-to-face before certifying that you need home health services. A doctor or other provider must order your care, and a Medicare-certified home health agency must provide it.

Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be "homebound," which means:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.
- Leaving your home isn't recommended because of your condition.
- You're normally unable to leave your home because it's a major effort.

You pay nothing for covered home health services. However, for Medicare-covered durable medical equipment, you pay 20% of the **Medicare-approved amount**. The Part B **deductible** applies.

Home infusion therapy services

Medicare covers equipment and supplies (like a pump, IV pole, tubing and catheters) for home infusion therapy to administer certain IV infusion drugs to a patient at home. Certain equipment and supplies (like the infusion pump) and the infusion drug are covered under the Durable Medicare Equipment benefit (see page 84). Medicare also covers services (like nurse visits), training for patients or caregivers, and monitoring. You pay 20% of the **Medicare-approved amount** for these services.

Kidney dialysis services & supplies

Generally, Medicare covers 3 dialysis treatments per week if you have End-Stage Renal Disease (ESRD). This includes most ESRD-related drugs and biological products, and all laboratory tests, home dialysis training, support services, 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 chronic 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, certain tests on tissue specimens, and some screening tests. You generally pay nothing for these services.

Lung cancer screening — This is a preventive service. Medicare covers a lung cancer screening with Low Dose Computed Tomography once per year if you meet all of these conditions:

- You're 55 – 77.
- You don't have signs or symptoms of lung cancer (you're asymptomatic).
- You're either a current smoker or have quit smoking within the last 15 years.
- You have a tobacco smoking history of at least 30 "pack years" (an average of one pack a day for 30 years).
- You get a written order from a doctor or other qualified health care provider.

You generally pay nothing for this service if the health care provider accepts **assignment**.

Note: Before your first lung cancer screening, you'll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether a lung cancer screening is right for you.

Medical nutrition therapy services — This is a preventive service.

Medicare covers medical nutrition therapy services if you have diabetes or kidney disease, or you've had a kidney transplant in the last 36 months, and your doctor refers you for services. Only a Registered Dietitian or nutrition professional who meets certain requirements can provide medical nutrition services. If you have diabetes you may also be eligible for diabetes self-management training. You pay nothing for these **preventive services** because the **deductible** and **coinsurance** don't apply.

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Mental health care (outpatient)

Medicare covers mental health care services to help with conditions like depression and 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. Covered mental health care includes Partial Hospitalization Program services, which are intensive outpatient mental health services provided during the day. Partial Hospitalization Program services are provided by a hospital to its outpatients or by a community mental health center.

Generally, you pay 20% of the **Medicare-approved amount** and the Part B deductible applies for mental health care services.

Note: Medicare Part A covers inpatient mental health care services you get in a hospital.

Obesity screening & counseling — This is a preventive service.

If you have a body mass index (BMI) of 30 or more, Medicare covers face-to-face individual behavioral therapy sessions to help you lose weight through proper nutrition and exercise. Medicare covers this counseling if your **primary care doctor** or other qualified provider gives the counseling in a primary care setting (like a doctor's office), where your personalized prevention plan can be coordinated with your other care. You pay nothing for this service if the doctor or other qualified health care provider accepts **assignment**.

Occupational therapy

Medicare covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing). This therapy helps to maintain current capabilities or slow decline when your doctor or other health care provider certifies you need it. You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies.

Opioid use disorder treatment services

Medicare covers opioid use disorder treatment services in opioid treatment programs. The services include medication (like methadone and buprenorphine), counseling, drug testing, and individual and group therapy. Medicare covers counseling and therapy services in person and by virtual delivery (using 2-way audio/video communication technology, like a computer).

Medicare pays doctors and other providers for office-based opioid use disorder treatment, including management, care coordination, psychotherapy, and counseling activities.

Under Original Medicare, you won't have to pay any **copayments** for these services if you get them from an opioid treatment program provider who's enrolled in Medicare. However, the Part B deductible still applies. Talk to your doctor or other health care provider to find out where to go for these services. You can also visit **Medicare.gov/contacts** and select "Opioid Treatment Program Services" to find a program near you.

Medicare Advantage Plans must also cover opioid treatment program services. If you're in a Medicare Advantage Plan, your current opioid treatment program must be Medicare-enrolled to make sure your treatment stays uninterrupted. If not, you may have to switch to a Medicare-enrolled opioid treatment program. Since Medicare Advantage Plans are able to apply copayments to opioid treatment program services, you should check with your plan to see if you have to pay a copayment.

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Outpatient hospital services

Medicare covers many diagnostic and treatment services in hospital outpatient departments. Generally, you pay 20% of the **Medicare-approved amount** for doctor or other health care provider 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 also usually pay the hospital a **copayment** for each service you get in a hospital outpatient setting (except for certain **preventive services** that don't have a copayment). In most cases, the copayment can't be more than the Part A hospital stay **deductible** for each service. The Part B deductible applies, except for certain preventive services. If you get hospital outpatient services in a **critical access hospital**, your copayment may be higher and may exceed the Part A hospital stay deductible.

Shopping tip

Visit **Medicare.gov/procedure-price-lookup** to get cost estimates for hospital outpatient procedures done in hospital outpatient departments.

Outpatient medical & surgical services & supplies

Medicare covers approved procedures like X-rays, casts, stitches, or outpatient surgeries. You pay 20% of the **Medicare-approved amount** for doctor or other health care provider services. You generally pay a copayment for each service you get in a hospital outpatient setting. In most cases, the copayment can't be more than the Part A hospital stay deductible for each service you get. The Part B deductible applies, and you pay all costs for items or services that Medicare doesn't cover.

Physical therapy

Medicare covers evaluation and treatment for injuries and diseases that change your ability to function, or to maintain current function or slow decline, when your doctor or other health care provider certifies your need for it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Pneumococcal shots — This is a preventive service.

Medicare covers pneumococcal shots (or vaccines) to help prevent pneumococcal infections (like certain types of pneumonia). The two shots are the 23-valent pneumococcal polysaccharide vaccine (PPSV23) and 13-valent pneumococcal conjugate vaccine (PCV13). The two shots protect against different strains of the bacteria. Medicare covers the first shot at any time, and also covers a different second shot if it's given one year (or later) after the first shot. Talk with your doctor or other health care provider to see if you need one or both of the pneumococcal shots. You pay nothing for these shots if the doctor or other qualified health care provider accepts **assignment** for giving the shots.

Prostate cancer screenings — This is a preventive service.

Medicare covers a Prostate Specific Antigen (PSA) test and a digital rectal exam once every 12 months for men over 50 (starting the day after your 50th birthday). You pay nothing for the PSA test. For the digital rectal exam, you pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies. You also pay a **copayment** in a hospital outpatient setting.

Prosthetic/orthotic items

Medicare covers these prosthetics/orthotics when a Medicare-enrolled doctor or other health care provider orders them: arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); and prosthetic devices needed to replace an internal body organ or function of the organ (including ostomy supplies, parenteral and enteral nutrition therapy, and some types of breast prostheses after a mastectomy).

You must go to a Medicare-enrolled supplier for Medicare to cover your prosthetic or orthotic. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Important!

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: If you live in or are visiting a competitive bidding area, you must use specific suppliers called “contract suppliers” for Medicare to cover your enteral nutrition therapy or off-the-shelf back braces or knee braces. Otherwise, Medicare won’t pay and you’ll likely pay full price. See page 85 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 a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible applies.

Rural Health Clinic services

Rural Health Clinics provide many outpatient primary care and preventive health services in rural and underserved areas. Generally, you're responsible for paying 20% of the charges, and the Part B deductible applies. You pay nothing for most **preventive services**.

Screening, Brief Intervention, & Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment is an early intervention approach for individuals with nondependent substance use to effectively help them before they need more extensive or specialized treatment.

Medicare covers these medically reasonable and necessary services in doctors' offices and outpatient hospitals. In these settings, providers assess you for substance use-related problems and you get limited interventions or treatment.

Second surgical opinions

Medicare covers second surgical opinions 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 infection screening & counseling — This is a preventive service.

Medicare covers sexually transmitted infection screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. Medicare covers these screenings if you're pregnant or at increased risk for a sexually transmitted infection when a primary care provider orders the tests. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Medicare also covers up to 2 individual, 20 – 30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for sexually transmitted infections. Medicare will only cover these counseling sessions with a **primary care doctor** in a primary care setting (like a doctor's office). Medicare won't cover counseling as a **preventive service** in an inpatient setting, like a skilled nursing facility.

You pay nothing for these services if the primary care doctor or other qualified health care provider accepts **assignment**.

Shots (or vaccines)

Part B covers:

- Yearly flu shots. See page 88.
- Hepatitis B shots. See page 90.
- Pneumococcal shots. See page 105.

Medicare drug coverage (Part D) covers all other recommended adult immunizations (like shingles, Tetanus, diphtheria, and pertussis vaccines) to prevent illness. Talk to your provider about which ones are right for you.

Speech-language pathology services

Medicare covers evaluation and treatment to regain and strengthen speech and language skills. This includes cognitive and swallowing skills, or to maintain current function or slow decline, when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Surgical dressing services

Medicare covers **medically necessary** treatment of a surgical or surgically treated wound. You pay 20% of the Medicare-approved amount for doctor or other health care provider services. You pay a fixed **copayment** for these services when you get them in a hospital outpatient setting. The Part B deductible applies. You pay nothing for the supplies.

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Telehealth (limited)

Medicare covers telehealth services provided by a doctor or other health care provider who's located elsewhere using interactive 2-way real-time audio and video technology. Telehealth can provide many services that generally occur in-person, including office visits, psychotherapy, consultations, and certain other medical or health services, but only when you're at an office or other medical facility located in a rural area.

You can get certain Medicare telehealth services without being in a rural health care setting, including:

- Monthly End-Stage Renal Disease (ESRD) visits for home dialysis.
- Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit.
- Services to treat a substance use disorder or a co-occurring mental health disorder in your home.

For most of these services, you'll pay the same amount you would if you got the services in person.

Compare tip

Medicare Advantage Plans and providers who are part of certain Medicare Accountable Care Organizations (ACOs) may offer more telehealth benefits than Original Medicare. These benefits are available no matter where you're located, and you may be able to use them at home instead of going to a health care facility. Check with your plan to see what telehealth benefits they offer. If your provider participates in an ACO, check with them to see what telehealth benefits may be available. For more information on Medicare Advantage Plans, see page 137. For more information on ACOs, see page 280.

Tests (other than lab tests)

Medicare covers X-rays, MRIs, CT scans, EKG/ECGs, 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**. In most cases, this amount can't be more than the Part A hospital stay deductible. See Laboratory services on page 96 for other Part B-covered tests.

Transitional care management services

Medicare may cover this service if you're returning to your community after a stay at certain facilities, like a hospital or skilled nursing facility. The health care provider who's managing your transition back into the community will work to coordinate and manage your care for the first 30 days after you return home. They'll work with you, your family, caregivers, and other providers. You'll also get an in-person office visit within 2 weeks of your return home. The health care provider may also review information on the care you received in the facility, provide information to help you transition back to living at home, work with other care providers, help you with **referrals** or arrangements for follow-up care or community resources, help you with scheduling, and help you manage your medications. The Part B deductible and **coinsurance** apply.

Transplants & immunosuppressive drugs

Medicare covers doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions, but only in Medicare-certified facilities. Medicare also covers bone marrow and cornea transplants under certain conditions.

Note: Medicare may cover transplant surgery as a hospital inpatient service under Part A. See pages 49 – 51 for more information.

Medicare covers immunosuppressive drugs if the transplant was covered by Medicare 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 covered transplant, and you must have Part B at the time you get immunosuppressive drugs. You pay 20% of the Medicare-approved amount for the drugs, and the Part B **deductible** applies.

If you're thinking about joining a **Medicare Advantage Plan** and are on a transplant waiting list or think 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.

Note: Medicare drug coverage covers immunosuppressive drugs if Part B doesn't cover them.

Medicare pays the full cost of care for your kidney donor. You and your donor won't have to pay a deductible, **coinsurance**, or any other costs for their hospital stay.

Travel (health care needed when traveling outside the U.S.)

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 cases where Medicare may pay for services 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:

- 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.

- You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another U.S. state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.

Medicare may cover **medically necessary** ambulance transportation to a foreign hospital only with admission for medically necessary covered inpatient hospital services. 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 doctor or other health care provider services, and a **copayment** in a hospital outpatient setting. The Part B **deductible** applies.

Virtual check-ins

Medicare covers virtual check-ins with your doctor or certain other providers, like nurse practitioners or physician assistants, using a device like your phone or integrated audio/video system. Your doctor can also conduct remote assessments using photo or video images you send for review to see whether you need to go to the doctor's office.

Your doctor or other provider can respond to you by phone, audio/visit, secure text message, email, or patient portal.

You can use these services if you have met these conditions:

- You have talked to your doctor or other provider about starting these types of visits.
- The virtual check-in must not be related to a medical visit within the past 7 days and must not lead to the medical visit within the next 24 hours (or the soonest appointment available).
- You must verbally consent to the virtual check-in, and your consent must be documented in your medical record. Your doctor may get one consent for a year's worth of these services.

"Welcome to Medicare" preventive visit — This is a preventive service.

During the first 12 months that you have Part B, you can get a "Welcome to Medicare" preventive visit. The visit includes a review of your medical and social history related to your health. It also includes education and counseling about **preventive services**, including certain screenings, shots or vaccines (like flu, pneumococcal, and other recommended shots or vaccines), and **referrals** for other care, if needed. When you make your appointment, let your doctor's office know that you'd like to schedule your "Welcome to Medicare" preventive visit. You pay nothing for the "Welcome to Medicare" preventive 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 Medicare doesn't cover under this preventive benefit, you may have to pay **coinsurance**, and the Part B deductible may apply. If Medicare doesn't cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.

Yearly "Wellness" visit — This is a preventive service.

If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit to develop or update your personalized plan to prevent disease or disability based on your current health and risk factors. Your provider may also perform a cognitive impairment assessment to look for signs of Alzheimer's disease or dementia and check for depression or other mood disorders. **The yearly "Wellness" visit isn't a physical exam.** Medicare covers this visit once every 12 months.

Your provider will ask you to fill out a 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. Your visit should also include a review of **preventive services** including education and counseling on screenings and recommended shots or vaccines as well as **referrals** for other care, if needed. Your provider may order other tests, if necessary, depending on your general health and medical history. When you make your appointment, let your doctor's office know that you'd like to schedule your yearly "Wellness" visit.

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

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 Medicare doesn't cover under this preventive benefit, you may have to pay a **coinsurance**, and the Part B **deductible** may apply. If Medicare doesn't cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.

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

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

- You have other coverage (including Medicaid) to cover the costs.
- You're in a **Medicare Advantage Plan** that covers these services. Most Medicare Advantage plans cover extra benefits, like vision, hearing, dental, and fitness programs.

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

- Most dental care
- Eye exams (for prescription glasses)
- Dentures.
- Cosmetic surgery
- Massage therapy
- Routine physical exams
- Hearing aids and exams for fitting them
- **Long-term care** (see page 123)
- Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care)

- Covered items or services you get from an opt-out doctor or other provider (except in the case of an emergency or urgent need)

Paying for long-term care

Long-term care (sometimes called "long-term services and supports") includes non-medical care for people who have a chronic illness or disability. This includes non-skilled personal care assistance, like help with everyday activities, including dressing, bathing, using the bathroom, home-delivered meals, adult day health care, and other services. **Medicare and most health insurance, including Medicare Supplement Insurance (Medigap), don't pay for this type of care, sometimes called "custodial care."** You may be eligible for this care through Medicaid, or you can choose to buy private long-term care insurance.

You can get long-term care 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 setting you want, now and in the future.

Long-term care resources

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

- Visit **longtermcare.gov** to learn more about planning for long-term care.
- Call your State Insurance Department to get information about long-term care insurance. Visit **Medicare.gov/contacts**, or call 1 800 633 - 4227 to get the phone number. TTY users can call 1 877 486 - 2048.
- Call your Medicaid office (State Medical Assistance Office), and ask for information about long-term care coverage. To get the phone number for your state, visit **Medicare.gov/contacts**. You can also call 1 800 633 - 4227.
- Get a copy of "A Shopper's Guide to Long-Term Care Insurance" from the National Association of Insurance Commissioners at **naic.org/documents/prod_serv_consumer_ltc_lp.pdf**.
- Call your State Health Insurance Assistance Program (SHIP). See pages 288 – 294 for the phone number.

- Visit the Eldercare Locator, a public service of the Administration for Community Living, at **eldercare.acl.gov** to find help in your community.

Compare tip

Special Needs Plans are a type of **Medicare Advantage Plan** that may be able to cover long-term care if you have Medicare and Medicaid. See page 159 to learn more. Also, some Medicare Advantage Plans may cover certain extra benefits, like adult day-care services. See page 137.

Notes

Section 3: Original Medicare

How does Original Medicare work?

Original Medicare is one of your Medicare health coverage choices. You'll have Original Medicare unless you choose a **Medicare Advantage Plan** or other type of **Medicare health plan**.

You generally have to pay a portion of the cost for each service Original Medicare covers. There's no limit to what you'll pay out of pocket in a year unless you have other insurance (like Medigap, Medicaid, or employee or union coverage). See page 129 for the general rules about 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 Medicare-enrolled doctor, other health care provider, hospital, or other facility that accepts Medicare patients. Visit **Medicare.gov** to find and compare providers, hospitals, and facilities in your area.

Does it cover prescription drugs?

No, with a few exceptions (see pages 47 – 48, 110, and 115), Original Medicare doesn't cover most drugs. You can add drug coverage by joining a Medicare drug plan (Part D). See pages 185 – 217.

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 Medicaid, military, or 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 if you're eligible. See pages 173 – 183.

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. Once Medicare pays its share, you pay a **coinsurance** or **copayment** for covered services and supplies. **There's no yearly limit for what you pay out of pocket** unless you have other insurance (like Medigap, Medicaid, or employee or union coverage).

- You usually pay a monthly **premium** for Part B.
- You generally don't need to file Medicare claims. Providers and suppliers must 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:

- Whether you have Part A and/or Part B. Most people have both.
- Whether your doctor, other health care provider, or supplier accepts "**assignment**." See page 133 for more information.
- The type of health care you need and how often you need it.
- If you choose to get services or supplies Medicare doesn't cover. If so, you pay all costs unless you have other insurance that covers them.
- Whether you have other health insurance that works with Medicare.
- Whether you have Medicaid or get help from your state to pay your Medicare costs.
- Whether you have Medicare Supplement Insurance (Medigap).
- Whether you and your doctor or other health care provider sign a private contract. See page 135.

How do I know what Medicare paid?

If you have Original Medicare, you'll get a "Medicare Summary Notice" (MSN) in the mail every 3 months that lists all the services billed to Medicare. It's not a bill. The MSN shows what Medicare paid and what you may owe the provider. Review your MSNs to be sure you got all the services, supplies, or equipment listed. If you disagree with Medicare's decision not to pay for (cover) a service, the MSN will tell you how to appeal. See page 239 for information on how to file an appeal.

If you need to change your address on your MSN, call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778. If you get Railroad Retirement Board (RRB) benefits, call the RRB at 1 877 772 - 5772. TTY users can call 1 312 751 - 4701.

Your MSN will tell you if you're enrolled in the Qualified Medicare Beneficiary (QMB) program. If you're in the QMB program, Medicare providers aren't allowed to bill you for Medicare Part A and/or Part B **deductibles**, **coinsurance**, or **copayments**. For more information about QMB and steps to take if a provider bills you for these costs, see page 226.

Important!

Get your Medicare Summary Notices electronically

You can go paperless and get your "Medicare Summary Notices" electronically (also called "eMSNs"). You can visit **MyMedicare.gov** to sign up. If you sign up for eMSNs, we'll send you an email each month when they're available in your online Medicare account. The eMSNs have the same information as paper MSNs. You won't get printed copies in the mail if you choose eMSNs.

You have options in how you get your Medicare claims information. A growing number of computer and mobile apps are connected to Medicare through Blue Button 2.0. If you agree to share your information with one of these apps, it can show you the details of the claims that Medicare has paid on your behalf. See page 274 for more information.

What's 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.

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.

Some providers haven't agreed and aren't required by law to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services. The providers who haven't agreed to accept assignment for all services are called "non-participating." You might have to pay more for their services if they don't accept assignment for the care they provide to you. 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. If they don't submit the Medicare claim once you ask them to, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.
- **They can charge you more than the Medicare-approved amount, but only up to a limit called "the limiting charge."**

If you have Original Medicare, you can see any provider you want that takes Medicare, anywhere in the U.S.

Compare tip

If you have a Medicare Advantage Plan, in many cases, you'll need to use doctors and other providers who are in the plan's network and **service area** for the lowest costs.

To find out if someone accepts **assignment** or participates in Medicare, visit **Medicare.gov/physiciancompare/** or **Medicare.gov/supplier**. You can also call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. You can also contact your State Health Insurance Assistance Program (SHIP) to get free help with these topics. See pages 288 – 294 for the phone number.

What if I have a provider who opts-out of Medicare?

Certain doctors and other health care providers who don't want to work with the Medicare program may "opt out" of Medicare. Medicare doesn't pay for any covered items or services you get from an opt-out doctor or other provider, except in the case of an emergency or urgent need. If you still want to see an opt-out provider, you and your provider can set up payment terms that you both agree to through a private contract.

A doctor or other provider who chooses to opt-out must do so for two years, which automatically renews every two years unless the provider requests not to renew their opt-out status. If you want to find an "opt out" provider, visit **data.cms.gov/opt-out-affidavits**. You can look up a provider by their **National Provider Identifier (NPI)**, or by first and last name.

Notes

Section 4: Medicare Advantage Plans & other options

What are Medicare Advantage Plans?

A **Medicare Advantage Plan** is another way to get your Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by Medicare-approved private companies that must follow rules set by Medicare. Most Medicare Advantage Plans include drug coverage (Part D). In many cases, you’ll need to use health care providers who participate in the plan’s network and service area for the lowest costs. These plans set a limit on what you’ll have to pay out-of-pocket each year for covered services, to help protect you from unexpected costs. Some plans offer out-of-network coverage, but sometimes at a higher cost. Remember, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Keep your red, white, and blue Medicare card in a safe place because you’ll need it if you ever switch back to Original Medicare.

Underlined words are defined on pages 295 – 302.

If you join a Medicare Advantage Plan, you'll still have Medicare but you'll get most of your Part A and Part B coverage from your Medicare Advantage Plan, not Original Medicare.

What are the different types of Medicare Advantage Plans?

- **Health Maintenance Organization (HMO) plan:** See page 151.
- **HMO Point-of-Service (HMOPOS) plan:** This HMO plan may allow you to get some services out-of-network for a higher **copayment** or **coinsurance**.
- **Medical Savings Account (MSA) plans:** See page 153.
- **Preferred Provider Organization (PPO) plan:** See page 155.
- **Private Fee-for-Service (PFFS) plan:** See page 157.
- **Special Needs Plan (SNP):** See page 159.

What do Medicare Advantage Plans cover?

Medicare Advantage Plans cover almost all Medicare Part A and Part B benefits. Plans must cover all emergency and urgent care, and almost all **medically necessary** services Original Medicare covers. However, if you're in a Medicare Advantage Plan, Original Medicare will still cover the cost for hospice care, some new Medicare benefits, and some costs for clinical research studies.

- End of Page

Plans can offer extra benefits

Most **Medicare Advantage Plans** offer coverage for things Original Medicare doesn't cover, like some vision, hearing, dental, and fitness programs (like gym memberships or discounts). Plans can also choose to cover even more benefits. For example, some plans may offer coverage for services like transportation to doctor visits, over-the-counter drugs, and services that promote your health and wellness. Plans can also tailor their benefit packages to offer these benefits to certain chronically-ill enrollees. These packages will provide benefits customized to treat specific conditions. Check with the plan before you enroll to see what benefits it offers, if you might qualify, and if there are any limitations.

- End of Page

Medicare Advantage Plans must follow Medicare's rules

Medicare pays a fixed amount for your coverage each 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's network 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.

Remember, you have the option each year to keep your current plan, choose a different plan, or switch to Original Medicare (see page 161).

Providers can join or leave a plan's provider network anytime during the year. Your plan can also change the providers in the network anytime during the year. If this happens, you won't be able to change plans but you can choose a new provider. You generally can't change plans during the year.

Even though the network of providers may change during the year, the plan must still give you access to qualified doctors and specialists. Your plan will make a good faith effort to give you at least 30 days' notice that your provider is leaving your plan so you have time to choose a new provider. Your plan will also help you choose a new provider to continue managing your health care needs.

Compare tip

In most cases, you don't need a referral to see a specialist if you have Original Medicare. See page 128. You can also see any provider you want that takes Medicare, anywhere in the U.S.

Important!

Read the information you get from your plan

If you're in a **Medicare Advantage Plan**, review the "Annual Notice of Change" and "Evidence of Coverage" from your plan each year:

- **Annual Notice of Change:** Includes any changes in coverage, costs, **service area**, and more that will be effective starting in January. Your plan will send you a printed copy by September 30.
- **Evidence of Coverage:** Gives you details about what the plan covers, how much you pay, and more. Your plan will send you a notice (or printed copy) by October 15, which will include information on how to access the Evidence of Coverage electronically or request a printed copy.

If you don't get these important documents, contact your plan.

What should I know about Medicare Advantage Plans?

Who can join?

To join a Medicare Advantage Plan you must:

- Have Part A and Part B.
- Live in the plan's service area.

Joining and leaving

- You can join a Medicare Advantage Plan even if you have a pre-existing condition.
- **You can join or leave a Medicare Advantage Plan only at certain times during the year.** See pages 161 – 163.
- 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 Advantage Plan or return to Original Medicare (see page 237).
- Medicare Advantage Plans must follow certain rules when giving you information about how to join their plan. See page 261 for more information about these rules and how to protect your personal information.

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

If you have ESRD, you can enroll in a Medicare Advantage Plan during Open Enrollment (October 15–December 7, 2020). Your plan coverage will start January 1, 2021.

Drug coverage (Part D)

If you join a Medicare Advantage Plan, you'll usually get drug coverage through that plan. In certain types of plans that can't offer drug coverage (like Medical Savings Account plans) or choose not to offer drug coverage (like certain Private Fee-for-Service plans), you can join a separate Medicare drug plan. **If you're in a Health Maintenance Organization, HMO Point-of-Service plan, or Preferred Provider Organization, and you join a separate drug plan, you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.**

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 your employer or union coverage for yourself, your spouse, and dependents and you may not be able to get it back. 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 Medicare Advantage Plan you join. Your employer or union may also offer a Medicare Advantage retiree health plan that they sponsor.

What if I have Medicare Supplement Insurance (Medigap)?

You can't enroll in (and don't need) Medigap while you're in a Medicare Advantage Plan. You can't use it to pay for any costs (**copayments**, **deductibles**, and **premiums**) you have under a Medicare Advantage Plan.

Important!

If you already have Medigap and join a Medicare Advantage Plan, you can drop Medigap. **Keep in mind that if you drop Medigap to join a Medicare Advantage Plan, you may not be able to get it back. See page 182.**

What do I pay?

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

- Whether the plan charges a monthly premium. Many Medicare Advantage Plans have a $0 premium. If you enroll in a plan that does charge a premium, you pay this in addition to the Part B premium.
- Whether the plan pays any of your monthly Medicare premiums. Some Medicare Advantage Plans will help pay all or part of your Part B premium. This benefit is sometimes called a “Medicare Part B premium reduction.”
- 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**). Medicare Advantage Plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and **skilled nursing facility care**.
- The type of health care services you need and how often you get them.
- Whether you get services from a network provider or a provider that doesn't contract with the plan. If you go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan's network for non-emergency or non-urgent care services, your plan may not cover your services, or your costs could be higher. In most cases, this applies to Medicare Advantage Plans, Health Maintenance Organizations and Preferred Provider Organizations.
- Whether you go to a doctor or supplier who accepts **assignment** (if you're in a Preferred Provider Organization or Private Fee-for-Service plan, or Medical Savings Account plan and you go out of network). See page 133 for more information about assignment.

- Whether the plan offers extra benefits (in addition to Original Medicare benefits) and if you need to pay extra to get them.
- The plan's yearly limit on your out of pocket costs for all Part A and Part B medical services. Once you reach this limit, you'll pay nothing for Part A and Part B covered services.
- Whether you have Medicaid or get help from your state through a Medicare Savings Program (see pages 226 – 230).

To learn more about your costs in specific **Medicare Advantage Plans** contact the plan, or visit **Medicare.gov/plan-compare**.

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How do I find out if my plan covers a service, drug or supply?

You can get a decision from your plan in advance to see if it covers a service, drug, or supply. You can also find out how much you'll have to pay. **This is called an "organization determination."** Sometimes you have to do this as prior authorization for your plan to cover the service, drug, or supply.

You, your representative, or your doctor can request an organization determination. Based on your health needs, you, your representative, or your doctor can ask for a fast decision on your organization determination request. If your plan denies coverage, the plan must tell you in writing, and you have the right to appeal (see pages 238 – 242).

If a plan provider refers you for a service or to a provider outside the network, but doesn't get an organization determination in advance, **this is called "plan directed care."** In most cases you won't have to pay more than the plan's usual cost sharing. Check with your plan for more information about this protection.

Types of Medicare Advantage Plans

Health Maintenance Organization (HMO) 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 HMO 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 option (HMOPOS).

Do these plans cover prescription drugs?

In most cases, yes. If you want Medicare drug coverage, you must join an HMO plan that offers drug coverage.

Do I need to choose a primary care doctor?

In most cases, yes.

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.

What else do I need to know about this type of plan?

- If your doctor or other health care provider leaves the plan's network, your plan will notify you. You may choose another doctor in the plan's network.
- If you get health care outside the plan's network, you may have to pay the full cost.
- It's important that you follow the plan's rules, like getting prior approval for a certain service when needed.
- Check with the plan for more information.

- End of Page

Medical Savings Account (MSA) plan

Can I get my health care from any doctor, other health care provider, or hospital?

Yes. MSA plans don't always have a network of doctors, other health care providers, and hospitals.

Do these plans cover prescription drugs?

No. If you join a Medicare MSA plan and need drug coverage, you'll have to join a separate Medicare drug plan.

Do I need to choose a primary care doctor?

No.

Do I have to get a referral to see a specialist?

No.

What else do I need to know about this type of plan?

The plan deposits money into a special savings account. The amount of the deposit varies by plan. You can use this money to pay your Medicare-covered health care costs before you meet the **deductible**. Money left in your account at the end of the year stays there. If you keep your plan the following year, your plan will add any new deposits to the amount left over.

- MSA plans don't charge a **premium**, but you must continue to pay your Part B premium.
- Some plans may cover extra benefits, like dental, vision and hearing. You may pay a premium if you use these services.
- For more information about using your MSA plan, visit **Medicare.gov**, or check with your plan.

Preferred Provider Organization (PPO) plan

Can I get my health care from any doctor, other health care provider, or hospital?

Yes. PPO plans have network doctors, specialists, hospitals, and other health care providers you can use, but you can also use out-of-network providers for covered services, usually for a higher cost. You're always covered for emergency and urgent care.

Do these plans cover prescription drugs?

In most cases, yes. If you want Medicare drug coverage, you must join a PPO plan that offers drug coverage. If you join a PPO plan without drug coverage, you can't join a separate Medicare drug plan.

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 if you use plan specialists (in-network), your costs for covered services will usually be lower than if you use non-plan specialists (out-of-network).

What else do I need to know about this type of plan?

- Because certain providers are “preferred,” you can save money by using them.
- A PPO plan isn’t the same as Original Medicare or Medicare Supplement Insurance (Medigap).
- It usually offers extra benefits than Original Medicare, but you may have to pay extra for these benefits.
- Check with the plan for more information.

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Private Fee-for-Service (PFFS) plan

Can I get my health care from any doctor, other health care provider, or hospital?

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. 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.

Do these plans cover prescription drugs?

Sometimes. If your PFFS plan doesn't offer drug coverage, you can join a separate Medicare drug plan to get coverage.

Do I need to choose a primary care doctor?

No.

Do I have to get a referral to see a specialist?

No.

What else do I need to know about this type of plan?

- The plan decides how much you pay for services. The plan will tell you about your cost sharing in the “Annual Notice of Change” and “Evidence of Coverage” documents that it sends each year.
- Some PFFS plans contract with a network of providers who agree to always treat you, even if you’ve never seen them before.
- Out-of-network doctors, hospitals, and other providers may decide not to treat you, even if you’ve seen them before.
- In a medical emergency, doctors, hospitals, and other providers must treat you.
- For each service you get, make sure to show your plan member card before you get treated.
- Check with the plan for more information.

Special Needs Plan (SNP)

An SNP provides benefits and services to people with specific diseases, certain health care needs, or limited incomes. SNPs tailor their benefits, provider choices, and list of drugs (formularies) to best meet the specific needs of the groups they serve.

Can I get my health care from any doctor, other health care provider, or hospital?

Some SNPs cover services out-of-network and some don't. Check with the plan to see if they cover services out-of-network, and if so, how it affects your costs.

Do these plans cover prescription drugs?

Yes. All SNPs must provide Medicare drug coverage.

Do I need to choose a primary care doctor?

Generally, yes.

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.

What else do I need to know about this type of plan?

- These groups are eligible to enroll in an SNP:
  - People who live in certain institutions (like nursing homes) or who require nursing care at home (also called an "Institutional SNP" or I-SNP).
  - People who are eligible for both Medicare and Medicaid (also called a "Dual Eligible SNP" or D-SNP). D-SNPs contract with your state Medicaid program to help coordinate your Medicare and Medicaid benefits.
  - People who have specific severe or disabling chronic conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia) (also called a "Chronic condition SNP" or C-SNP). Plans may further limit membership.
- A SNP provides benefits targeted to its members' special needs, including care coordination services.
- Visit **Medicare.gov/plan-compare** to find and compare **Medicare Advantage Plans** and see if SNPs are available in your area. Select "Add Special Needs Plans" if this option is available when you view plans.
- Check with the plan for more information.

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

- **Initial Enrollment Period.** When you first become eligible for Medicare, you can join a **Medicare Advantage Plan**. See page 26.
- **General Enrollment Period.** If you have Part A coverage and you get Part B for the first time during this period, you can also join a Medicare Advantage Plan. Your coverage may not start until July 1. See page 28.
- **Open Enrollment Period.** From October 15 – December 7 you 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).

Important!

If you drop your Medicare Supplement Insurance (Medigap) policy to join a Medicare Advantage Plan, you may not get it back. Rules vary by state and your situation. Also, if you don't drop your Medicare Advantage Plan and return to Original Medicare within 12 months of joining, you may be limited in your ability to return to Original Medicare and get a Medigap policy. See page 182 for more information.

Shopping tip

Always review the materials your plan sends you (like the "Annual Notice of Change" and "Evidence of Coverage"), and make sure your plan will still meet your needs for the following year. You can also visit **Medicare.gov/plan-compare** to compare other available options with your current plan.

Can I make changes to my coverage after December 7?

January 1–March 31 each year, you can make these changes during the **Medicare Advantage Open Enrollment Period**:

- If you're in a Medicare Advantage Plan (with or without drug coverage), you can switch to another Medicare Advantage Plan (with or without drug coverage).
- You can drop your Medicare Advantage Plan and return to Original Medicare. You'll also be able to join a Medicare drug plan.

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

- Switch from Original Medicare to a Medicare Advantage Plan.
- Join a Medicare drug plan if you're in Original Medicare.
- Switch from one Medicare drug plan to another if you're in Original Medicare.

You can only make one change during this period, and any changes you make will be effective the first of the month after the plan gets your request. If you're returning to Original Medicare and joining a drug plan, you don't need to contact your Medicare Advantage Plan to disenroll. The disenrollment will happen automatically when you join the drug plan.

Note: If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without a drug plan) within the first 3 months you have Medicare.

Important!

Thinking about joining a Medicare Advantage Plan during the Open Enrollment Period (October 15 – December 7), but aren't sure? If you join a Medicare Advantage Plan during the Open Enrollment Period but change your mind, you can switch back to Original Medicare or change to a different Medicare Advantage Plan (depending on which coverage works better for you) during the Medicare Advantage Open Enrollment Period (January 1 – March 31).

Special Enrollment Periods

In most cases, you must stay enrolled for the calendar year starting the date your coverage begins. However, in certain situations, like if you move or you lose other insurance coverage, you may be able to join, switch, or drop a Medicare Advantage Plan during a Special Enrollment Period. Visit **Medicare.gov** or check with your plan for more information.

5-star Special Enrollment Period: Medicare uses star ratings from 1-5 to help you compare plans based on quality and performance. If a Medicare Advantage Plan, Medicare drug plan, or Medicare Cost Plan with a 5-star rating is available in your area, you can use the 5-star Special Enrollment Period to switch from your current **Medicare plan** to a Medicare plan with a “5-star” quality rating. You can use this Special Enrollment Period only once between December 8 and November 30. Visit **Medicare.gov** for more information.

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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 page 161. 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 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. If you don't have drug coverage, you should consider joining a Medicare drug plan to avoid paying a penalty if you decide to join later. You may also want to consider buying a Medicare Supplement Insurance (Medigap) policy if you're eligible (see page 173).

To join or switch Medicare Advantage Plans, visit **Medicare.gov/plan-compare** or call 1 800 633 - 4227.

For more details about Medicare Advantage Plans, visit **Medicare.gov/publications** to view the booklet "Understanding Medicare Advantage Plans."

Are there other types of Medicare health plans and projects?

Yes, some of these plans provide Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, while others provide only Part B coverage. In addition, some also provide drug coverage (Part D). 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, limited areas of the country. Here's what you should know about Medicare Cost Plans:

- In general, 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, Original Medicare covers the services. You'll pay the Part A and Part B **coinsurance** and **deductibles**.
- You can join anytime the Medicare Cost Plan is accepting new members.

- You can leave anytime and return to Original Medicare.
- You can get your Medicare drug coverage from either the Medicare Cost Plan (if offered) or you can join a Medicare drug plan. Even if the Medicare Cost Plan offers drug coverage, you can choose to get drug coverage from a separate Medicare drug plan.

  Note: You can add or drop Medicare drug coverage only at certain times (see page 188).

To see if there are Medicare Cost Plans in your area, visit **Medicare.gov/plan-compare**. You can contact the plan you're interested in for more information. Your State Health Insurance Assistance Program (SHIP) can also help you. See pages 288 – 294 for the phone number.

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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 covers all Medicare- and Medicaid-covered care and services, and other services that the PACE team of health care professionals decides are necessary to improve and maintain your health. This includes drugs, as well as any other **medically necessary** care, like doctor or health care provider visits, transportation, home care, hospital visits, and even nursing home stays when 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 drug coverage (Part D). 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 **Medicare.gov/pace** to see if there's a PACE organization that serves your community.

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Medicare Innovation Projects

Medicare develops innovative models, **demonstrations**, and pilot projects to test and measure the effect of potential changes in Medicare. These projects help to find new ways to improve health care quality and reduce costs. Usually, they operate only for a limited time and for a specific group of people and/or are offered only in specific areas. Examples of current models, demonstrations, and pilot projects include innovations in primary care, care related to specific procedures (like hip and knee replacements), cancer care, and care for people with End-Stage Renal Disease (ESRD). Ask your doctor if they participate in these models, and what it means for your care. To learn more about the current Medicare models, demonstrations, and pilot projects, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Notes

Section 5: Medicare Supplement Insurance (Medigap)

How does Medigap work?

Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. Medicare Supplement Insurance (Medigap) policies sold by private companies, can help pay some of the remaining health care costs for covered services and supplies, like **copayments**, **coinsurance**, and **deductibles**.

Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. Generally, Medigap doesn't cover long-term care (like care in a nursing home), vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Underlined words are defined on pages 295 – 302.

Medigap plans are standardized

Medigap must follow federal and state laws designed to protect you, and they must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only a "standardized" plan, identified in most states as plans A – D, F, G, and K – N. All plans 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 plans are standardized in a different way.

Important!

Medigap sold to people who are new to Medicare aren't allowed to cover the Part B deductible. Because of this, Plans C and F aren't available to people who were newly eligible for Medicare on or after January 1, 2020. If you already have or were covered by Plan C or F (or the Plan F high deductible version) before January 1, 2020, you can keep your plan.

If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these policies.

How do I compare Medigap plans?

The text below shows basic information about the different benefits that Medicare Supplement Insurance (Medigap) plans cover for 2020. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest. Out-of-pocket costs (like **deductibles**) might change for 2021.

Medigap plans

- **Medicare Part A coinsurance and hospital costs** (up to an additional 365 days after Medicare benefits are used) covers 100% in plans A, B, C, D, F*, G*, K, L, M, and N.
- **Medicare Part B coinsurance or copayment** covers 100% in plans A, B, C, D, F*, G*, M and N. Covers 50% in plan K and 75% in plan L. 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.
- **Blood (first 3 pints)** covers 100% in plans A, B, C, D, F*, G*, M, and N. Covers 50% in plan K and 75% in plan L.

- **Part A hospice care coinsurance or copayment** covers 100% in plans A, B, C, D, F*, G*, M, and N. Covers 50% in plan K and 75% in plan L.
- **Skilled nursing facility care** coinsurance covers 100% in plans C, D, F*, G*, M, and N. Covers 50% in plan K and 75% in plan L.
- **Part A deductible** covers 100% in plans B, C, D, F*, G*, and N. Covers 50% in plan K and M and 75% in plan L.
- **Part B deductible** covers 100% in plans C and F*.
- **Part B excess charges** covers 100% in plans F* and G.
- **Foreign travel emergency** (up to plan limits) covers 80% in plans C, D, F*, G*, M, and N.
- **Out - of - pocket limit** for plan K** in 2020 is $5,880.
- **Out - of - pocket limit** for plan L** in 2020 is $2,940.

* Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,340 in 2020 before your policy pays anything. (You can't buy Plans C and F if you were newly eligible for Medicare on or after January 1, 2020. See previous page for more information.)
** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($198 in 2020), the Medigap plan pays 100% of covered services for the rest of the calendar year.
*** Plan N pays 100% of the Part B coinsurance. You must pay 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 Medigap?

- Before you can buy Medicare Supplement Insurance (Medigap), you must have Part A and Part B.
- You pay the private insurance company a monthly **premium** for Medigap in addition to the monthly Part B premium you pay to Medicare. Also, if you buy Medigap and a Medicare drug plan from the same company, you may need to make 2 separate premium payments. Contact the company to find out how to pay your premiums.
- A Medigap policy only covers one person. Spouses must buy separate coverage.
- You can't have drug coverage in both Medigap and your Medicare drug plan (see page 213).
- It's important to compare Medigap policies since the costs can vary between policies for exactly the same coverage, and may go up as you get older. Some states limit Medigap premium costs.
- In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. If you buy Medicare SELECT, you have rights to change your mind within 12 months and switch to standard Medigap.

Note: Medigap plans sold to people who are newly eligible for Medicare aren't allowed to cover the Part B **deductible**. Because of this, Plans C and F aren't available to people newly eligible for Medicare on or after January 1, 2020. If you already have or were covered by Plan C or F (or the Plan F high deductible version) before January 1, 2020, you can keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans that cover the Part B deductible.

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, you may not be able to buy Medigap. If you're able to buy Medigap, 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 generally doesn't require insurance companies to sell Medigap to people under 65. If you're under 65, you might not be able to buy the policy you want, or any policy, until you turn 65. However, some states require Medigap insurance companies to sell Medigap policies to people under 65. If you're able to buy one, it may cost more.

Check with your State Health Insurance Assistance Program (SHIP) (see pages 288 – 294 for the phone number), or your State Insurance Department to learn more about your rights to buy a Medigap policy.

Can I have Medigap and a Medicare Advantage Plan?

- 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're not planning to leave your Medicare Advantage Plan, and someone tries to sell you a Medigap policy, report it to your State Insurance Department.
- If you have Medigap and join a Medicare Advantage Plan, you may want to drop Medigap. You can't use Medigap to pay your Medicare Advantage Plan **copayments**, **deductibles**, and **premiums** because Medicare Advantage Plans provide other protections that Medigap doesn't.

Important!

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.

- If you join a Medicare Advantage Plan for the first time, and you aren't happy with the plan, you'll have special rights under federal law to buy a Medigap policy and a Medicare drug plan if you return to Original Medicare within 12 months of joining the Medicare Advantage Plan.
  - If you had Medigap 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 policy.
  - If you joined a Medicare Advantage Plan when you were first eligible for Medicare (and you're not happy with the plan), you can choose from any Medigap policy within the first year of joining.
  - Some states provide additional special rights to buy a Medigap policy.

Note: If you don't drop your Medicare Advantage Plan and return to Original Medicare within 12 months of joining, generally, you must keep your Medicare Advantage Plan for the rest of the year. You can disenroll or change plans during the Open Enrollment Period or if you qualify for a Special Enrollment Period. Depending on the type of Special Enrollment Period, you may or may not have the right to buy a Medigap policy.

Where can I get more information?

- Call your State Health Insurance Assistance Program (SHIP). See pages 288 – 294 for the phone number.
- Call your State Insurance Department. Visit **Medicare.gov/contacts**, or call 1 800 633 - 4227 to get the phone number. TTY users can call 1 877 486 - 2048.
- Visit **Medicare.gov/medigap-supplemental-insurance-plans** to find policies in your area.
- Visit **Medicare.gov/publications** to view "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

Notes

Section 6: Medicare drug coverage (Part D)

How does Medicare drug coverage work?

Medicare drug coverage helps pay for prescription drugs you need. Even if you don't take prescription drugs now, you should consider getting Medicare drug coverage. Medicare drug coverage is optional and is offered to everyone with Medicare. If you decide not to get it when you're first eligible, and you don't have other **creditable prescription drug coverage** (like drug coverage from an employer or union) or get **Extra Help**, you'll likely pay a late enrollment penalty if you join a plan later. Generally, you'll pay this penalty for as long as you have Medicare drug coverage (see page 196). To get Medicare drug coverage, you must join a Medicare-approved plan that offers drug coverage. Each plan can vary in cost and specific drugs covered. Visit **Medicare.gov/plan-compare** to find and compare plans in your area.

There are 2 ways to get Medicare drug coverage:

1. **Medicare drug plans.** These plans add drug coverage to Original Medicare, some Medicare Cost Plans, some Private Fee-for-Service plans, and Medical Savings Account plans. You must have Part A **and/or** Part B to join a separate Medicare drug plan.
2. **Medicare Advantage Plans or other Medicare health plans with drug coverage.** You get all of your Part A, Part B, and drug coverage, through these plans. Remember, you must have Part A **and** Part B to join a Medicare Advantage Plan, and not all of these plans offer drug coverage.

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

Important!

If you have employer or union coverage

Call your benefits administrator before you make any changes, or sign up for any other coverage. If you sign up for other coverage, you could lose your employer or union health and drug coverage for you and your dependents. If this happens, you may not be able to get your employer or union coverage back. If you want to know how Medicare drug coverage works with other drug coverage you may have, see page 210.

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When can I join, switch, or drop a plan?

You can join, switch, or drop a Medicare drug plan or a **Medicare Advantage Plan** with drug coverage during these times:

- **Initial Enrollment Period.** When you first become eligible for Medicare, you can join a plan (see page 26).
- **Open Enrollment Period.** From October 15 – December 7 each year, you can join, switch, or drop a plan. Your coverage will begin on January 1 (as long as the plan gets your request by December 7).
- **Medicare Advantage Open Enrollment Period.** From January 1 – March 31 each year, if you're enrolled in a Medicare Advantage Plan, you can switch to a different Medicare Advantage Plan or switch to Original Medicare (and join a separate Medicare drug plan) once during this time. See page 162 for more information.

If you have to pay a **premium** for Part A and enroll in Part B for the first time during the General Enrollment Period, you can also join a plan from April 1 – June 30. Your coverage will begin on July 1.

Special Enrollment Periods

Generally, you must stay enrolled in your plan for the entire year. But when certain events happen in your life, like if you move or lose other insurance coverage, you may qualify for a Special Enrollment Period. You may be able make changes to your plan mid-year if you qualify. Check with your plan for more information.

How do I switch plans?

You can switch to a new Medicare drug plan or Medicare Advantage Plan with drug coverage simply by joining another plan during one of the times listed above. Your old drug coverage will end when your new drug coverage begins. You should get a letter from your new plan telling you when your coverage begins, so **you don't need to cancel your old plan.** You can switch plans by calling 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

How do I drop my plan?

If you want to drop your Medicare drug plan or **Medicare Advantage Plan** with drug coverage and don't want to join a new plan, you can only do so during certain times (see page 188). You can disenroll by calling 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. 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 or **Medicare health plan** with drug coverage later, you have to wait for an enrollment period. You may have to pay a late enrollment penalty if you don't have **creditable prescription drug coverage** (see page 196).

Read the information you get from your plan

Review the "Evidence of Coverage" and "Annual Notice of Change" your plan sends you each year. The Evidence of Coverage gives you details about what the plan covers, how much you pay, and more. The Annual Notice of Change includes any changes in coverage, costs, provider networks, **service area**, and more that will be effective in January. If you don't get these important documents in early fall, contact your plan.

How much do I pay?

Your drug costs will vary based on the plan you choose. Remember, plan coverage and costs can change each year. You may have to pay a **premium**, **deductible**, **copayments**, or **coinsurance** throughout the year. Learn more about these costs on the next page.

Your actual drug coverage costs will vary depending on:

- Your prescriptions and whether they're on your plan's list of covered drugs (**formulary**) (see page 201).
- What "tier" the drug is in (see page 201).
- Which drug benefit phase you're in (like whether you've met your deductible, or if you're in the catastrophic coverage phase — see page 195).
- Which pharmacy you use (whether it offers preferred or standard cost sharing, is out of network, or is mail order). Your out-of-pocket drug costs may be less at a preferred pharmacy because it has agreed with your plan to charge less.
- Whether you get **Extra Help** paying your drug coverage costs (see pages 219 – 225).

Shopping tip

You may be able to lower the cost of your drugs. Some ways include choosing generics over brand name or paying the non-insurance cost of a drug. Ask your pharmacist—they can tell you if there's a less expensive option available. Check with your doctor to make sure the generic option is best for you.

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** or a Medicare Cost Plan with drug coverage, the monthly premium may include an amount for drug coverage.

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

Important!

If you have a higher income, you might pay more for your Medicare drug coverage. If your income is above a certain limit ($87,000 if you file individually or $174,000 if you're married and file jointly), you'll pay an extra amount in addition to your plan premium (sometimes called "Part D-IRMAA"). You'll also have to pay this extra amount if you're in a Medicare Advantage Plan that includes drug coverage. This doesn't affect everyone, so most people won't have to pay an extra amount. If you have Part B and you have a higher income, you may also have to pay an extra amount for your Part B premium, even if you don't have drug coverage (see page 37).

Usually, the extra amount will be deducted from your Social Security or RRB payment. If Medicare or the RRB bills you for the extra amount instead of deducting it from your Social Security or RRB payment, then you must pay the extra amount to Medicare or the RRB, not your plan. If you don't pay the extra amount, you could lose your drug coverage. You may not be able to enroll in another plan right away, and you may have to pay a late enrollment penalty for as long as you have drug coverage.

You'll pay Part D-IRMAA payments separately, even if your employer or another third party (like a retirement system) pays your plan premiums.

If you have to pay an extra amount and you disagree (for example, you have one or more life changing events that lower your income), visit **socialsecurity.gov** or call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778.

Yearly deductible

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

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Copayments or coinsurance

These are the amounts you pay for your covered drugs after the deductible (if the plan has one). You pay your share and your plan pays its share for covered drugs. If you pay coinsurance, these amounts may vary throughout the year due to changes in the drug's total cost. The amount you pay will also depend on the tier level assigned to your drug (see page 202).

Once you and your plan spend $4,130 combined on drugs (including deductible), you'll pay no more than 25% of the cost for prescription drugs until your out-of-pocket spending is $6,550, under the standard drug benefit.

Catastrophic coverage

Once your out-of-pocket spending reaches $6,550, you'll automatically get "catastrophic coverage." You'll pay no more than 5% of the cost 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 219 – 225).

Important!

Visit **Medicare.gov/plan-compare** to get specific Medicare drug plan and **Medicare Advantage Plan** costs, and call the plans you're interested in to get more details. For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP). See pages 288 – 294 for the phone number.

What's the Medicare drug coverage (Part D) late enrollment penalty?

The late enrollment penalty is an amount that's permanently added to your Medicare drug coverage (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 Medicare drug coverage or other **creditable prescription drug coverage**. You'll generally have to pay the penalty for as long as you have Medicare drug coverage.

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

3 ways to avoid paying a penalty:

1. **Enroll in Medicare drug coverage when you're first eligible.** Even if you don't take drugs now, you should consider joining a Medicare drug plan or a Medicare Advantage Plan with drug coverage to avoid a penalty. You may be able to find a plan that meets your needs with little to no monthly premiums. See pages 8 – 17 to learn more about your choices.
2. **Enroll in Medicare drug coverage if you lose 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 individual health insurance coverage. Your plan must tell you each year if your non-Medicare drug coverage is creditable coverage. If you go 63 days or more in a row without Medicare drug coverage or other creditable prescription drug coverage, you may have to pay a penalty if you sign up for Medicare drug coverage later.
3. **Keep records showing when you had other creditable drug coverage, and tell your plan when they ask about it.** If you don't tell your **Medicare plan** about your previous creditable prescription drug coverage, you may have to pay a penalty for as long as you have Medicare drug coverage.

How much more will I pay for a late enrollment penalty?

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**" ($32.74 in 2020) by the number of full, uncovered months that you were eligible but didn't enroll in Medicare drug coverage 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. After you enroll in Medicare drug coverage, the plan will tell you if you owe a penalty and what your premium will be. Visit **Medicare.gov** later this fall to find out how much the 2021 "national base beneficiary premium" will be.

Example:

Mrs. Martinez is currently eligible for Medicare, and her Initial Enrollment Period ended on May 31, 2016. She didn't join Medicare drug coverage by May 31, 2016, and didn't have other creditable prescription drug coverage. Mrs. Martinez joined a Medicare drug plan during the Open Enrollment Period that ended December 7, 2018. Her Medicare drug coverage was effective January 1, 2019.

2019

Since Mrs. Martinez didn't have Medicare drug coverage and was without creditable prescription drug coverage from June 2016–December 2018, her penalty in 2019 was 31% (1% for each of the 31 months) of $33.19 (the national base beneficiary premium for 2019), or $10.29. Since the monthly penalty is always rounded to the nearest $0.10, she paid $10.30 each month in addition to her plan's monthly premium.

Here's the math:

.31 (31% penalty) × **$33.19** (2019 base beneficiary premium) = **$10.29**

$10.29 rounded to the nearest $0.10 = **$10.30**
(Mrs. Martinez's monthly late enrollment penalty for 2019)

$33.19 + $10.30 = $43.49

The total amount Mrs. Martinez will pay for the premium and late enrollment penalty for 2019 is **$43.49**.

2020

In 2020, Medicare recalculated Mrs. Martinez's penalty using the 2020 base beneficiary premium ($32.74). So, Mrs. Martinez's new monthly penalty in 2020 is 31% of $32.74, or $10.15 each month. Since the monthly penalty is always rounded to the nearest $0.10, she pays $10.20 each month in addition to her plan's monthly premium.

Here's the math:

.31 (31% penalty) × **$32.74** (2020 base beneficiary premium) = **$10.15**

$10.15 rounded to the nearest $0.10 = **$10.20** (Mrs. Martinez's monthly late enrollment penalty for 2020)

$32.74 + $10.20 = $42.94

The total amount Mrs. Martinez will pay for the premium and late enrollment penalty for 2020 is **$42.94**.

What if I don't agree with the late enrollment penalty?

Your Medicare drug plan or **Medicare Advantage Plan** with drug coverage will send you a letter stating you have to pay a late enrollment penalty. If you disagree with your penalty, you can request a review (generally within 60 days from the date on the letter). Fill out the "reconsideration request form" you get with your letter by the date listed in the letter. You can provide proof that supports your case, like information about previous **creditable prescription drug coverage**. If you need help, call your plan.

Which drugs are covered?

All plans must cover a wide range of prescription drugs that people with Medicare take, including most drugs in certain "protected classes," like drugs to treat cancer or HIV/AIDs. 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 and **Medicare health plans** with drug coverage place drugs into different levels called "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.

What happens if my drug is 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's 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 **coinsurance** or **copayment** for the drug in the higher tier. See page 243 for more information on exceptions.

Plans can change their formularies at any time. Your plan may notify you of any formulary changes that affect drugs you're taking.

Note: Medicare drug coverage includes drugs for medication-assisted treatment for opioid use disorders. It also covers drugs like methadone and buprenorphine when prescribed for pain. However, Medicare Part A covers methadone when used to treat an opioid use disorder as an inpatient in a hospital, and Part B now covers methadone when you receive it through an opioid treatment program. See page 101 for more information about opioid treatment programs.

Contact the plan for its current formulary, or visit the plan's website. You can also visit **Medicare.gov/plan-compare**, or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Important!

Each month you fill a prescription, your plan mails you an "Explanation of Benefits" notice. 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 at 1 877 772 - 3379. See page 261 for more information.

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Plans may have coverage rules for certain drugs

- **Prior authorization:** You and/or your prescriber must contact your 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.

  Plans may also use prior authorization when they cover a drug for only certain medical conditions it is approved for, but not others. When this occurs, plans will likely have alternative drugs on their list of covered drugs (**formulary**) for the other medical conditions the drug is approved to treat.
- **Quantity limits:** Limits on how much medicine you can get at a time.
- **Step therapy:** You may need to try one or more similar, lower-cost drugs before the plan will cover the prescribed drug.

- **Prescription safety checks at the pharmacy (including opioid pain medicine):** Before the pharmacy fills your prescriptions, your Medicare drug plan and pharmacy perform additional safety checks, like checking for drug interactions and incorrect dosages. These safety checks also include checking for possible unsafe amounts of opioids, limiting the days supply of a first prescription for opioids, and use of opioids at the same time as benzodiazepines (commonly used for anxiety and sleep). Opioid pain medicine (like oxycodone and hydrocodone) can help with certain types of pain, but have risks and side effects (like addiction, overdose, and death). These can increase when you take opioids with certain other drugs, like benzodiazepines, anti-seizure medications, gabapentin, muscle relaxers, certain antidepressants, and drugs for sleeping problems. Check with your doctor or pharmacist if you have questions about risks or side effects.

- **Drug Management Programs:** Some Medicare drug plans and health plans with drug coverage have a program in place to help you use these opioids and benzodiazepines safely. If you get opioids from multiple doctors or pharmacies, your plan will contact the doctors who prescribed these drugs to make sure they're medically necessary and you're using them appropriately.

  If your plan decides your use of prescription opioids and benzodiazepines may not be safe, the plan will send you a letter in advance. This letter will tell you if the plan will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from one doctor or pharmacy you select. You and your doctor have the right to appeal these limitations if you disagree with the plan's decision (see page 239). The letter will also tell you how to contact the plan if you have questions or would like to appeal.

  The opioid safety reviews at the pharmacy and the Drug Management Programs generally don't apply if you have cancer, are getting palliative or end-of-life care, are in hospice, or live in a long-term care facility.

If you or your prescriber believe that your plan should waive one of these coverage rules, you may be able to ask for an exception (see page 243).

Important tips if you're prescribed opioids:

- Opioid medications can be an important part of pain management, but they also can have serious health risks if misused.
- Talk with your doctor about having naloxone at home. Naloxone is a drug Medicare covers that your doctor may prescribe as a safety measure to rapidly reverse the effects of an opioid overdose.
- Talk with your doctor about your dosage and the length of time you'll be taking them. You and your doctor may decide later you don't need to take all of your prescription.
- Talk with your doctor about other options that Medicare covers to treat your pain, like non-opioid medications and devices, physical therapy, acupuncture for lower back pain, individual and group therapy, behavioral health integration services, and more. There also may be other pain treatment options available that Medicare doesn't cover.
- Tell your doctor if you have a history of depression, substance abuse, childhood trauma or other health and/or personal issues that could make opioid use more dangerous for you.

- Never take more opioids than prescribed. Also, talk with your doctor about any other pain medicines you're taking.
- Safely store and dispose of unused prescription opioids through your community drug take-back program or your pharmacy mail-back program.

For more information on safe and effective pain management and opioid use, visit **Medicare.gov/coverage/pain-management** or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Do you get automatic prescription refills in the mail?

Some people with Medicare get their drugs through an "automatic refill" service that automatically delivers prescription drugs before they run out. To make sure you still need a prescription before they send you a refill, drug plans may offer a voluntary auto-ship program. Contact your plan for more information.

Medication Therapy Management program

Plans with Medicare drug coverage must offer additional free Medication Therapy Management services to plan members who meet certain requirements. Members who qualify can get these services to help them understand how to manage and use their drugs safely. Medication Therapy Management services usually include a discussion with a pharmacist or health care provider to review your medications. These services may vary in some plans.

The pharmacist or health care provider may talk with you about:

- How well your medications are working
- Whether your medications have side effects
- If there might be interactions between the drugs you're taking
- Whether you can get lower costs
- Other problems you're having

Contact your plan for specific details and to see if you're eligible for a Medication Therapy Management program. Or visit **Medicare.gov/plan-compare** to find and compare health and drug plans.

Part D Senior Savings Model

You may be able to join a drug plan that gives supplemental benefits for insulin starting January 1, 2021. The Part D Senior Savings Model is available to all people with Medicare. Plans that participate in this model will offer coverage choices that include multiple types of insulin at a maximum **copayment** of $35 for a 30-day supply. People who enroll in a participating plan could save up to $446 a year in out-of-pocket costs. Visit **Medicare.gov/plan-compare** to find a participating plan in your state.

How do other insurance and programs work with Medicare drug coverage?

Medicaid

If you have Medicare and full Medicaid coverage, Medicare covers your prescription drugs.

Medicaid may still cover some drugs that Medicare doesn't cover.

Note: You automatically qualify for **Extra Help** if you have Medicare and Medicaid (see page 219).

Employer or union health coverage

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

Note: If you get Medicare drug coverage, you, your spouse, or your dependents may lose your employer or union health coverage.

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COBRA

This is a federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. There may be reasons why you should take Part B instead of, or in addition to, COBRA coverage (see page 28). However, if you take COBRA and it includes **creditable prescription drug coverage**, you'll have a Special Enrollment Period to get Medicare drug coverage 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 288 – 294 for the phone number.

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Medicare Supplement Insurance (Medigap) with drug coverage

Medigap policies can no longer be sold with drug coverage, but if you currently have Medigap with drug coverage, you can keep it. 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 196 – 200).

You can't have drug coverage in both Medigap and your Medicare drug plan. If you join a Medicare drug plan, tell your Medigap insurance company so they can remove the drug coverage and adjust your **premiums**. Call your Medigap insurance company for more information.

Note: Keep any creditable 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 or certificates to Medicare.

How does other government insurance work with Medicare drug coverage?

The types of insurance listed below are all considered **creditable prescription drug coverage**. In most cases, it's to your advantage to keep this coverage if you have it.

Federal Employee Health Benefits Program (FEHB)

This is health coverage for current and retired federal employees and covered family members. These plans usually include creditable prescription drug coverage, so you don't need to get Medicare drug coverage. However, if you decide to get Medicare drug coverage, you can keep your FEHB plan, and in most cases, the **Medicare plan** will pay first. For more information, visit **opm.gov/healthcare-insurance/healthcare**, or call the Office of Personnel Management at 1 888 767 - 6738. TTY users can call 1 800 877 - 8339. If you're an active federal employee, contact your Benefits Officer. Visit **apps.opm.gov/abo** for a list of Benefits Officers. You can also call your plan if you have questions.

Veterans' benefits

This is health coverage for veterans and people who have served in the U.S. military. You may be able to get 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 drug at the same time. For more information, visit **va.gov**, or call the VA at 1 800 827 - 1000. TTY users can call 711.

CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs)

This is a comprehensive health care program in which the Department of Veterans Affairs shares the cost of covered health care services and supplies with eligible beneficiaries. You may join a Medicare drug plan, but if you do, you won't be able to use the Meds by Mail program which can give your maintenance drugs to you at no charge (no premiums, **deductibles**, and **copayments**). For more information, visit **va.gov/communitycare/programs/dependents/champva/** or call CHAMPVA at 1 800 733 - 8387.

TRICARE (military health benefits)

This is a health care plan for active-duty service members, military retirees, and their families. **Most people with TRICARE entitled to Part A must have Part B to keep TRICARE drug benefits**. If you have TRICARE, you don't need to join a Medicare drug plan. However, if you do, your Medicare drug plan pays first, and TRICARE pays second.

If you join a **Medicare Advantage Plan** with 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. Otherwise, you can file your own claim to get paid back for your out-of-pocket costs. For more information, visit **tricare.mil**, or call the TRICARE Pharmacy Program at 1 877 363 - 1303. TTY users can call 1 877 540 - 6261.

Indian Health Service (IHS)

The IHS is the primary health care provider to the American Indian/Alaska Native Medicare population. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services through a network of hospitals, clinics, and other entities. Many Indian health facilities participate in the Medicare drug program. If you get 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 or Medicare Advantage Plan with drug coverage may help your Indian health facility because the plan pays the Indian health facility for the cost of your drugs. 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.

Note: If you're getting care through an IHS or tribal health facility or program without being charged, you can continue to do so for some or all of your care. Getting Medicare doesn't affect your ability to get services through the IHS and tribal health facilities.

Notes

Section 7: Get help paying your health & drug costs

Get Extra Help paying your Medicare drug costs

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

Extra Help is a program to help people with limited income and resources pay Medicare drug costs.
You may qualify for Extra Help if your yearly income and resources are below these limits in 2020:

- **Single person:** If your yearly income is less than $19,140 per year and your other resources are less than $13,110 per year
- **Married person living with a spouse and no other dependents:** If your yearly income is less than $25,860 and your other resources are less than $26,160 per year

Underlined words are defined on pages 295 – 302.

These amounts may change in 2021. You may qualify even if you have a higher income (like if you still work, live in Alaska or Hawaii, or have dependents 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 or **Medicare Advantage Plan** with drug coverage, you'll:

- Get help paying your drug coverage costs.
- Have no late enrollment penalty.

Note: Extra Help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa. See page 233 for information about programs available in those areas.

Shopping tip

Most people with Medicare can only make changes to their drug coverage at certain times of the year. If you have Medicaid or receive **Extra Help**, you may be able to make changes to your coverage one time during each of these periods:

- January – March
- April – June
- July – September

If you make a change, it will begin the first day of the following month. You'll have to wait for the next period to make another change. You can't use this Special Enrollment Period October – December. However, all people with Medicare can make changes to their coverage October 15 – December 7. The changes will begin on January 1.

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 232 – 233.
- You get Supplemental Security Income (SSI) benefits.

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

- If you don't already have Medicare drug coverage, you must get it to use this Extra Help.
- If you don't have drug coverage, Medicare may enroll you in a Medicare drug plan so that you'll be able to use the **Extra Help**. If Medicare enrolls you in a plan, you'll get a yellow or green letter letting you know when your coverage begins, and you'll have a Special Enrollment Period to change plans.

- 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 **Medicare.gov/plan-compare**, or call 1 800 633 - 4227 to compare your plan with other plans in your area. TTY users can call 1 877 486 - 2048.
- If you have Medicaid and live in certain institutions (like a nursing home) or get home- and community-based services, you pay nothing for your covered 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 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. Tell them you don't want to be in a Medicare drug plan (you want to "opt out"). If you continue to qualify for Extra Help 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 get Medicare drug coverage, you may lose your employer or union coverage (for you and your dependents) even if you qualify for Extra Help. Call your employer's benefits administrator before you get Medicare drug coverage.

Drug costs in 2021 for people who qualify are generally no more than $3.70 for each generic drug and $9.20 for each brand-name drug. Look on the Extra Help letters you get, or contact your plan to find out your exact costs.

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

- Visit **socialsecurity.gov/i1020** to apply online.
- Call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778.

Note: When you apply for Extra Help, you also can start an application for a Medicare Savings Programs. These state programs provide help with other Medicare costs. Social Security will send information to your state unless you tell them not to on the Extra Help application.

To get answers to your questions about Extra Help and help choosing drug coverage, call your State Health Insurance Assistance Program (SHIP). See pages 288 – 294 for the phone number. You can also call 1 800 633 - 4227.

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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:** If you're eligible, the QMB Program helps pay for Part A and/or Part B **premiums.** In addition, Medicare providers aren't allowed to bill you for services and items Medicare covers, including **deductibles**, **coinsurance**, and **copayments**. If you get a bill for these charges, tell your provider or the debt collector that you're in the QMB Program and can't be charged for Medicare deductibles, coinsurance, and copayments. If you've already made payments on a bill for services and items Medicare covers, you have the right to a refund. If you're enrolled in a **Medicare Advantage Plan**, you should also contact the plan to ask them to stop the charges.

Note: To make sure your provider knows you're in the QMB Program, show both your Medicare and Medicaid or QMB card each time you get care. You can also give your provider a copy of your "Medicare Summary Notice" (MSN). Your MSN will show you're in the QMB Program and shouldn't be billed. Log into your secure Medicare account online at **MyMedicare.gov** any time to sign up to get your MSNs electronically.

If your provider won't stop billing you, call us at 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. We can also confirm that you're in the QMB Program.

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.** Funding for QI benefits is limited, 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.

If you qualify for a QMB, SLMB, or QI Program, you automatically qualify to get **Extra Help** paying for Medicare drug coverage (see pages 219 – 223).

Important!

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

How do I qualify?

In most cases, to qualify for a Medicare Savings Program, you must have income and resources below a certain limit.

States have different limits and ways of counting your income and resources, so you should check with your state Medicaid office to see if you qualify.

For more information

- Call or visit your Medicaid office (State Medical Assistance Office), and ask for information about Medicare Savings Programs. To get the phone number for your state, visit **Medicare.gov/contacts**. You can also call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.
- Contact your State Health Insurance Assistance Program (SHIP). See pages 288 – 294 for the phone number.

Medicaid

Medicaid is a joint federal and state program that helps pay health care costs if you have limited income and resources and meet other requirements. Some people qualify for both Medicare and Medicaid.

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**.
- If you have Medicare and full Medicaid coverage, Medicare covers your prescription drugs. You automatically qualify for **Extra Help** paying your Medicare drug costs (see page 219). Medicaid may still cover some drugs that Medicare doesn't cover.
- People with Medicaid may get coverage for services that Medicare doesn't cover or only partially covers, like nursing home care, personal care, transportation to medical services, home- and community-based services, and dental, vision, and hearing services.

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 most cases, you need to be enrolled in Medicare, if eligible, to get Medicaid.
- Call your Medicaid office for more information and to see if you qualify. Visit **Medicare.gov/contacts**, or call 1 800 633 - 4227.

Medicare-Medicaid Plans

Medicare is working with some states and health plans to offer **demonstration** plans for certain people who have both Medicare and Medicaid and make it easier for them to get the services they need. They’re called Medicare-Medicaid Plans. These plans include drug coverage and are only in certain states. If you’re interested in joining a Medicare-Medicaid Plan, visit **Medicare.gov/plan-compare** to see if one is available in your area.

State Pharmacy Assistance Programs

Many states have State Pharmacy Assistance Programs that help certain people pay for prescription drugs based on financial need, age, or medical condition. To find out if there's a State Pharmacy Assistance Programs in your state and how it works, call your State Health Insurance Assistance Program (SHIP). See pages 288 – 294 for the phone number. You can also visit **Medicare.gov/pharmaceutical-assistance-program/#state-programs**.

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 **Medicare.gov/pharmaceutical-assistance-program** 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 169 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 blind, 65 or older, or have a disability. These benefits aren't the same as Social Security retirement benefits. You may be able to get both SSI and Social Security benefits at the same time if your Social Security benefit is less than the SSI benefit amount, due to a limited work history, a history of low-wage work, or both. If you're eligible for SSI, you automatically qualify for **Extra Help**, and are usually eligible for Medicaid.

You can visit **benefits.gov/ssa**, 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 can 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 Medicaid office (State Medical Assistance Office) to learn more. Visit **Medicare.gov/contacts**, or call 1 800 633 - 4227 to get the phone number. TTY users can call 1 877 486 - 2048.

Notes

Section 8: Know your rights & protect yourself from fraud

What are my Medicare rights?

All people with Medicare have certain rights and protections. You have the right to:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Have personal and health information kept private
- Get information in a format and language you understand from Medicare, health care providers, **Medicare plans**, and Medicare contractors
- Get answers to your Medicare questions
- Have access to doctors, other health care providers, specialists, and hospitals for **medically necessary** services

Underlined words are defined on pages 295 – 302.

- Learn about your treatment choices in clear language you can understand, and participate in treatment decisions
- Get Medicare-covered services in an emergency
- Get a decision about health care payment, coverage of services, or drug coverage
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or drug coverage
- File complaints (sometimes called “grievances”), including complaints about the quality of their care

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What are my rights if my plan stops participating in Medicare?

Medicare health and drug plans can decide not to participate in Medicare for the coming year. In these cases, your coverage under the plan will end after December 31. Your plan will send you a letter explaining your options. If this happens:

- You can choose another plan between October 15–December 7. Your coverage will begin January 1.
- **You'll also have a special right to join another Medicare plan until February 28, 2021.**
- You may have the right to buy certain Medigap policies within 63 days after your plan coverage ends.

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 drug you think Medicare should cover.
- A request for payment of a health care service, supply, item, or drug you already got.
- A request to change the amount you must pay for a health care service, supply, item, or drug.

You can also appeal:

- If Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or drug you think you still need.
- An at-risk determination made under a drug management program that limits access to coverage for frequently abused drugs, like opioids and benzodiazepines (see page 205).

If you decide to file an appeal, you can ask your doctor, supplier, or other health care provider for any information that may help your case. This will make your appeal stronger. Keep a copy of everything related to your appeal, including what you send to Medicare or your plan.

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

- Get the "Medicare Summary Notice" (MSN) that shows the item or service you're appealing. See page 131 for more information about MSNs.
- Circle the item(s) on the MSN you disagree with. Write an explanation of why you disagree with the decision. You can write on the MSN or on a separate piece of paper and attach it to the MSN.
- Include your name, phone number, and Medicare Number on the MSN. Keep a copy for your records.

- Send the MSN, or a copy, to the company that handles bills for Medicare (Medicare Administrative Contractor) listed on the MSN. You can include any other additional information you have about your appeal. Or, you can use CMS Form 20027. To view or print this form, visit **CMS.gov/cmsforms/downloads/cms20027.pdf**, or call 1 800 633 - 4227 to have a copy mailed to you. TTY users can call 1 877 486 - 2048.
- You must file your appeal by the date in the MSN. If you missed the deadline for appealing, you may still file an appeal and get a decision if you can show good cause for missing the deadline.
- You'll generally get a decision from the Medicare Administrative 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.
- You may have the right to a fast appeal if you think your Medicare services from a hospital or other facility are ending too soon. See page 244.

If you have a Medicare Advantage or other Medicare health plan

The timeframe for filing an appeal may be different than Original Medicare. Learn more by looking at the materials your plan sends you, calling your plan, or visiting **Medicare.gov/appeals**.

In some cases, you can file a fast appeal. See materials from your plan and page 243.

If you have a Medicare drug plan

You have the right to do all of these (even before you buy a certain drug):

- Get a written explanation for drug coverage decisions (called a “coverage determination”) from your Medicare drug plan. A coverage determination is the first decision your Medicare drug plan (not the pharmacy) makes about your benefits. This can be a decision about if your drug is covered, if you met the plan’s requirements to cover the drug, or how much you pay for the drug. You’ll also get a coverage determination decision if you ask your plan to make an exception to its rules to cover your drug.

- Ask for an exception if you or your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) believes you need a drug that isn't on your plan's list of covered drugs (**formulary**).
- Ask for an exception if you or your prescriber believes that your plan should waive a coverage rule (like prior authorization).
- Ask for an exception if you think you should pay less for a higher tier drug because you or your prescriber believe you can't take any of the lower tier drugs for the same condition.

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How do I ask for a coverage determination or exception?

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.

If you're asking for drug benefits you haven't gotten yet, you or your prescriber may make a standard request or an expedited (fast) request by phone or in writing. 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 your plan should approve the exception.

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 (or that you're being discharged too soon), you can ask for a fast appeal. Your provider will give you a notice before your services end telling you how to ask for a fast appeal. The notice might call it an "immediate appeal" or an "expedited appeal." You should read this notice carefully. If you don't get this notice, ask your provider for it. With a fast appeal, an independent reviewer will decide if your covered services should continue. You can contact your Beneficiary and Family Centered Care-Quality Improvement Organization for help with filing an appeal. See page 285 for more information.

A fast appeal only covers the decision to end services. You may need to start a separate appeals process for any items or services you may have received after the decision to end services. Visit **Medicare.gov/publications** to view the booklet "Medicare Appeals."

How can I get help filing an appeal?

You can appoint a representative to help you. Your representative can be a family member, friend, advocate, attorney, financial advisor, doctor, or someone else who will act on your behalf. For more information, visit **Medicare.gov/appeals**. You can also get help filing an appeal from your State Health Insurance Assistance Program (SHIP). See pages 288 – 294 for the phone number.

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) if they think the care they'll provide isn't covered by Medicare. 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 notice.
- If you choose to get the items or services listed on the notice, you're agreeing to pay if Medicare doesn't.
- You'll be asked to sign the notice 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 a notice for services that Medicare never covers (see page 122).

- An ABN isn't an official denial of coverage by Medicare. If Medicare denies payment, you can still file an appeal once you receive the Medicare Summary Notice showing the item or service in question. However, you'll have to pay for the items or services if Medicare decides 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 "Skilled Nursing Facility ABN" when the facility believes Medicare will no longer cover your stay or other items and services.
- You may get an ABN if you're getting Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) that are included in the DMEPOS Competitive Bidding Program and the supplier isn't a contract supplier.

What if I didn't get an ABN?

If your provider was required to give you this notice but didn't, in most cases, your provider must give you a refund for what you paid for the item or service.

Where can I get more information about appeals and the ABN?

- Visit **Medicare.gov/appeals**.
- Visit **Medicare.gov/publications** to view the booklet "Medicare Appeals."
- If you're in a **Medicare plan**, call your plan to see if it covers a service or item.

Compare tip

If you have a **Medicare Advantage Plan**, you have the right to an organization determination to see if a service, drug, or supply is covered. Contact your plan to get one and follow the instructions to file a timely appeal. You also may get plan directed care. This is when a plan provider refers you for a service or to a provider outside the network without getting an organization determination in advance (see page 150).

Your right to access your personal health information

By law, you or your legal representative generally has the right to view and/or get copies of your personal health information from health care providers who treat you, or by health plans that pay for your care, including Medicare. In most cases, you also have the right to have a provider or plan send copies of your information to a third party that you choose, like other providers who treat you, a family member, a researcher, or a mobile “app” you use to manage your personal health information.

This includes:

- Claims and billing records
- Information related to your enrollment in health plans, including Medicare
- Medical and case management records (except psychotherapy notes)
- Any other records that have information that doctors or health plans use to make decisions about you

You may have to fill out a health information “request” form, and pay a cost-based fee for copies. Your providers or plans should tell you about the fee when you make the request. If they don’t, you should ask. The fee can only be for the labor to make the copies, copying supplies, and postage (if needed). In most cases, you shouldn’t be charged for viewing, searching, downloading, or sending your information through an electronic portal.

Generally, you can get your information on paper or electronically. If your providers or plans store your information electronically, they generally must give you electronic copies, if that’s your preference.

You have the right to get your information in a timely manner, but it may take up to 30 days to fill the request.

For more information, visit **hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers**.

If you need help getting and using your health records, the Office of the National Coordinator (ONC) in the U.S. Department of Health and Human Services (HHS) created "The Guide to Getting & Using Your Health Records." This guide can help you through the process of getting your health records and show you how to make sure your records are accurate and complete, so you can get the most out of your health care. Visit **healthit.gov/how-to-get-your-health-record** to view the guide.

How does Medicare use my personal information?

Medicare protects the privacy of your health information. The next 5 pages describe how Medicare may use and give out your information, 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.

The law requires Medicare to protect the privacy of your personal medical information. It also requires us to give you this notice so you know how we may use and share ("disclose") the personal medical information we have about you.

We must provide your information to:

- You, to someone you name ("designate"), or someone who has the legal right to act for you (your personal representative)
- The Secretary of the Department of Health and Human Services, if necessary
- Anyone else that the law requires to have it

We have the right to use and provide your information to pay for your health care and to operate Medicare. For example:

- Medicare Administrative Contractors use your information to pay or deny your claims, collect your **premiums**, share your benefit payment with your other insurer(s), or prepare your "Medicare Summary Notice."
- We may use your information to provide you with customer services, resolve complaints you have, contact you about research studies, and make sure you get quality care.

We may use or share your information under these limited circumstances:

- To state and other federal agencies that have the legal right to get Medicare data (like to make sure Medicare is making proper payments and to help federal/state Medicaid programs)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like investigating fraud and abuse)

- For judicial and administrative proceedings (like responding to a court order)
- For law enforcement purposes (like providing limited information to find a missing person)
- For research studies that meet all privacy law requirements (like research to prevent a disease or disability)
- To avoid a serious and imminent threat to health or safety
- To contact you about new or changed Medicare benefits
- To create a collection of information that no one can trace to you
- To practitioners and their contractors for care coordination and quality improvement purposes, like participation in Accountable Care Organizations (ACOs)

We don't sell or use and share your information to tell you about health products or services ("marketing"). We must have your written permission (an "authorization") to use or share your information for any purpose that isn't described in this notice.

You may take back ("revoke") your written permission at any time, unless we've already shared information because you gave us permission.

You have the right to:

- See and get a copy of the information we have about you.
- Have us change your information if you think it's wrong or incomplete, and we agree. If we disagree, you may have a statement of your disagreement added to your information.
- Get a list of people who get your information from us. The listing won't cover information that we gave to you, your personal representative, or law enforcement, or information that we used to pay for your care or for our operations.
- Ask us to communicate with you in a different manner or at a different place (for example, by sending materials to a PO Box instead of your home address).
- Ask us to limit how we use your information and how we give it out to pay claims and run Medicare. We may not be able to agree to your request.

- Get a letter that tells you about the likely risk to the privacy of your information ("breach notification").
- Get a separate paper copy of this notice.
- Speak to a Customer Service Representative about our privacy notice. Call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

If you believe your privacy rights have been violated, you may file a privacy complaint with:

- The Centers for Medicare & Medicaid Services (CMS). Visit **Medicare.gov**, or call 1 800 633 - 4227.
- The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR). Visit **hhs.gov/hipaa/filing-a-complaint**.

Filing a complaint won't affect your coverage under Medicare.

The law requires us to follow the terms in this notice. We have the right to change the way we use or share your information. If we make a change, we'll mail you a notice within 60 days of the change.

The Notice of Privacy Practices for Original Medicare became effective September 23, 2013.

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, and your online Medicare account user name and password. Guard your cards and protect your Medicare and Social Security Numbers. **Keep this information safe.**

Only give personal information, like your Medicare Number, to doctors, insurance companies or plans acting on your behalf, or trusted people in the community who work with Medicare like your State Health Insurance Assistance Program (SHIP). Don't share your Medicare Number or other personal information with anyone who contacts you by phone, email, or in person. Medicare, or someone representing Medicare, will only call you in limited situations:

- A **Medicare plan** can call you if you're already a member of the plan. The agent who helped you join can also call you.

- A customer service representative from 1 800 633 - 4227 can call you if you've left a message, or a representative said that someone would call you back. TTY users can 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 can call 1 866 653 - 4261. Visit **ftc.gov/idtheft** to learn more about identity theft.

- End of Page

How can I protect myself from fraud and medical identity theft?

Medical identity theft is when someone steals or uses your personal information (like your name, Social Security Number, or Medicare Number) to submit fraudulent claims to Medicare and other health insurance companies without your permission. 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 a provider bills you for services you didn't get, take these steps 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 health 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 **MyMedicare.gov** to view your Medicare claims if you have Original Medicare. Your claims are generally available online within 24 hours after processing. You can also use Medicare's Blue Button to download your claims information. See page 274. You can also call 1 800 633 - 4227.

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 1 800 633 - 4227.

For more information about Medicare fraud, visit **Medicare.gov**, or contact your local Senior Medicare Patrol Program. For more information about the Senior Medicare Patrol or to find help in your state, visit **smpresource.org** or call 1 877 808 - 2468.

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

Plans must follow rules

Medicare plans and agents 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, or you've given them permission to contact you.

Important!

Call 1-800-MEDICARE to report any plans or agents that:

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

You can also call the Medicare Drug Integrity Contractor (MEDIC) at 1 877 772 - 3379. The MEDIC fights fraud, waste, and abuse in Medicare Advantage and Medicare drug plans.

Fighting fraud can pay

You may get a reward if you help us fight fraud and meet certain conditions. For more information, visit **Medicare.gov**, or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Investigating fraud takes time

Every tip counts. 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, but rest assured that your information is helping us protect Medicare.

- End of Page

What's the Medicare Beneficiary Ombudsman?

An "ombudsman" is a person who reviews questions, concerns, and challenges with how a program is administered, and helps to resolve them when possible.

There are several resources to get answers to your Medicare questions and get help with your Medicare coverage, like **Medicare.gov**, or call 1 800 633 - 4227, and State Health Insurance Assistance Programs (SHIPs). The Medicare Beneficiary Ombudsman works closely with those resources and Medicare to help make sure information and help are available for you and works to improve your experience with Medicare.

Visit **Medicare.gov** for information on how the Medicare Beneficiary Ombudsman can help you.

CMS Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. **Call us:**
   For Medicare: 1 800 633 - 4227
   TTY: 1 877 486 - 2048
2. **Email us: altformatrequest@cms.hhs.gov**
3. **Send us a fax:** 1 844 530 - 3676

4. **Send us a letter:**
   Centers for Medicare & Medicaid Services
   Offices of Hearings and Inquiries (OHI)
   7500 Security Boulevard, Mail Stop S1 - 13 - 25
   Baltimore, MD 21244 - 1850
   Attn: Customer Accessibility Resource Staff

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State Medicaid office.

Nondiscrimination Notice

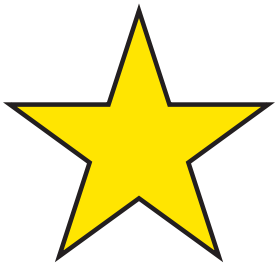
The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. **Online:**
   hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html
2. **By phone:**
   Call 1 800 368 - 1019. TTY users can call 1 800 537 - 7697.
3. **In writing:** Send information about your complaint to:
   Office for Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201

Notes



Section 9: Get more information

Where can I get personalized help?

1 800 633 - 4227
TTY users call 1 877 486 2048
Get information 24 hours a day, including weekends

- Speak clearly and follow the voice prompts to pick the category that best meets your needs.
- Have your Medicare card in front of you, and be ready to give your Medicare Number.
- When prompted for your Medicare Number, speak the numbers and letters clearly one at a time.
- If you need help in a language other than English or Spanish, or need to request a Medicare publication in an accessible format (like large print or Braille), let the customer service representative know.

Underlined words are defined on pages 295 – 302.

Important!

Do you need someone to be able to call 1 800 633 - 4227 on your behalf?

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. Visit **Medicare.gov/medicareonlineforms** to find the form or call 1 800 633 - 4227. You may want to do this now in case you're unable to do it later.

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

If you want to get only one copy of this handbook in the future, call 1 800 633 - 4227. If you want to stop getting paper copies in the mail, visit **Medicare.gov/gopaperless**.

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 at no cost to you. SHIPs aren't connected to any insurance company or health plan. SHIP staff and trained volunteers work hard to help you with these Medicare questions:

- Your Medicare rights.
- Billing problems.
- Complaints about your medical care or treatment.
- Plan comparison and enrollment.
- How Medicare works with other insurance.
- Finding help paying for health care costs.

See pages 288 – 294 for the phone number of your local SHIP. **Contact a SHIP in your state to get free personalized help with your Medicare questions, or learn how to become a volunteer SHIP counselor.**

Where can I find general Medicare information online?

Visit Medicare.gov

- Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.
- Find Medicare-participating doctors or other health care providers and suppliers.
- See what Medicare covers, including **preventive services** (like screenings, shots or vaccines, and yearly "Wellness" visits).
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospices, **inpatient rehabilitation facilities**, and **long-term care hospitals**.
- Look up helpful websites and phone numbers.

Where can I get my personal Medicare information online?

Create an account at MyMedicare.gov

- Add your prescriptions and pharmacies to help you better compare health and drug plans in your area
- Sign up to go paperless—get your yearly "Medicare & You" handbook and claims statements, called "Medicare Summary Notices," electronically
- View your Original Medicare claims as soon as they're processed
- Print a copy of your official Medicare card
- See a calendar of preventive services you're eligible to get in Original Medicare
- Learn about your Medicare premiums, and pay them online if you get a bill from Medicare

MyMedicare.gov's Blue Button®

MyMedicare.gov's Blue Button makes it easy for you to download your personal health information to a file. Having access to your information can help you make more informed decisions about your health care. Blue Button is safe, secure, reliable, and easy to use. By getting your information through Blue Button, you can:

- Download and save a file of your personal health information on your computer or other device, including your Part A, Part B, and Part D claims.
- Print or email the information to share with others after you've saved the file.
- Import your saved file into other computer-based personal health management tools.

Visit **MyMedicare.gov** to use Blue Button today.

Blue Button 2.0®

Medicare has released a new data service that makes it easy for you to share your Part A, Part B, and Part D claim information with a growing list of authorized apps, services, and research programs. You authorize each app individually and you can return to **MyMedicare.gov** any time to change the way an app uses your information.

Once you authorize sharing of your information with an app (by using your MyMedicare.gov account information), you can use that app to view your past and current Medicare claims.

For **Medicare Advantage Plans**, only Part D information is available through this service. If you have a Medicare Advantage Plan, check with your plan to see if they offer a similar service to Blue Button 2.0.

Medicare keeps a list of authorized apps. Learn more by visiting **Medicare.gov/manage-your-health/medicares-blue-button-blue-button-20/blue-button-apps**.

How do I compare the quality of health care providers?

Medicare collects information about the quality and safety of medical care and services given by most health care providers (and facilities).

Visit **Medicare.gov** and get a snapshot of information to help you determine the quality of care health care providers (and facilities) give their patients. Some feature a star rating system to help you compare quality measures that are important to you. You can ask your doctor or other health care provider about the quality of care information you find on **Medicare.gov**. You can also ask what he or she thinks about the quality of care of other providers.

How do I compare the quality of Medicare health and drug plans?

When you visit **Medicare.gov/plan-compare** to find and compare health and drug plans, you'll see a star rating system for Medicare health and drug plans. The overall star rating gives an overall rating of the plan's quality and performance for the types of services each plan offers.

For plans covering health services, this is an overall rating for the quality of many medical/health care services that fall into 5 categories and includes:

1. **Staying healthy—screening tests and vaccines:** Whether members got various screening tests, vaccines, and other check-ups to help them stay healthy.
2. **Managing chronic (long-term) conditions:** How often members with certain conditions got recommended tests and treatments to help manage their condition.
3. **Member experience with the health plan:** Member surveys of the plan.
4. **Member complaints and changes in the health plan's performance:** How often members had problems with the plan. Includes how much the plan's performance improved (if at all) over time.
5. **Health plan customer service:** How well the plan handles member calls and questions.

For plans that cover prescription drugs, this is an overall rating for the quality of drug-related services that fall into 4 categories and includes:

1. **Drug plan customer service:** How well the plan handles member calls and questions.
2. **Member complaints and changes in the drug plan's performance:** How often members had problems with the plan. Includes how much the plan's performance improved (if at all) over time.
3. **Member experience with drug plan:** Member surveys of the plan.
4. **Drug safety and accuracy of drug pricing:** How accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that's safer and clinically recommended for their condition.

For plans that cover **both** health services and prescription drugs, the overall rating for quality and performance covers all of the topics above.

You can compare the quality of health care providers and **Medicare plan** services nationwide by visiting **Medicare.gov** or by calling your State Health Insurance Assistance Program (SHIP). See pages 288 – 294 for the phone number.

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.

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

Electronic Health Records

Electronic Health Records are a history of your health care or treatment that your doctor, other health care provider, medical office staff, or hospital keeps on a computer.

- They can help lower the chances of medical errors, eliminate duplicate tests, and may improve your overall quality of care.
- Your doctor's Electronic Health Records may be able to link to a hospital, lab, pharmacy, other doctors, or immunization information systems (registries), so the people who care for you can have a more complete picture of your health.

Electronic prescribing

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

Accountable Care Organizations (ACO)

An ACO is a group of doctors, hospitals, and/or other health care providers that work together to improve the quality and experience of care you get. These organizations help health care providers better coordinate your care and give you better quality care. Coordinated care saves time and costs by avoiding repeated tests and unneeded appointments. It may make it easier to spot potential problems before they become more serious—like drug interactions that can happen if one doctor isn't aware of what another has prescribed. Medicare evaluates how well each organization meets these goals every year. ACOs that do a good job can earn a financial bonus. If they earn a bonus, these organizations may use the payment to invest more in your care or share a portion directly with your health care providers. Sometimes, ACOs may owe money to Medicare if their care increases costs.

An ACO can't limit your choice of health care providers. Your Medicare benefits aren't changing. You still have the right to visit any doctor, hospital, or other provider that accepts Medicare at any time, just like you do now. It **isn't** a **Medicare Advantage Plan**, which is an "all in one" alternative to Original Medicare, offered by private companies approved by Medicare. It also **isn't** an HMO plan, or an insurance plan of any kind.

Note: If your doctor has notified you that they're participating in an ACO and you need **skilled nursing facility care**, talk to your doctor about the Skilled Nursing Facility 3-Day Rule Waiver. This waiver may allow Medicare to cover certain skilled nursing facility services without requiring you to have a 3-day inpatient hospital stay before getting skilled nursing facility coverage. The 3-Day Rule Waiver doesn't apply if you could be treated as an outpatient, or require long-term care.

Sharing your information with ACOs

To help your providers coordinate your health care better, Medicare gives certain information about your care available to ACOs that are working with your health care providers. Giving your data to your ACO and doctor helps make sure all the providers involved in your care have access to your health information when and where they need it. If you don't want Medicare to share your health care information in this manner, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. If you decide you don't want Medicare to give your health care information to your ACO or doctor, Medicare will continue to use your information for some purposes, like evaluating the financial and quality of care performance of the health care providers participating in ACOs. If you have questions or concerns, you can talk about them during your office visit with your health care provider.

Note: Patients whose primary doctor participates in an ACO may have access to additional tools or services. Log into your Medicare account online at **MyMedicare.gov** to select a primary doctor who can help you manage your health care in an ACO.

For more information about ACOs, visit **Medicare.gov**, or call 1 800 633 - 4227.

Are there other ways to get Medicare information?

Publications

Visit **Medicare.gov/publications** to view, print, or download copies of publications on different Medicare topics. You can also call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. Accessible formats are available at no cost. See page 264 for more information.

Social media

Stay up to date and connect with other people with Medicare by following us on Facebook (**facebook.com/Medicare**) and Twitter (**twitter.com/MedicareGov**).

Videos

Visit **YouTube.com/cmshhsgov** to see videos covering different health care topics.

Blogs

Visit **Medicare.gov/blog** for up-to-date information on important topics.

Other helpful contacts

Social Security

At **socialsecurity.gov** to apply for and enroll in Original Medicare, and see if you qualify for **Extra Help** with Medicare drug costs. Also, when you open a personal "my Social Security" account, you can review your Social Security Statement, verify your earnings, change your direct deposit information, request a replacement Medicare card, and more. Visit **socialsecurity.gov/myaccount** to open your personal account. You can also call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778.

Benefits Coordination & Recovery Center

Contact the Benefits Coordination & Recovery Center at 1 855 798 - 2627. TTY users can call 1 855 797 - 2627 to report changes in your insurance information or to let Medicare know if you have other insurance.

Beneficiary and Family Centered Care-Quality Improvement Organization

Contact your Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if you think Medicare coverage for your service is ending too soon (like if your hospital says that you must be discharged and you disagree). You may have the right to a fast appeal if you think your Medicare-covered services are ending too soon. You can also contact them to ask questions or report complaints about the quality of care you got for a Medicare-covered service (and you aren't satisfied with the way your provider has responded to your concern). Visit **Medicare.gov/contacts**, or call 1 800 633 - 4227 to get the phone number of your BFCC-QIO. TTY users can call 1 877 486 - 2048.

Department of Defense

Get information about TRICARE for Life (TFL) and the TRICARE Pharmacy Program.

TFL:

1-866-773-0404, TTY: 1-866-773-0405
tricare.mil/tfl
tricare4u.com

TRICARE Pharmacy Program:

1 877 363 - 1303, TTY: 1 877 540 - 6261
tricare.mil/pharmacy
express-scripts.com/tricare

Department of Veterans Affairs (VA)

Contact the VA if you're a veteran or have served in the U.S. military and you have questions about veteran benefits.

1 800 827 - 1000, TTY: 711
va.gov
vets.gov
eBenefits.va.gov

Office of Personnel Management

Get information about the Federal Employee Health Benefits Program for current and retired federal employees.

Retirees: 1 888 767 - 6738, TTY: 1 800 877 - 8339
opm.gov/healthcare-insurance

Active federal employees: Contact your Benefits Officer. Visit **apps.opm.gov/abo** for a list of Benefits Officers.

Railroad Retirement Board (RRB)

If you get 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

rrb.gov

State Health Insurance Assistance Programs (SHIPs)

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

Alabama State Health Insurance Assistance Program (SHIP) 1 800 243 - 5463

Alaska Medicare Information Office
1 800 478 - 6065 TTY: 1 800 770 - 8973

Arizona Arizona State Health Insurance Assistance Program (SHIP) 1 800 432 - 4040

Arkansas Senior Health Insurance Information Program (SHIIP) 1 800 224 - 6330

California California Health Insurance Counseling & Advocacy Program (HICAP) 1 800 434 - 0222

Colorado State Health Insurance Assistance Program (SHIP) 1 888 696 - 7213

Connecticut Connecticut's Program for Health Insurance Assistance, Outreach, Information & Referral, Counseling, Eligibility Screening (CHOICES)
1 800 994 - 9422

Delaware Delaware Medicare Assistance Bureau 1 800 336 - 9500

Florida Serving Health Insurance Needs of Elders (SHINE) 1 800 963 - 5337 TTY: 1 800 955 - 8770

Georgia GeorgiaCares SHIP 1 866 552 - 4464 (option 4)

Guam Guam Medicare Assistance Program (GUAM MAP) 1 671 735 - 7415

Hawaii Hawaii SHIP 1 888 875 - 9229
TTY: 1 866 810 - 4379

Idaho Senior Health Insurance Benefits Advisors (SHIBA)
1 800 247 - 4422

Illinois Senior Health Insurance Program (SHIP)
1 800 252 - 8966 TTY: 1 888 206 - 1327

Indiana State Health Insurance Assistance Program (SHIP) 1 800 452 - 4800
TTY: 1 866 846 - 0139

Iowa Senior Health Insurance Information Program (SHIIP) 1 800 351 - 4664 TTY: 1 800 735 - 2942

Kansas Senior Health Insurance Counseling for Kansas (SHICK) 1 800 860 - 5260

Kentucky State Health Insurance Assistance Program (SHIP) 1 877 293 - 7447

Louisiana Senior Health Insurance Information Program (SHIIP) 1 800 259 - 5300

Maine Maine State Health Insurance Assistance Program (SHIP) 1 800 262 - 2232

Maryland State Health Insurance Assistance Program (SHIP) 1 800 243 - 3425

Massachusetts Serving Health Insurance Needs of Everyone (SHINE) 1 800 243 - 4636
TTY: 1 877 610 - 0241

Michigan MMAP, Inc. 1 800 803 - 7174

Minnesota Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 1 800 333 - 2433

Mississippi MS State Health Insurance Assistance Program (SHIP) 844 822 - 4622

Missouri CLAIM 1 800 390 - 3330

Montana Montana State Health Insurance Assistance Program (SHIP) 1 800 551 - 3191

Nebraska Nebraska SHIP 1 800 234 - 7119

Nevada State Health Insurance Assistance Program (SHIP) 1 800 307 - 4444

New Hampshire NH SHIP – ServiceLink Resource Center 1 866 634 - 9412

New Jersey State Health Insurance Assistance Program (SHIP) 1 800 792 - 8820

New Mexico New Mexico ADRC/SHIP 1 800 432 - 2080

New York Health Insurance Information Counseling and Assistance Program (HIICAP) 1 800 701 - 0501

North Carolina Seniors' Health Insurance Information Program (SHIIP) 1 855 408 - 1212

North Dakota State Health Insurance Counseling (SHIC) 1 888 575 - 6611 TTY: 1 800 366 - 6888

Ohio Ohio Senior Health Insurance Information Program (OSHIIP) 1 800 686 - 1578

Oklahoma Oklahoma Medicare Assistance Program (MAP) 1 800 763 - 2828

Oregon Senior Health Insurance Benefits Assistance (SHIBA) 1 800 722 - 4134

Pennsylvania APPRISE 1 800 783 - 7067

Puerto Rico State Health Insurance Assistance Program (SHIP) 1 877 725 - 4300
TTY: 1 878 919 - 7291

Rhode Island Senior Health Insurance Program (SHIP) 1 888 884 - 8721

South Carolina Insurance Counseling Assistance and Referrals for Elders (I-CARE) 1 800 868 - 9095

South Dakota Senior Health Information & Insurance Education (SHIINE) 1 800 536 - 8197

Tennessee TN SHIP 1 877 801 - 0044
TTY: 1 800 848 - 0299

Texas Health Information Counseling and Advocacy Program (HICAP) 1 800 252 - 9240

Utah Senior Health Insurance Information Program (SHIP) 1 800 541 - 7735

Vermont State Health Insurance Assistance Program (SHIP) 1 800 642 - 5119

Virgin Islands Virgin Islands State Health Insurance Assistance Program (VISHIP)
1 340 772 - 7368 St. Croix area
1 340 714 - 4354 St. Thomas area

Virginia Virginia Insurance Counseling and Assistance Program (VICAP) 1 800 552 - 3402

Washington Statewide Health Insurance Benefits Advisors (SHIBA)
1 800 562 - 6900 TTY: 1 360 586 - 0241

Washington D.C. DC SHIP 1 202 727 - 8370

West Virginia West Virginia State Health Insurance Assistance Program (WV SHIP) 1 877 987 - 4463

Wisconsin WI State Health Insurance Assistance Program (SHIP) 1 800 242 - 1060

Wyoming Wyoming State Health Insurance Information Program (WSHIIP) 1 800 856 - 4398

Section 10: Definitions

Assignment

An agreement by your doctor, 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 SNF. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF 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 drug.
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 drug.

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 located in a rural area more than 35 miles (or 15 miles if mountainous terrain or in areas with only secondary roads) from another hospital or critical access hospital. This facility provides 24/7 emergency care, has 25 or fewer inpatient beds, and maintains an average length of stay of 96 hours or less for acute care patients.

Custodial care

Non-skilled personal care, like 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 improvements in Medicare coverage, payment, and quality of care. They usually operate only 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 program costs, like premiums, deductibles, and coinsurance.

Formulary

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Inpatient rehabilitation facility

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

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 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

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Medicare services aren't paid for by Original Medicare

Most Medicare Advantage Plans offer prescription drug coverage.

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 Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private companies and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare plan

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.

National Provider Identifier (NPI)

A unique identification number for covered health care providers.

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

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.

Referral

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

Service area

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

Skilled nursing facility (SNF) care

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.

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Help in other languages

If you, or someone you're helping, has questions about Medicare, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1 800 633 - 4227.

العربية (Arabic) إن كان لديك أو لدى شخص تُساعده أسئلة بخصوص Medicare فإن من حقك الحصول على المساعدة و المعلومات بلغتك من دون أي تكلفة. للتحدث مع مترجم إتصل بالرقم MEDICARE (1-800-633-4227).

հայերեն (Armenian) Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Medicare-ի մասին, ապա Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք 1-800-MEDICARE (1-800-633-4227) հեռախոսահամարով:

中文 (Chinese-Traditional) 如果您，或是您正在協助的個人，有關於聯邦醫療保險的問題，您有權免費以您的母語，獲得幫助和訊息。與翻譯員交談，請致電 1-800-MEDICARE (1-800-633-4227).

فارسی (Farsi) اگر شما، یا شخصی که به او کمک میرسانید سوالی در مورد اعلامیه مختصر مدیکردارید، حق این را دارید که کمک و اطلاعات به زبان خود به طور رایگان دریافت نمایید. برای مکالمه با مترجم با این شماره زیر تماس بگیرید 1-800-MEDICARE (1-800-633-4227).

Français (French) Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions au sujet de l'assurance-maladie Medicare, vous avez le droit d'obtenir de l'aide et de l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le 1-800-MEDICARE (1-800-633-4227).

Deutsch (German) Falls Sie oder jemand, dem Sie helfen, Fragen zu Medicare haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-MEDICARE (1-800-633-4227) an.

Kreyòl (Haitian Creole) Si oumenm oswa yon moun w ap ede, gen kesyon konsènan Medicare, se dwa w pou jwenn èd ak enfòmasyon nan lang ou pale a, san pou pa peye pou sa. Pou w pale avèk yon entèprèt, rele nan 1-800-MEDICARE (1-800-633-4227).

Italiano (Italian) Se voi, o una persona che state aiutando, vogliate chiarimenti a riguardo del Medicare, avete il diritto di ottenere assistenza e informazioni nella vostra lingua a titolo gratuito. Per parlare con un interprete, chiamate il numero 1-800-MEDICARE (1-800-633-4227).

日本語 **(Japanese)** Medicare (メディケア) に関するご質問がある場合は、ご希望の言語で情報を取得し、サポートを受ける権利があります (無料)。通訳をご希望の方は、1-800-MEDICARE (1-800-633-4227) までお電話ください。

한국어(Korean) 만약 귀하나 귀하가 돕는 어느 분이 메디케어에 관해서 질문을 가지고 있다면 비용 부담이 없이 필요한 도움과 정보를 귀하의 언어로 얻을 수 있는 권리가 귀하에게 있습니다. 통역사와 말씀을 나누시려면 1-800-MEDICARE (1-800-633-4227)로 전화하십시오.

Polski (Polish) Jeżeli Państwo lub ktoś komu Państwo pomagają macie pytania dotyczące Medicare, mają Państwo prawo do uzyskania bezpłatnej pomocy i informacji w swoim języku. Aby rozmawiać z tłumaczem, prosimy dzwonić pod numer telefonu 1-800-MEDICARE (1-800-633-4227).

Português (Portuguese) Se você (ou alguém que você esteja ajudando) tiver dúvidas sobre a Medicare, você tem o direito de obter ajuda e informações em seu idioma, gratuitamente. Para falar com um intérprete, ligue para 1-800-MEDICARE (1-800-633-4227).

Русский **(Russian)** Если у вас или лица, которому вы помогаете, возникли вопросы по поводу программы Медикэр (Medicare), вы имеете право на бесплатную помощь и информацию на вашем языке. Чтобы воспользоваться услугами переводчика, позвоните по телефону 1-800-MEDICARE (1-800-633-4227).

Español (Spanish) Si usted, o alguien que esta ayudando, tiene preguntas sobre Medicare, usted tiene el derecho a obtener ayuda e informacion en su idioma sin costo alguno. Para hablar con un interprete, llame al 1-800-MEDICARE (1-800-633-4227).

Tagalog (Tagalog) Kung ikaw, o ang isang tinutulungan mo, ay may mga katanungan tungkol sa Medicare, ikaw ay may karapatan na makakuha ng tulong at impormasyon sa iyong lenguwahe ng walang gastos. Upang makipag-usap sa isang tagasalin ng wika, tumawag sa 1-800-MEDICARE (1-800-633-4227).

Tiếng Việt (Vietnamese) Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Medicare, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện qua thông dịch viên, gọi số 1-800-MEDICARE (1-800-633-4227).

The information in “Medicare & You” describes the Medicare Program at the time it was printed. Changes may occur after printing. Visit **Medicare.gov**, or call 1 800 633 - 4227 to get the most current information. TTY users can 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.

General comments about this handbook are welcome. Email us at **medicareandyou@cms.hhs.gov**.

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HEALTH AND HUMAN SERVICES

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