CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare & You

2011

This is the official U.S. government Medicare handbook with important information about the following:

- ★ What's new
- ★ Medicare costs
- ★ What Medicare covers
- ★ Health and prescription drug plans
- ★ Your Medicare rights
- ★ Signing up to get future handbooks electronically

Welcome to Medicare & You 2011

I'm honored and excited to announce the 2011 Medicare handbook—the best and official source of answers to your Medicare questions. At the Department of Health and Human Services, we're doing more than ever to carry Medicare into the future.

The Affordable Care Act makes many improvements to Medicare. Moreover, it guarantees that you will continue to have your basic Medicare benefits—whether you get them through Original Medicare or a Medicare Advantage Plan.

As an example of the types of improvements underway, if you have Medicare prescription drug coverage with a coverage gap (also known as the "donut hole"), the new law will reduce that gap over several years to make prescription drugs even more affordable. If you reach the coverage gap in 2010, you may qualify to get a one-time $250 rebate check. If you reach the coverage gap in 2011, you may get a 50% discount on brand-name prescription drugs when you buy them. There will be additional savings in the coverage gap each year through 2020, when the donut hole is closed completely. The new law also prevents Medicare Advantage Plans from charging you more than Original Medicare for cancer treatment and certain other services that you might need.

If you have Original Medicare, you will now be able to get a yearly wellness exam and most preventive services for free. If you're in a Medicare Advantage Plan, check with your plan to see if these benefits will also be free for you.

Doctors, hospitals, and Medicare Advantage Plans will have new incentives to improve the quality of care you receive. There will be better coordination of your care after you're discharged from a hospital to ensure that you get the services you need after your hospital stay. It will also be easier to find out which long-term care hospitals, inpatient rehabilitative hospitals, and hospice care programs provide better care in your area.

These are just a few of the exciting new changes to help improve your health care now and in the future, while continuing to keep you healthy, Medicare strong, and your personal information safe.

If you have questions, visit Medicare's new and improved Web site at www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). You can also call your local State Health Insurance Assistance Program (SHIP) or area agency on aging, or visit the Administration on Aging at www.aoa.gov.

Sincerely,

/s/

Kathleen Sebelius

Secretary

U.S. Department of
Health and Human Services

/s/

Donald M. Berwick, MD

Administrator

Centers for Medicare & Medicaid
Services

Tools to Help You Find What You Need in This Handbook

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

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	Highlights important information	Throughout handbook
	Highlights preventive services	Pages 29–45
	Highlights information related to Medicare Part A	Throughout handbook
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"Medicare & You" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Want to Save?

Extra Help is available!

Many people qualify to get Extra Help paying their Medicare prescription drug costs but don't know it. Most who qualify and join a Medicare drug plan will get 95% of their costs covered. Don't miss out on a chance to save. Extra Help and other programs (like Medicare Savings Programs) may help make your health care and prescription drug costs more affordable. See pages 85–92 for more information about Extra Help and other programs.

Choose to get future handbooks electronically.

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

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

This may happen if there is a slight difference in how your or your spouse's address is entered in Social Security or the Railroad Retirement Board's (RRB) mailing system. If you would like to get only one copy in the future, call 1-800-MEDICARE (1-800-633-4227), and say "Agent." TTY users should call 1-877-486-2048. If you get RRB benefits, call your local RRB office or 1-877-772-5772.

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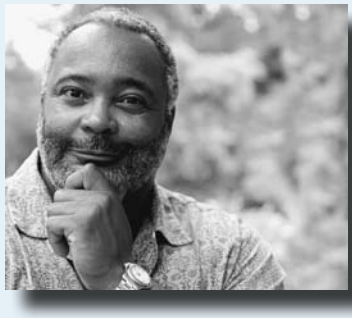

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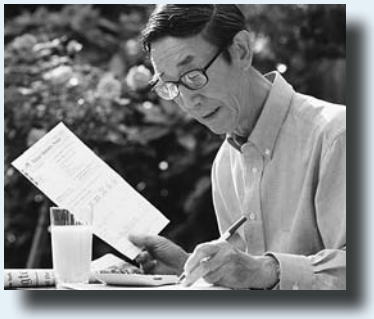

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What You Need to Know in 2011

Blue words in the text are defined on pages 127–130.

Pay Less for Preventive Services See pages 29–45.

You will pay no deductible or coinsurance for most preventive services.

Durable Medical Equipment (DME) See pages 34–35.

If you live in certain areas, you may have to get your durable medical equipment (such as walkers) from specific suppliers. This program will help save you and Medicare money and make sure that you get quality equipment and supplies.

New Yearly Wellness Exam See page 39.

You can get a wellness exam each year to help you stay healthy.

New Dates to Change Plans See pages 13, 68, and 73.

Find out when you can make changes to your health and prescription drug coverage.

Help in the Prescription Drug Coverage Gap See page 76.

If you reach the coverage gap in your Medicare prescription drug coverage, you may qualify for savings on brand-name and generic drugs.

Fighting Medicare Fraud See pages 105–107.

Find out what Medicare is doing and what you can do to protect against fraud, waste, and abuse.

Ways to Manage Your Health Information Online See pages 120–121.

There are tools to help you manage your health information while reducing paperwork and errors, and improving your quality of care.

What You Pay for Medicare See pages 131–134.

Medicare Part A and Part B premiums, deductibles, copayments, and coinsurance are on pages 131–133. Information about Medicare Part C and Part D costs is on page 134.

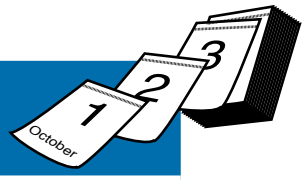
Medicare Health and Prescription Drug Plans

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

Coverage and Costs Change Yearly.

Your Medicare health or prescription drug plan can change how much it costs and what it covers each year. Even if your plan's cost and coverage stay the same, your health or finances may have changed. Review your plan each year to make sure it will still meet your needs. If you're satisfied with your current coverage, you don't need to change plans.

Fall Open Enrollment Period



Mark your calendar with these important dates!

Note: The Open Enrollment Period dates will change to give you more time if you want to choose and join a Medicare health or prescription drug plan.

September 2011	Compare your coverage with other available options to see if there's a better choice for you. See page 15.
October 15, 2011–December 7, 2011	You can change your Medicare health or prescription drug coverage for 2012. See pages 68 and 73 for other times when you can switch your coverage.
January 1, 2012	New coverage begins if you switched or joined a plan. New costs and coverage changes also begin if you kept your existing coverage.

Is your health or drug plan leaving Medicare? Health and prescription drug plans can decide not to participate in Medicare for the coming year. Your plan will send you a letter if it leaves Medicare or stops providing coverage in your area. See page 94 for more information about your rights and options.

Medicare Basics

What Is Medicare?

Medicare is health insurance for the following:

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

The Different Parts of Medicare

The different parts of Medicare help cover specific services:

Medicare Part A (Hospital Insurance)

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

See pages 26–28.

Medicare Part B (Medical Insurance)

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

See pages 29–45.

Medicare Part D (Medicare Prescription Drug Coverage)

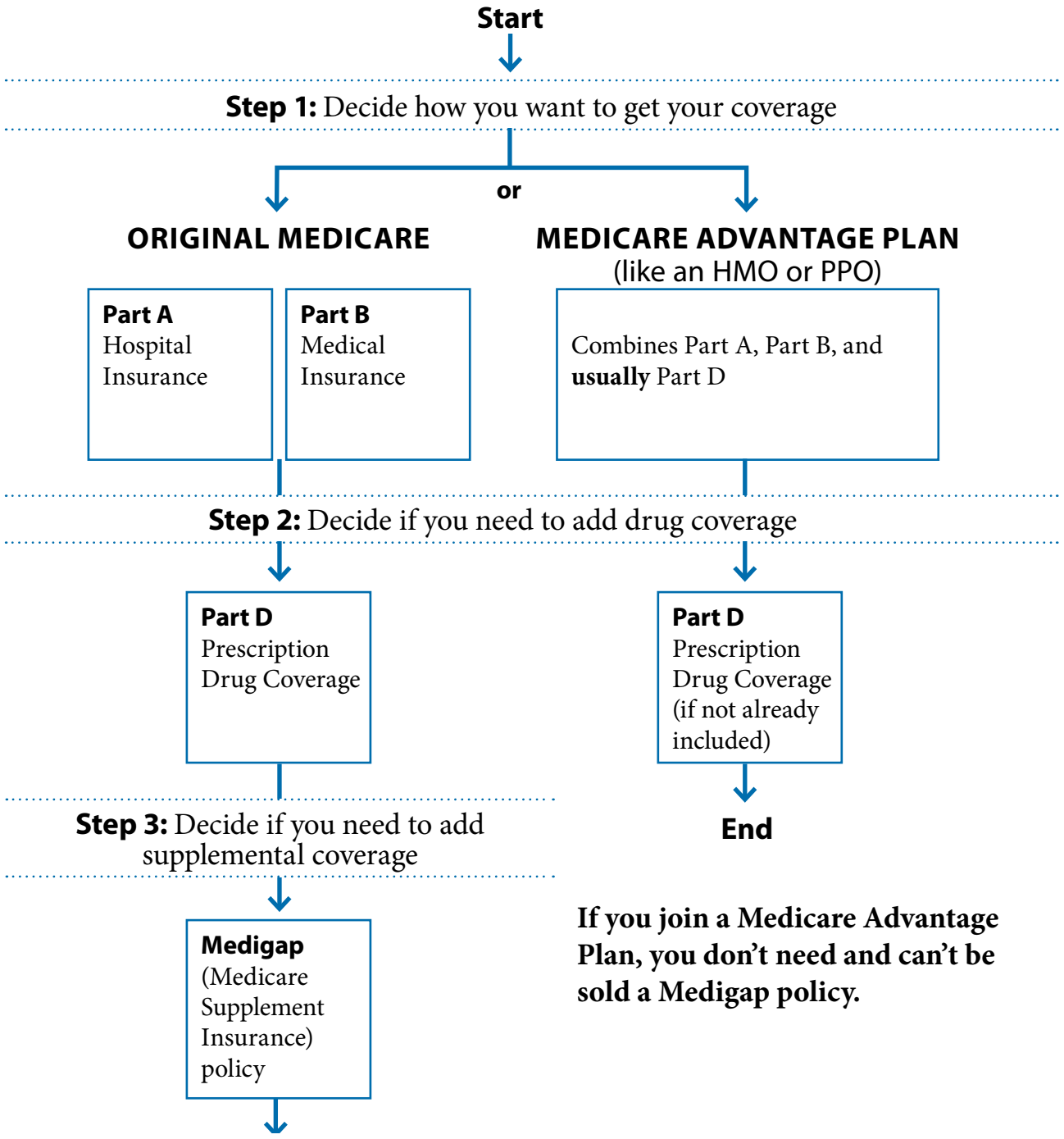
- A prescription drug option run by Medicare-approved private insurance companies
- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

See pages 72–83.

Medicare Advantage Plans (like an HMO or PPO) are health plans run by Medicare-approved private insurance companies. Medicare Advantage Plans (also called "Part C") include Part A, Part B, and usually other coverage like Medicare prescription drug coverage (Part D), sometimes for an extra cost. See pages 60–69.

Your Medicare Coverage Choices at a Glance

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



If you join a Medicare Advantage Plan, you don't need and can't be sold a Medigap policy.

See page 49 for more details.

Where to Get Your Medicare Questions Answered

1-800-MEDICARE

To get general or claims-specific Medicare information and important telephone numbers. If you need help in a language other than English or Spanish, say "Agent" to talk to a customer service representative.
1-800-633-4227
TTY 1-877-486-2048
www.medicare.gov

State Health Insurance Assistance Program (SHIP)

To get free personalized Medicare counseling on decisions about coverage; help with claims, billing, or appeals; and information on programs for people with limited income and resources. See pages 123–126.
Call 1-800-MEDICARE to get the telephone numbers of SHIPs in other states.

Social Security

To get a replacement Medicare card; change your address or name; get information about Part A and/or Part B eligibility, entitlement, and enrollment; apply for Extra Help with Medicare prescription drug costs; ask questions about premiums; and report a death.
1-800-772-1213
TTY 1-800-325-0778
www.socialsecurity.gov

Coordination of Benefits Contractor

To get information on whether Medicare or your other insurance pays first and to report changes in your insurance information.
1-800-999-1118
TTY 1-800-318-8782

Department of Defense

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

Department of Health and Human Services

Office of Inspector General—If you suspect Medicare fraud.
1-800-447-8477
TTY 1-800-377-4950
www.stopmedicarefraud.gov

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

Department of Veterans Affairs

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

Office of Personnel Management

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

Railroad Retirement Board (RRB)

If you have benefits from the RRB, call them to change your address or name, check eligibility, enroll in Medicare, replace your Medicare card, and report a death.
Local RRB office or 1-877-772-5772

Quality Improvement Organization (QIO)

To ask questions or report complaints about the quality of care for a Medicare-covered service or if you think your service is ending too soon.
Call 1-800-MEDICARE to get the telephone number for your QIO.

SECTION 1

Medicare Part A and Part B

(Signing Up and What's Covered)

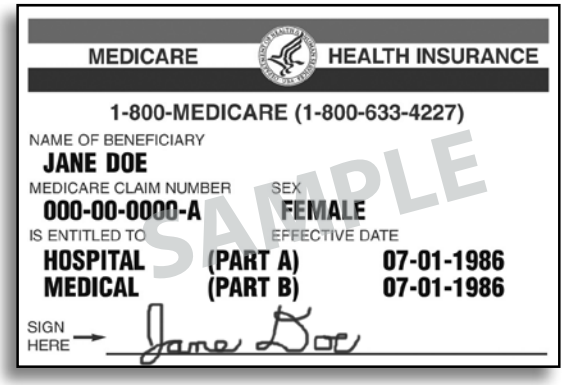
Section 1 includes information about the following:

Signing Up for Part A and Part B

This section explains how and when to sign up and why you might decide to wait to get Part B.

Some People Get Part A and Part B Automatically

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



- You will get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday or your 25th month of disability. If you don't want Part B, follow the instructions that come with the card, and send the card back. If you keep the card, you keep Part B and will pay Part B premiums.
- If you live in Puerto Rico and you get benefits from Social Security or the RRB, you will automatically get Part A. If you want Part B, you will need to sign up for it. Contact your local Social Security office or RRB for more information.
- If you have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), you automatically get Part A and Part B the month your disability benefits begin.

If you have Part A and TRICARE (coverage for active-duty military or retirees and their families), you must have Part B to keep your TRICARE coverage. See page 23.

Some People Need to Sign Up for Part A and Part B

- If you aren't getting Social Security or RRB benefits (for instance, because you're still working) and you want Part A or Part B, you will need to sign up (even if you're eligible to get Part A premium-free). See page 24. If you're not eligible for premium-free Part A, you can buy Part A and Part B. You should contact Social Security 3 months before you turn 65. If you worked for a railroad, contact the RRB to sign up.
- If you have End-Stage Renal Disease (ESRD), you should visit your local Social Security office, or call Social Security at 1-800-772-1213 to sign up for Part A and Part B. TTY users should call 1-800-325-0778. For more information, visit http://go.usa.gov/lov to view the booklet, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

- Call Social Security at 1-800-772-1213 for more information about your Medicare eligibility, and to sign up for Part A and/or Part B. If you're 65 or older, you can also apply for premium-free Part A and Part B online at www.socialsecurity.gov/retirement. The whole process can take less than 10 minutes.
- If you get RRB benefits, call the RRB at 1-877-772-5772.
- For general information about enrolling, visit www.medicare.gov/MedicareEligibility. You can also get free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). See pages 123–126 for the telephone number.

Blue words in the text are defined on pages 127–130.

When Can You Sign Up?

Initial Enrollment Period

You can sign up when you're first eligible for Part B. (For example, if you're eligible for Part B when you turn 65, this is a 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.)

3 months before the month you turn **65**	**2 months before** the month you turn **65**	**1 month before** the month you turn **65**	The month you turn **65**	**1 month after** you turn **65**	**2 months after** you turn **65**	**3 months after** you turn **65**
Sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during the first three months before the month you turn 65.				If you wait until the last four months of your Initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed.		

If you enroll in Part B during the first three months of your Initial Enrollment Period, your coverage start date will depend on your birthday:

- If your birthday **isn't** on the first day of the month, your Part B coverage starts the first day of your birthday month. For example, Mr. Green's 65th birthday is July 20, 2011. If he enrolls in April, May, or June, his coverage will start on July 1, 2011.
- If your birthday **is** on the first day of the month, your coverage will start the first day of the prior month. For example, Mr. Kim's 65th birthday is July 1, 2011. If he enrolls in March, April, or May, his coverage will start on June 1, 2011. To read the chart correctly, use the month **before** your birthday as "the month you turn 65."

If you enroll in Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, your Part B start date will be delayed. For example, Mrs. Simpson turns 65 in July. When her coverage starts depends on the month she enrolls:

Month she enrolls	Month coverage starts
July	August 1
August	October 1
September	December 1
October	January 1

When Can You Sign Up? (continued)

General Enrollment Period

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

If you sign up during these months	Your coverage will begin on
January	July 1
February	
March	

Special Enrollment Period

If you didn't sign up for Part A and/or Part B (for which you pay monthly premiums) when you were first eligible because you're covered under a group health plan based on current employment, you can sign up for Part A and/or Part B as follows:

Anytime that you or your spouse (or family member if you're disabled) are working, and you're covered by a group health plan through the employer or union based on that work	Or	During the 8-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first

Usually, you don't pay a late enrollment penalty if you sign up during a Special Enrollment Period. This Special Enrollment Period doesn't apply to people with End-Stage Renal Disease (ESRD). See page 19. You may also qualify for a Special Enrollment Period if you're a volunteer serving in a foreign country.

Note: If you have COBRA coverage or a retiree health plan, you don't have coverage based on current employment. You're not eligible for a special enrollment period when that coverage ends.

Blue words in the text are defined on pages 127–130.

When Can You Sign Up? (continued)

Medigap Open Enrollment Period

You have a 6-month Medigap (Medicare Supplement Insurance) policy open enrollment period which starts the first month you're both 65 and enrolled in Part B. This period gives you a guaranteed right to buy any Medigap policy sold in your state. Once this period starts, it can't be delayed or replaced. See pages 57–59.

To learn more details about enrollment periods, read the fact sheet "Understanding Medicare Enrollment Periods" by visiting http://go.usa.gov/lsi. You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

Should You Get Part B?

The following information can help you decide if you want to sign up for Part B.

Employer or Union Coverage—If you or your spouse (or family member if you're disabled) **is still working** and you have coverage through an employer (including the Federal Employee Health Benefits Program) or union, contact your employer or union benefits administrator to find out how your insurance works with Medicare. It may be to your advantage to delay Part B enrollment. When the employment ends, three things happen:

1. You may get to elect COBRA coverage, which continues your health coverage through the employer's plan (in most cases for only 18 months) and probably at a higher cost to you.
2. You have 8 months to sign up for Part B without a penalty. See page 21. This period will run whether or not you elect COBRA. If you elect COBRA, don't wait until your COBRA ends to enroll in Part B. If you enroll in Part B after the 8 months, you may have to pay a penalty. See page 25.
3. When you sign up for Part B, your Medigap open enrollment period begins. See page 58.

Should You Get Part B? (continued)

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

- You don't have to enroll in Part B to keep your TRICARE coverage while the service member is on active duty.
- Before the active-duty service member retires, you must enroll in Part B to keep TRICARE without a break in coverage.
- You can get Part B during a special enrollment period if you have Medicare because you're 65 or older, or you're disabled.

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.

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

- You're 65 or older, and you're entitled to (or enrolling in) Part B and meet the citizenship and residency requirements.
- You're under 65, disabled, and your premium-free Part A coverage ended because you returned to work. (If you're under 65 and disabled, you can continue to get premium-free Part A for up to 8.5 years after you return to work.)

Note: The 2011 premium amount for people who buy Part A is $450.

In most cases, if you choose to **buy** Part A, you must also have Part B and pay monthly premiums for both. If you have limited income and resources, your state may help you pay for Part A and/or Part B. See page 90. Call Social Security at 1-800-772-1213 for more information about the Part A premium. TTY users should call 1-800-325-0778.

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 will have to pay the higher premium for twice the number of years you could have had Part A, but didn't sign-up. For example, if you were eligible for Part A for 2 years but didn't sign-up, you will have to pay the higher premium for 4 years. Usually, you don't have to pay a penalty if you meet certain conditions that allow you to sign up for Part A during a Special Enrollment Period. See pages 21–22.

How Much Does Part B Coverage Cost?

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

Your modified adjusted gross income is your adjusted gross income plus your tax exempt interest income. Each year, Social Security will notify you if you have to pay more than the standard premium. Whether you pay the standard premium or a higher premium can change each year depending on your income. If you have to pay a higher amount for your Part B premium and you disagree (even if you get RRB benefits), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also view the fact sheet "Medicare Part B Premiums: Rules For Beneficiaries With Higher Incomes" by visiting www.socialsecurity.gov/pubs/10536.pdf.

See page 131 for the 2011 Part B premium amounts and to find out if your Part B premium will be higher based on your income.

Part B Late Enrollment Penalty

If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it. Usually, you don't pay a late enrollment penalty if you meet certain conditions that allow you to sign up for Part B during a special enrollment period. See pages 21–22.

If you have limited income and resources, see page 90 for information about help paying your Medicare premiums.

What Services Does Medicare Cover?

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

- See pages 27–28 for the Part A-covered services list.
- See pages 30–44 for the Part B-covered services list.

What Does Part A (Hospital Insurance) Cover?

Part A helps cover the following:

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

See pages 27–28 for more information on Part A-covered services.

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

What You Pay for Part A-Covered Services

Copayments, coinsurance, and deductibles may apply for each service in the chart on the next two pages. **See page 132 for specific costs and other information about these services.**

If you join a Medicare Advantage Plan (like an HMO or PPO) or have other insurance (like a Medigap policy, or employer or union coverage), your costs may be different. Contact the plans you're interested in to find out about the costs, or visit www.medicare.gov/find-a-plan.

Part A-Covered Services

Blood	In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.
Home Health Services	Limited to medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort. For durable medical equipment information, see pages 34–35.
Hospice Care	For people with a terminal illness. Your doctor must certify that you're expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; certain durable medical equipment and other covered services as well as services Medicare usually doesn't cover, such as spiritual and grief counseling. A Medicare-approved hospice usually gives hospice care in your home or other facility where you live like a nursing home. Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility which contracts with the hospice. Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness. You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill.

Part A-Covered Services

Hospital Stays (Inpatient)	Includes semi-private room, meals, general nursing, drugs as part of your inpatient treatment, and other hospital services and supplies. Examples include inpatient care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This **doesn't** include private-duty nursing, a television or telephone in your room (if there is a separate charge for these items), or personal care items like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it covers the doctor's services you get while you're in a hospital. **Note: Staying overnight in a hospital doesn't always mean you're an inpatient.** You're considered an inpatient the day a doctor formally admits you to a hospital with a doctor's order. Being an inpatient or an outpatient **affects your out-of-pocket costs.** Always ask if you're an inpatient or an outpatient. For more information, view the publication "Are You a Hospital Inpatient or Outpatient? If You Have Medicare—Ask!" at http://go.usa.gov/im9. You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.
Religious Nonmedical Health Care Institution (Inpatient care)	Medicare will only cover the non-medical, non-religious health care items and services (like room and board) in this type of facility for people who qualify for hospital or skilled nursing facility care, but for whom medical care isn't in agreement with their religious beliefs. Non-medical items and services like wound dressings or use of a simple walker during your stay don't require a doctor's order or prescription. Medicare doesn't cover the religious aspects of care.
Skilled Nursing Facility Care	Includes semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies that are medically necessary after a 3-day minimum **inpatient** hospital stay for a related illness or injury. An inpatient hospital stay begins the day you're formally admitted with a doctor's order and doesn't include the day you're discharged. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy. Medicare **doesn't** cover long-term care or custodial care.

What Does Part B (Medical Insurance) Cover?

Part B helps cover medically-necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services. Part B also covers some preventive services. Look at your Medicare card to find out if you have Part B.

Pages 30–44 include a list of common Part B-covered services. Medicare may cover some services and tests more often than the timeframes listed in the charts if needed to diagnose a condition. To find out if Medicare covers a service not on this list, visit www.medicare.gov/coverage, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You will see this apple next to the preventive services on the list. Use the checklist on page 45 to ask your doctor or other health care provider which preventive services you need.

What You Pay for Part B-Covered Services

The charts on the following pages give general information about what you pay if you have Original Medicare and see doctors or providers who accept assignment. You will pay more for doctors or providers who don't accept assignment. See page 54. **If you're in a Medicare Advantage Plan (like an HMO or PPO) or have other insurance, your costs may be different. Contact your plan or benefits administrator directly to find out about the costs.**

Blue words in the text are defined on pages 127–130.

Under Original Medicare, if the Part B deductible applies you must pay all costs until you meet the yearly Part B deductible before Medicare begins to pay its share. Then, after your deductible is met, you typically pay 20% of the Medicare-approved amount of the service. There is no yearly limit for what you pay out-of-pocket. **See page 133 for the Part B deductible and coinsurance amounts.**

NEW—You pay nothing for most preventive services if you get the services from a doctor or other health care provider who accepts assignment. For some preventive services, you will pay nothing for the service, but you may have to pay coinsurance for the office visit when you get these services.

Part B-Covered Services

Abdominal Aortic Aneurysm Screening	A one-time screening ultrasound for people at risk. You must get a referral for it as part of your one-time "Welcome to Medicare" physical exam. See page 39. You pay nothing for the screening if the doctor accepts assignment.
Ambulance Services	Ground ambulance transportation when you need to be transported to a hospital or skilled nursing facility for medically-necessary services, and transportation in any other vehicle could endanger your health. Medicare may pay for ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide. In some cases, Medicare may pay for limited non-emergency ambulance transportation if you have orders from your doctor saying that ambulance transportation is medically necessary. Medicare will only cover services to the nearest appropriate medical facility that is able to give you the care you need. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Ambulatory Surgical Centers	Facility fees for approved surgical procedures provided in an ambulatory surgical center (facility where surgical procedures are performed, and the patient is released within 24 hours). Except for certain preventive services (for which you pay nothing), you pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you, and the Part B deductible applies. You pay all facility fees for procedures Medicare doesn't allow in ambulatory surgical centers.
Blood	In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. However, you will pay a copayment for the blood processing and handling services for every unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else. You pay a copayment for additional units of blood you get as an outpatient (after the first 3), and the Part B deductible applies.

Part B-Covered Services

Bone Mass Measurement (Bone Density)	Helps to see if you're at risk for broken bones. This service is covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. You pay nothing for this test if the doctor accepts assignment.
Cardiac Rehabilitation	Medicare covers comprehensive programs that include exercise, education, and counseling for patients who meet certain conditions. Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. You pay the doctor 20% of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you also pay the hospital a copayment.
Cardiovascular Screenings	Blood tests that help detect conditions that may lead to a heart attack or stroke. This service is covered every 5 years to test your cholesterol, lipid, and triglyceride levels. You pay nothing for the tests, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.
Chiropractic Services (limited)	Helps correct a subluxation (when one or more of the bones of your spine move out of position) using manipulation of the spine. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **Note:** You pay all costs for any other services or tests ordered by a chiropractor.
Clinical Laboratory Services	Includes certain blood tests, urinalysis, some screening tests, and more. You pay nothing for these services, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.
Clinical Research Studies	Tests how well different types of medical care work and if they are safe. Medicare covers some costs, like doctor visits and tests, in qualifying clinical research studies. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **Note:** If you're in a Medicare Advantage Plan, see page 62 for more information.

Part B-Covered Services

Colorectal Cancer Screenings	To help find precancerous growths or find cancer early, when treatment is most effective. One or more of the following tests may be covered. Talk to your doctor. ▪ Fecal Occult Blood Test—Once every 12 months if 50 or older. You pay nothing for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit. ▪ Flexible Sigmoidoscopy—Generally, once every 48 months if 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk. You pay nothing for this test if the doctor accepts assignment. ▪ Colonoscopy—Generally once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. No minimum age. You pay nothing for this test if the doctor accepts assignment. ▪ Barium Enema—Once every 48 months if 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy. You pay 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you also pay the hospital a copayment.
Defibrillator (Implantable Automatic)	For some people diagnosed with heart failure. You pay the doctor 20% of the Medicare-approved amount for the doctor's services. You also pay the hospital a copayment but no more than the Part A hospital stay deductible (see page 132) if you get the device as a hospital outpatient. The Part B deductible applies.

Part B-Covered Services

Diabetes Screenings	Medicare covers these screenings if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every year. You pay nothing for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.
Diabetes Self-Management Training	For people with diabetes with a written order from a doctor or other health care provider. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Diabetes Supplies	Includes blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Insulin is covered only if used with an external insulin pump. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **Note:** Insulin and certain medical supplies used to inject insulin, such as syringes, and some oral diabetic drugs may be covered by Medicare prescription drug coverage (Part D).
Doctor Services	Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. Except for certain preventive services, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B-Covered Services

Durable Medical Equipment (like walkers)	Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **In all areas of the country, you must get your covered equipment or supplies and replacement or repair services from a Medicare-approved supplier for Medicare to pay.** For more information, visit http://go.usa.gov/loh to view a copy of "Medicare Coverage of Durable Medical Equipment and Other Devices." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048. **New**—Medicare is phasing in a new program called "competitive bidding" to help save you and Medicare money; ensure that you continue to get quality equipment, supplies, and services; and help limit fraud and abuse. **In some areas of the country if you need certain items, you must use specific suppliers, or Medicare won't pay for the item and you likely will pay full price. It's important to see if you're affected by this new program to ensure Medicare payment and avoid any disruption of service.** **This program is effective in the following states:** CA, FL, IN, KS, KY, MO, NC, OH, PA, SC, TX **In certain areas in the states listed above, you need to use specific suppliers for Medicare to pay for the following items:** ▪ Oxygen supplies and equipment ▪ Standard power wheelchair, scooter, and related accessories ▪ Certain complex rehabilitative power wheelchairs and related accessories ▪ Mail-order diabetes supplies ▪ Enteral nutrients, equipment, and supplies ▪ Hospital beds and related accessories ▪ Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories ▪ Walkers and related accessories ▪ Support surfaces including certain mattresses and overlays (Miami, Fort Lauderdale, and Pompano Beach only)

Part B-Covered Services

Durable Medical Equipment (like walkers) (continued)	**If you're currently renting or need durable medical equipment or supplies and have any questions about what's covered or about suppliers, you can get information in one of the following ways:** ▪ Visit www.medicare.gov/supplier. Medicare-approved suppliers are listed. The specific suppliers you need to use for this new program will have a symbol beside their names. ▪ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Call your State Health Insurance Assistance Program (SHIP) for free health insurance counseling and personalized help understanding these changes. See pages 123–126 for the telephone number.
EKG Screening	Medicare covers a one-time screening EKG if ordered by your doctor as part of your one-time "Welcome to Medicare" physical exam. See page 39. You pay the doctor 20% of the Medicare-approved amount, and the Part B deductible applies. An EKG is also covered as a diagnostic test. See page 42. If you have the test at a hospital or a hospital-owned clinic, you also pay the hospital a copayment.
Emergency Department Services	When you have an injury, a sudden illness, or an illness that quickly gets much worse. You pay a specified copayment for the hospital emergency department visit, and you pay 20% of the Medicare-approved amount for the doctor's services. The Part B deductible applies.
Eyeglasses (limited)	One pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Federally-Qualified Health Center Services	Includes many outpatient primary care and preventive services you get through certain community-based organizations. Generally, you pay 20% of the Medicare-approved amount.

Part B-Covered Services

Flu Shots	Generally covered once per flu season in the fall or winter. You pay nothing for the flu shot if the doctor or other health care provider accepts assignment for giving the shot. You pay nothing if your doctor accepts assignment for giving the shot.
Foot Exams and Treatment	If you have diabetes-related nerve damage and/or meet certain conditions. You pay the doctor 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.
Glaucoma Tests	Covered once every 12 months for people at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African-American and 50 or older, or are Hispanic and 65 or older. An eye doctor who is legally allowed by the state must do the tests. You pay the doctor 20% of the Medicare-approved amount, and the Part B deductible applies for the doctor's visit. In a hospital outpatient setting, you also pay the hospital a copayment.
Hearing and Balance Exams	If your doctor orders these tests to see if you need medical treatment. You pay the doctor 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment. **Note:** Medicare doesn't cover hearing aids and exams for fitting hearing aids.
Hepatitis B Shots	Covered for people at high or medium risk for Hepatitis B. Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (ESRD), or certain conditions that increase your risk for infection. Other factors may increase your risk for Hepatitis B, so check with your doctor. You pay nothing for the shot if the doctor accepts assignment.
HIV Screening	Medicare covers HIV (Human Immunodeficiency Virus) screening for people with Medicare of any age who ask for the test, pregnant women, and people at increased risk for the infection. Medicare covers this test once every 12 months or up to 3 times during a pregnancy. You pay nothing for the test, but you generally have to pay the doctor 20% of the Medicare-approved amount for the doctor's visit.

Part B-Covered Services

Home Health Services	Covers medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort. You pay nothing for covered home health services. For Medicare-covered durable medical equipment information, see pages 34–35.
Kidney Dialysis Services and Supplies	For people with End-Stage Renal Disease (ESRD). Medicare covers dialysis either in a facility or at home when your doctor orders it. You pay 20% of the Medicare-approved amount per session, and the Part B deductible applies.
Kidney Disease Education Services	Medicare may cover up to six sessions of kidney disease education services if you have Stage IV chronic kidney disease, and your doctor refers you for the service. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Mammograms (screening)	A type of X-ray to check women for breast cancer. Medicare covers screening mammograms once every 12 months for women 40 and older. Medicare covers one baseline mammogram for women between 35–39. You pay nothing for the test if the doctor accepts assignment.
Medical Nutrition Therapy Services	Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you have had a kidney transplant in the last 36 months, and your doctor refers you for the service. You pay nothing for these services if the doctor accepts assignment.

Part B-Covered Services

Mental Health Care (outpatient)	To get help with mental health conditions such as depression or anxiety. Includes services generally given outside a hospital or in a hospital outpatient setting, including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist, or clinical social worker; substance abuse services; and lab tests. Certain limits and conditions apply. What you pay will depend on whether you're being diagnosed and monitored or whether you're getting treatment. ▪ For visits to a doctor or other health care provider to **diagnose** your condition, you pay 20% of the Medicare-approved amount. ▪ For outpatient **treatment** of your condition (such as counseling or psychotherapy), you pay 45% of the Medicare-approved amount in 2011. This coinsurance amount will continue to decrease over the next 3 years. The Part B deductible applies for both visits to diagnose or treat your condition. **Note:** Inpatient mental health care is covered under Part A hospital stays. See page 132. Talk to your doctor if you feel sad, have little interest in things you used to enjoy, feel dependent on drugs or alcohol, or have thoughts about ending your life.
Non-doctor Services	Medicare covers services provided by certain non-doctors, such as physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Except for certain preventive services, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Occupational Therapy	Evaluation and treatment to help you return to usual activities (such as dressing or bathing) after an illness or accident when your doctor certifies you need it. There may be limits on these services and exceptions to these limits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B-Covered Services

Outpatient Medical and Surgical Services and Supplies	For approved procedures (like X-rays, a cast, or stitches). You pay the doctor 20% of the Medicare-approved amount for the doctor's services. You also pay the hospital a copayment for each service you get in a hospital outpatient setting. For each service, the copayment can't be more than the Part A hospital stay deductible. See page 132. The Part B deductible applies, and you pay all charges for items or services that Medicare doesn't cover.
Pap Tests and Pelvic Exams (includes clinical breast exam)	Checks for cervical, vaginal, and breast cancers. Medicare covers these screening tests once every 24 months, or once every 12 months for women at high risk, and for women who have Medicare and are of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past 3 years. You pay nothing for the Pap lab test, Pap test specimen collection, and pelvic and breast exams if the doctor accepts assignment.
Physical Exams **Note:** Your first yearly "Wellness" exam can't take place within 12 months of your "Welcome to Medicare" physical exam.	**Medicare covers two types of physical exams—one when you're new to Medicare and one each year after that.** ▪ **"Welcome to Medicare" physical exam**—A one-time review of your health, education and counseling about preventive services, and referrals for other care if needed. Medicare will cover this exam if you **get it within the first 12 months you have Part B**. You pay nothing for the exam if the doctor accepts assignment. When you make your appointment, let your doctor's office know that you would like to schedule your "Welcome to Medicare" physical exam. **Keep in mind, you don't need to get the "Welcome to Medicare" physical exam before getting a yearly "Wellness" exam.** ▪ **Yearly "Wellness" exam**—If you've had Part B for longer than 12 months, you can get a yearly wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. You pay nothing for this exam if the doctor accepts assignment. This exam is covered once every 12 months.

Part B-Covered Services

Physical Therapy	Evaluation and treatment for injuries and diseases that change your ability to function when your doctor certifies your need for it. There may be limits on these services and exceptions to these limits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Pneumococcal Shot	Helps prevent pneumococcal infections (like certain types of pneumonia). Most people only need this shot once in their lifetime. Talk with your doctor. You pay nothing if the doctor or supplier accepts assignment for giving the shot.
Prescription Drugs (limited)	Includes a limited number of drugs such as injections you get in a doctor's office, certain oral cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump) and under very limited circumstances, certain drugs you get in a hospital outpatient setting. You pay 20% of the Medicare-approved amount for these covered drugs. If the covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay the copayment for the services. However, if you get other types of drugs in a hospital outpatient setting (sometimes called "self-administered drugs" or drugs you would normally take on your own), what you pay depends on whether you have Part D or other prescription drug coverage, whether your drug plan covers the drug, and whether the hospital's pharmacy is in your drug plan's network. Contact your prescription drug plan to find out what you pay for drugs you get in a hospital outpatient setting that aren't covered under Part B. See page 81 for more information. Other than the examples above, you pay 100% for most prescription drugs, unless you have Part D or other drug coverage.

Part B-Covered Services

Prostate Cancer Screenings	Medicare covers a digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for men over 50 (coverage for this test begins the day after your 50th birthday). You pay nothing for the PSA test. You pay the doctor 20% of the Medicare-approved amount, and the Part B deductible applies for the doctor's visit. In a hospital outpatient setting, you also pay the hospital a copayment.
Prosthetic/Orthotic Items	Includes arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when your doctor orders it. For Medicare to cover your prosthetic or orthotic, you must go to a supplier that is enrolled in Medicare. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
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 your chronic respiratory disease. You pay the doctor 20% of the Medicare-approved amount if you get the service in a doctor's office. You also pay the hospital a copayment per session if you get the service in a hospital outpatient setting.
Rural Health Clinic Services	Includes many outpatient primary care services. You pay 20% of the amount charged, and the Part B deductible applies.
Second Surgical Opinions	Covered in some cases for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B-Covered Services

Smoking Cessation (counseling to stop smoking)	Includes up to 8 face-to-face visits in a 12-month period if you're diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco. You pay the doctor 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.
NEW 	Medicare coverage of smoking cessation counseling is now considered a covered preventive service if you haven't been diagnosed with an illness caused or complicated by tobacco use. You pay nothing for the counseling sessions.
Speech-Language Pathology Services	Evaluation and treatment given to regain and strengthen speech and language skills including cognitive and swallowing skills when your doctor certifies you need it. There may be limits on these services and exceptions to these limits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Surgical Dressing Services	For treatment of a surgical or surgically-treated wound. You pay 20% of the Medicare-approved amount for the doctor's services. You pay a fixed copayment for these services when you get them in a hospital outpatient setting. You pay nothing for the supplies. The Part B deductible applies.
Telehealth	Includes a limited number of medical or other health services, like office visits and consultations provided using an interactive two-way telecommunications system (like real-time audio and video) by an eligible provider who isn't at your location. Available in some rural areas, under certain conditions, and only if you're located at one of the following places: a doctor's office, hospital, rural health clinic, federally-qualified health center, hospital-based dialysis facility, skilled nursing facility, or community mental health center. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Tests (other than lab tests)	Includes X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. If you get the test at a hospital as an outpatient, you also pay the hospital a copayment that may be more than 20% of the Medicare-approved amount, but it can't be more than the Part A hospital stay deductible. See page 132. See "Clinical Laboratory Services" on page 31 for other Part B-covered tests.

Part B-Covered Services

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

Part B-Covered Services

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

Preventive Services Checklist

Take this checklist to your doctor or other health care provider, and ask which preventive services are right for you. You can also keep track of your preventive services by visiting www.MyMedicare.gov. See page 118.

	Medicare-Covered Preventive Service	Details on page	Notes
	Abdominal Aortic Aneurysm Screening	30	
	Bone Mass Measurement	31	
	Cardiovascular Screenings	31	
	Colorectal Cancer Screenings	32	
	Fecal Occult Blood Test	32	
	Flexible Sigmoidoscopy	32	
	Colonoscopy	32	
	Barium Enema	32	
	Diabetes Screenings	33	
	Diabetes Self-management Training	33	
	Flu Shots	36	
	Glaucoma Tests	36	
	Hepatitis B Shots	36	
	HIV Screening	36	
	Mammogram (screening)	37	
	Medical Nutrition Therapy Services	37	
	Pap Test and Pelvic Exam (includes breast exam)	39	
	Physical Exams	39	
	One-time "Welcome to Medicare" physical exam	39	
	Yearly "Wellness" exam	39	
	Pneumococcal Shot	40	
	Prostate Cancer Screenings	41	
	Smoking Cessation (counseling to stop smoking for people with no sign of disease)	42	

For some services, you will need to wait a certain amount of time before getting the service again. See the page numbers listed for more information.

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

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

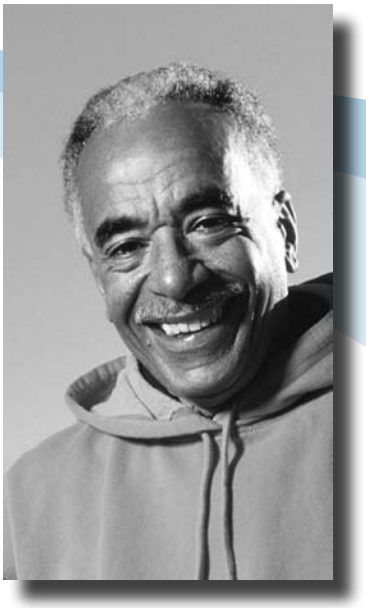
Some of the items and services that Medicare doesn't cover include the following:

- Long-term care. See pages 110–112.
- Routine dental care.
- Dentures.
- Cosmetic surgery.
- Acupuncture.
- Hearing aids.
- Exams for fitting hearing aids.

To find out if Medicare covers a service you need, visit www.medicare.gov/coverage. Call 1-800-MEDICARE (1-800-633-4227) for general coverage information. TTY users should call 1-877-486-2048.

Blue words in the text are defined on pages 127–130.

SECTION 2



Your Medicare Choices

Section 2 includes information about the following:

This handbook has basic information. You will need more detailed information than this handbook provides to make a choice. Before making any decisions, learn as much as you can about the types of coverage available to you. See page 48 to get help with your Medicare decisions.

Decide How to Get Your Medicare

You can choose different ways to get your Medicare coverage. If you choose Original Medicare and you want prescription drug coverage, you must also join a Medicare Prescription Drug Plan (Part D). If you choose to join a Medicare Advantage Plan (like an HMO or PPO), the plan usually includes Medicare prescription drug coverage. If you don't choose a Medicare Advantage Plan or other Medicare health plan, you will have Original Medicare. See the next page for more information about your coverage choices, and the decisions you need to make.

Note: If you have End-Stage Renal Disease (ESRD), you will usually get your health care through Original Medicare. See page 64 for more information.

Each year in the fall, you should review your health and prescription needs because your health, finances, or plan's coverage may have changed. If you decide other coverage will better meet your needs, you can switch plans during certain times. See pages 68 and 73. If you're satisfied with your current plan's coverage for the following year, you don't need to change plans.

Need Help Deciding?

1. Visit www.medicare.gov/find-a-plan to find and compare plans in your area.
2. Get free personalized counseling about choosing coverage. See pages 123–126 for the telephone number of your State Health Insurance Assistance Program (SHIP).
3. Call 1-800-MEDICARE (1-800-633-4227), and say "Agent." TTY users should call 1-877-486-2048. If you need help in a language other than English or Spanish, let the customer service representative know.

See pages 102–103 to find out how Original Medicare or a Medicare plan you may join uses and releases your personal information.

Blue words in the text are defined on pages 127–130.

Your Medicare Coverage Choices

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

Step 1

Decide if You Want Original Medicare or a Medicare Advantage Plan

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

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

See pages 51–56.

Step 2

Decide If You Want Prescription Drug Coverage (Part D)

- If you want this coverage, you must join a Medicare Prescription Drug Plan. You usually pay a monthly premium.
- These plans are run by private companies approved by Medicare.
- See pages 72–83.

Step 3

Decide If You Want Supplemental Coverage

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

See pages 57–59.

Medicare Advantage Plan

(like an HMO or PPO)

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

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

See pages 60–69.

Step 2

Decide If You Want Prescription Drug Coverage (Part D)

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

See pages 66–67.

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

See pages 57–59.

In addition to Original Medicare or a Medicare Advantage Plan, you may be able to join other types of Medicare health plans. See pages 70–71. You may be able to save money or have other choices if you have limited income and resources. See pages 86–92. You may also have other coverage, like employer or union, military, or Veterans' benefits. See pages 82–83.

Things to Consider When Choosing or Changing Your Coverage

Coverage	Are the services you need covered?
Your other coverage	Do you have, or are you eligible for, other types of health or prescription drug coverage (like from a former or current employer or union)? If so, read the materials from your insurer or plan, or call them to find out how the coverage works with, or is affected by, Medicare. If you have coverage through a former or current employer or union or other source, talk to your benefits administrator, insurer, or plan before making any changes to your coverage. If you drop your coverage, you may not be able to get it back.
Cost	How much are your premiums, deductibles, and other costs? How much do you pay for services like hospital stays or doctor visits? What's the yearly limit on what you pay out-of-pocket? Your costs vary and may be different if you don't follow the coverage rules.
Doctor and hospital choice	Do your doctors accept the coverage? Are the doctors you want to see accepting new patients? Do you have to choose your hospital and health care providers from a network? Do you need referrals?
Prescription drugs	Do you need to join a Medicare drug plan? Do you already have creditable prescription drug coverage? Will you pay a penalty if you join a drug plan later? What will your prescription drugs cost under each plan? Are your drugs covered under the plan's formulary? Are there any coverage rules that apply to your prescriptions?
Quality of care	Are you satisfied with your care? The quality of care and services given by plans and other health care providers can vary. Medicare has information to help you compare plans and providers. See page 119.
Convenience	Where are the doctors' offices? What are their hours? Which pharmacies can you use? Can you get your prescriptions by mail? Do the doctors use electronic health records or prescribe electronically? See page 120.
Travel	Will the plan cover you in another state or outside the U.S.?

Original Medicare

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

How Does It Work?

Original Medicare is fee-for-service coverage managed by the Federal government. Generally, there is a cost for each service. Here are the general rules for how it works:

	Original Medicare
Can I get my health care from any doctor or hospital?	In most cases, yes. You can go to any doctor, supplier, hospital, or other facility that's enrolled in Medicare and is accepting new Medicare patients.
Are prescription drugs covered?	With a few exceptions (see pages 28 and 40), most prescriptions aren't covered. You can add comprehensive drug coverage by joining a Medicare Prescription Drug Plan (Part D).
Do I need to choose a primary care doctor?	No.
Do I have to get a referral to see a specialist?	No, but the provider must be enrolled in Medicare.
Should I get a supplemental policy?	You may already have employer or union coverage that may pay costs that Original Medicare doesn't. If not, you may want to buy a Medigap (Medicare Supplement Insurance) policy. See pages 57–59.
What else do I need to know about Original Medicare?	▪ You generally pay a set amount for your health care (deductible) before Medicare pays its share. Then, Medicare pays its share, and you pay your share (coinsurance/copayment) for covered services and supplies. There is no yearly limit for what you pay out-of-pocket. See pages 132–133 to find out what you pay. ▪ You usually pay a monthly premium for Part B. See page 131. See page 90 for more information about Medicare Savings Programs for help paying your Part B premium. ▪ You generally don't need to file Medicare claims. The law requires providers (like doctors, hospitals, skilled nursing facilities, and home health agencies) and suppliers to file your claims for the covered services and supplies you get.

What You Pay

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

- Whether you have Part A and/or Part B. Most people have both.
- Whether your doctor or supplier accepts "assignment." See the next page.
- The type of health care you need and how often you need it.
- Whether you choose to get services or supplies Medicare doesn't cover. If you do, you pay all the costs unless you have other insurance that covers it.
- Whether you have other health insurance (like employer or union coverage) that works with Medicare.
- Whether you have Medicaid or get state help paying your Medicare costs.
- Whether you have a Medigap (Medicare Supplement Insurance) policy.
- Whether you and your doctor sign a private contract. See page 55.

For more information on how other insurance works with Medicare, see page 84. For more information about help to cover the costs that Original Medicare doesn't cover, see pages 57–59 and 90.

Medicare Summary Notices

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

- If you have other insurance, check to see if it covers anything that Medicare didn't.
- Keep your receipts and bills, and compare them to your MSN to be sure you got all the services, supplies, or equipment listed. See pages 105–107 for information on Medicare fraud.
- If you paid a bill before you got your MSN, compare your MSN with the bill to make sure you paid the right amount for your services.
- If an item or service is denied, call your doctor's office to make sure they submitted the correct information. If not, the office may resubmit. If you want to file an appeal, see pages 95–96.

Medicare Summary Notices (continued)

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

You don't have to wait for your MSN to view your Medicare claims. Visit www.MyMedicare.gov to track your Medicare claims or view electronic MSNs. Your claims will generally be available within 24 hours after processing. See page 118.

Keeping Your Costs Down with "Assignment"

Assignment means that your doctor, provider, or supplier has signed an agreement with Medicare (or is required by law) to accept the Medicare-approved amount as full payment for covered services. Some providers who are enrolled in Medicare don't accept assignment.

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

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

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

Blue words in the text are defined on pages 127–130.

Keeping Your Costs Down with "Assignment" (continued)

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

- They're supposed to submit a claim to Medicare when they give you Medicare-covered services. They can't charge you for submitting a claim. If they don't submit the claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

  Note: You might have to pay the entire charge at the time of service, and then submit your claim to Medicare to get paid back using form CMS-1490S. Visit www.medicare.gov/medicareonlineforms for the form and instructions, or call 1-800-MEDICARE.

- They may charge you more than the Medicare-approved amount, but there is a limit called "the limiting charge." They can only charge you up to 15% over the Medicare-approved amount. The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment.

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

Note: If you need home health care or durable medical equipment, your care must be ordered by a doctor or other health care provider who is enrolled in Medicare.

What to Know About Private Contracts

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

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

Blue words in the text are defined on pages 127–130.

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

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

You may want to contact your State Health Insurance Assistance Program (SHIP) to get help before signing a private contract with any doctor or other health care provider. See pages 123–126 for the telephone number.

See pages 94–107 for information about your appeal rights and how to protect yourself and Medicare from fraud.

Adding Medicare Drug Coverage (Part D)

In Original Medicare, **if you don't already have creditable prescription drug coverage** (for example, from a current or former employer or union) and you would like Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan. These plans are available through private companies under contract with Medicare. If you don't currently have creditable prescription drug coverage, you should think about joining a Medicare Prescription Drug Plan as soon as you're eligible. If you don't join a Medicare Prescription Drug Plan when you're first eligible and you decide to join later, you may have to pay a late enrollment penalty. See pages 78–79 for more information.

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

Blue words in the text are defined on pages 127–130.

Extra Help Paying for Coverage

People with limited income and resources may qualify for Extra Help paying their Medicare prescription drug coverage costs. See pages 86–89 to find out if you may qualify for Extra Help.

Medigap (Medicare Supplement Insurance) Policies

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

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

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

The types of Medigap Plans that you can buy changed:

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

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

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

More About Medigap Policies

- You must have Part A and Part B.
- You pay a monthly premium for your Medigap policy in addition to your monthly Part B premium.
- A Medigap policy only covers one person. Spouses must buy separate policies.
- It's important to compare Medigap policies since the costs can vary and may go up as you get older. Some states limit Medigap costs.
- The best time to buy a Medigap policy is during the 6-month period that begins on the first day of the month in which you're 65 or older **and** enrolled in Part B. (Some states have additional open enrollment periods.) After this enrollment period, your option to buy a Medigap policy may be limited and it may cost more. For example, if you turn 65 and are enrolled in Part B in June, the best time for you to buy a Medigap policy is from June to November.
- If you're under 65, you won't have this open enrollment period until you turn 65, but state law might give you a right to buy a policy before then.
- If you have a Medigap policy and join a Medicare Advantage Plan (like an HMO or PPO), you may want to drop your Medigap policy. Your Medigap policy **can't** be used to pay your Medicare Advantage Plan copayments, deductibles, and premiums. If you want to cancel your Medigap policy, contact your insurance company. If you drop your policy to join a Medicare Advantage Plan, in most cases you won't be able to get it back.
- 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. Contact your State Insurance Department if this happens to you.

Blue words in the text are defined on pages 127–130.

More About Medigap Policies (continued)

- If you join a Medicare health plan for the first time, and you aren't happy with the plan, you will have special rights to buy a Medigap policy if you return to Original Medicare within 12 months of joining.
  - — If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.
  - — The Medigap policy can no longer have prescription drug coverage even if you had it before, but you may be able to join a Medicare Prescription Drug Plan.
  - — If you joined a Medicare health plan when you were first eligible for Medicare, you can choose from any policy.
- You can't have prescription drug coverage in both your Medigap policy and a Medicare drug plan. See page 82.

For More Information About Medigap Policies

- Visit http://go.usa.gov/lot to view the booklet, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." You can also call 1-800-MEDICARE (1-800-633-4227) to see if a copy can be mailed to you. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.
- Call your State Insurance Department. Call 1-800-MEDICARE to get the telephone number. You can also visit www.medicare.gov/contacts.
- Call your State Health Insurance Assistance Program (SHIP). See pages 123–126 for the telephone number.

Medicare Advantage Plans (Part C)

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

Blue words in the text are defined on pages 127–130.

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

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

There are different types of Medicare Advantage Plans:

- Health Maintenance Organization (HMO) Plans. See page 66.
- Preferred Provider Organization (PPO) Plans. See page 66.
- Private Fee-for-Service (PFFS) Plans. See page 67.
- Special Needs Plans (SNP). See page 67.

Medicare Advantage Plans (continued)

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

- HMO Point-of-Service (HMOPOS) Plans—An HMO plan that may allow you to get some services out-of-network for a higher cost.
- Medical Savings Account (MSA) Plans—A plan that combines a high deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year. For more information about MSAs, visit http://go.usa.gov/irD to view the booklet, "Your Guide to Medicare Medical Savings Account Plans." You can also call 1-800-MEDICARE (1-800-633-4227) to see if a copy can be mailed to you. TTY users should call 1-877-486-2048.

Make sure you understand how a plan works before you join. See pages 66–67 for more information about Medicare Advantage Plan types. If you want more information about a Medicare Advantage Plan, you can call any plan and request a Summary of Benefits (SB) document. Contact your State Health Insurance Assistance Program (SHIP) for help comparing plans. See pages 123–126 for their telephone number.

More About Medicare Advantage Plans

- As with Original Medicare, you still have Medicare rights and protections, including the right to appeal. See pages 95–97.
- Check with the plan before you get a service to find out whether they will cover the service and what your costs may be.
- You must follow plan rules, like getting a referral to see a specialist to avoid higher costs if your plan requires it. Check with the plan.
- You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease. See page 64.
- You can only join or leave a plan at certain times during the year. See page 68.
- If you go to a doctor, facility, or supplier that doesn't belong to the plan, your services may not be covered, or your costs could be higher, depending on the type of Medicare Advantage Plan. In most cases, this applies to Medicare Advantage HMOs and PPOs.
- If the plan decides to stop participating in Medicare, you will have to join another Medicare health plan or return to Original Medicare. See pages 94–95.
- You usually get prescription drug coverage (Part D) through the plan. In some types of plans that don't offer drug coverage, you can join a Medicare Prescription Drug Plan. **If you're in a Medicare Advantage Plan that includes prescription drug coverage and you join a Medicare Prescription Drug Plan, you will be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.** You can't have prescription drug coverage through both a Medicare Advantage Plan and a Medicare Prescription Drug Plan.
- You don't need to buy (and can't be sold) a Medigap (Medicare Supplement Insurance) policy while you're in a Medicare Advantage Plan. It won't cover your Medicare Advantage Plan deductibles, copayment, or coinsurance.

Blue words in the text are defined on pages 127–130.

NEW

- If you join a clinical research study, your costs may be lower and some costs may be covered by your plan. Call your plan for more information.
- Medicare Advantage Plans can't charge you more than Original Medicare for certain services like chemotherapy, dialysis, and skilled nursing facility care.
- Medicare Advantage Plans will have an annual cap on how much you pay for Part A and Part B services during the year. This annual maximum out-of-pocket amount can be different between Medicare Advantage Plans. You should consider this when you choose a plan.

Who Can Join?

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

- You have Part A and Part B.
- You live in the service area of the plan.
- You don't have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) except as explained on page 64.

Note: In most cases, you can join a Medicare Advantage Plan only at certain times during the year. See page 68.

If You Have Other Coverage

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

If You Have a Medigap (Medicare Supplement Insurance) Policy

If you have a Medigap policy and join a Medicare Advantage Plan (like an HMO or PPO), you will probably want to drop your Medigap policy. You can't use it to pay for any expenses (copayments, deductibles, and premiums) you have under a Medicare Advantage Plan. If you drop your Medigap policy, you may not be able to get it back. See pages 58–59.

If You Have End-Stage Renal Disease (ESRD)

If you have End-Stage Renal Disease (ESRD), you usually can't join a Medicare Advantage Plan. However, you may be able to join a Medicare Advantage Plan in the following situations:

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

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

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

For more information about ESRD, visit http://go.usa.gov/lov to view the booklet, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services." You can also call 1-800-MEDICARE to see if a copy can be mailed to you.

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

What You Pay

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

- Whether the plan charges a monthly premium.
- Whether the plan pays any of your monthly Part B premium.
- Whether the plan has a yearly deductible or any additional deductibles.
- How much you pay for each visit or service (copayments or coinsurance).
- The type of health care services you need and how often you get them.
- Whether you follow the plan's rules, like using network providers.
- Whether you need extra benefits and if the plan charges for it.
- The plan's yearly limit on your out-of-pocket costs for all medical services.

Blue words in the text are defined on pages 127–130.

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

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

- Extra Help paying your premium and other prescription drug coverage costs under Part D. See pages 86–89.
- Help from your state to pay your Medicare premiums. In some cases, the state may also pay your Part A and Part B deductibles and coinsurance. See page 90.

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

How Do Medicare Advantage Plans Work?

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

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

How Do Medicare Advantage Plans Work? (continued)

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

Join, Switch, or Drop a Medicare Advantage Plan

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

- When you first become eligible for Medicare (the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65).
- If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of disability.
- **NEW—**Between October 15–December 7 in 2011. Your coverage will begin on January 1, 2012, as long as the plan gets your enrollment request by December 7.

NEW—Making changes to your coverage after December 31
Between January 1–February 14, 2011, if you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare. If you switch to Original Medicare during this period, you will have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Your coverage will begin the first day of the month after the plan gets your enrollment form.

During this period, you **can't** do the following:

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

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

- If you move out of your plan's service area.
- If you qualify for Extra Help. See pages 86–89.
- If you live in an institution (like a nursing home).

You can call your State Health Insurance Assistance Program (SHIP) for more information. See pages 123–126 for the telephone number.

Blue words in the text are defined on pages 127–130.

How Do You Join?

If you choose to join a Medicare Advantage Plan, you may be able to join by completing a paper application, calling the plan, or enrolling on the plan's Web site or on www.medicare.gov. You can also enroll by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. When you join a Medicare Advantage Plan, you will have to provide your Medicare number and the date your Part A and/or Part B coverage started. This information is on your Medicare card. **Note: Medicare Advantage Plans aren't allowed to call you to enroll you in a plan. Call 1-800-MEDICARE to report a plan that does this.**

How Do You Switch?

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

- To switch to a new Medicare Advantage Plan, simply join the plan you choose during one of the enrollment periods explained on page 68. You will be disenrolled automatically from your old plan when your new plan's coverage begins.
- To switch to Original Medicare, contact your current plan, or call 1-800-MEDICARE. You will also need to decide about Medicare prescription drug coverage (Part D) and if you want a Medigap (Medicare Supplement Insurance) policy. See pages 57–59 for more information about buying a Medigap policy.

For more information on joining, dropping, and switching plans, read the fact sheet "Understanding Medicare Enrollment Periods" by visiting http://go.usa.gov/lsi. You can also call 1-800-MEDICARE to see if a copy can be mailed to you.

No one should call you or come to your home uninvited to sell Medicare products. See pages 104–107 for more information about how to protect yourself from identity theft and fraud. If you believe a plan has misled you, call 1-800-MEDICARE.

Other Medicare Health Plans

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

Blue words in the text are defined on pages 127–130.

Medicare Cost Plans

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

- You can join even if you only have Part B.
- If you have Part A and Part B and go to a non-network provider, the services are covered under Original Medicare. You would pay the Part A and Part B coinsurance and deductibles.
- You can join anytime the plan is accepting new members.
- You can leave anytime and return to Original Medicare.
- You can either get your Medicare prescription drug coverage from the plan (if offered), or you can join a Medicare Prescription Drug Plan. **Note:** You can add or drop Medicare prescription drug coverage only at certain times. See page 73.

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

For more information about Medicare Cost Plans, contact the plans you're interested in. You can also visit www.medicare.gov. Your State Health Insurance Assistance Program (SHIP) can also give you more information. See pages 123–126 for the telephone number.

Other Medicare Health Plans (continued)

Demonstrations/Pilot Programs

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

To find out about current Medicare demonstrations and pilot programs, call 1-800-MEDICARE (1-800-633-4227), and say "Agent." TTY users should call 1-877-486-2048.

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

PACE 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 the following conditions:

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

PACE provides coverage for prescription drugs, doctor visits, transportation, home care, check-ups, hospital visits, and even nursing home stays whenever necessary. If you have Medicare, Medicare pays for all Medicare-covered services. If you have Medicare and Medicaid, you will either have a small monthly payment or pay nothing for the long-term care portion of the PACE benefit. If you have Medicare but not Medicaid, you will be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE there is never a deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.

Call your State Medical Assistance (Medicaid) office to find out if you're eligible and if there is a PACE site near you, or visit www.pace4you.org to find a program. You can also visit http://go.usa.gov/loL to view the fact sheet, "Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)." You can call 1-800-MEDICARE to see if a copy can be mailed to you.

Medicare Prescription Drug Coverage (Part D)

Medicare offers prescription drug coverage to everyone with Medicare. Even if you don't take a lot of prescriptions now, you should still consider joining a Medicare drug plan. To get Medicare prescription drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered. If you decide not to join a Medicare drug plan when you're first eligible, and you don't have other creditable prescription drug coverage, you will likely pay a late enrollment penalty. See pages 78–79.

There are two ways to get Medicare prescription drug coverage:

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

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

Who Can Get Medicare Drug Coverage?

To join a Medicare Prescription Drug Plan, you must have Medicare Part A **or** Part B. To join a Medicare Advantage Plan, you must have Part A **and** Part B. You must also live in the service area of the Medicare drug plan you want to join.

If you have employer or union coverage, call your benefits administrator before you make any changes, or before you sign up for any other coverage. If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union **drug** coverage without also dropping your employer or union **health** (doctor and hospital) coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependants. If you want to know how Medicare prescription drug coverage works with other drug coverage you may have, see pages 82–83.

Join, Switch, or Drop a Medicare Drug Plan

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

- When you're first eligible for Medicare (the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65).
- If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of disability. You will have another chance to join 3 months before the month you turn 65 to 3 months after the month you turn 65.
- **NEW**—Between October 15–December 7 in 2011. Your coverage will begin on January 1, 2012, as long as the plan gets your enrollment request by December 7.
- Anytime, if you qualify for Extra Help.

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

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

If you want to join a plan or switch plans, do so as soon as possible so you will have your membership card when your coverage begins, and you can get your prescriptions filled without delay.

Call your State Health Insurance Assistance Program (SHIP) for more information. See pages 123–126 for the telephone number. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, you may qualify for Extra Help to pay for Medicare prescription drug coverage. You may also be able to get help from your state. See pages 86–91.

Blue words in the text are defined on pages 127–130.

How Do You Join?

Once you choose a Medicare drug plan, you may be able to join by completing a paper application, calling the plan, or enrolling on the plan's Web site or on www.medicare.gov. You can also enroll by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. When you join a Medicare drug plan, you will have to provide your Medicare number and the date your Part A and/or Part B coverage started. This information is on your Medicare card. **Note: Medicare drug plans aren't allowed to call you to enroll you in a plan. Call 1-800-MEDICARE to report a plan that does this.**

How Do You Switch?

You can switch to a new Medicare drug plan simply by joining another drug plan during one of the times listed on page 73. **You don't need to cancel your old Medicare drug plan or send them anything.** Your old Medicare drug plan coverage will end when your new drug plan begins. You should get a letter from your new Medicare drug plan telling you when your coverage begins.

If you want to drop your Medicare drug plan and don't want to join a new plan, you can do so during one of the times listed on page 73. You can disenroll by calling 1-800-MEDICARE. You can also send a letter to the plan to tell them you want to disenroll. If you drop your plan and want to join another Medicare drug plan later, you have to wait for an enrollment period. You may have to pay a late enrollment penalty. See pages 78–79.

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

For more information on joining, dropping, and switching plans, read the fact sheet "Understanding Medicare Enrollment Periods" by visiting http://go.usa.gov/lsi. You can also call 1-800-MEDICARE to see if a copy can be mailed to you.

What You Pay

Below and continued on the next page are descriptions of the payments you make throughout the year in a Medicare drug plan. **Your actual drug plan costs will vary** depending on the prescriptions you use, the plan you choose, whether you go to a pharmacy in your plan's network, whether your drugs are on your plan's formulary (drug list), and whether you get Extra Help paying your Part D costs.

Monthly premium

Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. If you belong to a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium you pay to your plan may include an amount for prescription drug coverage.

Note: Contact your drug plan (not Social Security) if you want your premium deducted from your monthly Social Security payment. Your first deduction will usually take 3 months to start, and 3 months of premiums will likely be deducted at once. After that, only one premium will be deducted each month. You may also see a delay in premiums being withheld if you switch plans.

NEW—Your Part D monthly premium could be higher based on your income. This includes Part D coverage you get from a Medicare Prescription Drug Plan, or a Medicare Advantage Plan or Medicare Cost Plan that includes Medicare prescription drug coverage. If your modified adjusted gross income as reported on your IRS tax return from 2 years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you will pay a higher monthly premium. See page 134 for more information.

Yearly deductible

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

Copayments or coinsurance

Amounts you pay at the pharmacy for your covered prescriptions after the deductible (if the plan has one). You pay your share, and your drug plan pays its share for covered drugs.

Blue words in the text are defined on pages 127–130.

What You Pay (continued)

Coverage gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Not everyone will reach the coverage gap. Your yearly deductible, your coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan premium you pay or what you pay for drugs that aren't covered.

There are plans that offer some coverage during the gap, like for generic drugs. However, plans with gap coverage may charge a higher monthly premium. Check with the drug plan first to see if your drugs would be covered during the gap. For more information, visit http://go.usa.gov/loF to view the fact sheet "Bridging the Coverage Gap." You can also call 1-800-MEDICARE (1-800-633-4227) to see if a copy can be mailed to you. TTY users should call 1-877-486-2048.

NEW—If you reached the coverage gap in **2010**, (and you weren't already getting Extra Help), you may have received a one-time $250 rebate check to help you with your drug costs.

If you reach the coverage gap in 2011, you will get a 50% discount on covered brand-name prescription drugs at the time you buy them. There will be additional savings for you in the coverage gap each year through 2020 when you will have full coverage in the gap. Talk to your doctor or other health care provider to make sure that you're taking the lowest cost drug available that works for you. For more information, visit http://go.usa.gov/1np to view the publication, "Closing the Coverage Gap—Medicare Prescription Drugs Are Becoming More Affordable."

Blue words in the text are defined on pages 127–130.

Catastrophic coverage

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

Note: If you get Extra Help paying your drug costs, you won't have a coverage gap and will pay only a small or no copayment once you reach catastrophic coverage. See pages 86–89.

What You Pay (continued)

The example below shows costs for covered drugs in 2011 for a plan that has a coverage gap.

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2011. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions.

Monthly Premium—Ms. Smith pays a monthly premium throughout the year.			
1. Yearly Deductible →	2. Copayment or Coinsurance (What you pay at the pharmacy) →	3. Coverage Gap →	4. Catastrophic Coverage
Ms. Smith pays the first $310 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their **combined** amount (plus the deductible) reaches $2,840.	Once Ms. Smith and her plan have spent $2,840 for covered drugs, she is in the coverage gap. In 2011, she gets a 50% discount on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap.	Once Ms. Smith has spent $4,550 out-of-pocket for the year, her coverage gap ends. Now she only pays a small copayment for each drug until the end of the year.

Call the plans you're interested in to get more details. You can visit www.medicare.gov/find-a-plan, or call 1-800-MEDICARE (1-800-633-4227) to compare the cost of plans in your area. TTY users should call 1-877-486-2048. For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP). See pages 123–126 for the telephone number.

What is the Part D Late Enrollment Penalty?

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

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

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

Here are a few ways to avoid paying a penalty:

- **Join a Medicare drug plan when you're first eligible.** You won't have to pay a penalty, even if you've never had prescription drug coverage before.
- **Don't go 63 days or more in a row without a Medicare drug plan or other creditable coverage.** Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, Department of Veterans Affairs, or health insurance coverage. Your plan will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

Blue words in the text are defined on pages 127–130.

- **Tell your plan about any drug coverage you had if they ask about it.** When you join a plan, and they believe you went at least 63 days in a row without other creditable prescription drug coverage, they will send you a letter. The letter will include a form asking about any drug coverage you had. Complete the form. If you don't tell the plan about your creditable coverage, you may have to pay a penalty.

How Much More Will You Pay?

The cost of the late enrollment penalty depends on how long you didn't have creditable prescription drug coverage. Currently, the late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" ($32.34 in 2011) times the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $.10 and added to your monthly premium. Since the "national base beneficiary premium" may increase each year, the penalty amount may also increase every year. You may have to pay this penalty for as long as you have a Medicare drug plan.

Example: Mrs. Jones didn't join when she was first eligible—by May 15, 2007. She joined a Medicare drug plan between November 15—December 31, 2010, for an effective date of January 1, 2011. Since Mrs. Jones didn't join when she was first eligible and went without other creditable drug coverage for 43 months (June 2007–December 2010), she will be charged a monthly penalty of $13.90 in 2011 ($32.34 x.01 = $.3234 x 43 = $13.90) in addition to her plan's monthly premium.

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

If You Don't Agree With Your Penalty

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

Important Drug Coverage Rules

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

To Fill a Prescription Before You Get Your Membership Card

You should get a welcome package with your membership card within 5 weeks or sooner after the plan gets your completed application. If you need to go to the pharmacy before your membership card arrives, you can use any of the following as proof of membership:

- A letter from the plan that includes your complete membership information.
- An enrollment confirmation number that you got from the plan, the plan name, and telephone number.
- A temporary card that you may be able to print from MyMedicare.gov. Visit www.MyMedicare.gov, or see page 118.

If you don't have any of the items listed above, and your pharmacist can't get your drug plan information any other way, you may have to pay out-of-pocket for your prescriptions. **If you do, save the receipts and contact your plan to get your money back.**

If you qualify for Extra Help, see pages 88–89 for more information about what you can use as proof of Extra Help.

What's Covered?

Information about a plan's list of covered drugs (called a formulary) isn't included in this handbook because each plan has its own formulary. Many Medicare drug plans place drugs into different "tiers" on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier. In some cases, if your drug is on a higher tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can file an exception to ask your plan for a lower copayment.

Contact the plan for its current formulary, or visit the plan's Web site. Visit www.medicare.gov/find-a-plan, or call 1-800-MEDICARE (1-800-633-4227) to get telephone numbers for the plans in your area. TTY users should call 1-877-486-2048.

Note: Medicare drug plans must cover all commercially-available vaccines (like the shingles vaccine) when medically necessary to prevent illness except for vaccines covered under Part B. See pages 36 and 40.

Important Drug Coverage Rules (continued)

Plans may have the following coverage rules:

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

Blue words in the text are defined on pages 127–130.

If you or your prescriber believes that one of these coverage rules should be waived, you can ask for an exception. See pages 98–100.

In most cases, the prescription drugs (sometimes called "self administered drugs" or drugs you would normally take on your own) you get in an outpatient setting like an emergency department or during observation services aren't covered by Part B. Your Medicare drug plan may cover these drugs **under certain circumstances**. You will likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Or, if you get a bill for self-administered drugs you got in a doctor's office, call your Medicare drug plan (Part D) for more information. You can also visit http://go.usa.gov/lo6 to view the fact sheet, "How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings." You can also call 1-800-MEDICARE (1-800-633-4227) to see if a copy can be mailed to you. TTY users should call 1-877-486-2048.

Other Private Insurance

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

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

COBRA—A Federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependant of the covered employee. As explained on page 22, there may be reasons why you should take Part B instead of, or in addition to, COBRA. However, if you take COBRA and it includes creditable prescription drug coverage, you will have a special enrollment period to join a Medicare drug plan without paying a penalty when the COBRA coverage ends. Talk with your State Health Insurance Assistance Program (SHIP) to see if COBRA is a good choice for you. See pages 123–126 for the telephone number.

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

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

Other Government Insurance

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

Blue words in the text are defined on pages 127–130.

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

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

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

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

How Other Insurance Works with Medicare

When you have other insurance (like employer group health coverage), there are rules that decide whether Medicare or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

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

These types of coverage usually pay first for services related to each type:

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

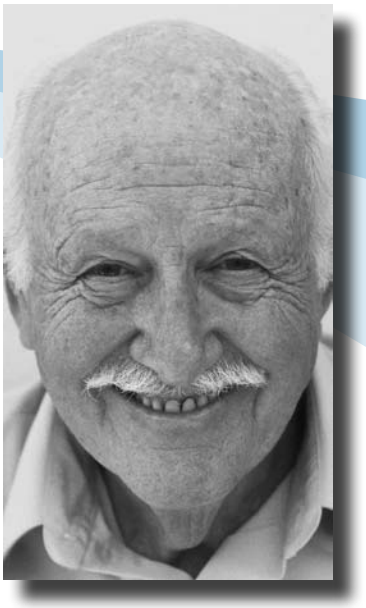
Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

For more information, view the booklet "Medicare and Other Health Benefits: Your Guide to Who Pays First" by visiting http://go.usa.gov/loH. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

SECTION 3

Get Help Paying Your Health and Prescription Drug Costs



Section 3 includes information about the following:

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

Programs for People with Limited Income and Resources

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

The U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Commonwealth of Northern Mariana Islands provide their residents help with Medicare drug costs. This help isn't the same as the Extra Help described below. See page 92 for more information.

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

You may qualify for Extra Help, also called the low-income subsidy (LIS), from Medicare to pay prescription drug costs if your yearly income and resources are below the following limits in 2010:

- Single person—Income less than $16,335 and resources less than $12,640
- Married person living with a spouse and no other dependants—Income less than $22,065 and resources less than $25,260

These amounts may change in 2012. You may qualify even if you have a higher income (like if you still work, or if you live in Alaska or Hawaii, or have dependants living with you). Resources include money in a checking or savings account, stocks, and bonds. Resources **don't** include your home, car, household items, burial plot, up to $1,500 for burial expenses (per person), or life insurance policies.

Blue words in the text are defined on pages 127–130.

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

- Help paying your Medicare drug plan's monthly premium, any yearly deductible, coinsurance, and copayments
- No coverage gap
- No late enrollment penalty

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

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

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

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

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

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

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

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

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

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

Note: You can apply for Extra Help at anytime. With your consent, Social Security will forward information to your state to start an application for a Medicare Savings Program. See page 90.

Drug costs in 2011 for most people who qualify will be no more than $2.50 for each generic drug and $6.30 for each brand-name drug. Look on the Extra Help letters you get, or contact your plan to find out your exact costs.

To get answers to your questions about Extra Help and help choosing a plan, call your State Health Insurance Assistance Program (SHIP). See pages 123–126 for the telephone number. You can also call 1-800-MEDICARE.

Paying the Right Amount

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

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

Blue words in the text are defined on pages 127–130.

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

Paying the Right Amount (continued)

You can also give your plan **any** of the following documents (also called "Best Available Evidence") as proof that you qualify for Extra Help. Your plan must accept these documents. Each item listed below must show that you were eligible for Medicaid during a month after June 2010.

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

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

For more information, visit http://go.usa.gov/loo to view the fact sheet "Are You Paying the Right Amount for Your Prescriptions?" You can also call 1-800-MEDICARE (1-800-633-4227) to see if a copy can be mailed to you. TTY users should call 1-877-486-2048.

Medicare Savings Programs (Help with Medicare Costs)

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

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

- Have Part A
- Have monthly income less than $1,246 and resources less than $6,680—single person
- Have monthly income less than $1,675 and resources less than $10,020—married and living together

Note: These amounts may change each year. Many states figure your income and resources differently, so you may qualify in your state even if your income or resources are higher. Resources include money in a checking or savings account, stocks, and bonds. Resources don't include your home, car, burial plot, burial expenses up to your state's limit, furniture, or other household items.

For More Information

- Call or visit your State Medical Assistance (Medicaid) office, and ask for information on Medicare Savings Programs. The names of these programs and how they work may vary by state. Call if you think you qualify for any of these programs, even if you aren't sure.
- Call 1-800-MEDICARE (1-800-633-4227), and say "Medicaid" to get the telephone number for your state. TTY users should call 1-877-486-2048.
- Visit http://go.usa.gov/loA to view the brochure, "Get Help With Your Medicare Costs: Getting Started." You can also call 1-800-MEDICARE to see if a copy can be mailed to you.
- Contact your State Health Insurance Assistance Program (SHIP) for free health insurance counseling. See pages 123–126 for the telephone number.

Blue words in the text are defined on pages 127–130.

Medicaid

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

- If you have Medicare and full Medicaid coverage, most of your health care costs are covered. You have the option of Original Medicare or a Medicare Advantage Plan (like an HMO or PPO) for your Medicare coverage.
- If you have Medicare and Medicaid, Medicare provides you with prescription drug coverage instead of Medicaid. Medicaid may still cover some drugs and other care Medicare doesn't cover.
- People with Medicaid may get coverage for services that Medicare doesn't fully cover, such as nursing home and home health care.
- Medicaid programs vary from state to state. They may also have different names, such as "Medical Assistance" or "Medi-Cal."

- Each state has different Medicaid eligibility income and resource limits and other eligibility requirements.
- In some states, you may need Medicare to be eligible for Medicaid.
- Call your State Medical Assistance (Medicaid) office for more information and to see if you qualify. Call 1-800-MEDICARE (1-800-633-4227) and say "Medicaid" to get the telephone number for your State Medical Assistance (Medicaid) office. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.

State Pharmacy Assistance Programs (SPAPs)

Many states have State Pharmacy Assistance Programs (SPAPs) that help certain people pay for prescription drugs based on financial need, age, or medical condition. Each SPAP makes its own rules about how to provide drug coverage to its members. Depending on your state, the SPAP will help you in different ways. To find out about the SPAP in your state, call your State Health Insurance Assistance Program (SHIP). See pages 123–126 for the telephone number.

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

PACE is a Medicare and Medicaid program offered in many states that allows people who need a nursing home-level of care to remain in the community. See page 71 for more information.

Supplemental Security Income (SSI) Benefits

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

You can visit www.socialsecurity.gov, and use the "Benefit Eligibility Screening Tool" to find out if you may be eligible for SSI or other benefits. Call Social Security at 1-800-772-1213, or contact your local Social Security office for more information. TTY users should call 1-800-325-0778.

Note: People who live in Puerto Rico, the Virgin Islands, Guam, or American Samoa can't get SSI.

Blue words in the text are defined on pages 127–130.

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

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

Children's Health Insurance Program

Do you have children or grandchildren who need health insurance? The Children's Health Insurance Program provides low cost health insurance coverage to children in families who earn too much income to qualify for Medicaid but can't afford private health insurance.

In many states, uninsured children 18 and younger, whose families earn up to $44,100 a year (for a family of four) are eligible for free or low-cost health insurance that pays for doctor visits, dental care, prescription drugs, hospitalizations, and much more. Pregnant women and other adults may also be eligible for coverage. Each state has its own program, with its own eligibility rules. Call 1-877-KIDS-NOW (1-877-543-7669), or visit www.insurekidsnow.gov to learn more.

SECTION 4

Protecting Yourself and Medicare

Section 4 includes information about the following:

Your Medicare Rights

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

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

Your Rights if Your Plan Stops Participating in Medicare

Medicare health and prescription drug plans can decide not to participate in Medicare for the coming year. Plans that choose to leave the Medicare Program entirely or in certain areas are said to be "non-renewing." In these cases, the plan will send you a letter about your options, and you will have the right to join another Medicare plan.

If you want to continue to have Medicare prescription drug coverage (Part D) or a Medicare Advantage Plan (like an HMO or PPO), you need to join a new plan for the coming year. You should join a new Medicare plan by December 31st to make sure you have coverage as of January 1. If you don't join a plan by December 31st, you will continue to have Medicare coverage (through Original Medicare only) as of January 1.

Blue words in the text are defined on pages 127–130.

Your Rights if Your Plan Stops Participating in Medicare (continued)

Your Medicare plan will send you a letter about your options. You will have until January 31, 2011, to choose and join a new Medicare plan.

- Generally, if you're in a Medicare Advantage Plan, you will automatically return to Original Medicare if you don't choose to join another Medicare Advantage Plan. You will also have the right to buy certain Medigap policies. If you return to Original Medicare, you can also join a Medicare Prescription Drug Plan.
- If you're in a Medicare Prescription Drug Plan, you will have the right to join another Medicare Prescription Drug Plan or a Medicare Advantage Plan with drug coverage. If you don't join a new plan, you won't have Medicare prescription drug coverage (Part D).

What is an Appeal?

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

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

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

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

How to File an Appeal

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

- If you have Original Medicare, do the following to file an appeal:
  1. Get the Medicare Summary Notice (MSN) that shows the item or service you're appealing. Your MSN is the statement you get every 3 months that lists all the services billed to Medicare and tells you if Medicare paid for the services. See pages 52–53.
  2. Circle the item(s) you disagree with on the MSN, and write an explanation on the MSN of why you disagree.
  3. Sign, write your telephone number, and provide your Medicare number on the MSN. Keep a copy for your records.
  4. Send the MSN, or a copy, to the Medicare contractor's address listed on the MSN. You can also send any additional information you may have about your appeal.
  5. You must file the appeal within 120 days of the date you get the MSN. If you want to file an appeal, read your MSN carefully, and follow the instructions on the back. Or, use CMS Form 20027, and file it with the Medicare contractor at the address listed on the MSN. To view or print this form, visit www.medicare.gov/medicareonlineforms, or call 1-800-MEDICARE (1-800-633-4227) for a copy. TTY users should call 1-877-486-2048.

     You will generally get a decision from the Medicare contractor (either in a letter or a Medicare Summary Notice) within 60 days after they get your request.

- If you have a Medicare health plan, learn how to file an appeal by looking at the materials your plan sends you each year, calling your plan, or visiting http://go.usa.gov/low to view the booklet, "Your Medicare Rights and Protections." You can also call 1-800-MEDICARE to see if a copy can be mailed to you.
- If you have a Medicare Prescription Drug Plan, look at your plan materials, call your plan, or look on pages 98–100 to learn how to file an appeal.

You can also file a fast appeal in some cases. See page 97.

Contact your State Health Insurance Assistance Program (SHIP) if you need help filing an appeal. See pages 123–126 for the telephone number.

Blue words in the text are defined on pages 127–130.

Your Right to a Fast Appeal

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

- You may ask your doctor for any information that may help your case if you decide to file a fast appeal.
- You must call your local QIO to request a fast appeal no later than the time shown on the notice you get from your provider. Use the telephone number for your local QIO listed on your notice.
- If you miss the deadline, you still have appeal rights:
  - — If you have Original Medicare, call your local QIO.
  - — If you're in a Medicare health plan, call your plan. Look in your plan materials to get the telephone number.

Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for the QIO in your state, or visit www.medicare.gov. TTY users should call 1-877-486-2048.

Appealing Your Medicare Drug Plan's Decisions

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

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

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 show you a notice that explains how to contact your Medicare drug plan so you can make your request. If the pharmacist doesn't show you this notice, ask to see it.

Appealing Your Medicare Drug Plan's Decisions (continued)

You or your prescriber may make a standard request by phone or in writing, if you're asking for prescription drug benefits you haven't received yet. If you're asking to get paid back for prescription drugs you already bought, you or your prescriber must 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 received the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting.

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

If you disagree with your Medicare drug plan's coverage determination or exception decision, you can appeal. There are five levels of appeal. The first level is appealing to your plan. Once your Medicare drug plan gets your appeal, it has 7 days (for a standard appeal) or 72 hours (for an expedited appeal) to notify you of its decision. If you disagree with the plan's decision, you can ask for an independent review of your case. The notice you get with the plan's decision will explain the next level of appeal.

Appealing Your Medicare Drug Plan's Decisions (continued)

You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP). See pages 123–126 for the telephone number.

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

For more information about your rights and the different levels of appeal, visit http://go.usa.gov/igx to view the booklet "Your Guide to Medicare Prescription Drug Coverage," or call 1-800-MEDICARE to see if a copy can be mailed to you.

Advance Beneficiary Notice (ABN)

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

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

Blue words in the text are defined on pages 127–130.

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

For more information about ABNs, visit http://go.usa.gov/low to view the booklet, "Your Medicare Rights and Protections," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How Medicare Uses Your Personal Information

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

Notice of Privacy Practices for Original Medicare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note: If you join a Medicare plan, the plan will let you know how it will use and release your personal information as permitted or required by law including for treatment, payment, health care operations, and for research and other purposes.

Protect Yourself from Identity Theft

Identity theft is a serious crime. Identity theft happens when someone uses your personal information without your consent to commit fraud or other crimes. Personal information includes things like your name and your Social Security, Medicare, or credit card numbers. Guard against identity theft by keeping your personal information safe.

If you think someone is using your personal information without your consent, call your local police department and the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338 to make a report. TTY users should call 1-866-653-4261.

Blue words in the text are defined on pages 127–130.

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

Medicare plans can't ask you for credit card or banking information over the telephone or email, unless you're already a member of that plan. Medicare plans can't enroll you into a plan over the telephone unless you call them and ask to enroll. **Call 1-800-MEDICARE to report any plans that ask for your personal information over the telephone or that call to enroll you in a plan.** You can also call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). The MEDIC fights fraud, waste, and abuse in Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) Programs. The MEDIC is committed to partnering with you to prevent inappropriate activity in Medicare.

For more information about identity theft or to file a complaint online, visit www.ftc.gov/idtheft. You can also visit www.stopmedicarefraud.gov/fightback_brochure_rev.pdf to view the brochure, "Medical Identity Theft & Medicare Fraud."

The Senior Medicare Patrol (SMP) Program Can Help You

The SMP Program educates and empowers people with Medicare to take an active role in detecting and preventing health care fraud and abuse. The SMP Program not only protects people with Medicare, they also help preserve the Medicare Program. There is an SMP Program in every state, the District of Columbia, Guam, the U.S. Virgin Islands, and Puerto Rico. Contact your local SMP Program to get one-on-one counseling and to find out about community events in your area. For more information or to find your local SMP Program, visit www.smpresource.org, or call 1-877-808-2468. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Protect Yourself and Medicare from Fraud

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

Remember these tips to help prevent billing fraud:

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

If you believe a Medicare plan or provider has used false information to mislead you, call 1-800-MEDICARE.

Protect Yourself and Medicare from Fraud (continued)

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. These include the Medicare Summary Notice if you have Original Medicare, or similar statements that list the services you got or prescriptions you filled.

If you think you see an error, do the following to find out what was billed:

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

Blue words in the text are defined on pages 127–130.

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

1. Contact your health care provider to be sure the bill is correct.
2. Call 1-800-MEDICARE.
3. Call the fraud hotline of the Department of Health and Human Services Office of Inspector General at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950. You can also email HHSTips@oig.hhs.gov. **Note:** If you live in Florida or were charged for a service from a doctor, other provider, or supplier in Florida and suspect fraud, call Medicare's Florida fraud hotline at 1-866-417-2078. You can also e-mail floridamedicarefraud@hp.com.
4. Call the Medicare Drug Integrity Contractor at 1-877-7SAFERX (1-877-772-3379) if you're in a Medicare Advantage Plan or a Medicare Prescription Drug Plan.

For more information on protecting yourself from Medicare fraud and tips for spotting and reporting fraud, visit www.stopmedicarefraud.gov, or contact your local SMP Program.
See page 105.

Fighting Fraud Can Pay

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

- You report suspected Medicare fraud.
- The suspected Medicare fraud you report must be proven as potential fraud by the Program Safeguard Contractor or the Zone Program Integrity Contractor (the Medicare contractors responsible for investigating potential fraud and abuse) and formally referred as part of a case by one of the contractors to the Office of Inspector General for further investigation.
- You aren't an "excluded individual." For example, you didn't participate in the fraud offense being reported. Or, there isn't another reward that you qualify for under another government program.
- The person or organization you're reporting isn't already under investigation by law enforcement.
- Your report leads directly to the recovery of at least $100 of Medicare money.

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

Reporting Suspected Medicaid Fraud

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

How Medicare Protects You

With help from honest health care providers, suppliers, law enforcement, and citizens like you, Medicare is improving its ability to prevent fraud and identity theft. Medicare is also working with other government agencies to protect Medicare from fraud and to protect you from identity theft. The Department of Justice and the Department of Health and Human Services' Medicare Fraud Strike Force is a multi-agency team of Federal, state, and local investigators designed to combat Medicare fraud through Medicare data analysis and community policing.

These agencies are also working together to both prevent fraud and enforce current anti-fraud laws around the country on a Health Care Fraud Prevention and Enforcement Action Team (HEAT). In 2009, as a result of these efforts, approximately $2.5 billion was deposited to the Medicare Trust Fund, a $569 million increase over the previous year.

Because of all of these efforts, some dishonest health care providers have been removed from Medicare, and some have gone to jail. These actions are saving money for taxpayers and protecting Medicare for the future.

You Are Protected from Discrimination

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

Blue words in the text are defined on pages 127–130.

The Medicare Beneficiary Ombudsman

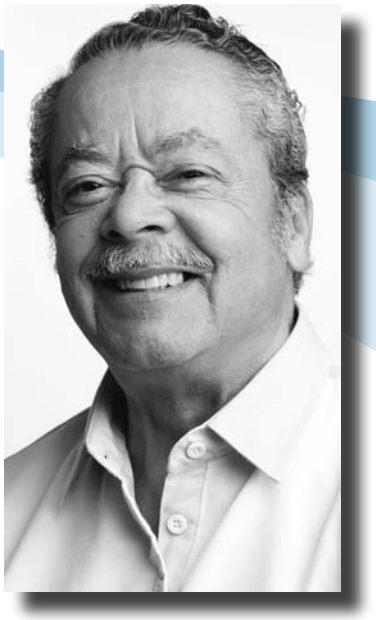
An "ombudsman" is a person who reviews issues and helps resolve them. The Medicare Beneficiary Ombudsman makes sure information about the following is available to all people with Medicare:

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

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

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

SECTION 5



Planning Ahead

Section 5 includes information about the following:

Plan for Long-Term Care

Blue words in the text are defined on pages 127–130.

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

Paying for Long-Term Care

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

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

Your current or former employer or union may offer long-term care insurance. Current and retired Federal employees, active and retired members of the uniformed services, and their qualified relatives can apply for coverage under the Federal Long-term Care Insurance Program. If you have questions, visit www.opm.gov/insure/ltc, or call the Federal Long-term Care Insurance Program at 1-800-582-3337. TTY users should call 1-800-843-3557.

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

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

Paying for Long-Term Care (continued)

Medicaid—Medicaid is a joint Federal and state program that pays for certain health services for people with limited income and resources. If you qualify, you may be able to get help to pay for nursing home care or other health care costs. See page 91 for more information about Medicaid.

Home and Community-based Services Programs—If you're already eligible for Medicaid (or, in some states, would be eligible for Medicaid coverage in a nursing home), you or your family members may be able to get help with the costs of services that help you stay in your home instead of moving to a nursing home. Examples include homemaker services, personal care, and respite care. For more information, contact your State Medical Assistance (Medicaid) office. Call 1-800-MEDICARE (1-800-633-4227), and say "Medicaid" to get the telephone number, or visit www.medicare.gov. TTY users should call 1-877-486-2048.

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

Programs of All-inclusive Care for the Elderly (PACE)—PACE is a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community. See page 71 for more information.

Coming Soon—The Community Living Assistance Services and Supports (CLASS) Program is a national, voluntary insurance program to help you pay for services and supports so you can maintain independence in your community if you become disabled. People over 18 who are working will have the opportunity to enroll in the CLASS program starting in late 2012, either through payroll deductions or individual enrollment. Enrollees who become disabled (at any point after a five year vesting period) and need help with basic daily living activities such as eating, using the bathroom, and getting in and out of bed will be able to get a benefit that will average no less than $50 a day to help pay for supports to stay independent. Talk to your employer or benefits administrator for more information.

Paying for Long-Term Care (continued)

Long-Term Care Contacts

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

- Visit www.medicare.gov/LTCPlanning. You can also visit www.medicare.gov/NHCompare or www.medicare.gov/HHCompare to compare nursing homes or home health agencies in your area.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.longtermcare.gov to learn more about planning for long-term care.
- Call your State Insurance Department to get information about long-term care insurance. Call 1-800-MEDICARE to get the telephone number. You can also call your State Health Insurance Assistance Program. See pages 123–126 for their telephone number.
- Call the National Association of Insurance Commissioners at 1-866-470-6242 to get a copy of "A Shopper's Guide to Long-term Care Insurance."
- Visit the Eldercare Locator at www.eldercare.gov to find your local Aging and Disability Resource Center (ADRC). You can also call 1-800-677-1116. ADRCs offer a full range of long-term care services and support in a single, coordinated program.

Blue words in the text are defined on pages 127–130.

Advance Directives

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

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

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

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

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

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

Advance Directives (continued)

If you already have advance directives, take time now to review them to be sure you're still satisfied with your decisions, and your health care proxy is still willing and able to carry out your plans. Find out how to cancel or update them in your state if they no longer reflect your wishes. Each state has its own laws for creating advance directives. Most states may allow you to combine your advance directives in one document. For more information, contact your health care provider, an attorney, your local Area Agency on Aging, or your State Health Department.

Tips

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

SECTION 6

Helpful Resources and Tools

Section 6 includes information about the following:

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

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

TTY Users 1-877-486-2048.

Get Information 24 Hours a Day, Including Weekends.

- Speak clearly, have your Medicare card in front of you, and be ready to provide your Medicare number. This helps reduce the amount of time you may wait to speak to a customer service representative. It also allows us to play messages that may specifically impact your coverage and may help us get you to a representative more quickly.
- To enter your Medicare number, speak clearly the numbers and letters one at a time. Or, you can enter your Medicare number on the telephone keypad. Use the star key to indicate any place there may be a letter. For example, if your Medicare number is 000-00-0000A, you would enter 0-0-0-0-0-0-0-0-0-*. The voice system will then ask you for that letter.
- **Say "AGENT" at anytime to talk to a customer service representative, or use this chart.** If you need help in a language other than English or Spanish, let the customer service representative know the language.

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

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

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

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

State Health Insurance Assistance Programs (SHIP)

State Health Insurance Assistance Programs are state programs that get money from the Federal government to give free local health insurance counseling to people with Medicare. SHIPs are independent and not connected to any insurance company or health plan. SHIP volunteers work hard to help you with the following Medicare questions or concerns:

- Your Medicare rights
- Complaints about your medical care or treatment
- Billing problems
- Plan choices

If you're interested in becoming a volunteer SHIP counselor, contact the SHIP in your state to learn more. See pages 123–126 for the telephone number.

Go Online to Get the Information You Need

Need General Information about Medicare?

Visit www.medicare.gov:

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

If you don't have a computer, your local library or senior center may be able to help you look up this information. You can also call your State Health Insurance Assistance Program (SHIP). See pages 123–126 for the telephone number.

Need Personalized Medicare Information?

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

- Create and print an "On the Go" report that lists information you can share with your providers.
- Add or modify self-reported health management information such as medical conditions and allergies.
- View or modify your personal drug list and pharmacy information, and see your prescription drug costs.
- Search for and create a list of your favorite providers, and access quality information about them.
- Complete your Initial Enrollment Questionnaire so your bills can get paid correctly.
- Track your Original Medicare claims, and order a Medicare Summary Notice.
- Check your Part B deductible status.
- View your eligibility information.
- Get notices about what services you will be eligible for in the coming year.

Go Online to Get the Information You Need (continued)

Need Personalized Medicare Information? (continued)

- Find a Medicare health or prescription drug plan.
- Access online forms, publications, and messages sent by Medicare.
- Sign up to get this handbook electronically.

Compare the Quality of Plans and Providers

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

Blue words in the text are defined on pages 127–130.

Compare the quality of care and services given by health and prescription drug plans or health care providers nationwide by visiting www.medicare.gov or by calling your State Health Insurance Assistance Program (SHIP). See pages 123–126 for the telephone number.

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

- "Drug and Health Plans"
- "Dialysis Facilities"
- "Home Health Agencies"
- "Hospitals"
- "Nursing Homes"

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

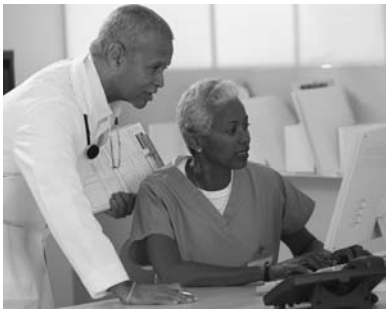
- Ask what your plan or provider does to ensure and improve the quality of care and services. Every plan and health care provider should have someone you can talk to about quality.
- Ask your doctor what he or she thinks about the quality of care or services the plan or other health care provider gives.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

Managing Your Health Information Online

Even if you don't use a computer, there are new ways to help manage your health information and improve how you communicate with your health care providers. This technology (also called Health Information Technology or Health IT) reduces paperwork, medical errors, and health care costs. It can also help improve the quality and coordination of your health care.

Here are examples of Health IT that **your health care providers** can use:

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



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

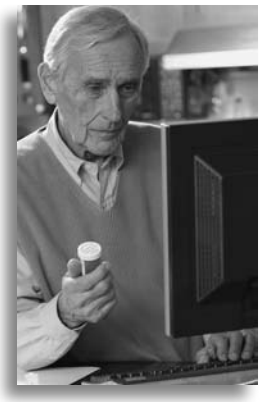
Electronic Health Records (EHRs)—A safe and confidential record that your doctor, your doctor's staff, or a hospital keeps on a computer about your health care or treatments. If your providers use electronic health records, they can join a network to securely share your records with each other.

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

Managing Your Health Information Online (continued)

The following is an example of Health IT that **you** can use:

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



- These easy-to-use tools can help you manage your health information from anywhere you have internet access.
- With a PHR, you can keep track of health information, like the date of your last physical, major illnesses, operations, allergies, or a list of your prescriptions.
- PHRs are often offered by providers, health plans, and private companies. Some are free, while others charge fees.
- When you use a PHR, make sure that it's on a secure Web site. With a secure Web site, you usually have to create a unique user ID and password, and the information you type is encrypted (put in code) so other people can't read it.

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

Visit www.medicare.gov/phr to learn more about Personal Health Records.

Medicare Publications

To read, print, or download copies of booklets, brochures, or fact sheets on different Medicare topics, visit www.medicare.gov/publications. You can search by keyword (such as "rights" or "mental health"), or select "View All Medicare Publications."

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

Blue words in the text are defined on pages 127–130.

Caregiver Resources

Do You Help Someone With Medicare?

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

ask Medicare

- Visit "Ask Medicare" at www.medicare.gov/caregivers to help someone you care for choose a drug plan, compare nursing homes, get help with billing, and more!
- Sign up for the free bi-monthly "Ask Medicare" electronic newsletter (e-Newsletter) when you go to the site mentioned above. The e-Newsletter has the latest information including important dates, Medicare changes, and resources in your community.
- Visit the Eldercare Locator at www.eldercare.gov, or call 1-800-677-1116 to find caregiver support services in your area.
- Follow official Medicare information on Twitter at www.Twitter.com/CMSGov and the Children's Health Insurance Program at www.Twitter.com/IKNGov.
- Visit www.YouTube.com/cmshhsgov to see videos covering an array of health care topics on Medicare's YouTube channel.

State Health Insurance Assistance Programs (SHIPs)

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

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Definitions

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

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

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

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

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

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

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

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

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

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

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

Lifetime Reserve Days—In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance. In 2011, you pay $566 for each lifetime reserve day.

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Costs

Your Monthly Premiums for Medicare

Part A (Hospital Insurance) Monthly Premium

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

In 2011, you pay up to $450 each month if you don't get premium-free Part A. If you pay a late enrollment penalty, this amount is higher.

Part B (Medical Insurance) Monthly Premium (See page 25.)

Most people will continue to pay the same Part B premium they paid last year.

If Your Yearly Income in 2009 was		You Pay
File Individual Tax Return	File Joint Tax Return	
$85,000 or less	$170,000 or less	$115.40
above $85,000 up to $107,000	above $170,000 up to $214,000	$161.50
above $107,000 up to $160,000	above $214,000 up to $320,000	$230.70
above $160,000 up to $214,000	above $320,000 up to $428,000	$299.90
above $214,000	above $428,000	$369.10

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

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

What You Pay if You Have Original Medicare

Part A Costs for Covered Services and Items

Blood	In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated.
Home Health Care	**You pay:** ▪ $0 for home health care services ▪ 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	**You pay:** ▪ $0 for hospice care ▪ A copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management ▪ 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest) Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).
Hospital Inpatient Stay	**You pay:** ▪ $1,132 deductible and no coinsurance for days 1–60 each benefit period ▪ $283 per day for days 61–90 each benefit period ▪ $566 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime) ▪ All costs for each day after the lifetime reserve days ▪ Inpatient mental health care in a psychiatric hospital limited to 190 days in a lifetime See "Medical and Other Services" on page 133 for what you pay for doctor services while you're a hospital inpatient.
Skilled Nursing Facility Stay	**You pay:** ▪ $0 for the first 20 days each benefit period ▪ $141.50 per day for days 21–100 each benefit period ▪ All costs for each day after day 100 in a benefit period

Note: If you're in a Medicare Advantage Plan, costs vary by plan and may be either higher or lower than those noted above. Review the Evidence of Coverage from your plan.

What You Pay if You Have Original Medicare (continued)

Part B Costs for Covered Services and Items

Part B Deductible	**You pay** the first $162 yearly for Part B-covered services or items.
Blood	In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. However, you will pay a copayment for the blood processing and handling services for every unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else. You pay a copayment for additional units of blood you get as an outpatient (after the first 3), and the Part B deductible applies.
Clinical Laboratory Services	**You pay** $0 for Medicare-approved services.
Home Health Services	**You pay** $0 for Medicare-approved services. You pay 20% of the Medicare-approved amount for durable medical equipment.
Medical and Other Services	**You pay** 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy*, and durable medical equipment.
Mental Health Services	**You pay** 45% of the Medicare-approved amount for most outpatient mental health care.
Other Covered Services	**You pay** copayment or coinsurance amounts.
Outpatient Hospital Services	**You pay** a coinsurance (for doctor services) or a copayment amount for most outpatient hospital services. The copayment for a single service can't be more than the amount of the inpatient hospital deductible.

*In 2011, there may be limits on physical therapy, occupational therapy, and speech-language pathology services. If so, there may be exceptions to these limits.

Note: All Medicare Advantage Plans must cover these services. Costs vary by plan and may be either higher or lower than those noted above. Review the Evidence of Coverage from your plan.

Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D) Premiums

Visit www.medicare.gov/find-a-plan to get plan premiums. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

The chart below shows your estimated prescription drug plan monthly premium amount based on your income. If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your premium. The amounts shown are estimates. What you pay may be higher or lower.

Part D Monthly Premium (See page 75.)

If Your Yearly Income in 2009 was		You Pay
File Individual Tax Return	**File Joint Tax Return**	
$85,000 or less	$170,000 or less	Your Plan Premium
above $85,000 up to $107,000	above $170,000 up to $214,000	$12.00 + Your Plan Premium
above $107,000 up to $160,000	above $214,000 up to $320,000	$31.10 + Your Plan Premium
above $160,000 up to $214,000	above $320,000 up to $428,000	$50.10 + Your Plan Premium
above $214,000	above $428,000	$69.10 + Your Plan Premium

The income-related monthly adjustment amount will be deducted from your monthly Social Security check, no matter how you usually pay your plan premium. If that amount is more than the amount of your check, you will get a bill from Medicare.

Part C and Part D Costs for Covered Services and Supplies

Cost information for the Medicare plans in your area is available by visiting www.medicare.gov. You can also contact the plan, or call 1-800-MEDICARE. You can also call your State Health Insurance Assistance Program (SHIP). See pages 123–126 for the telephone number.

The figure below is used to estimate the Part D late enrollment penalty. The national base beneficiary premium amount can change each year. For more information about estimating your penalty amount, see page 79.

2011 Part D National Base Beneficiary Premium	$32.34

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

**U.S. DEPARTMENT OF
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- Also available in Spanish, Braille, Audiotape, and Large Print (English and Spanish).
- Suspect fraud? Call the Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950. In Florida, call 1-866-417-2078.
- Moving? Call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

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

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