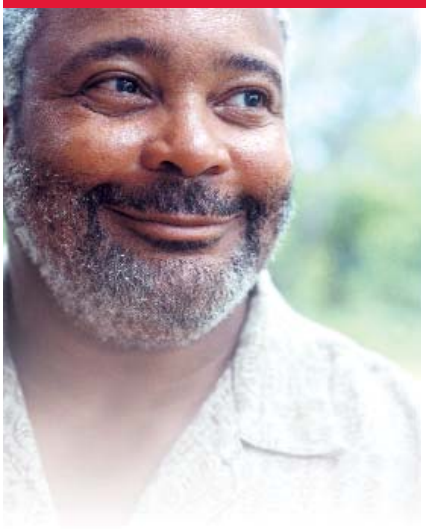
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare & You 2008



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

- ★ 2008 costs
- ★ What's covered
- ★ Preventive services
- ★ Health plans
- ★ Prescription drug plans
- ★ Your rights and appeals

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Welcome to Medicare & You 2008

A healthy life is a better life. Medicare strives to make sure you can get the health care and prescription coverage you need and the quality of care you deserve.

With more Medicare choices than ever, it's important that you look at your coverage every year. Plan costs and benefits change, and so can your health. The coverage that worked for you this year might still meet your needs in 2008. Or, there might be a better option. This handbook has information on your Medicare health and prescription drug plan choices, tips on what to consider when comparing plans, and resources where you can get detailed information and personalized help.

The information in this handbook is good from January 1, 2008, through December 31, 2008. You will get a new handbook every fall to help you compare plans and learn about new benefits.

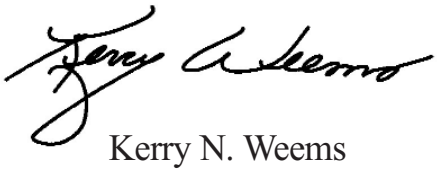
Use the information in this handbook to make the most of your Medicare benefits.

- Get the Medicare-covered preventive services you need, like cancer screenings (mammogram, colorectal, prostate), cardiovascular screenings, and yearly flu shots. These tests and services are critical to your overall health and can help you prevent diseases or detect them early on, when treatment works best.
- Visit www.medicare.gov on the web to help you compare the quality of the health care providers in your area, like health plans, hospitals, and home health care agencies. To promote high-quality care at a lower cost, Medicare works closely with health care providers and Congress to develop reporting and payment systems that support and reward quality.

As always, Medicare is here for you anytime, day or night. You can visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Yours in good health,

Michael O. Leavitt
Secretary
Department of Health and
Human Services



Kerry N. Weems
Acting Administrator
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Medicaid Services

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

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

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If your household got more than one copy of "Medicare & You," you can call 1-800-MEDICARE (1-800-633-4227) and tell a customer service representative if you would like to get only one copy in the future. TTY users should call 1-877-486-2048.

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Medicare Basics

What's New and Important in 2008?

- What You Pay for Medicare—The 2008 amounts for Part A and Part B are on pages 110–112.
- Medicare Advantage Plans (Part C) (like HMOs and PPOs) and Medicare Prescription Drug Plans (Part D)—Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.
- Durable Medical Equipment—There may be a change in how you get your durable medical equipment in certain areas. See page 20.
- Preventive Services—Medicare offers a number of preventive services and screenings to help you stay healthy. See pages 18–25.

Plan Benefits and Costs Change Yearly.

Mark your calendar with these important dates!

October 2007: Prepare and Compare

Look at the cost, coverage, and convenience your current plan will offer in 2008. Compare with other plans in your area to see if one may be a better choice for you. Visit www.medicare.gov on the web to find plans in your area. After comparing plans, if you are satisfied with your current plan's cost, coverage, convenience, and the customer service you get, you don't need to do anything. You will remain enrolled through next year.

November 15, 2007:

First day you can change your Medicare health or prescription drug coverage for 2008.

December 31, 2007:

Last day* you can change your Medicare prescription drug coverage for 2008. See page 48 for information about changing a Medicare Advantage Plan.

January 1, 2008:

New coverage begins if you made a change.

* There may be other times you can change a Medicare plan. See pages 48 and 57.

Medicare Basics

What Is Medicare?

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Different Parts of Medicare

You can get the most from your Medicare benefits by learning what Medicare covers and by taking advantage of all that Medicare has to offer. Medicare has the following parts:

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals. Part A also helps cover skilled nursing facility, hospice, and home health care if you meet certain conditions. See pages 10–13.

Medicare Part B (Medical Insurance) helps cover medically-necessary services like doctors' services and outpatient care. Part B also helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse. See pages 14–25.

Blue words in the text are defined on pages 103–107.

Medicare Part C (Medicare Advantage Plans) is another way to get your Medicare benefits. It combines Part A, Part B, and, sometimes, Part D (prescription drug) coverage. Medicare Advantage Plans are managed by private insurance companies approved by Medicare. These plans must cover medically-necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services. See pages 38–49.

Medicare Part D (Medicare Prescription Drug Coverage) helps cover prescription drugs. This coverage may help lower your prescription drug costs and help protect against higher costs in the future. See pages 52–66.

Your Medicare Plan Choices

With Medicare, you can choose how you get your health and prescription drug coverage. You have the following options:

- The **Original Medicare Plan**, managed by the Federal government, provides your Medicare Part A and Part B coverage. You are usually charged a fee for each health care service or supply you get. See pages 33–37.

  If you are in the Original Medicare Plan, you can add drug coverage (Part D) by joining a **Medicare Prescription Drug Plan**. These plans are run by insurance companies and other private companies approved by Medicare. See pages 52–66.

  You can also choose to buy a Medigap (Medicare Supplement Insurance) policy to help fill the gaps in Part A and Part B coverage. See pages 72–74.

- **Medicare Advantage Plans (like an HMO or PPO)** are another way to get Medicare benefits. Medicare Advantage Plans are health plan options approved by Medicare and run by private companies. If you join a Medicare Advantage Plan that doesn't offer drug coverage, like a Medicare Medical Savings Account (MSA) Plan or some Medicare Private Fee-for-Service (PFFS) Plans, you may be able to join a Medicare Prescription Drug Plan. See pages 38–49.

- **Other Medicare Plans** are plans that aren't Medicare Advantage Plans, but are still part of the Medicare Program. Other Medicare health plans include Medicare Cost Plans, Demonstrations/Pilot Programs, and Programs of All-Inclusive Care for the Elderly (PACE). These plans provide Part A and Part B coverage, and some also provide Part D (Medicare prescription drug coverage). See pages 50–51 and 82.

See page 31 for a chart that explains your Medicare plan choices and the decisions you may need to make.

Throughout this book, this symbol is used to bring your attention to important points.

"To Do" List for People New to Medicare

- ❑ If you have insurance from an employer or union, VA, or TRICARE, check how it works with Medicare. See pages 67–71.
- ❑ Follow three steps to decide how you want to get Medicare coverage. See pages 30–31.
  1. Choose a Medicare Health Plan. See Step 1 on page 31.
  2. Decide if you want prescription drug coverage. See Step 2 on page 31.
  3. Decide if you want supplemental coverage. See Step 3 on page 31.
- ❑ Take the quiz that starts on page 114 to learn how you may be able to get help to pay your Medicare costs. Also, see pages 76–82.
- ❑ Get a "Welcome to Medicare" physical exam within your first 6 months of having Medicare Part B. See "physical exam" on page 23.
- ❑ Ask your doctor which preventive services (like screenings, shots, and tests) you should get. See pages 18–25 and bring the checklist on **page 108** to your doctor.
- ❑ Use the password and instructions Medicare mailed to you to access personalized information at www.MyMedicare.gov on the web. See page 96.
- ❑ Pay attention to enrollment dates throughout this handbook. You can only make changes at certain times.
- ❑ Call your State Health Insurance Assistance Program (SHIP) to get free counseling and personalized help. See pages 98–101 for the telephone number.

Section

1

Medicare's Covered Services

Medicare is your partner in staying healthy. We are committed to providing you with benefits that meet your needs and information that can help you make informed health care decisions. To get the most from your benefits, you need to know what Medicare covers.

Section 1 includes information about the following:

- Medicare Part A (Hospital Insurance) and what it covers 10–13
- Medicare Part B (Medical Insurance) and what it covers 14–25
- What's Not Covered by Part A and Part B? 26
- How Medicare's Information About Quality Can Help You 27

Section

1 Medicare's Covered Services

What Services Does Medicare Cover?

Medicare covers certain medical services and supplies in hospitals, doctors' offices, and other health care settings. Services are either covered under Medicare Part A (Hospital Insurance) or Medicare Part B (Medical Insurance). If you have both Part A and Part B, these services and supplies must be covered as long as they are reasonable and necessary for your health, no matter what type of Medicare plan you have.

A list of the services covered by Part A is on page 13.

A list of the services covered by Part B is on pages 18–25.

Blue words in the text are defined on pages 103–107.

What Is Part A (Hospital Insurance)?

Part A helps cover the following:

- Inpatient care in hospitals. This includes critical access hospitals and inpatient rehabilitation facilities
- Inpatient stays in a skilled nursing facility (not custodial or long-term care)
- Hospice care services
- Home health care services
- Inpatient care in a Religious Nonmedical Health Care Institution (coverage is related to non-medical, non-religious parts of care)

See page 13 for more information and for the conditions you must meet to get hospital, skilled nursing facility, and hospice care.

Medicare's Covered Services

What Is Part A (Hospital Insurance)? (continued)

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 it if you meet one of these conditions:

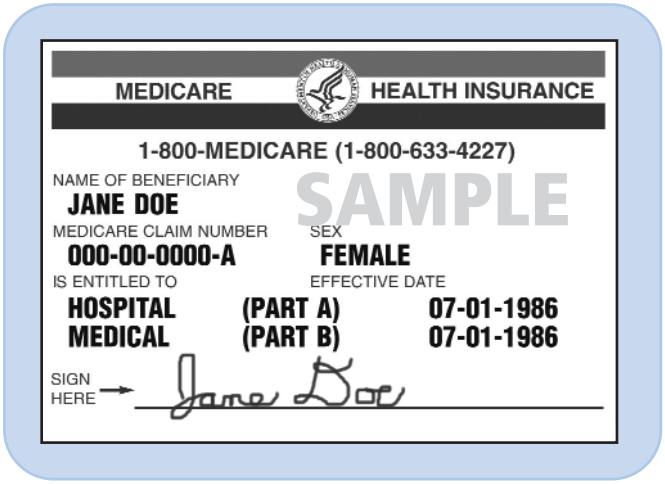
- You didn't work or didn't pay enough Medicare taxes while you worked and you are age 65 or older
- You are disabled and have returned to work

Note: The 2008 Part A premium amount for people who buy Part A is up to $423 each month.

In most cases, if you choose to buy Part A, you must also have or enroll in Part B and pay the monthly Part B premium.

If you have limited income and resources, your state may help you pay for Part A and/or Part B. See page 80.

If you have Part A, "HOSPITAL (PART A)" is printed on your red, white, and blue Medicare card (see sample card below).



Note: Your card may look slightly different. It's still valid. **Keep this card safe**. You will use this card to get your Medicare-covered services in the Original Medicare Plan. If you join a Medicare health plan, you will use a card from the plan to get your Medicare-covered services. See page 91 to find out about protecting yourself from identity theft and fraud.

When Can You Sign Up for Part A?

If you get benefits from Social Security or the Railroad Retirement Board (RRB), you will automatically get Part A starting the first day of the month you turn age 65. If you are under age 65 and disabled, you will automatically get Part A after you get disability benefits from Social Security or RRB for 24 months. Your Medicare card will be mailed to you about 3 months before your 65th birthday, or your 25th month of disability benefits.

People with ALS (Amyotrophic Lateral Sclerosis, or Lou Gehrig's disease) automatically get Part A the month their disability benefits begin.

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

- **Initial Enrollment Period**—the 7-month period that begins 3 months before your 65th birthday and ends 3 months after your 65th birthday.
- **General Enrollment Period** from January 1–March 31 each year
- **Special Enrollment Period** if you have group health coverage through your or your spouse's employer or union. See page 15.

Blue words in the text are defined on pages 103–107.

If you aren't getting Social Security or RRB benefits (for instance, if you are still working), you will need to sign up for Part A. You should contact Social Security 3 months before you turn age 65 to sign up for Part A.

For more information, visit www.socialsecurity.gov on the web or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the RRB, call your local RRB office or 1-800-808-0772.

Do You Need to Replace Your Medicare Card?

If your Medicare card is lost or damaged, you can order a new one by visiting www.socialsecurity.gov on the web, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772, or visit www.rrb.gov on the web and select "Benefit Online Services."

Medicare's Covered Services

Part A-Covered Services

Blood	Starting with the 4th pint of blood you get at a hospital or skilled nursing facility during a covered stay. The first three pints aren't covered.
Home Health Services	Limited to reasonable and necessary part-time or intermittent skilled care or continuing need for physical therapy, occupational therapy, or speech-related pathology ordered by the doctor and provided by a Medicare-certified home health agency. Home health services may also include medical social services, home health aide services or other services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), and medical supplies for use at home.
Hospice Care	For people with a terminal illness who are expected to live 6 months or less if the disease runs its normal course. Coverage includes drugs, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare (like grief counseling) for terminal and related conditions. Hospice care is usually given in your home (or other facility where you may live). Medicare covers some short-term inpatient stays (for pain and symptom management) and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).
Hospital Stays	Semi-private room, meals, general nursing, and other hospital services and supplies. This includes inpatient care you get in acute care hospitals, critical access hospitals, inpatient care as part of a clinical research study (see page 19), and mental health care. This doesn't include private-duty nursing or a television or telephone in your room. It also doesn't include a private room, unless medically necessary. Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.
Skilled Nursing Facility Care	Semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies (only after a 3-day minimum inpatient hospital stay for a related illness or injury) for up to 100 days in a benefit period. To get care in a skilled nursing facility, you must need skilled care like intravenous injections or physical therapy. Medicare doesn't cover long-term care or custodial care in this setting.

See page 111 for specific costs and other information about these services.

What Is Part B (Medical Insurance)?

Part B helps cover medically-necessary services like doctors' services, outpatient care, and other medical services that Part A doesn't cover. Part B also covers some preventive services.

If you aren't sure if you have Part B, look at your Medicare card. See the sample card on page 11. If you have Part B, "MEDICAL (PART B)" is printed on your card.

How Much Does Part B Cost?

Blue words in the text are defined on pages 103–107.

You pay the Part B premium each month. Most people will pay the standard premium amount, which is $96.40 in 2008. However, your monthly premium will be higher if you are single (file an individual tax return) and your yearly income is more than $82,000, or if you are married (file a joint tax return) and your yearly income is more than $164,000. See page 110.

You also pay a Part B deductible each year before Medicare starts to pay its share. In 2008, the deductible amount is $135.

What Is the Part B Late-Enrollment Penalty?

If you don't sign up for Part B when you are first eligible, the cost for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it. If you delay taking Part B because you or your spouse (or a family member, if you are disabled) are working and have group health plan coverage based on that work, you may not have to pay the higher premium. See page 15 (Special Enrollment Period) for more information.

When Can You Sign Up for Part B?

If you get benefits from Social Security or the Railroad Retirement Board (RRB), you will automatically get Part B starting the first day of the month you turn age 65. If you are under age 65 and disabled, you will automatically get Part B after you get disability benefits from Social Security or RRB for 24 months. You will get your Medicare card in the mail about 3 months before your 65th birthday or your 25th month of disability benefits. 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.

People with ALS (Amyotrophic Lateral Sclerosis, or Lou Gehrig's disease) automatically get Part B the month their disability benefits begin.

If you aren't getting Social Security or RRB benefits, and you want to get Part B, you will need to sign up for Part B when you are close to age 65.

If you didn't sign up for Part B when you first became eligible, you may be able to sign up during one of these times:

- **General Enrollment Period** from January 1–March 31 each year. Your coverage will begin on July 1. However, the cost of your Part B will go up 10% for each full 12-month period you could have had Part B but didn't sign up for it, unless you qualify for a Special Enrollment Period (see below). You may have to pay this late-enrollment penalty as long as you have Part B.
- **Special Enrollment Period** if you wait to sign up for Part B because you or your spouse are working and have group health plan coverage based on that work or if you are disabled and you or a family member are working and have group health plan coverage based on that work. You can sign up for Part B any time while you have group health plan coverage based on current employment or during the 8-month period that begins the month the employment ends, or the group health plan coverage ends, whichever happens first.
- **Special Enrollment Period for International Volunteers** if you waited to enroll in Part B because you had health insurance while volunteering in a foreign country.

  Usually, you don't pay a late-enrollment penalty to sign up for Part B during a Special Enrollment Period.

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

Call Social Security at 1-800-772-1213 for more information about enrolling in Part B. TTY users should call 1-800-325-0778. If you get Railroad Retirement Board (RRB) benefits, call your local RRB office or 1-800-808-0772. You can also visit www.medicare.gov on the web or get personalized help from your State Health Insurance Assistance Program (SHIP). See pages 98–101 for the telephone number.

Part B and TRICARE Coverage

If you have TRICARE coverage and Medicare Part A, you must have Medicare Part B to keep TRICARE coverage. However, if you are an active-duty service member or the spouse or dependent child of an active-duty service member, the following apply to you:

- You aren't required to have Part B to keep TRICARE.
- When the active-duty service member retires, you must enroll in Part B to keep your TRICARE coverage.
- You can get Part B during a Special Enrollment Period (see page 15), if you have Medicare because you are 65 or older or you are disabled. In most cases, you won't have to pay a late-enrollment penalty. If you have Medicare because you have End-Stage Renal Disease (ESRD), you can only get Part B during the General Enrollment Period (see page 15) and you may have to pay a late-enrollment penalty.

Blue words in the text are defined on pages 103–107.

If you are in a Medicare Advantage Plan, let the plan know you have TRICARE. See pages 67–68 for more information about TRICARE.

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

Your Part B enrollment rights can be affected if you have coverage through an employer or union and you or your spouse are still working. COBRA coverage is different from coverage based on active employment and may affect your rights differently. See pages 69–70 for more information about employer or union coverage and COBRA. Your decision about when to sign up for Part B can also affect your rights to buy a Medigap (Medicare Supplement Insurance) policy.

Medicare's Covered Services

Part B Helps Cover the Following:

- **Medically-necessary services**—This means the item or service is needed for the diagnosis or treatment of your medical condition.
- **Preventive services**—Services that help prevent or lessen complications from a condition you already have, find health problems early when treatment works best, or manage a medical problem.

Pages 18–25 include an alphabetical list of common medically-necessary and preventive services covered by Medicare Part B.

This symbol identifies preventive services.

Use the checklist on page 108. Ask your doctor which preventive services you need. Your doctor may be able to help you better understand the preventive services Medicare covers.

What You Pay for Medicare Part B-Covered Services

Costs for Part B services vary depending on the type of service you get and the type of plan you choose. General cost information is provided in the Part B coverage charts for the Original Medicare Plan on pages 18–25. This information may help you understand the coverage charts:

- "No cost" means that Medicare will pay for the service, and there is no cost to you.
- "You pay coinsurance" means that, in most cases, you will pay 20% of the Medicare-approved amount for the service.
- "You pay coinsurance and Part B deductible applies" means that you must pay all costs until you meet the yearly Part B deductible before Medicare begins to pay its share. See page 112 for the Part B deductible amount. Then, you pay the coinsurance (in most cases, 20% of the Medicare-approved amount of the service).

Note: If you join a Medicare Advantage Plan (like an HMO or PPO) or have other insurance (such as a Medigap policy, or employer or union coverage), your costs may be different from what's shown on pages 18–25. See page 26 for a list of what isn't covered by Part A or Part B.

Part B-Covered Services

Abdominal Aortic Aneurysm Screening	A one-time screening ultrasound for people at risk (like people who have smoked). Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam. See "physical exam" on page 23. You pay coinsurance.
Ambulance Services	When you need to be transported to a hospital or skilled nursing facility for medically-necessary services, and transportation in any other vehicle would endanger your health. You pay coinsurance, and Part B deductible applies.
Ambulatory Surgery Center Fees	Facility fees for approved services at an Ambulatory Surgery Center (facility where surgical procedures are performed, and the patient is released the same day). You pay coinsurance, and Part B deductible applies.
Blood	Pints of blood you get, starting with the 4th, as an outpatient or as part of a Part B-covered service. The first three pints aren't covered. You pay coinsurance, and Part B deductible applies.
Bone Mass Measurement	To help see if you are at risk for broken bones. This service is covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. You pay coinsurance, and Part B deductible applies.
Cardiovascular Screenings	To help prevent a heart attack or stroke. This service is covered every 5 years to test your cholesterol, lipid, and triglyceride levels. No cost.
Chiropractic Services (limited)	To correct a subluxation (when one or more of the bones of your spine move out of position) using manipulation of the spine. You pay coinsurance, and Part B deductible applies.
Clinical Laboratory Services	Including certain blood tests, urinalysis, some screening tests, and more. No cost.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Clinical Research Studies	To help doctors and researchers find better ways to prevent, diagnose, or treat diseases. Clinical research studies test new types of medical care, like how well a new cancer drug works. Usual patient care costs are covered if you take part in a qualifying clinical research study. If the item or service isn't covered outside of a clinical research study, the cost of the investigational item or service may not be covered. You pay coinsurance, and Part B deductible applies.
Colorectal Cancer Screenings	To help find precancerous growths and help prevent or find cancer early, when treatment is most effective. One or more of the following tests may be covered. Talk to your doctor. ■ Fecal Occult Blood Test—Once every 12 months if age 50 or older. No cost. ■ Flexible Sigmoidoscopy—Generally, once every 48 months if age 50 or older, or for those not at high risk, 120 months after a previous screening colonoscopy. You pay coinsurance. ■ Screening Colonoscopy—Generally once every 120 months (high risk every 24 months), or 48 months after a previous flexible sigmoidoscopy. No minimum age. You pay coinsurance. ■ Barium Enema—Once every 48 months if age 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy. You pay coinsurance.
Diabetes Screenings	To check for diabetes. These screenings are covered if you have any of the following risk factors: high blood pressure (hypertension), dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar. Tests are also covered if you answer yes to two or more of the following questions: ■ Are you age 65 or older? ■ Are you overweight? ■ Do you have a family history of diabetes (parents, siblings)? ■ Do you have a history of gestational diabetes (diabetes during pregnancy), or did you deliver a baby weighing more than nine pounds? Based on the results of these tests, you may be eligible for up to two diabetes screenings every year. No cost.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Diabetes Self-management Training	For people with diabetes. Your doctor or other health care provider must provide a written order. You pay coinsurance, and Part B deductible applies.
Diabetes Supplies	Including glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes (in some cases). Syringes and insulin are only covered if used with an insulin pump, but may be covered by Medicare prescription drug coverage (Part D). You pay coinsurance, and Part B deductible applies.
Doctor Services	Services that are medically necessary or covered preventive services. Doesn't cover routine physical except for the one-time "Welcome to Medicare" physical exam (see page 23). You pay coinsurance, and Part B deductible applies.
Durable Medical Equipment	Items such as oxygen, wheelchairs, walkers, and hospital beds needed for use in the home. For certain equipment, such as wheelchairs and hospital beds, Medicare pays rental fees for up to 13 months (36 months for oxygen). After this, you own the equipment, and Medicare pays for maintenance. For Medicare to cover your equipment, you must go to a supplier that is enrolled in Medicare. You pay coinsurance, and Part B deductible applies. In some cases, if you buy the equipment without renting it first, Medicare pays no part. **NEW:** In 2008, you may have to use certain Medicare-contracted suppliers to get certain durable medical equipment in some geographic areas. Call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.
Emergency Room Services	When you believe your health is in serious danger. You may have a bad injury, a sudden illness, or an illness that quickly gets much worse. You pay coinsurance, and Part B deductible applies.
Eye Exams	For people with diabetes to check for diabetic retinopathy once every 12 months. You pay coinsurance, and 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 coinsurance, and Part B deductible applies.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Flu Shots	To help prevent influenza or flu virus. This is covered once a flu season in the fall or winter. The flu is a serious illness. You need a flu shot for the current virus each year. No cost.
Foot Exams and Treatment	If you have diabetes-related nerve damage and/or meet certain conditions. You pay coinsurance, and Part B deductible applies.
Glaucoma Tests	To help find the eye disease glaucoma. This is covered once every 12 months for people at high risk for glaucoma. You are considered high risk for glaucoma if you have diabetes, a family history of glaucoma, are African-American and age 50 or older, or are Hispanic and age 65 or older. Tests must be done by an eye doctor who is legally authorized by the state. You pay coinsurance, and Part B deductible applies.
Hearing and Balance Exams	If your doctor orders it to see if you need medical treatment. Hearing aids and exams for fitting hearing aids aren't covered. You pay coinsurance, and Part B deductible applies.
Hepatitis B Shots	To help protect people from getting Hepatitis B. This is covered (three shots) for people at high or medium risk for Hepatitis B. Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), or a condition that lowers your resistance to infection. Other factors may increase your risk for Hepatitis B, so check with your doctor to see if you are at high or medium risk. You pay coinsurance, and Part B deductible applies.
Home Health Services	Limited to reasonable and necessary part-time or intermittent skilled care or continuing need for physical therapy, occupational therapy, or speech-related pathology ordered by the doctor and provided by a Medicare-certified home health agency. Home health services may also include medical social services, home health aide services or other services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and medical supplies for use at home. No cost for home health services. You pay coinsurance, and Part B deductible applies for durable medical equipment.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Kidney Dialysis Services and Supplies	Either in a facility or at home when your doctor orders it. You pay coinsurance, and Part B deductible applies.
Mammograms (screening)	A type of x-ray to check women for breast cancer before they or their doctor may be able to feel it. Screening mammograms are covered once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between age 35 and 39. You pay coinsurance.
Medical Nutrition Therapy Services	Medicare may cover medical nutrition therapy if you have diabetes or kidney disease and your doctor refers you for the service. You pay coinsurance, and Part B deductible applies.
Mental Health Care (outpatient)	To get help with mental health issues such as depression or anxiety. Includes services generally given outside a hospital or in a hospital outpatient department, including visits with a doctor, clinical psychologist or clinical social worker, and lab tests. Certain limits and conditions apply. You pay coinsurance, and Part B deductible applies. **Note:** Talk to your doctor if you feel sad, have little interest in things you used to enjoy, or have thoughts about ending your life. See page 13 for more information about inpatient mental health care.
Occupational Therapy	Services to help you return to usual activities (such as bathing) after an illness when your doctor orders them. You pay coinsurance, and Part B deductible applies.
Outpatient Hospital Services	Services you get as an outpatient as part of a doctor's care. You pay coinsurance, and Part B deductible applies.
Outpatient Medical and Surgical Services and Supplies	For approved procedures. You pay coinsurance, and Part B deductible applies.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Pap Tests and Pelvic Exams (includes clinical breast exam)	To check for cervical and vaginal cancers. Medicare covers these screening tests once every 24 months for women at low risk, and once every 12 months for women at high risk and for women of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past three years. No cost for the Pap lab test. You pay coinsurance for Pap test collection, and pelvic and breast exams.
Physical Exam (one-time "Welcome to Medicare" physical exam)	A one-time review of your health, and education and counseling about preventive services, including certain screenings and shots and referrals for other care if needed. **Important:** You must have the physical exam within the first 6 months you have Part B for it to be covered by Medicare. You pay coinsurance, and Part B deductible applies.
Physical Therapy	Evaluation and treatment of injuries and disease using various procedures, such as exercises and testing, when your doctor orders it. It may also include heat, light, and ultrasound therapy. You pay coinsurance, and Part B deductible applies.
Pneumococcal Shot	To help prevent pneumococcal infections (like certain types of pneumonia). Most people only need this preventive shot once in their lifetime. Talk with your doctor. No cost.
Practitioner Services	Such as services provided by clinical social workers, physician assistants, and nurse practitioners. You pay coinsurance, and Part B deductible applies.
Prescription Drugs (limited)	Includes certain injectable cancer drugs or immunosuppressive drugs. You pay coinsurance, and Part B deductible applies. **Note:** See pages 52–66 for information about additional Medicare prescription drug coverage (Part D).
Prostate Cancer Screenings	These tests help detect prostate cancer. Medicare covers a digital rectal exam (you pay coinsurance, and Part B deductible applies for the exam) and Prostate Specific Antigen (PSA) test once every 12 months for all men with Medicare over age 50. No cost for the PSA test.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Prosthetic/ Orthotic Items	Including arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); breast prostheses (after mastectomy); prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy). For Medicare to cover your prosthetic or orthotic, you must go to a supplier that is enrolled in Medicare. You pay coinsurance, and Part B deductible applies.
Rural Health Clinic and Federally-Qualified Health Center Services	A broad range of primary care services usually provided on an outpatient basis. You pay coinsurance, and Part B deductible applies for rural health clinic services.
Second Surgical Opinions	Covered in some cases for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay coinsurance, and Part B deductible applies.
Smoking Cessation (counseling to stop smoking)	Covered if your doctor orders it. Includes counseling for 2 cessation attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Counseling for each cessation attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.
Speech-Language Pathology Services	Treatment given to regain and strengthen speech skills when your doctor orders it. You pay coinsurance, and Part B deductible applies.
Surgical Dressing Services	For treatment of a surgical or surgically-treated wound. You pay coinsurance, and Part B deductible applies.
Telemedicine	In some rural areas, under certain conditions and only in a provider's office, a hospital, or a federally-qualified health center. You pay coinsurance, and Part B deductible applies.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Tests	Including X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests. You pay coinsurance, and Part B deductible applies.
Transplants	Including doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and only in a Medicare-certified facility. Bone marrow and cornea transplants are covered (under certain conditions). Immunosuppressive drugs are covered if Medicare paid for the transplant, or an employer or union group health plan that was required to pay before Medicare paid for it. You must have been entitled to Part A at the time of the transplant and entitled to Part B at the time you get immunosuppressive drugs, and the transplant must have been performed in a Medicare-certified facility. If you join a Medicare Advantage Plan, check with the plan for information on transplant coverage. You pay coinsurance, and Part B deductible applies. **Note:** Medicare drug plans may cover immunosuppressive drugs, even if Medicare or an employer or union group health plan didn't pay for the transplant.
Travel (health care needed when traveling outside the United States)	Limited to medical services provided in Canada when you travel on the most direct route through Canada between Alaska and another state. Medicare also covers hospital, ambulance, and doctor services if you are in the U.S., but the nearest hospital that can treat you isn't in 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). In some limited cases, Medicare may pay for services you get while on board a ship within the territorial waters adjoining the land areas of the U.S. You pay coinsurance, and Part B deductible applies.
Urgently-Needed Care	To treat a sudden illness or injury that isn't a medical emergency. You pay coinsurance, and Part B deductible applies.

Part B deductible and coinsurance amounts are on page 112. Use the **preventive services checklist** on page 108 when you see your doctor.

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

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

- Acupuncture
- Chiropractic services (except as listed on page 18)
- Cosmetic surgery
- Custodial care (like help with bathing or using the bathroom), except when you also get skilled nursing care in a skilled nursing facility, at home, or in a hospice
- Deductibles, coinsurance, or copayments when you get certain health care services. See pages 111–112 for these amounts. People with limited income and resources may get help paying these costs. See pages 76–82.
- Dental care and dentures (with only a few exceptions)
- Eye care (routine exam), eye refractions (exam that measures your ability to see at specific distances), and most eyeglasses (except as listed on page 20)
- Foot care (routine), like cutting corns or calluses (with few exceptions)
- Hearing aids and exams for the purpose of fitting a hearing aid
- Hearing tests that haven't been ordered by your doctor
- Laboratory tests for screening purposes, except those listed on pages 18–25
- Long-term care, for example, if you only need custodial care in a nursing home
- Orthopedic shoes (with few exceptions)
- Physical exams (routine or yearly). Medicare will cover a one-time physical exam within the first 6 months of enrolling in Part B (coinsurance and Part B deductible applies). See page 23.
- Prescription drugs. Most prescription drugs aren't covered by Part A or Part B. See pages 52–66 for information about Medicare prescription drug coverage (Part D).
- Shots to prevent illness, except as listed on pages 18–25
- Syringes or insulin, unless the insulin is used with an insulin pump, but it may be covered by Medicare prescription drug coverage (Part D)
- Travel (health care while you're traveling outside the United States, except as listed on page 25)

Blue words in the text are defined on pages 103–107.

Medicare's Covered Services

How Medicare's Information About Quality Can Help You

Information about quality can help you tell how well a health plan or other provider (like a doctor or hospital) keeps its members healthy or treats them when they are sick. Medicare collects information from Medicare plans and providers to find out about their quality. Medicare also collects information from people with Medicare about how satisfied they are with their plans or providers.

Use Medicare's Web Tools

Medicare has information about quality that you can see by visiting www.medicare.gov on the web. The website can help you compare plans and providers, and make informed decisions about which ones meet your needs. The website has "Search Tools" that can help you compare what each plan or provider offers in your area.

- To compare Medicare Health Plans and Medigap (Medicare Supplement Insurance) policies, visit "Medicare Options Compare."
- To compare Medicare drug coverage, visit the "Medicare Prescription Drug Plan Finder."
- To compare characteristics and quality information for each of these Medicare and/or Medicaid-certified facilities in your area, visit:
  - "Compare Dialysis Facilities in Your Area"
  - "Compare Home Health Agencies in Your Area"
  - "Compare Hospitals in Your Area"
  - "Compare Nursing Homes in Your Area"

If you have a question or complaint about the quality of care for a Medicare-covered service, call your local Quality Improvement Organization (QIO). Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number. TTY users should call 1-877-486-2048.

You may have the right to appeal decisions about health care payments or services. For example, you may want to appeal if something you need isn't covered and you think it should be. See pages 83–88 for more information about your appeal rights.

To Get More Information About

- Part B services and their costs—visit www.medicare.gov on the web. Under "Search Tools," select "Find out What Medicare Covers." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Coverage in Medicare Advantage Plans (like an HMO or PPO)—see pages 38–49.
- Medicare prescription drug coverage (Part D)— see pages 52–66.
- When Medicare will cover your next preventive service—visit www.MyMedicare.gov on the web, and select "My Preventive Services." You will need to register on the site to get your personal information. See page 96.

Blue words in the text are defined on pages 103–107.

Section

2

Your Plan Choices

Medicare gives you choices in how you get your health and prescription drug coverage. Before making any decisions, learn as much as you can about the types of plans and coverage available to you.

Section 2 includes information about the following:

- Choosing a Medicare Health Plan 30–32
  - The Original Medicare Plan 33–37
  - Medicare Advantage Plans 38–49
  - Other Medicare Health Plans 50–51
- Medicare Prescription Drug Coverage. 52–66
- Other Government and Private Insurance 67–71
- Medigap (Medicare Supplement Insurance) Policies 72–74

This handbook has general information. You may need more information than this handbook provides to make a choice. See page 30 to find out how to get personalized help.

Section

2 Your Plan Choices

Decide How to Get Your Medicare Benefits

You can choose different ways to get your Medicare benefits. **In most cases, if you do nothing when you are first eligible for Medicare, you will automatically be in the Original Medicare Plan, and you can join a Medicare Prescription Drug Plan.** Or, you can choose to join a Medicare Advantage Plan (like an HMO or PPO) to get all of your Medicare benefits. In most cases, the plan will include Medicare prescription drug coverage.

Each year you should review your health and prescription needs. If you decide another plan will better meet your needs, you can switch to a different plan during certain times. See pages 48 and 57.

Note: In some cases, you may have to pay a late-enrollment penalty if you don't join a Medicare plan when you are first eligible. See pages 14 and 58.

Blue words in the text are defined on pages 103–107.

You Can Get Personalized Help Choosing a Medicare Plan

1. Visit www.medicare.gov on the web. Under "Search Tools," select "Compare Health Plans and Medigap Policies in Your Area" or "Compare Medicare Prescription Drug Plans."
2. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
3. Call your State Health Insurance Assistance Program (SHIP) to get free counseling about choosing a plan. See pages 98–101 for the telephone number.
4. Find a Medicare partner in your local community. Medicare works with many organizations around the country and in your local community. See pages 95–97 for a more detailed list of telephone numbers and places to get personalized help.

Your Plan Choices

STEP 1 *Decide Which Medicare Health Plan You Want* STEP 1

Original Medicare Plan OR Medicare Advantage Plan (like an HMO or PPO)

Part A (Hospital Insurance) & Part B (Medical Insurance)

- Medicare provides this coverage.
- You have your choice of doctors.
- Generally, Medicare Part B pays 80% of covered costs, and you pay 20% after you meet your deductible.

See pages 33–37.

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 must see plan doctors.
- You usually pay a copayment for covered services.
- Costs, extra benefits, and rules vary by plan. **See pages 38–49.**

STEP 2 *Decide If You Want Prescription Drug Coverage (Part D)* STEP 2

- If you want this coverage, you must choose and join a Medicare Prescription Drug Plan.
- These plans are run by private companies approved by Medicare.

See pages 52–66.

- Most Medicare Advantage Plans include prescription drug coverage (Part D), usually for an extra cost.

See pages 40–44.

- If not, you may be able to join a Medicare Prescription Drug Plan.

See pages 52–66.

STEP 3 *Decide If You Want Supplemental Coverage*

You may want to get private coverage that fills gaps in Part A and Part B coverage.

- You can choose to buy private supplemental coverage, like a Medigap (Medicare Supplement Insurance) policy. **See pages 72–74.**
- Costs vary by policy and company.
- Employers/unions may offer similar coverage.

Note: If you join a Medicare Advantage Plan, you usually **don't need, and can't buy, a Medigap policy.** If you already have a Medigap policy, you can keep it, but Medigap won't pay for any plan costs, such as copayments. **See page 45.**

In addition to the Original Medicare Plan or a Medicare Advantage Plan, you may be able to join other types of Medicare health plans. See pages 50–51. You may have other choices if you have limited income and resources (see pages 76–82), or if you have other coverage, like employer or union, military, or Veterans' benefits (see pages 67–70).

Your Plan Choices

Things to Consider When Choosing or Changing Your Coverage

- **Cost**—What will you pay out-of-pocket for premiums, coinsurance, copayments, and deductibles?
- **Benefits**—When choosing between the Original Medicare Plan and a Medicare Advantage Plan (like an HMO or PPO), are extra benefits like eye exams or hearing aids covered? How does what you pay for hospital stays and other costs differ?
- **Doctor and hospital choice**—Does your doctor(s) accept the plan? Can you see the doctor(s) you want? Are they accepting new patients? Do you have to choose your health care providers from the plan's network? Do you need a referral to see a specialist? Can you go to the hospital you want, or do you have to go to a network hospital? Do you pay less to go to certain doctors or hospitals?
- **Convenience**—Where are the doctors' offices? What are their hours?
- **Travel**—Do you spend part of each year in another state? Will the plan cover you there?
- **Prescription drugs**—What will your prescription drugs cost under the plan's formulary? What are your drug needs?
- **Pharmacy choice**—What pharmacies can you use?
- **Quality of care**—Quality of care varies among plans, doctors, hospitals, and other health care providers. Quality information to help you make informed choices is available by visiting www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- **Your other coverage**—Do you have, or are you eligible for, other types of health or prescription drug coverage? If so, read the materials you get from your insurer or plan, or call them.

Blue words in the text are defined on pages 103–107.

Talk to your benefits administrator, insurer, or plan before you change your current employer or other coverage, or you might lose that coverage.

Original Medicare Plan

The Original Medicare Plan is one of your health coverage choices as part of the Medicare Program. You will be in the Original Medicare Plan unless you choose to join another type of plan. Most people get their coverage through the Original Medicare Plan.

How Does the Original Medicare Plan Work?

The Original Medicare Plan is a fee-for-service plan (generally, a fee is charged each time you get a service) managed by the Federal government. Here are the general rules for how it works:

- You use your red, white, and blue Medicare card when you get health care. See the sample card on page 11.
- You can go to any doctor, supplier, hospital, or other facility that accepts Medicare and is accepting new Medicare patients.
- Each year, you generally must pay a set amount for your health care (a deductible of $135 in 2008) before Medicare pays its share. Then, Medicare pays its share (usually 80%), and you pay your share (coinsurance or copayment—usually 20%) for Part B-covered services and supplies.
- If you have Part A, you get all the medically-necessary Part A-covered services listed on page 13.
- If you have Part B, you get all the medically-necessary and Part B-covered preventive services listed on pages 18–25. You usually pay a monthly premium for Part B. See page 110.
- You may have supplemental coverage, such as a Medigap policy or employer or union coverage, that may pay costs that the Original Medicare Plan doesn't. See pages 72–74 for more information about Medigap policies.

How Does the Original Medicare Plan Work? (continued)

In most cases, you get a Medicare Summary Notice (MSN) in the mail (usually every 3 months) if you had a Medicare-covered service during that period. The MSN isn't a bill; it's for your records. The notice lists the services you had and the amount you may be billed. MSNs are sent by companies that handle bills for Medicare. If you disagree with the charges or amounts paid, you can file an appeal using the steps included on the notice. For more information about the MSN, visit www.medicare.gov on the web and select "Medicare Billing," or call 1-800-MEDICARE (1-800-633-4227) and say "Billing." TTY users should call 1-877-486-2048.

The www.MyMedicare.gov website makes it easy to track the health care services you get. You can visit www.MyMedicare.gov on the web to view your most recent MSN if you are registered on the site. See page 96.

Blue words in the text are defined on pages 103–107.

Your Out-of-Pocket Costs in the Original Medicare Plan Depend on the Following:

- Whether you have Part A and/or Part B (most people have both)
- Whether your doctor or supplier accepts "assignment." See page 35.
- How often you need health care
- What type of health care you need
- Whether you choose to get services or supplies not covered by Medicare. In this case, you would pay all the costs for these services yourself.
- Whether you have other health insurance that works with Medicare
- Whether you have Medicaid or get help paying your Medicare costs. See pages 79–80.

The lists on pages 110–112 show what you pay in the Original Medicare Plan for covered services in 2008. For details about these covered services, see page 13 for Part A and pages 18–25 for Part B. You can also visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

See pages 72–74 and 76–82 for information about help to cover the costs that the Original Medicare Plan doesn't cover.

Your Out-of-Pocket Costs and "Assignment" in the Original Medicare Plan

Assignment is an agreement between you (the person with Medicare), Medicare, and doctors, other health care suppliers, or providers. You "assign" Medicare to pay your doctor, supplier, or provider directly for services. Most doctors, suppliers, and providers accept assignment. Getting treatment from a doctor, provider, or supplier who is enrolled in Medicare and who accepts assignment can reduce your out-of-pocket costs.

If a doctor, provider, or supplier accepts assignment, they agree to the following conditions:

- To be paid by Medicare
- To accept only the amount Medicare approves for their services
- To only charge you, or other insurance you have, the Medicare deductible or coinsurance amount

In some cases, doctors, providers, and suppliers must accept assignment. For example, assignment must be accepted if you get Medicare-covered physician assistant services.

Doctors, providers, and suppliers have to submit your claim to Medicare directly. They can't charge you for submitting the claim (this includes claims for glucose test strips).

What if Your Health Care Provider Doesn't Accept Assignment?

If your doctor, provider, or supplier doesn't agree to accept assignment, they are required to submit a claim to Medicare and they may charge you more than the Medicare-approved amount.

However, there is a limit to what they can charge you for most services. The highest amount you can be charged is called the "limiting charge." The limiting charge is 15% over the Medicare-approved amount (but may be lower in your state). The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment. In addition, you might have to pay the entire charge at the time of service, and then submit your claim to Medicare to get reimbursed.

To find doctors and suppliers who accept assignment, visit www.medicare.gov on the web. Under "Search Tools," select "Find a Doctor." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What Is a Private Contract?

A "private contract" is a written agreement between you and a doctor or other health care provider who has decided not to provide services through the Medicare Program. The private contract only applies to the services provided by the doctor who asked you to sign it. You can't be asked to sign a private contract in an emergency situation or when you need urgent care. If you sign a private contract with your doctor:

- Medicare won't pay any amount for the services you get from this doctor
- You will have to pay whatever this doctor or provider charges you for the services you get
- If you have a Medigap policy, it won't pay anything for this service. Call your Medigap insurance company before you get the service if you have questions.
- Many other Medicare health plans won't pay for the service either
- Your doctor must tell you if Medicare will pay for the service if you get it from another doctor who participates in Medicare
- Your doctor must tell you if he or she has been excluded from the Medicare Program

Blue words in the text are defined on pages 103–107.

If you want to pay out-of-pocket for services Medicare doesn't cover, your doctor doesn't have to leave Medicare or ask you to sign a private contract. You are always free to get non-covered services on your own if you choose to pay for the service yourself. See page 26 for a list of services and items that Medicare doesn't cover.

You may want to contact your State Health Insurance Assistance Program (SHIP) to get help before signing a private contract with any doctor or other health care provider. See pages 98–101 for the telephone number.

See pages 83–93 for information about your appeal rights and how to protect yourself from fraud.

Adding Medicare Prescription Drug Coverage (Part D)

People in the Original Medicare Plan can add drug coverage by joining a Medicare Prescription Drug Plan. These plans are available through private companies that work with Medicare to provide prescription drug coverage. See page 54 for a list of things to consider before joining a Medicare drug plan. See pages 52–66 for more details about Medicare prescription drug coverage. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get information about the Medicare Prescription Drug Plans available in your area. TTY users should call 1-877-486-2048.

Help Paying for a Medicare Prescription Drug Plan

People with limited income and resources may qualify for extra help paying their Medicare prescription drug coverage costs. If you automatically qualify for extra help, you won't pay a premium if you join certain basic Medicare drug plans. If you don't automatically qualify, you may still get help to pay your prescription drug costs. See pages 76–78 to find out if you may qualify for extra help.

If you have drug coverage through a previous or current employer or union, contact your benefits administrator before you make any changes to your prescription drug coverage. If you join a Medicare drug plan, you could lose employer or union health and/or prescription drug coverage for yourself, your spouse, and your dependents.

Medicare Advantage Plans (Part C)

Medicare Advantage Plans are health plan options (like HMOs and PPOs) approved by Medicare and run by private companies. These plans are part of the Medicare Program and are sometimes called "Part C" or "MA plans." Medicare pays an amount for your care every month to these private health plans. Medicare Advantage Plans must follow rules set by Medicare. Medicare Advantage Plans aren't supplemental insurance.

How Do Medicare Advantage Plans Work?

Medicare Advantage Plans provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) benefits and must cover at least all of the medically-necessary services that the Original Medicare Plan provides. However, Medicare Advantage Plans can charge different copayments, coinsurance, and deductibles for these services. It's important to call any plan before joining to find out what your services will cost and to make sure the plan meets your needs.

Blue words in the text are defined on pages 103–107.

Medicare Advantage Plans may offer extra benefits, such as vision, hearing, dental, and/or health and wellness programs, and most include Medicare prescription drug coverage (usually for an extra cost). Medicare Advantage Plans generally have provider networks. This means you probably have to see doctors who belong to the plan or go to certain hospitals to get covered services. You may need a referral to see specialists.

If you use providers who aren't in the network, you may have to pay the entire cost of the covered service. Some plans may let you use out-of-network providers, sometimes for a higher cost. You should check with your doctors or hospital to find out if they accept the plan.

How Do Medicare Advantage Plans Work? (continued)

There are five different kinds of Medicare Advantage Plans. Most of these plans, like HMOs, have networks of doctors that see you if you belong to the plan. Others, such as Private Fee-for-Service (PFFS) Plans, allow you to go to any doctor **if the doctor agrees to accept the plan's terms of payment before treating you**. There are also Medicare Advantage Plans called Medicare Special Needs Plans (SNPs) that serve certain people with Medicare who are chronically ill, who live in institutions like nursing homes, or who have other special needs.

The different benefits offered by the various types of Medicare Advantage Plans are outlined in the chart that starts on page 42. Below is a list of the different kinds of Medicare Advantage Plans and the page number where you can find more information about each type of plan. In all plan types, you are always covered for emergency and urgent care.

Medicare Advantage Plans include the following:

- Preferred Provider Organization (PPO) Plans. See page 42.
- Health Maintenance Organization (HMO) Plans. See page 42.
- Private Fee-for-Service (PFFS) Plans. See page 43.
- Medical Savings Account (MSA) Plans. See page 43.
- Special Needs Plans (SNP). See page 44.

How Do Medicare Advantage Plans Work? (continued)

Who Can Join?

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

- You have Part A and Part B.
- You live in the service area of the plan. Contact the plan you're interested in to find out about its service area.
- You don't have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant) except as explained on page 46.

Note: In most cases, you can join a Medicare Advantage Plan only at certain times. See page 48.

If You Join a Medicare Advantage Plan

Blue words in the text are defined on pages 103–107.

- You are still in the Medicare Program.
- You still have Medicare rights and protections, including the right to appeal. See pages 83–88.
- You still get Part A and Part B coverage. See pages 13 and 18–25.
- You usually get prescription drug coverage (Part D) through the plan. In most Medicare Advantage Plans, if you want drug coverage, and your plan offers it, you must get it from your Medicare Advantage Plan. If you are in a Medicare Advantage Plan, you usually can't join a Medicare Prescription Drug Plan unless you are in a Medicare Medical Savings Account (MSA) Plan or certain Medicare Private Fee-for-Service (PFFS) Plans. **In most cases, if you are in a Medicare Advantage Plan and you join a Medicare Prescription Drug Plan, you will be disenrolled from your Medicare Advantage Plan and returned to the Original Medicare Plan.**

  No Medicare MSA Plans and only some Medicare PFFS Plans offer Medicare prescription drug coverage. If your Medicare PFFS Plan doesn't offer Medicare prescription drug coverage, or if you have a Medicare MSA Plan, you can join a Medicare Prescription Drug Plan to get this coverage. See pages 52–66.
- You may be able to get extra benefits, like some coverage for vision, hearing, dental, and/or health and wellness programs.

How Do Medicare Advantage Plans Work? (continued)

If You Join a Medicare Advantage Plan (continued)

- You can join or switch plans only during certain times of the year. See page 48.
- You generally still pay the monthly Part B premium. You also pay the Medicare Advantage Plan's premium (if they charge one) that includes coverage for Part A and Part B benefits, prescription drug coverage (Part D, if offered), and any other extra benefits (if offered).
- You may have to use providers who belong to the plan.
- You must follow plan rules, like getting a referral to see a specialist or getting prior authorization for certain procedures. Check with the plan.
- You usually will have to pay some other costs (such as copayments, deductibles, or coinsurance) for the services you get. Out-of-pocket costs in these plans vary by the services you get. Check with your plan before you get a service to find out what your costs may be.
- You don't need to (and can't) buy a Medigap policy. It won't cover your Medicare Advantage Plan deductibles, copayment, or coinsurance.
- If you see a doctor who doesn't belong to the plan, your services won't be covered, or your costs could be higher.
- The plan will send you an Evidence of Coverage each year. This document gives you details about what benefits the plan will cover, how much you pay, how to file an appeal, and more.
- Plan benefits may change each year. The plan will send you an Annual Notice of Change each fall. This notice has information about any changes in benefits, costs, or service area that will be effective in January. If the plan covers prescription drugs, the notice will include changes to the formulary. You should review this notice carefully to learn about changes for the upcoming year to decide if you want to look at other plans in your area.
- If the plan decides to no longer participate in the Medicare program, you will have to join another Medicare Advantage Plan or return to the Original Medicare Plan. See page 48.

If your former employer or union pays for your Medicare Advantage Plan, see page 69.

How Do Medicare Advantage Plans Work? (continued)

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	Preferred Provider Organization (PPO) Plan	Health Maintenance Organization (HMO) Plan
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want drug coverage, you must enroll in a PPO Plan that offers prescription drug coverage.	In most cases, yes. Ask the plan. If you want drug coverage, you must enroll in an HMO Plan that offers prescription drug coverage.
Do I need to choose a primary care doctor?	No.	Yes. You generally must see a primary care doctor to get a referral before you see any other health care provider.
Can I get my health care from any doctor or hospital?	Yes. PPOs have network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.	No. You generally must get your care and services from doctors or hospitals in the plan's network (except emergency or urgent care). If the plan has a Point-of-Service option, you can go out-of-network, but it will cost more.
Do I have to see a primary care doctor to get a referral to see a specialist?	In most cases, no.	In most cases, yes. Exceptions include yearly screening mammograms and in-network Pap tests and pelvic exams (at least every other year), which don't require a referral.
What else do I need to know about this type of plan?	You may be able to get extra benefits for an additional premium.	• If your doctor leaves, 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 authorization when needed. • You may be able to get extra benefits for an extra premium.

Medicare Advantage Plans can vary. Read individual plan materials carefully to make sure you follow the plan's rules.

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Private Fee-for-Service (PFFS) Plan	Medical Savings Account (MSA) Plan
Sometimes. If your PFFS Plan doesn't offer drug coverage, you can to join a Medicare Prescription Drug Plan to get coverage.	No. You can join a Medicare Prescription Drug Plan to get drug coverage.
No.	No.
In most cases, yes. You can go to any Medicare-approved doctor or hospital if they agree to the plan's terms and conditions of payment before treating you. Not all providers will accept the plan's payment terms or agree to treat you.	Yes. Some plans may have network doctors and hospitals you could go to for a lower cost.
No.	No.
• PFFS Plans aren't the same as the Original Medicare Plan and they have different rules from other Medicare Advantage Plans. • PFFS Plans are offered by private companies. The private company, not Medicare, decides how much the plan will pay and how much you pay for services. • You may be able to get extra benefits for an extra premium. • Before you join a PFFS Plan, make sure you find doctors, hospitals, and other types of providers willing to contact the plan for payment information and accept the plan's payment terms.	• Medicare MSA Plans have two parts: a high-deductible health plan and a bank account. Medicare gives the plan an amount each year for your health care, and the plan deposits a portion of this money into your account. • You can use the money in your account to pay your health care costs. When you use account money for Medicare-covered Part A and Part B services, it counts toward your plan's deductible. After you reach your deductible, your plan will cover your Medicare-covered services. • Any money left in your account at the end of the year is added to your next deposit.

You should also contact the plan before you get a service to find out if the service is covered and how much it costs.

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How Do Medicare Advantage Plans Work? (continued)

	Special Needs Plan (SNP)
Are prescription drugs covered?	Yes. All SNPs must provide Medicare prescription drug coverage. Formularies may be designed to cover the drugs members need most.
Do I need to choose a primary care doctor?	In some cases, yes, or you may need to have a care coordinator help you develop personal care plans and coordinate your care.
Can I get my health care from any doctor or hospital?	You generally must get your care and services from doctors or hospitals in the plan's network (except emergency or urgent care). Plans typically have specialists for the diseases or conditions that affect their members.
Do I have to see a primary care doctor to get a referral to see a specialist?	In most cases, yes. Yearly screening mammograms and an in-network Pap test and pelvic exam (at least every other year) don't require a referral.
What else do I need to know about this type of plan?	• SNPs serve people who either 1) live in certain institutions (like a nursing home) or who require nursing care at home, or 2) are eligible for both Medicare and Medicaid, or 3) have one or more specific chronic or disabling conditions (like diabetes, congestive heart failure, mental illness, or HIV/AIDS). • A plan may limit membership to people in one of these groups or further limit membership within these groups. It may also enroll other people. • Plans manage the services and providers you need to help you stay healthy and follow your doctor's orders. For example, a SNP for people with diabetes might use a care coordinator to help you monitor your blood sugar, get needed preventive services, and get the right medicines to prevent complications. A plan for people with both Medicare and Medicaid may help you get help from your community and coordinate your health care. • If you have Medicare and Medicaid, check to make sure that all of the plan doctors or other health care providers you use accept Medicaid. • If you live in an institution, check to make sure that plan doctors or other health care providers serve people where you live. • You may be disenrolled if you no longer meet the plan's membership requirements, like if you lose Medicaid or leave the nursing home. If you are disenrolled, you will be returned to the Original Medicare Plan and will have 3 months to join another Medicare health or drug plan.

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

How Do Medicare Advantage Plans Work? (continued)

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

In some cases, joining a Medicare Advantage Plan when you have employer or union coverage might cause you to lose this coverage. In other cases, if you join a Medicare Advantage Plan and you have employer or union coverage, you may still be able to use your employer or union coverage along with the plan you join. Talk to your employer or union benefits administrator about the rules that apply. **Remember, if you drop your employer or union coverage, you may not be able to get it back**. See page 69.

What Happens if You Drop Your Medigap Policy When You Join a Medicare Advantage Plan?

In most cases, if you drop your Medigap policy, you won't be able to get it back. **However, if this is the first time** you have joined a Medicare Advantage Plan or other Medicare health plan, or bought a Medicare SELECT policy (a Medigap policy that requires you to use specific hospitals and, in some cases, specific doctors to get full benefits), you may have special Medigap protections. These protections give you a right to get your old Medigap policy back or buy a new one if you choose to leave your Medicare health plan within the first year. In either case, the new Medigap policy can't include prescription drug coverage. However, you may be able to join a Medicare Prescription Drug Plan if you join a Medicare Advantage Plan and leave it within the first year. Check with your State Health Insurance Assistance Program (SHIP) to see if your state offers other rights to buy Medigap policies. See pages 98–101 for the telephone number.

How Do Medicare Advantage Plans Work? (continued)

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

If you have ESRD (permanent kidney failure requiring dialysis or a kidney transplant) and you are in the Original Medicare Plan, you may join a Medicare Prescription Drug Plan, but you usually can't join a Medicare Advantage Plan. However, if you are already in a Medicare Advantage Plan, you can stay in it or join another plan offered by the same company under certain circumstances. Also, if you are a member of a health plan (like through a former employer or union) offered by the same company that offers one or more Medicare Advantage Plans, you may be able to join a Medicare Advantage Plan offered by that company. If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan.

If you have ESRD and 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 change directly to the Original Medicare Plan after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan later, as long as the plan you choose is accepting new members.

Blue words in the text are defined on pages 103–107.

You may also be able to join a Medicare Special Needs Plan (SNP) for people with ESRD if one is available in your area.

For more information about ESRD, visit www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication" to view the booklet "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services."

If you need to find a dialysis facility, visit www.medicare.gov on the web. Under "Search Tools," select "Compare Dialysis Facilities in Your Area."

Your Out-of-Pocket Costs in a Medicare Advantage Plan Depend on the Following:

- Whether the plan charges a monthly premium in addition to your Part B premium. See page 110 for the Part B premium amount. Medicare Advantage Plans charge one combined premium for Part A and Part B health benefits, Medicare prescription drug coverage (if offered), and extra benefits (if offered).
- Whether the plan pays all or part of the monthly Part B premium
- Whether the plan has a yearly deductible or any additional deductible for some health services
- How much you pay for each visit or service
- The type of health care services you need and how often you get them
- Whether you follow the plan's rules
- The types of extra benefits you need and what it charges for them

To learn more about your costs in specific Medicare Advantage Plans, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Saving on Your Part B Premium

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

- A few Medicare Advantage Plans may pay all or part of your Part B premium. You still get all Part A and Part B-covered services.
- You can also call your State Medical Assistance (Medicaid) office to see if you can get help paying your Part B premium costs. See page 80.

Saving on Your Prescription Drug Coverage Premium

Your Medicare Advantage Plan's premium may include the premium for Medicare prescription drug coverage. Some plans may pay all or part of the premium for your prescription drug coverage. Read the plan materials carefully to see if the plan offers this help. Plans decide each year if they will reduce part or all of your prescription drug coverage premium.

If you have limited income and resources, you may be able to get extra help paying for your prescriptions. See pages 76–78.

When Can You Join, Switch, or Drop a Medicare Advantage Plan?

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

- When you first become eligible for Medicare (3 months before you turn age 65 to 3 months after the month you turn age 65)
- If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of disability benefits
- From November 15–December 31 each year. Your coverage will begin on January 1 of the following year.
- From January 1–March 31 of each year. However, you can't add or change to a plan with prescription drug coverage during this time unless you already have Medicare prescription drug coverage.

Blue words in the text are defined on pages 103–107.

In certain situations, you may be able to join, switch, or drop Medicare Advantage Plans at other times (like if you move out of the service area, have both Medicare and Medicaid, or live in an institution).

What Happens if Your Medicare Advantage Plan Leaves the Medicare Program?

If your plan leaves the Medicare Program, the plan will send you a letter about your options. Generally, you will be automatically returned to the Original Medicare Plan if you don't choose to join another Medicare Advantage Plan. You will also have the right to buy a Medigap Policy. See pages 72–74.

How Do You Join a Medicare Advantage Plan?

Once you choose a Medicare Advantage Plan, you may be able to join by completing a paper application, calling the plan, or enrolling online. Talk with the plan to find out how you can join. When you join a Medicare Advantage Plan, you will have to provide your Medicare number from your Medicare card and the date your Part A and/or Part B coverage started.

How Do You Switch Medicare Advantage Plans?

If you are already in a Medicare Advantage Plan and want to switch during one of the times listed on page 48, this is what you need to do:

- To switch to the Original Medicare Plan, contact your current plan or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- To switch to a new Medicare Advantage Plan, simply join the plan you choose during one of the periods listed on page 48. You will be disenrolled automatically from your old plan when your new plan's coverage begins.

No one should call you or come to your home uninvited to sell Medicare-covered products. See page 91 for more information about how to protect yourself from identity theft and fraud.

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

Other Medicare Health Plans

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

Some types of Medicare plans that provide health care coverage aren't Medicare Advantage Plans, but are still part of the Medicare Program. These plans provide Part A (Hospital Insurance) and Part B (Medical Insurance) coverage, and some also provide Part D (Medicare prescription drug coverage). These plans work in a way that's very similar to Medicare Advantage Plans and they have some of the same rules. Some of these rules are explained briefly below and on page 51. However, each type of plan has special rules and exceptions, so you should contact any plan you are interested in to get more details.

Blue words in the text are defined on pages 103–107.

Medicare Cost Plans

Medicare Cost Plans are a type of Medicare health plan available in certain areas of the country. Medicare Cost Plans work like this:

- You can join even if you only have Part B
- If you go to a non-network provider, the services are covered under the Original Medicare Plan. You would pay the Part B premium, and the Part A and Part B coinsurance and deductibles.
- You can join a Medicare Cost Plan any time it is accepting new members
- You can leave a Medicare Cost Plan any time and return to the Original Medicare Plan
- You can either get your Medicare prescription drug coverage from the plan (if offered), or you can buy a Medicare Prescription Drug Plan to add prescription drug coverage

For more information about Medicare Cost Plans, contact the plan you're interested in. You can also visit www.medicare.gov on the web. Your State Health Insurance Assistance Program (SHIP) can also give you more information. See pages 98–101 for the telephone number.

Other Medicare Health Plans (continued)

Demonstrations/Pilot Programs

Demonstrations are special projects that test improvements in Medicare coverage, payment, and quality of care. Demonstrations are usually 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 they work.

Currently, Medicare's pilot program is for people with Medicare with one or more chronic illnesses. This program is designed to help you reduce your health risks, improve your quality of life, and save money.

For more information about current Medicare demonstrations and pilot programs, visit www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

PACE combines medical, social, and long-term care services, and prescription drug coverage for frail, elderly people who get health care in the community. PACE is a joint Medicare and Medicaid program that may be available in states that have chosen it as an optional Medicaid benefit. See page 82 for more information about PACE.

Medicare Prescription Drug Coverage (Part D)

Medicare offers prescription drug coverage for everyone with Medicare. This coverage is called "Part D." Medicare prescription drug coverage can protect against future drug costs and give you access to drugs that you can use to stay physically and mentally healthy. To get Medicare drug coverage, you must join a Medicare drug plan. Medicare drug plans are run by insurance companies and other private companies approved by Medicare. Each plan can vary in cost and drugs covered.

Even if you don't take a lot of prescription drugs now, you should still consider joining a Medicare drug plan. If you decide not to join a Medicare drug plan when you are first eligible, you may pay a late-enrollment penalty if you choose to join later. See page 58. If you qualify for extra help and don't choose a plan yourself, Medicare will enroll you in one.

Blue words in the text are defined on pages 103–107.

There are two ways to get Medicare prescription drug coverage:

1) **Join a Medicare Prescription Drug Plan.** These plans (sometimes called "PDPs") add drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.

2) **Join a Medicare Advantage Plan (like an HMO or PPO) or another Medicare health plan that includes prescription drug coverage.** You get all of your Medicare coverage (Part A and Part B), including prescription drugs (Part D), through these plans. These plans are sometimes called "MA-PDs."

Both types of plans are called "Medicare drug plans" in this section. If you join a Medicare drug plan, you usually pay a separate monthly premium in addition to your Part B premium. See page 66 to learn about ways to pay your premium.

Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get information about the Medicare Prescription Drug Plans available in your area. TTY users should call 1-877-486-2048.

Your Plan Choices

How Do Medicare Drug Plans Work?

After you join a Medicare drug plan, the plan will mail you membership materials, including a card to use when you get your prescriptions filled. When you use the card, you may have to pay a copayment, coinsurance, and/or deductible if any are charged by the plan. See pages 62–65 for more detailed information about how drug plans work, including important rules.

Choosing Medicare Prescription Drug Coverage

Joining a Medicare drug plan when you are first eligible means you won't have to pay a late-enrollment penalty. Every year (from November 15–December 31), you can switch to a different Medicare drug plan if your plan coverage changes or your needs change. When you join or switch to a new Medicare drug plan, your coverage will generally begin on January 1 of the following year. **See page 58 for important information about the late-enrollment penalty.**

Who Can Get Medicare Drug Coverage?

Everyone with Medicare can get prescription drug coverage.

If you have limited income and resources, you may qualify for extra help from Medicare paying for prescription drug coverage. See pages 76–78. You may also be able to get help from your state. See pages 79–80.

Note: The Medicare drug plan you join will release your personal information to Medicare and other plans as necessary for treatment, payment, and health care operations. Medicare may release your personal information for research and other purposes. See pages 89–90 to find out more about how Medicare can use your personal information.

For your protection, only give personal information to doctors, other health care providers, plans approved by Medicare, and the people in your community who work with Medicare, like your State Health Insurance Assistance Program (SHIP) or Social Security.

Things to Consider When You Compare Plans

- **Coverage: Check to see if the plan covers your prescription drugs.** Medicare drug plans have a list of drugs covered by the plan (formulary) that must always meet Medicare's requirements. Even if a drug is on the plan's list, there may be special rules for filling the prescription. See pages 63–65 for important drug coverage rules. Your plan's formulary may change during the year because drug therapies change, new drugs are released, and new medical information becomes available. If there is a formulary change that affects a drug you take, your plan must notify you at least 60 days in advance. You may have to change the drug you use or pay more for it. In some cases, you can continue taking the drug you were on until the end of the year. You can also ask for an exception or appeal. See page 87.
- **Cost: Check to see how much your prescription drugs cost in each plan.** If you currently have prescription drug coverage, compare your current costs to the costs of the Medicare drug plans you are considering. Your monthly premiums, deductibles, and your share of the cost of each drug (copayments and/or coinsurance) will vary with each plan. You may be able to pick a plan with or without a monthly premium, yearly deductible, or coverage gap. See page 56.
- **Convenience: Make sure the plan's pharmacies include the ones you want to use.** Some plans also allow you to get your prescriptions through the mail. If you spend part of the year in another state, see if the plan will cover you there.

Blue words in the text are defined on pages 103–107.

Get Personalized Help Comparing Plans

- Visit www.medicare.gov on the web. Under "Search Tools," select "Compare Medicare Prescription Drug Plans."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP). See pages 98–101 for the telephone number.

Have your Medicare card, a list of your drugs and their dosages, and the name of the pharmacy you use available.

Your Plan Choices

How to Compare Medicare Drug Plans

Each Medicare drug plan is different. When you choose a Medicare drug plan for the first time, or switch to a different Medicare drug plan, you should compare the plans in your area. Choose one that meets your needs based on coverage, cost, and convenience. If Medicare automatically enrolled you in a plan, you can change to a plan that better meets your needs. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get information about the Medicare drug plans available in your area. TTY users should call 1-877-486-2048.

How Much Does Medicare Drug Coverage Cost?

Your costs will vary depending on the drugs you use, the plan you choose, and whether you qualify for extra help paying your Part D costs. Exact coverage and costs are different for each plan, but all Medicare drug plans must provide at least a standard level of coverage set by Medicare. **Call the plan you're interested in to find out more about plan costs.**

Payments you make in a Medicare drug plan include the following:

- **Monthly premium**—Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. Some drug plans charge no premium.
- **Yearly deductible**—This is the amount you pay for your prescriptions before your plan begins to pay. Some drug plans charge no deductible.
- **Copayments or coinsurance**—Amounts you pay for your prescriptions after the deductible. You pay your share, and your plan pays its share for covered drugs.

If you belong to a Medicare Advantage Plan (like an HMO or PPO), or a Medicare Cost Plan that offers Medicare prescription drug coverage, the monthly premium you pay includes an amount for prescription drug coverage.

How Much Does Medicare Drug Coverage Cost? (continued)

- **Coverage gap**—Most Medicare drug plans have a coverage gap. This means that after you and your plan have spent a certain amount of money (varies by plan) for covered drugs, you have to pay all costs out-of-pocket for your drugs while you are in the "gap." Once you reach the limit set by your plan, you will get "catastrophic coverage" (see below).

  You must continue to pay the monthly premium even while you are in the coverage gap.

Blue words in the text are defined on pages 103–107.

Each state offers at least one plan with some type of coverage during the gap. However, it's important to note the following:

- Plans with gap coverage may charge a higher monthly premium.
- Some plans have a coverage gap for brand-name drugs only and may offer generic drug coverage during the gap.
- Even if a plan offers gap coverage, not all drugs may be covered in the gap. Check with the plan first to see if your drugs would be covered in the gap.

Note: If you get extra help paying your drug costs, you won't have a coverage gap. However, you will probably have to pay a small copayment or coinsurance amount.

- **Catastrophic coverage**—Medicare drug plans provide special coverage if you have extremely high drug costs. This is called "catastrophic coverage." It assures that once you have paid no more than $4,050* in 2008 for your covered drugs, you only pay a coinsurance amount (like 5% of the drug cost) or a copayment (like $2.25 or $5.60 for each prescription) for the rest of the calendar year.

* This amount may vary since each Medicare drug plan is different. **Contact the plan you are interested in to get specific cost information. Visit www.medicare.gov on the web, 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.**

When Can You Join, Switch, or Drop a Medicare Drug Plan?

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

- When you first become eligible for Medicare (3 months before you turn age 65 to 3 months after the month you turn age 65)
- If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of cash disability payments.
- From November 15–December 31 of each year. Your coverage will begin on January 1 of the following year.
- At any time if you qualify for extra help. This includes people who have Medicare and Medicaid, belong to a Medicare Savings Program, get Supplemental Security Income (SSI) benefits (but not Medicaid), and those who apply and qualify. See pages 76–78 for more information about extra help.

In certain situations, you may be able to join, switch, or drop Medicare drug plans at other times (like if you move out of the service area or live in an institution).

How Do You Join a Medicare Drug Plan?

Once you choose a Medicare drug plan, you may be able to join a plan by completing a paper application, calling the plan, or enrolling online. Medicare drug plans aren't allowed to call you to enroll you in a plan. Contact the plan to find out how you can join. When you join a Medicare drug plan, you will have to provide your Medicare number and the date your Part A or Part B coverage started from your Medicare card. **Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to find Medicare drug plans available in your area. TTY users should call 1-877-486-2048.**

How Do You Switch Your Medicare Drug Plan?

Depending on your circumstances, you can switch to a new Medicare drug plan by simply joining another drug plan during one of the times listed above. You don't need to tell your old Medicare drug plan you are leaving or send them anything. You will be disenrolled automatically from your old Medicare drug plan when coverage in your new drug plan begins. You should get a letter from your new

What Is the Part D Late-Enrollment Penalty?

If you don't join a Medicare drug plan when you are first eligible for Medicare Part A and/or B and you go without creditable prescription drug coverage for 63 continuous days or more, you may have to pay a late-enrollment penalty to join a plan later.

This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage.

If you qualify for extra help, you may not have to pay a late-enrollment penalty, or you may get help paying your penalty. See pages 76–78.

Blue words in the text are defined on pages 103–107.

How Much Will Your Part D Late-Enrollment Penalty Be?

Your late-enrollment penalty is calculated when you join a Medicare drug plan. To estimate your penalty amount, multiply 1% of the national base beneficiary premium for the current year ($27.93 x 1% = $.28 in 2008) by the number of full months you were eligible to join a Medicare drug plan but didn't. Round this to the nearest ten cents. This penalty amount is added each month to your Medicare drug plan's premium for as long as you have a plan.

For an explanation of how to determine your late-enrollment penalty amount, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also call your State Health Insurance Assistance Program (SHIP). See pages 98–101 for the telephone number.

What If You Have Full Coverage from Your State Medicaid Program and Are Eligible for Medicare?

- Medicare will automatically enroll you in a Medicare drug plan if you don't join one on your own. Medicare, not Medicaid, will provide most of your drug coverage and help pay for your prescription drugs.
- In most cases, you will pay $0–$5.60 out-of-pocket for each covered prescription.
- The drugs that are covered will vary depending on the plan.
- You can switch to another Medicare drug plan at any time. You should compare your current plan with other plans available in your area and decide which is best for your prescription needs.
- Medicaid may still cover other care that Medicare doesn't cover. For some drugs, Medicaid may also add to Medicare drug coverage.
- If you live in certain institutions (like a nursing home or long-term care hospital), you will pay nothing for your covered prescription drugs.

Call your State Medical Assistance (Medicaid) office to get more information. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state. TTY users should call 1-877-486-2048.

What If You Get Certain Benefits or Other Help to Pay Prescription Costs, and Medicare Automatically Enrolls You in a Plan?

If you have other prescription drug coverage that's at least as good as Medicare's drug coverage (creditable prescription drug coverage), you may not want to keep the drug plan Medicare enrolls you in. If you don't want to keep this plan, or to have Medicare enroll you in another drug plan, call 1-800-MEDICARE (1-800-633-4227) or the plan. TTY users should call 1-877-486-2048. Tell them you want to disenroll from this plan (or opt-out of "automatic" or "facilitated" enrollment).

What If You Get Prescription Drug Coverage from TRICARE, the Department of Veterans Affairs (VA), or the Federal Employee Health Benefits Program (FEHBP)?

- Most people keep their TRICARE, VA, or FEHBP prescription drug coverage as long as they still qualify.
- Contact your benefits administrator or your insurer for information about your TRICARE, VA, or FEHBP coverage before making any changes. In most cases, it will be to your advantage to keep your current coverage. However, in some cases, adding Medicare prescription drug coverage can provide you with extra coverage and savings, especially if you qualify for extra help.
- If you lose your TRICARE, VA, or FEHBP coverage, **and** you join a Medicare drug plan, **and** your drug coverage begins within 63 days, in most cases, you won't have to pay a late-enrollment penalty when you join.

Blue words in the text are defined on pages 103–107.

What if You Get Prescription Drug Coverage from the Indian Health Service, Tribe or Tribal Health Organization, or Urban Indian Health Program?

- You and your community may benefit if you join a Medicare drug plan. Ask your health provider or benefits coordinator if joining a plan is right for you. If it is, they can help you find a plan.
- If you get prescription drugs through an Indian health pharmacy, you pay nothing and your coverage won't be interrupted. Joining a Medicare drug plan may be helpful to your Indian health provider because the drug plan pays part of the cost of your prescription. This helps the Indian health provider with the cost of services.
- If you have full coverage from Medicaid and live in a nursing home, you pay nothing for your Medicare prescription drugs. For more information on how to join a plan, see your Indian health provider or check with the benefits coordinator at your local Indian health pharmacy.
- If you get health care from the Indian Health Service, Tribal Health Program, or Urban Indian Health Program, you have creditable prescription drug coverage. You won't have to pay a penalty to join a Medicare drug plan at a later date. Ask your Indian health care provider for a letter stating you have creditable coverage.

What If You (or Your Spouse) Have Prescription Drug Coverage from a Former or Current Employer or Union?

In some cases, joining a Medicare drug plan might cause you, or your spouse, or other dependents to lose all of your employer or union coverage. In other cases, if you join a Medicare drug plan and you also have employer or union coverage, you may still be able to use your employer or union coverage along with the plan you join. Talk to your employer or union benefits administrator about the rules.

Employers and unions that provide prescription drug coverage must notify you each year about how your current coverage compares to Medicare's basic prescription drug coverage. You may get this information in a letter, in a notice from your plan, or in your benefits handbook. Use this information to help you decide whether to join a Medicare drug plan. **Keep the notices you get. You may need to show them as proof of creditable prescription drug coverage if you join a Medicare drug plan later**. If you don't get this information, contact your benefits administrator.

If your employer or union stops offering prescription drug coverage that is creditable, you won't have to pay a late-enrollment penalty if you join a Medicare drug plan and your coverage begins before you go 63 days without coverage. If your employer or union drug coverage isn't as good as Medicare prescription drug coverage (not creditable), talk to your benefits administrator to learn about your choices.

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 dependents.

Call your benefits administrator before you make any changes.

Important Drug Coverage Rules

Once you join a Medicare drug plan, your coverage will generally begin January 1, or the first day of the month after you join. There are things you should know so you can get the most out of your coverage. The following information can help answer questions as you begin to use your coverage.

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

You'll get an acknowledgement letter in the mail about a week after you ask to join a plan. Your plan membership card should arrive 3 to 5 weeks later.

If you need to go to the pharmacy before your membership card arrives, you can use any of the following as proof of membership in your Medicare drug plan:

- An acknowledgement or confirmation letter from the plan
- A welcome letter from the plan
- An enrollment confirmation number that you got from the plan, the plan name, and telephone number

You should also bring your Medicare and/or Medicaid card and a photo ID. 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 reimbursed.

Blue words in the text are defined on pages 103–107.

Enroll early in the month. This gives the plan time to mail your membership card, acknowledgement letter, and welcome package before your coverage becomes effective. This way, even if you go to the pharmacy on your first day of coverage, you can get your prescriptions filled without delay.

Important Drug Coverage Rules (continued)

All Medicare drug plans must generally cover at least two drugs in each category of drugs, but plans can choose which specific drugs are covered in each category. Plans are required to cover almost all drugs in six classes that include anti-psychotics, anti-depressants, anti-convulsants, immunosuppressants, cancer, and HIV/AIDS drugs.

There are certain drugs that Medicare drug plans aren't required to cover, such as benzodiazepines, barbiturates, drugs for weight loss or gain, and drugs for erectile dysfunction. Some plans may choose to cover these drugs as an added benefit. In addition, drug plans generally aren't allowed to cover over-the-counter drugs. Some states may cover these drugs if you have Medicaid.

Plans may also exclude certain drugs from coverage. Although your Medicare drug plan may not have a certain drug on its list of covered drugs (formulary), a different drug that is safe and effective for the same purpose will be covered. This may be a generic version of the drug, or it may be another brand-name drug that may provide the same benefit as the drug that isn't on the plan's formulary. All plans must have a process for you to ask them to pay for a drug you need that isn't on their formulary. See page 87. They may or may not agree to cover the drug.

Specific formulary information isn't included in this handbook because each plan has its own formulary. Formularies can change. Contact the plan for its most current formulary. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get telephone numbers for the plans available in your area. TTY users should call 1-877-486-2048.

Plans may have coverage rules to make sure that certain drugs are used correctly and only when necessary. These rules may include the following:

- Prior authorization—before the plan will cover these prescriptions, you and/or your doctor must contact the plan. Your doctor may need to show that the drug is medically necessary for it to be covered.
- Quantity limits—how many pills you can get at a time.
- Step therapy—you must try one or more similar, lower cost drugs before the plan will cover the step-therapy drug. See page 64.

Important Drug Coverage Rules (continued)

Example of step therapy:

Step 1—Dr. Smith wants to prescribe an ACE inhibitor to treat Mr. Mason's heart failure. There is more than one type of ACE inhibitor. Some of the drugs Dr. Smith considers prescribing are brand-name drugs covered by Mr. Mason's Medicare drug plan. The plan rules require Mr. Mason to use the generic drug lisinopril first. For most people, lisinopril works as well as brand-name drugs.

Step 2—If Mr. Mason takes lisinopril but has side effects or limited improvement, his doctor can provide that information to the plan to get approval to prescribe a brand-name drug, like Prinivil® or Zestril®. Mr. Mason's Medicare drug plan will now cover this drug.

Blue words in the text are defined on pages 103–107.

What If a Drug You Take Isn't on Your Plan's Formulary When Your Coverage Begins?

Your drug plan will provide a one-time, temporary 30-day supply of your current drug during your first 90 days in a plan. Plans are required to give you this temporary supply so that you and your doctor have time (30 days) to find another drug on the plan's drug list that will work as well as the drug you're taking now. Different rules may apply for people who move into an institution (such as a nursing home or long-term care hospital).

However, if you have already tried similar drugs on your plan's drug list and they didn't work, or if your doctor determines that you need a certain drug because of your medical condition, you or your doctor can contact your plan to request an exception as soon as you get your temporary 30-day supply. You can also request an exception if your doctor thinks you need to have a coverage rule waived, such as a dose or quantity limit. If you or your doctor's request is approved, the plan will cover the drug. If the exception isn't approved, you can appeal the plan's decision. See pages 87–88.

Important Drug Coverage Rules (continued)

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

Many Medicare drug plans place drugs into different "tiers." Drugs in each tier have a different cost. **Some plans may have more tiers and some may have less. Here is an example:**

Tier	You Pay	What Is Covered?
1	Lowest copayment	Most generic prescription drugs
2	Medium copayment	*Preferred, brand-name prescription drugs
3	Higher copayment	Non-preferred, brand-name prescription drugs
Specialty Tier	Highest copayment or coinsurance	Unique, very high-cost drugs

* A preferred brand-name prescription drug is a drug that has been determined by the plan to be less costly, but as effective, as other drugs.

In some cases, if your drug is on a higher tier and your doctor thinks you need that drug instead of a similar drug on a lower tier, you can file an exception and ask your plan for a lower copayment. See page 87.

Are Generic Drugs as Good as Brand-Name Drugs?

Yes. According to the Food and Drug Administration (FDA), a generic drug is the same as a brand-name drug in safety, strength, quality, the way it works, how it's taken, and the way it should be used. Generic drugs use the same active ingredients as brand-name drugs and work the same way. So, they have similar risks and benefits as brand-name drugs. Generic drug makers must prove to the FDA that their product performs in the same way as the brand-name drug. Today, almost half of all prescriptions are filled with generics. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your doctor.

Ways to Pay Your Medicare Drug Plan Premium

You have choices in the way you pay your Medicare drug plan premium. Depending on your plan and your situation, you may be able to pay your Medicare drug plan premium in one of four ways:

1. **Deducted** from your checking or savings account
2. **Charged** to a credit or debit card
3. **Billed to you** each month directly by the plan (Some plans bill in advance for coverage the next month.)
4. **Deducted from your Social Security payment.** Contact your plan (not Social Security) to ask for this payment option. **If you choose this option, your first two months of premiums will be combined.**

   Example: Ms. Andrews' monthly drug plan premium is $25 and her coverage begins in January. Her first premium payment is collected in February for $50. It includes her premium for January and February. After February, only one month of premium payments ($25) will be deducted from her Social Security payment.

   If you choose this option and you have another insurer or benefit, such as an employer health plan or a State Pharmacy Assistance Program (SPAP) that pays part of your drug plan premium, Social Security will deduct your entire monthly premium. Your drug plan will need to give you a refund for the amount your employer health plan or SPAP paid.

   Example: Mr. Walters' monthly drug plan premium is $20. His SPAP or employer pays $10 toward his premium.

   - If Mr. Walters gets his premium deducted from his Social Security payments, the full $20 will be withheld. The drug plan will have to give him a refund of $10 for the share of the premium paid by his SPAP or employer.
   - If the drug plan bills Mr. Walters directly, he will pay his share ($10) to his plan. His SPAP or employer will pay its share ($10) directly to his plan.

For more information about your Medicare drug plan premium or ways to pay for it, contact your plan.

Blue words in the text are defined on pages 103–107.

If you have limited income or resources, you may qualify for extra help paying your prescription drug costs. See pages 76–78.

Other Government Insurance

Federal Employee Health Benefits Program (FEHBP)

The FEHBP offers health coverage for current and retired Federal employees and covered family members. Generally, plans under FEHBP help pay for the same kind of expenses as Medicare. These plans also cover prescription drugs, routine physicals, emergency care outside of the U.S., and some preventive services that Medicare doesn't cover. Some FEHBP plans also cover dental and vision care. Prescription drug coverage under FEHBP is considered creditable (as good as Medicare prescription drug coverage). However, you may also add Medicare prescription drug coverage. See pages 52–66.

Contact the Office of Personnel Management at 1-888-767-6738 or your plan if you have questions.

Veterans Benefits

If you are a veteran or have served in the U.S. military, call the U.S. Department of Veterans Affairs (VA) at 1-800-827-1000, or visit www.va.gov on the web for information about veterans benefits and services available in your area. You may be able to get prescription drug coverage through the VA program. This coverage is considered creditable. You may also add Medicare prescription drug coverage. See pages 52–66.

Military Benefits (TRICARE)

TRICARE is a health care program for active-duty service members, retirees, and their families. The uniformed services determine who is eligible for TRICARE coverage. TRICARE coverage includes the following:

- TRICARE for Life (TFL)—medical coverage for Medicare-entitled uniformed services retirees, their eligible family members and survivors, and certain former spouses
- TRICARE Prime—a managed care option
- TRICARE Standard—a fee-for-service plan that lets members see any TRICARE certified/authorized provider
- TRICARE Extra—an option for people with TRICARE Standard who want to save on out-of-pocket expenses by making an appointment with a TRICARE network provider (doctor, nurse practitioner, lab, etc.)

Other Government Insurance (continued)

Military Benefits (TRICARE) (continued)

All people with TRICARE are eligible for TRICARE pharmacy benefits. Most people keep their TRICARE pharmacy benefits since they're considered creditable prescription drug coverage. You may also add Medicare prescription drug coverage. See pages 52–66.

If you have Medicare Part A and TRICARE, you must have Part B to keep your TRICARE benefits. However, if you are an active-duty service member, or the spouse or dependent child of an active-duty service member, you may not have to get Medicare Part B when you're first eligible. See page 16.

Blue words in the text are defined on pages 103–107.

In general, for services covered by both Medicare and TRICARE, Medicare pays first for Medicare-covered services, and TRICARE pays second for services covered by TRICARE. For services covered only by Medicare, Medicare pays its share, and you pay any deductible, copayment, or coinsurance. For services covered only by TRICARE, TRICARE pays and you pay the TRICARE deductible and your share of the cost. For more information, call the contractor that handles TRICARE claims at 1-866-773-0404, or visit www.tricare.osd.mil on the web.

Indian Health Services

If you get health care from the Indian Health Service, a Tribal Health Program, or Urban Indian Health Program, contact your local health care provider to get information about how Medicare works with your health care system. See page 60 for more information about prescription drug coverage.

Other Private Insurance

Employer or Union Health Coverage

Call the benefits administrator at your, your spouse's, or other family member's current or former employer or union. Ask if you have or can get health care coverage based on past or current employment. Coverage from an employer or union is usually provided voluntarily. The employer or union generally has the right to change benefits and premiums or stop offering coverage.

If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you each year about how your drug plan will work with Medicare prescription drug coverage. **Keep the notices you get. You may need to show them as proof of creditable prescription drug coverage if you join a Medicare drug plan later.** See page 61 for more information about how Medicare drug coverage works with employer or union 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 dependents.

Call your benefits administrator before you make any changes.

Other Private Insurance (continued)

Note About COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) may allow you to temporarily keep health coverage from your or your spouse's employer after the employment ends, or after you lose coverage as a dependent of the covered employee. If you elect to get COBRA coverage when your employer coverage ends, you should consider signing up for Part B at the same time because you won't get a Special Enrollment Period (see page 15) when the COBRA coverage ends. You will have to sign up for Part B during the 8-month period that begins the month the employment ends or the coverage ends, whichever is first. If you don't sign up for Part B during this 8-month period, you will only be able to sign up during the General Enrollment Period (see page 15), and you may have to pay the late-enrollment penalty.

Blue words in the text are defined on pages 103–107.

Medicare prescription drug coverage (Part D) works a little differently. For Part D, if your employer-sponsored creditable prescription drug coverage (including COBRA) ends, you have a Special Enrollment Period to join a Medicare drug plan without paying a penalty.

Talk with your State Health Insurance Assistance Program (SHIP) to see if COBRA is a good choice for you. See pages 98–101 for the telephone number.

Long-Term Care Insurance

Long-term care isn't covered by Medicare. Long-term care also doesn't replace your Medicare coverage. It's important to think about how to get and pay for long-term care before you need it. Your health status, risk factors, finances, preferences, and family situation affect your costs and coverage. Before you choose a policy, you, your family, lawyer, financial advisor, and/or insurance agent should consider these factors.

For more information about long-term care, visit www.medicare.gov on the web. Under "Search Tools," select "Plan for Your Long-Term Care Needs." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also visit www.longtermcare.gov on the web.

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. Call the Office of Personnel Management at 1-888-767-6738 or your plan with questions.

How Your Bills Get Paid If You Have Other Health Insurance

Sometimes your other insurance pays your health care bills first, and the Original Medicare Plan or Medicare Advantage Plan pays second. Other insurance that may pay first includes the following:

- Employer or union group health plan coverage (when coverage is based on your or a family member's **current** employment)
  - If you are under age 65 and disabled, Medicare is secondary if your employer has 100 or more employees.
  - If you are over age 65 and still working, Medicare will be secondary if your employer has 20 or more employees.
- Employer or union group health plan coverage (as described above), regardless of size and regardless of current employment status, for 30 months if you have Medicare because of ESRD
- No-fault insurance (including automobile insurance)
- Liability insurance (including automobile insurance)
- Black-lung benefits
- Workers' compensation

If you have other insurance, tell your doctor, hospital, and pharmacy so your bills get paid correctly. If you have questions about who pays first, or you need to update your other insurance information, call Medicare's Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

If you have other coverage that pays first and you retire or lose this coverage, call 1-800-MEDICARE (1-800-633-4227) so Medicare can change your records and your bills can be paid correctly. TTY users should call 1-877-486-2048.

Medigap (Medicare Supplement Insurance) Policies

The Original Medicare Plan pays for many, but not all, health care services and supplies. To help you pay your out-of-pocket costs, you might want to buy a Medigap policy sold by private insurance companies.

A Medigap policy is private health insurance designed to supplement the Original Medicare Plan. This means it helps pay some of the health care costs ("gaps") that the Original Medicare Plan doesn't cover, like copayments, coinsurance, and deductibles. Some Medigap policies cover extra benefits for an extra cost. If you are in the Original Medicare Plan and you buy a Medigap policy, then both plans will pay their share of Medicare-approved amounts for covered health care costs. Medicare doesn't pay any of the costs for a Medigap policy.

Blue words in the text are defined on pages 103–107.

Medigap policies only work with the Original Medicare Plan, and they can't be used to pay your copayments or deductibles for Medicare Advantage Plans. They must follow Federal and state laws designed to protect you. Every Medigap policy must be clearly identified as "Medicare Supplement Insurance."

Medigap insurance companies can only sell you a "standardized" Medigap policy. Standardized Medigap policies are identified by letters (Medigap Plans A through L). In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. In some states, you may be able to buy another type of Medigap policy called Medicare SELECT (a Medigap policy that requires you to use specific hospitals and in some cases, specific doctors to get full benefits).

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

Generally, when you buy a Medigap policy, you must have Medicare Part A and Part B. In addition to the monthly Part B premium (see page 110), you will also have to pay a premium to the Medigap insurance company. A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, you each must buy separate Medigap policies.

Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it. **Usually the only difference between Medigap policies sold by different insurance companies is the cost.**

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

It's important to compare Medigap policies. The benefits in any Medigap policy are the same no matter which insurance company offers the policy, but the costs can vary a lot, and they may go up as you get older. Each insurance company decides which Medigap policies it wants to sell and the price for each policy, although prices may be limited by state law.

When Is the Best Time to Buy a Medigap Policy?

The best time to buy a Medigap policy is during your Medigap open enrollment period. In all states, there is an open enrollment period that lasts for 6 months and begins on the first day of the month in which you are **both** age 65 or older **and** enrolled in Part B. Some states have additional open enrollment periods. Once your Medigap open enrollment period starts, it can't be changed. For more information about buying a Medigap policy, call your State Health Insurance Assistance Program (SHIP). See pages 98–101 for the telephone number.

Medigap Policies and Medicare Advantage Plans

A Medigap policy only works with the Original Medicare Plan. If you join a Medicare Advantage Plan (like an HMO or PPO), you generally don't need (and can't use) a Medigap policy. You may want to drop your Medigap policy if you join a Medicare Advantage Plan, but you should talk to your Medigap insurance company before you do. If you already have a Medicare Advantage Plan, it is illegal for anyone to sell you a Medigap policy unless you are switching back to the Original Medicare Plan. See pages 38–49 for information about what Medicare Advantage Plans cover.

Do Medigap Policies Cover Prescription Drugs?

Medigap policies that are currently being sold can't include prescription drug coverage. This is because Medicare now makes prescription drug coverage available to everyone with Medicare. See pages 52–66 to learn about Medicare prescription drug coverage.

To avoid the Part D late-enrollment penalty, you should join a Medicare drug plan when you are first eligible. See page 58.

Do You Have a Medigap Policy with Prescription Drug Coverage?

Before 2006, some Medigap policies included prescription drug coverage. If you still have a Medigap policy with prescription drug coverage, you may have to pay a Part D late-enrollment penalty (higher premium) to join a Medicare Prescription Drug Plan if the prescription drug coverage under your Medigap policy isn't as good as Medicare drug coverage (creditable prescription drug coverage). You will pay this higher premium for as long as you are in the Medicare Prescription Drug Plan.

Blue words in the text are defined on pages 103–107.

Each year, you will get a notice from your Medigap insurance company telling you whether your Medigap prescription drug coverage is creditable prescription drug coverage. **Keep the notices you get. You may need to show them as proof of creditable prescription drug coverage if you join a Medicare drug plan later**.

You can't have **Medigap** prescription drug coverage and **Medicare** prescription drug coverage at the same time. You can keep your Medigap policy, but if you sign up for a Medicare Prescription Drug Plan, your Medigap insurance company must remove the prescription drug coverage from your Medigap policy.

For more information about Medigap policies, visit www.medicare.gov on the web to view a copy of "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." Under "Search Tools," select "Find a Medicare Publication." 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, there are programs that might help you pay costs Medicare doesn't cover. See pages 76–82.

Section

3

Getting the Help You Need

Medicare is here to help you get the information you need.

Section 3 includes information about the following:

- Help for people with limited income and resources. 76–82
- Your Medicare rights and filing an appeal 83–90
- Protecting yourself from identity theft and fraud 91–93
- How the Medicare Beneficiary Ombudsman can help you 94
- Where to get more information 95–102
- What the words in blue mean 103–107

Note: Keep important information you get from Medicare, Social Security, or your Medicare health or prescription drug plan, Medigap policy, or employer or union, like an Annual Notice of Change, notice of creditable prescription drug coverage or a Medicare Summary Notice (MSN). Also keep copies of any applications you submit for extra help, state programs, or Medicare Savings Programs. You may need this information to apply for the programs explained on pages 76–82.

Section

3 Getting the Help You Need

Help for People with Limited Income and Resources

There is financial help to pay for some health care and prescription drug costs. If you have limited income and resources, you might qualify for one or more of the programs described in this section.

Extra Help Paying for Medicare Prescription Drug Coverage

What is this program?

You may qualify for "extra help" (the low-income subsidy) from Medicare to pay prescription drug costs if you have a yearly income (in 2007) below $15,315 ($20,535 for a married person living with a spouse and no other dependents) and resources (in 2007) less than $11,710 ($23,410 for a married person living with a spouse and no other dependents). Amounts will change in early 2008.

Blue words in the text are defined on pages 103–107.

If you qualify for extra help in 2008, you will get the following:

- Help paying your Medicare drug plan's monthly premium. Depending on your income and resources and your plan's premium, you may pay a reduced premium or no premium for a basic plan. For an enhanced plan, you must pay a portion of the premium for the extra coverage.
- Help paying any yearly deductible
- Help paying prescription coinsurance and copayments
- No coverage gap. See page 56.

You automatically qualify for extra help if you have Medicare and meet one of these conditions:

- You have full Medicaid benefits. See page 79.
- You get help from your state Medicaid program paying your Part B premiums (you belong to a Medicare Savings Program). See page 80.
- You get Supplemental Security Income (SSI) benefits without Medicaid. See page 81.

Extra Help Paying for Medicare Prescription Drug Coverage (continued)

What happens if you automatically qualify for extra help?

Medicare will mail you a letter to let you know you automatically qualify for extra help. You don't need to apply for extra help if you get this letter.

- Keep the letter for your records.
- You must join a Medicare drug plan to get this extra help.
- If you don't join a drug plan, Medicare will enroll you in one to make sure you get this help.
- Check to see if the plan you are enrolled in covers the drugs you use and if you can go to the pharmacies you want. If not, you can change plans.
- If Medicare enrolls you in a plan, Medicare will send you a yellow or green letter letting you know when your coverage begins.

If you don't want to join a Medicare drug plan (for example, because you want to keep your employer or union coverage instead), you can call 1-800-MEDICARE (1-800-633-4227) or the plan listed in your letter and tell them you don't want to be in a Medicare drug plan. TTY users should call 1-877-486-2048.

Extra Help Paying for Medicare Prescription Drug Coverage (continued)

If you didn't automatically qualify for extra help, you can still apply

- Call Social Security at 1-800-772-1213 to apply by phone or to get a paper application. TTY users should call 1-800-325-0778.
- Visit www.socialsecurity.gov on the web to apply online.
- Apply at your State Medical Assistance (Medicaid) office. See page 95 to find out how to get the telephone number for your state.

To get answers to your questions about extra help paying for your prescription drug costs, call your State Health Insurance Assistance Program (SHIP). See pages 98–101 for the telephone number.

Blue words in the text are defined on pages 103–107.

Note: If you apply and qualify for extra help, you must join a Medicare drug plan to get this extra help. If you don't join a drug plan, Medicare will enroll you in one to make sure you get coverage. If Medicare enrolls you in a plan, Medicare will send you a green or yellow letter letting you know when your coverage begins. Check to see if the plan you are enrolled in covers the drugs you use and if you can go to the pharmacies you want. If not, you can change plans.

Getting the Help You Need

State Pharmacy Assistance Programs (SPAPs)

Several states have State Pharmacy Assistance Programs (SPAPs) that help certain people pay for prescription drugs. Each SPAP makes its own rules about how to provide drug coverage to its members. Depending on your state, the SPAP will have different ways of helping you pay your prescription drug costs. To find out about the SPAPs in your state, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, call your State Health Insurance Assistance Program (SHIP). See pages 98–101 for the telephone number.

Medicaid

Medicaid is a joint Federal and state program that helps pay medical costs for some people with limited income and resources. Some people qualify for both Medicare and Medicaid (they are called "dual-eligibles").

- Most of your health care costs are covered if you have Medicare and Medicaid.
- Medicaid programs vary from state to state. They may also be called by different names, such as "Medical Assistance" or "Medi-Cal."
- People with Medicaid may get coverage for services that aren't fully covered by Medicare, such as nursing home and home health care.
- The income limits for Medicaid vary from state to state.

Call your State Medical Assistance (Medicaid) office to see if you qualify or for more information about Medicaid. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your State Medical Assistance office. TTY users should call 1-877-486-2048.

Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to find Medicare Special Needs Plans (SNPs) in your area. TTY users should call 1-877-486-2048. Some of these plans may provide special coverage for people with both Medicare and Medicaid.

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

States have programs for people with limited income and resources. These programs pay Medicare premiums and, in some cases, may also pay Medicare Part A and Part B deductibles and coinsurance. These programs help millions of people with Medicare save money each year.

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

- Have Medicare Part A
- Be an individual with resources of $4,000 or less, or a married couple with resources of $6,000 or less. Resources include money in a checking or savings account, stocks, and bonds. Resources don't include your home, car, burial plot, up to $1,500 for burial expenses, furniture, or other household items.
- Be an individual with a monthly income of less than $1,169, or a married couple with a monthly income of less than $1,561

Blue words in the text are defined on pages 103–107.

Note: Individual states may have different income and/or resource limits. Income limits will increase slightly in 2008 or if you have other dependents in your household.

Call your State Medical Assistance (Medicaid) office. Since the names of these programs may vary by state, ask for information on Medicare Savings Programs. It's very important to call if you think you qualify for any of these programs, even if you aren't sure. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state, or contact your State Health Insurance Assistance Program (SHIP). See pages 98–101 for the telephone number. TTY users should call 1-877-486-2048.

Supplemental Security Income (SSI) Benefits

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

You must also meet these conditions:

- Be a resident of the U.S. or the Northern Mariana Islands
- Not be absent from the country for more than 30 days
- Be either a U.S. citizen or national, or in one of certain categories of eligible non–citizens. People who live in Puerto Rico, the Virgin Islands, Guam, or American Samoa generally can't get SSI.

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. You can also visit www.socialsecurity.gov on the web, and use the "Benefit Eligibility Screening Tool" to find out if you are eligible for SSI or other benefits.

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

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

PACE combines medical, social, and long-term care services for frail elderly people who live in and get health care in the community. PACE programs provide all medically-necessary services, including prescription drugs. PACE is a joint Medicare and Medicaid program that may be available in states that have chosen it as an optional Medicaid benefit. PACE might be a better choice for you instead of getting care through a nursing home.

To qualify for PACE, you must meet these conditions:

- Be at least age 55
- Live in the PACE service area
- Be certified by your state as eligible for nursing home care

Call your State Medical Assistance (Medicaid) office to find out if you are eligible and if there is a PACE site near you. You can also visit www.cms.hhs.gov/pace on the web for PACE locations and telephone numbers.

Blue words in the text are defined on pages 103–107.

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

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs.

Programs vary in these areas. Call your State Medical Assistance (Medicaid) office to find out more about their rules. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

Getting the Help You Need

Your Medicare Rights

No matter what type of Medicare you have, you have certain rights.

As a person with Medicare, you have the right to all of the following:

- Get a decision about health care payment or services
- Appeal (or get a review of) certain decisions about health care payment or services, or prescription drug coverage
- Get information (including information on covered services and costs)
- Get emergency room or urgently-needed care services
- See doctors, specialists (including women's health specialists), and go to Medicare-certified hospitals
- Participate in treatment decisions
- Know your treatment choices
- Get information in a language or way you understand from Medicare, its providers, and contractors under certain circumstances
- File complaints, including complaints about the quality of your care
- Nondiscrimination (see page 93)
- Have your personal and health information kept private

What Is an Appeal?

If you have Medicare, you have certain guaranteed rights. One of these is the right to a fair process to appeal decisions about health care payment of services. An appeal is a kind of complaint you make in situations like these:

- A service, item, or prescription drug you need isn't covered, and you think it should be paid
- A service, item, or prescription drug you want is denied, and you think it should be provided
- A service you get is ending too soon
- You question the amount that Medicare paid for a service or item you got

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

How to File an Appeal

How you file an appeal depends on the type of Medicare plan you have.

- If you have a Medicare Advantage Plan or a Medicare Prescription Drug Plan, look at your plan materials to learn how to file an appeal, or visit www.medicare.gov on the web. More information about appeals in a Medicare Advantage Plan is on page 86. More information about appeals in a Medicare Prescription Drug Plan is on page 87.
- If you have the Original Medicare Plan, you can file an appeal by following the instructions below:
  1. Get the Medicare Summary Notice (MSN) that shows the item or service you are appealing. (Your MSN is the statement you get every 3 months that lists all the services you had and tells you if Medicare paid for the services.)
  2. Circle the item(s) on the MSN you disagree with and write an explanation on the MSN of why you disagree.
  3. Sign and write your telephone number on the MSN.
  4. Send the MSN, or a copy, to the Medicare contractor's address in the "Appeals Information" section of the MSN. You can also send any additional information you may have about your appeal.

Blue words in the text are defined on pages 103–107.

You must file the appeal within 120 days of the date you get the MSN. If you want to file an appeal, make sure you read your MSN carefully and follow the instructions.

In some cases, you can also file a fast appeal. See page 86.

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

How to File an Appeal (continued)

How Do You Know If Medicare Was Billed for the Services You Got?

If you are in the Original Medicare Plan, you can find out what Medicare was billed in one of the following ways:

- Ask your health care provider or supplier for an itemized statement (you should get this within 30 days).
- Check your Medicare Summary Notice (MSN) (sent every 3 months) to see if the service was billed to Medicare. You can view your current MSN at www.MyMedicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get a copy. TTY users should call 1-877-486-2048.
- Check with your health care provider or supplier to see if they submitted the bill to Medicare.

What Is an Advance Beneficiary Notice (ABN)?

If you are in the Original Medicare Plan, your health care provider or supplier may give you a notice called an "Advance Beneficiary Notice" (ABN):

- This notice says Medicare probably (or certainly) won't pay some Medicare services in certain situations.
- You will be asked to sign an agreement that says you will pay for the service you want to get if Medicare doesn't pay for it.
- You can still ask your health care provider or supplier to submit the bill to Medicare. If payment is denied, you can still file an appeal. An ABN isn't an official denial of coverage by Medicare.
- You can ask the company that handles bills for Medicare for a prior determination of coverage to find out if Medicare will cover the item or service in your situation. This information is only available for a limited number of services and items.
- You may also get an ABN for other reasons, such as when your doctor reduces your home health care.

If you are in a Medicare plan like an HMO or PPO, or Medicare Prescription Drug Plan, call your plan to find out if a service or item will be covered.

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

If you are getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your Medicare-covered services are ending too soon, you may have the right to a fast appeal (also called an "expedited review" or an "immediate appeal"). You will get a notice from your provider that will tell you how to ask for a fast appeal. If you ask for this fast appeal, an independent reviewer will decide if your services should continue.

- Ask your doctor for any information that may help your case if you decide to file a fast appeal.
- Contact your State Health Insurance Assistance Program (SHIP) if you need help filing an appeal. See pages 98–101 for the telephone number. You can also call your local Quality Improvement Organization (QIO). Call 1-800-MEDICARE (1-800-633-4227) to get their telephone number. TTY users should call 1-877-486-2048.
- Find out if you have other appeal rights if you miss the timeframe for filing a fast appeal:
  - If you are in the Original Medicare Plan, call your local Quality Improvement Organization (QIO). Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number.
  - If you are in a Medicare Advantage Plan (like an HMO or PPO), call your plan to find out if a service or item will be covered. Look in your plan materials to get the telephone number.

Blue words in the text are defined on pages 103–107.

Getting the Help You Need

Can You Appeal Your Medicare Drug Plan's Decisions?

As a person with Medicare prescription drug coverage, you have the right to do all of the following:

- Get a written explanation (called a "coverage determination") from your Medicare drug plan if your plan won't cover or pay for a prescription drug you need, or if you think you were asked to pay more than you think your plan charges for a drug.
- Ask your drug plan for an exception if you or your doctor believe you need a drug that isn't on your drug plan's list of covered drugs.
- Ask for an exception if you or your doctor believe that a coverage rule (such as prior authorization) should be waived.
- Ask for an exception if you think you should pay less for a non-preferred drug because you or your doctor believe you can't take any of the preferred drugs for the same condition.

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

A standard request for a coverage determination or exception must be made in writing unless your plan accepts requests by phone. You or your doctor can call or write your plan for an expedited (fast) request. **If you are requesting an exception, your prescribing doctor must provide a statement explaining the medical reason why similar drugs covered by your plan won't work or may be harmful to you.**

Once your Medicare drug plan gets your request for a coverage determination or your doctor's statement, the Medicare drug plan has 72 hours (for a standard request) or 24 hours (for an expedited request) to notify you of its decision.

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

If You Want to Appeal a Decision Through Your Plan

- You have 60 calendar days from the date of the drug plan's decision to request an appeal.
- A standard request must be made in writing, unless your Medicare drug plan accepts requests by phone.
- You or your doctor can call or write your plan for an expedited request.
- The Medicare drug plan has 7 days (for a standard request) or 72 hours (for an expedited request) from the date it gets your request to notify you of its decision. You may have additional appeal rights if you don't agree with the plan's decision.
- You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP). See pages 98–101 for the telephone number.

Blue words in the text are defined on pages 103–107.

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

After you appeal through your plan, you will get a notice explaining the next level of appeal, if you disagree with the plan's decision.

For more information about your rights and the different levels of appeals, visit www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication" to view the booklet "Your Medicare Rights and Protections."

How Medicare Uses Your Personal Information

You have the right to have your personal and health information kept private. The box below and on page 90 describes how your information may be used and disclosed and explains how you can get this information.

Notice of Privacy Practices for the Original Medicare Plan

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 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, and
- 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:

- Medicare Carriers 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 Medicare beneficiaries get quality health care, to provide customer services 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 benefits under Medicare, and
- 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 at any time, except if Medicare has already acted based on your permission.

By law, you have the right to

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

Visit www.medicare.gov on the web for more information on

- exercising your rights set out in this notice.
- filing a complaint, if you believe the Original Medicare Plan has violated these privacy rights. Filing a complaint won't affect your benefits 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. Visit www.hhs.gov/ocr/hipaa on the web, or call the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

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 the Original Medicare Plan became effective April 14, 2003.

Protect Yourself from Identity Theft and Fraud

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. Keep this information safe.

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

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

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048
- The Fraud Hotline of the HHS Office of the Inspector General at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950
- The Federal Trade Commission's ID Theft Hotline at 1-877-438-4338 to make a report. TTY users should call 1-866-653-4261. For more information about identity theft, visit www.consumer.gov/idtheft on the web.

Medicare plans can't ask you for credit card or banking information over the telephone, unless you are already a member of that plan. In most cases, Medicare plans can't call you to enroll in a plan; instead, you must call them. Call 1-800-MEDICARE (1-800-633-4227) to report any plans that ask for your personal information over the telephone or that call you to enroll in a plan. TTY users should call 1-877-486-2048.

Note: Medicare plans that are offering demonstrations or pilot programs are allowed to call you to see if you want to enroll. See page 51 for more information about demonstrations and pilot programs.

Protect Yourself and Medicare from Billing Fraud

Most doctors, pharmacists, plans, and other health care providers who work with Medicare are honest. Unfortunately, there may be some who are dishonest. Medicare is working with other government agencies to protect you and the Medicare Program from such dishonesty.

Blue words in the text are defined on pages 103–107.

Medicare fraud happens when Medicare is billed for services or supplies you never got. Medicare fraud takes a lot of money every year from the Medicare Program. You pay for it with higher premiums. A fraud scheme can be carried out by individuals, companies, or groups of individuals.

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

1. Contact your health care provider to be sure the bill is correct.
2. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
3. Call the Inspector General's hotline 1-800-HHS-TIPS (1-800-447-8477).

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

Fighting Fraud Can Pay

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

- You report suspected Medicare fraud
- The Inspector General's Office reviews your suspicion
- The suspected fraud you report isn't already being investigated
- Your report leads directly to the recovery of at least $100 of Medicare money

For more information, call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication" to view the booklet "Protecting Medicare and You from Fraud." TTY users should call 1-877-486-2048.

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. Also, your rights to health information privacy are protected. If you think that you haven't been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights for your state, or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr on the web for more information.

The Medicare Beneficiary Ombudsman Works for You

An "ombudsman" is a person who reviews issues and helps to resolve them. Congress requires that Medicare have a Beneficiary Ombudsman to help people with Medicare. The Medicare Beneficiary Ombudsman shares information with the Secretary of Health and Human Services, Congress, and other organizations about what works well in the Medicare Program, and what doesn't work well. The Ombudsman helps improve the quality of the services and care you get from Medicare by reporting problems and making recommendations.

How Does the Medicare Beneficiary Ombudsman Help You?

The Ombudsman makes sure information is available for you about all of the following:

- Your Medicare benefits
- Whether you have the information you need to make good health care decisions
- Your Medicare rights and protections
- How you can get issues resolved

For more information about the Medicare Beneficiary Ombudsman, visit www.medicare.gov on the web. Or, visit www.cms.hhs.gov on the web. Under "Browse by Special Topic," select "Ombudsman Center."

Blue words in the text are defined on pages 103–107.

Getting the Help You Need

Get Information 24 Hours a Day, Including Weekends.

Call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048

- Speak clearly and have your Medicare card in front of you.
- **If you need help, say "Agent" at any time to talk to a customer service representative. Or, use this chart.**

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

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

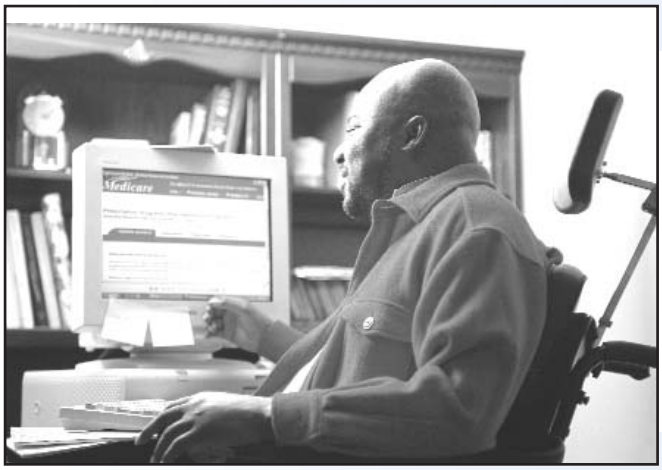
Note: If you want Medicare to give your personal health information to someone other than you, you need to let Medicare know in writing. You can fill out a "Medicare Authorization to Disclose Personal Health Information" form. Call 1-800-MEDICARE (1-800-633-4227) to get a copy of the form. You may want to do this now, in case you become unable to do it later. TTY users should call 1-877-486-2048.

Get the Information You Need on the Web

Need Personalized Information?

Register at www.MyMedicare.gov on the web (Medicare's secure online service for accessing your personal Medicare information)

- Track your health care claims
- Check your Part B deductible status
- View your eligibility information
- Track the preventive services you can use
- Find your Medicare health or prescription plan, or search for a new one
- Keep your Medicare information in one convenient place



"It's easy... I keep up with my Medicare claims, get copies of my Medicare Summary Notices, and track which Medicare-covered preventive services I can get."

Need General Information about Medicare?

Visit www.medicare.gov on the web

- See what Medicare plans are in your area
- Find doctors who participate in Medicare
- See what Medicare covers, including preventive services
- Get Medicare appeals information and forms
- Get information on the quality of care provided by nursing homes, hospitals, home health agencies, plans, and dialysis facilities
- Look up helpful telephone numbers for your area
- View Medicare publications

If you don't have a computer, your local library or senior center may be able to help you look at this information.

Other Important Contacts

1-800-MEDICARE See page 95.	1-800-633-4227 TTY 1-877-486-2048
Social Security Call for address or name changes, death notification, to enroll in Medicare, to replace your Medicare card, to get information about signing up for extra help with prescription drug costs, and about Social Security benefits.	1-800-772-1213 TTY 1-800-325-0778
State Health Insurance Assistance Program (SHIP)	See pages 98–101
Coordination of Benefits Contractor Call for information on whether Medicare or your other insurance pays first.	1-800-999-1118 TTY 1-800-318-8782
Department of Defense	
TRICARE	1-888-363-5433
TRICARE for Life	1-866-773-0404
Department of Health and Human Services	
Office of the Inspector General	1-800-447-8477 TTY 1-800-377-4950
Office for Civil Rights	1-800-368-1019 TTY 1-800-537-7697
Department of Veterans Affairs	1-800-827-1000 TTY 1-800-829-4833
Railroad Retirement Board (RRB) Call for address or name changes, death notification, to enroll in Medicare, and to replace your Medicare card.	Local RRB office or 1-800-808-0772
Quality Improvement Organization (QIO) Call with questions or complaints about the quality of care for a Medicare-covered service.	Call 1-800-MEDICARE (1-800-633-4227) to get the number for your area. TTY 1-877-486-2048

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site at www.medicare.gov/contacts/home.asp on the web. Thank you.

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Medicare Publications

To read, print, or download copies of booklets, brochures, or fact sheets on the topics listed below or to see what's available, visit www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication." You can search by keyword (such as "rights" or "mental health") on www.medicare.gov, or click on "View All Medicare Publications."

Blue words in the text are defined on pages 103–107.

Some publications are available for ordering. If the publication you are interested in has a check box after "Order Publication," you can have a printed copy mailed to you. Or, you can call 1-800-MEDICARE (1-800-633-4227) to find out if a printed copy can be mailed to you. TTY users should call 1-877-486-2048.

Search for booklets on Medicare topics like these:

- Preventive services
- Hospice care
- Home health care
- Medicare prescription drug coverage
- Medicare Advantage Plans
- Choosing a nursing home
- Mental health care
- Kidney dialysis and transplant services
- Skilled nursing facility care
- Fighting fraud
- Rights and protections

Definitions of Words in Blue

ALS—Amyotrophic lateral sclerosis, also known as Lou Gehrig's disease.

Appeal—A special kind of complaint you make if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if you request a health care service, supply, or prescription that you think you should be able to get, or if you request payment for health care you already got, and Medicare or your plan denies the request. You can also appeal if you are already getting coverage and Medicare or the plan stops paying.

Benefit Period—The way that the Original Medicare Plan measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods, although inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Coinsurance—An amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible. In a Medicare Prescription Drug Plan, the coinsurance will vary by plan and will depend on how much you have spent.

Copayment—An amount you pay in some Medicare health and prescription drug plans, for each medical service, like a doctor's visit, or prescription. A copayment is usually a set amount. For example, you could pay $10 or $20 for a doctor's visit or prescription. Copayments are lower for people with Medicaid and people who qualify for extra help. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Coverage Determination (Part D)—The first decision made by a Medicare drug plan (not the pharmacy) about the drug benefits you may be entitled to get, including decisions about the following:

- Whether to provide or pay for a drug
- An exception request you may have made
- The amount you have been asked to pay for a drug
- Whether you have satisfied a coverage rule for a requested drug

If the drug plan doesn't give you a prompt decision, and you can show that the delay would affect your health, the plan's failure to act is considered to be a coverage determination. If you disagree with the coverage determination, the next step is an appeal.

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.

Critical Access Hospital—A small facility that gives limited outpatient and inpatient services to people in rural areas.

Definitions of Words in Blue (continued)

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 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 the Original Medicare Plan, your prescription drug plan, or other insurance begins to pay. For example, in the Original Medicare Plan, you pay a new deductible for each benefit period for Part A and each year for Part B. These amounts can change every year. People who qualify for extra help either pay no deductible, or a small deductible for prescription drug coverage.

Demonstration—A type of Medicare project designed to explore future improvements in coverage, costs, and quality of care within the Medicare Program.

Durable Medical Equipment—Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds. DME is paid for under both Part A and Part B for home health services.

Exception—A type of coverage determination. A formulary exception is a decision to cover a drug that's not on the formulary or a decision to waive a coverage rule. A tiering exception is a decision to charge you a lower amount for a drug that is on the non-preferred drug tier. See page 65. Your doctor must send a supporting statement explaining the medical reason for the exception.

Extra Help—A program to help people with limited income and resources pay prescription drug costs. Also called the "low-income subsidy." See pages 76–77.

Formulary—A list of drugs covered by a plan.

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

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

Lifetime Reserve Days—In the Original Medicare Plan, these are additional days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance. See page 111 for specific cost information.

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

Medicaid—A joint Federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

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

Definitions of Words in Blue (continued)

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called "Part C," Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and aren't paid for under the Original Medicare Plan. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved Amount—In the Original Medicare Plan, 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 Cost Plan—A type of health plan. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under the Original Medicare Plan (your Cost Plan pays for emergency services, or urgently needed services).

Medicare Health Maintenance Organization (HMO)—A type of Medicare Advantage Plan (Part C) available in some areas of the country. Plans must cover all Part A and Part B health care. Many HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your costs may be lower than in the Original Medicare Plan.

Medicare Medical Savings Account (MSA) Plan—MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare in the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Preferred Provider Organization (PPO) Plan—A type of Medicare Advantage Plan (Part C) available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost. Many Medicare Advantage Plans are PPOs.

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

Medicare Private Fee-For-Service (PFFS) Plan—A type of Medicare Advantage Plan (Part C) in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare Program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Definitions of Words in Blue (continued)

Medicare Special Needs Plan (SNP)—A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

Medicare Savings Program—Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums and deductibles.

Medicare Summary Notice (MSN)—A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage.

Original Medicare Plan—The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). It's a fee-for-service health plan. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Penalty—An amount added to your monthly premium for Medicare Part A and/or Part B, or for a Medicare drug plan (Part D), if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

Point-of-Service—A Health Maintenance Organization (HMO) option that lets you use doctors and hospitals outside the plan for an additional cost.

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

Programs of All-Inclusive Care for the Elderly (PACE)—A program that combines medical, social, and long-term care services to help frail people stay independent and living in their community as long as possible, while getting the high-quality care they need. PACE is available only in states that have chosen to offer it under Medicaid.

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.

Definitions of Words in Blue (continued)

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

Religious Nonmedical Health Care Institution—A facility that provides nonmedical health care items and services to people for whom the acceptance of medical services would be inconsistent with their religious beliefs. To qualify, you would need hospital or skilled nursing facility care if it weren't for your religious beliefs and you need to file a written election at the facility.

Service Area—The area where a plan accepts members. For plans that require you to use their doctors and hospitals, it's also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.

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

Special Enrollment Period—A time when a person who didn't sign up for Medicare coverage under Part A, Part B, or Part D when first eligible can sign up without waiting for a general enrollment period. In most cases, the person can also sign up without paying a penalty (higher premium).

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

State Pharmacy Assistance Program (SPAP)—A state program that provides help paying for drug coverage based on financial need, age, or medical condition.

Supplemental Security Income (SSI)—A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits aren't the same as Social Security benefits.

Telemedicine—Medical or other health services given to a patient using a communications system (like a computer, telephone, or television) by a practitioner in a location different than the patient's.

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.

What Preventive Services Do You Need?

Take this checklist and ask your doctor which preventive services are right for you.

Look on pages 18–25 for more details about how much, how often, and whether you meet the conditions to get these services. Write down any notes (like the date you get the service).

Medicare-covered Preventive Service		Details on page	Notes
❑	Abdominal Aortic Aneurysm Screening	18	
❑	Bone Mass Measurement	18	
❑	Cardiovascular Screenings	18	
	Colorectal Cancer Screenings	19	
	❑ Fecal Occult Blood Test	19	
	❑ Flexible Sigmoidoscopy	19	
	❑ Screening Colonoscopy	19	
	❑ Barium Enema	19	
❑	Diabetes Screenings	19	
❑	Diabetes Self-management Training	20	
❑	Flu Shots	21	
❑	Glaucoma Tests	21	
❑	Hepatitis B Shots	21	
❑	Mammogram (screening)	22	
❑	Medical Nutrition Therapy Services	22	
❑	Pap Test and Pelvic Exam (includes breast exam)	23	
❑	Physical Exam (One-time "Welcome to Medicare" physical exam)	23	
❑	Pneumococcal Shot	23	
❑	Prostate Cancer Screenings	23	
❑	Smoking Cessation (counseling to stop smoking)	24	

Visit www.MyMedicare.gov on the web to keep track of your preventive services (see page 96).

NOTES

2008 Medicare Costs

Your 2008 Monthly Premiums for Medicare

Part A (Hospital Insurance) Monthly Premium

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

You pay up to $423 each month if you don't get premium-free Part A.*

Part B (Medical Insurance) Monthly Premium

If Your Yearly Income is		You pay
File Individual Tax Return	File Joint Tax Return	
$82,000 or below	$164,000 or below	$96.40*
$82,001-$102,000	$164,001-$204,000	$122.20*
$102,001-$153,000	$204,001-$306,000	$160.90*
$153,001-$205,000	$306,001-$410,000	$199.70*
Above $205,000	Above $410,000	$238.40*

Part C (Medicare Advantage Plan) Monthly Premium

Actual plan premiums are available on www.medicare.gov on the web, or from the plan. You also pay the Part B premium* (and Part A if you don't get it premium-free). An extra premium may be charged for extra benefits.

Part D (Medicare Prescription Drug Plan) Monthly Premium

Actual plan premiums* are available on www.medicare.gov on the web, or from the plan. You also pay the Part B premium (and Part A if you don't get it premium-free), or an amount for your Part D coverage is added to your Part C premium.

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

What you pay for the Original Medicare Plan in 2008

Part A Costs for Covered Services and Items

Blood	**You pay** all costs for the first 3 pints of blood you get as an inpatient, then 20% of the Medicare-approved amount for additional pints of blood (unless you or someone else donate to replace what's used).
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** a copayment of up to $5 per prescription for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest). You may have to pay room and board if you get hospice care in a facility other than for short-term general inpatient care or respite care.
Hospital Stay	**You pay:** ■ $1,024 deductible and no coinsurance for days 1–60 each benefit period ■ $256 per day for days 61–90 each benefit period ■ $512 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime)
Skilled Nursing Facility Stay	**You pay:** ■ $0 for the first 20 days each benefit period ■ $128 per day for days 21–100 each benefit period ■ All costs for each day after day 100 in the benefit period

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

What you pay for the Original Medicare Plan in 2008 (continued)

Part B Costs for Covered Services and Items

Blood	**You pay** all costs for the first three pints of blood you get as an outpatient, then 20% of the Medicare-approved amount for additional pints of blood (unless donated to replace what's used).
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, outpatient therapy*, most preventive services, and durable medical equipment.
Mental Health Services	**You pay** 50% for most outpatient mental health care.
Other Covered Services	**You pay** copayment or coinsurance amounts.
Outpatient Hospital Services	**You pay** a coinsurance or copayment amount that varies by service.

Part B Deductible	**You pay** the first $135 yearly for Part B-covered services or items.

*In 2008, there may be limits on physical therapy, occupational therapy, and speech-language pathology services. If so, there may be exceptions to these limits.

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

Part C (Medicare Advantage Plan) Costs for Covered Services and Supplies

Cost information for the Medicare Advantage Plans in your area is available on www.medicare.gov on the web or from the plan. Medicare Advantage Plans must cover all Part A and Part B-covered services and supplies. Check your plan's materials for actual amounts.

Part D (Medicare Prescription Drug Plan) Costs for Covered Prescription Drugs

Cost information for the Medicare Prescription Drug Plans in your area is available on www.medicare.gov on the web or from the plan. Check your plan's materials for actual amounts.

The figures below are used to determine the Part D late-enrollment penalty.

For more information about estimating your penalty amount, see page 58.

	2008
Part D National Base Beneficiary Premium	$27.93
1% Penalty Calculation	$.28

Medicare is using a new paper for this handbook that will save tax payers millions of dollars while maintaining quality. If you have comments about this paper or general comments about this handbook, email us at medicareandyou@cms.hhs.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare cares about what you think. We won't be able to respond to your comments about the handbook, but we will consider your feedback when writing future versions.

Is Your Money Going Down the Drain?

Get the Most Value From Medicare!

Take this quick quiz to find ways to help stay healthy and save money.

1. **How often do you ask your doctor about Medicare's preventive services?**
   A. Every year
   B. Only when my doctor mentions it
   C. What are preventive services?

   Talk about preventive services, and share your family health history with your doctor. See page 108.

2. **Did you know that Medicare pays for you to get a flu shot every year?**
   A. Yes, I get my flu shot every flu season.
   B. Yes, I sometimes get a flu shot.
   C. No, I didn't know that Medicare covers flu shots.

   Bring the Medicare preventive services checklist with you to your doctor. See page 108.

3. **When do you compare your health care coverage and prescription drug coverage options?**
   A. Every fall
   B. Sometimes in the fall
   C. Never

   Compare plans in your area by visiting www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

4. **What are you doing to see if there is a program to help you save money on your Medicare health care costs?**
   A. I've worked with people in my community to look at all the programs that can help me save money.
   B. I know that there are programs that can help me save money, but I haven't looked into them.
   C. I didn't know I could save money on my Medicare health care costs.

You may be able to save money on your Medicare health care costs. See pages 80–82, or call your State Health Insurance Assistance Program (SHIP). See pages 98–101 for the telephone number.

5. **What are you doing to save money on your prescription drug costs?**
   A. I have prescription drug coverage through Medicare or another source.
   B. I looked into extra help to pay for my prescription drugs.
   C. I didn't know I could save on my prescription drug costs.

You may be able to get extra help paying for your prescriptions. See pages 76–79, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

ANSWERS

Mostly As—You're doing great!

Mostly Bs—You're on the right track!

Mostly Cs—Medicare is here to help!

For more information:

www.medicare.gov

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

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- 1-800-MEDICARE (1-800-633-4227)
- TTY 1-877-486-2048
- Other versions available: Spanish, Braille, Audiotape, Large-Print
- New address? Call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

- Otras versiones disponibles: Español, Audiocasete, Letra-Grande
- ¿Nueva dirección? Llame al Seguro Social al 1-800-772-1213. Los usuarios de TTY deben llamar al 1-800-325-0778.

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