Medicare & You

2005

This is the official government handbook with important information about:

★ New changes to Medicare.

★ Your Medicare benefits.

★ Choosing a health plan that's right for you.

★ Your Medicare privacy rights.

Medicare is here for you 24 hours a day, seven days a week.

★ Visit www.medicare.gov

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

Important Information Before You Read This Handbook

If you have limited income and resources

See pages 9–11 to see if you can get $600 in 2005, to help pay for your prescription drugs. See page 15 for other important information.

If you have Employer or Union Health Coverage

Call your employer or union before you make any changes to your health coverage. Your employer or union may offer different plans (which may work with your Medicare benefits) from those described in this handbook.
See pages 23–24, 62, and 73 for important information.

If you are a Railroad Retirement Beneficiary

Call your local Railroad Retirement Board (RRB) office for answers to Medicare questions. You can find your local office by calling 1-800-808-0772. More information about Medicare for Railroad Retirement beneficiaries is at www.rrb.gov on the web.

If you need help paying health care costs

See pages 78 and 79 for information about state programs that may help pay your Medicare premiums, coinsurance, or deductibles.

If your address changes

Call the Social Security Administration (SSA) 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.

If you got more than one copy of *Medicare & You 2005*

Call and tell a Customer Service Representative at 1-800-MEDICARE (1-800-633-4227) if your household gets more than one handbook, but wants to share one copy in the future. TTY users should call 1-877-486-2048. Please have your red, white, and blue Medicare card with you when you call. Most households with up to four people with Medicare will get one handbook to share. The handbook will be addressed to one person. This will help save money for the Medicare program.

Medicare & You 2005 explains the Medicare program. It isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Important Information Before You Read This Handbook

You may have seen or heard information about a Medicare law called the "Medicare Modernization Act of 2003." This new law gives people with Medicare more choices in health care coverage and better health care benefits. Some of these new changes are

- Medicare-approved drug discount cards that started in 2004 (see pages 7–12),
- Medicare prescription drug plans starting in 2006 (see pages 13–15), and
- preventive benefits starting in 2005 (see pages 26–28).

This handbook helps you learn about these changes and the health care choices you have as a person with Medicare. You can find basic information about the Medicare program as well as specific information about each Medicare health plan choice.

This handbook is a good resource to have throughout the year. The information is valid starting January 1, 2005. Use it in place of any older version you have. Keep it where you can find it when you need it.

How can you find the information you need in this handbook?

There are two ways to find the information you need:

1. Look at the **"List of Topics"** section on pages 1–4. This is an alphabetical list of specific topics discussed in this handbook, with page numbers. This is the easiest way to find information.

2. Look at the **"Table of Contents."** This lists topic areas by section, with page numbers.

Note: You may see blue words in the text of this handbook. You can find definitions of these words in the "Words to Know" section on pages 85–88. Look there to get a brief explanation of what a word in blue means.

Important Information Before You Read This Handbook

Where can you get help or more information if you need it?

After reading this handbook, if you need help or more information, you can

- look at www.medicare.gov on the web. This is Medicare's official consumer website. You can find the most up-to-date Medicare information and answers to your questions anytime.
- call 1-800-MEDICARE (1-800-633-4227). This toll-free helpline is available 24 hours a day, seven days a week to answer your questions. You can speak to a Customer Service Representative in English or Spanish. TTY users should call 1-877-486-2048.
- call your State Health Insurance Assistance Program (see pages 93–95 for their telephone number).

Medicare is committed to getting you accurate and timely information about your Medicare benefits and giving you the tools you need to make the choices that are best for you.

Use This Three Step Approach if You Suspect Fraud

1. Call your health care provider.
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).

Table of Contents

Table of Contents

If you want a more detailed listing of topics in this handbook, look at pages 1–4.

Important: The information in this handbook was correct when it was printed. Changes may occur after printing. For the most up-to-date version, look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). A Customer Service Representative can tell you if you have the most up-to-date version. TTY users should call 1-877-486-2048.

Section 1: List of Topics

Section 1: List of Topics

M (continued)

N

O

O (continued)

P

Q

Section 2

New Changes in Medicare

The Medicare Modernization Act of 2003 is bringing many new and exciting changes to the Medicare program. These new changes will give you even more choices in how you get your health care benefits, including coverage for prescription drugs. This handbook can help you learn about these new changes as well as your Medicare benefits, your rights, and your health plan choices. The new changes explained in this handbook are below:

New ways to help with your prescription drug costs

- Medicare-approved drug discount card—Available Now (see pages 7–12)
- Medicare prescription drug plans—Coming in 2006, enrollment starts in 2005 (see pages 13–15)

New health plan choices

- Medicare Advantage health plans—Available Now (see page 53)
- Regional Preferred Provider Organization plans—Coming in 2006 (see page 56)

New preventive benefits—Available January 1, 2005

- Cardiovascular screening blood tests (see page 26)
- Diabetes screening tests (see page 27)
- "Welcome to Medicare" physical examination (see page 28)

Remember, for help with all of your Medicare questions, you can visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week.

Tommy G. Thompson
Secretary
Department of Health and Human Services

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Section 2: What's NEW in Medicare

New Information for 2005

Each year, *Medicare & You* provides important information about your Medicare benefits, your rights, and your health plan choices. The following chart shows the new information in *Medicare & You* and the page number(s) where you can find this information.

New Information	Page Number(s)
Medicare-approved drug discount card	7–12
$600 credit in 2005 on a drug discount card	9–11
Medicare prescription drug plans	13–15
Medicare Part B deductible in 2005	20
Cardiovascular screening blood tests	26
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Note: Throughout this handbook you will see the letters TTY. Medicare and other organizations provide teletypewriter (TTY) services for people who are deaf, hard of hearing, or have severe speech impairments. TTY before a telephone number means it's for TTY users.

Medicare-Approved Drug Discount Cards

Section 3

Save Now with a Medicare-Approved Drug Discount Card

Medicare has contracted with private companies to offer Medicare-approved drug discount cards. These companies negotiate drug prices. Anyone with Medicare can get one of the drug discount cards except those who have outpatient prescription drug coverage from Medicaid when they apply. Enrolling in a Medicare-approved drug discount card is your choice. If you're paying for the full cost of your prescription drugs yourself, a Medicare-approved drug discount card can help you save on your outpatient prescription drug costs. These discount cards are available now. This is a **temporary** program to help with your prescription costs until Medicare prescription drug plans start in 2006. All drug discount cards approved by Medicare will have this seal on them:

If you have a lower income, see pages 9–11 to see if you can get extra help with your drug costs.

MEDICARE Rx SM
APPROVED

How They Work

Enrollment in Medicare-approved drug discount cards started May 3, 2004. If you are eligible and haven't enrolled yet, you can enroll anytime until December 31, 2005. Enrolling is your choice.

The drugs that are discounted and the amount of the discount offered vary among different cards and can change, so you should compare the Medicare-approved drug discount cards carefully. Each drug discount card has a list of pharmacies where the discount card can be used, to help you compare. You must go to a pharmacy that accepts your Medicare-approved drug discount card to get the discounted price.

Remember, blue words in the text are defined on pages 85–88.

Companies offering the discount cards can charge an enrollment fee of no more than $30 each year. You can save on covered brand name drugs and even more on generic drugs.

If you are enrolled in a Medicare Advantage Plan or a state program that helps you pay for your prescriptions, different rules might apply. Contact your Medicare Advantage Plan or state program for more information.

Section 3: Medicare-Approved Drug Discount Cards

How to Join

First, get more information and compare the Medicare-approved drug discount cards that are available to you. To get this information have the following information ready:

1. Your ZIP code
2. Your medicines and doses (you can find this information on your pill bottles)
3. Your total monthly income (if you are interested in the $600 credit for people with Medicare who have lower incomes)

Then, look at www.medicare.gov on the web. Select "Prescription Drug and Other Assistance Programs." Or, call 1-800-MEDICARE (1-800-633-4227), and ask about "drug cards." TTY users should call 1-877-486-2048.

You can have only one Medicare-approved drug discount card at a time. If you have non-Medicare-approved drug discount cards, you may use these and your Medicare-approved drug discount card, but not on the same prescription at the same time.

Next, compare your drug discount card options and decide on the card that best meets your needs. Then, call the company that offers the card you want, and ask them to send you an enrollment form. You can also find enrollment forms at www.medicare.gov on the web. You can apply by mailing or faxing the completed enrollment form to the company offering the card.

Once your enrollment form has been processed and accepted, the company will send you its Medicare-approved drug discount card. You can start using the card the first day of the month after the month in which you enroll. For example, if the company receives your completed enrollment form on January 5, 2005, you can start using your Medicare-approved drug discount card on February 4, 2005. You can continue to use your discount card until May 15, 2006 or until you enroll to get the new Medicare prescription drug coverage, whichever comes first.

For more information about Medicare-approved drug discount cards look at www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) and get a free copy of the booklet *Guide to Choosing a Medicare-Approved Drug Discount Card* (CMS Pub. No. 11062).

$600 Credit for People with Lower Incomes

If you choose a Medicare-approved drug discount card and have a low income, you might get extra help. You might qualify for up to a $600 credit on your discount card in 2005, to help pay for your prescriptions. If you qualify for the $600 credit, you won't have to pay the annual enrollment fee.

To qualify for the $600 credit, you must meet ALL of the following conditions:

- You have Medicare Part A and/or Part B.
- You don't have any outpatient prescription drug coverage through an employer group health plan or other health insurance (except through Veteran's benefits, a Medicare Advantage Plan, or a Medigap policy).
- Your monthly income in 2004 is no more than $1,048 ($12,569 a year) if you are single, or no more than $1,406 ($16,862 a year) if you are married (if you live in Alaska or Hawaii, income limits are higher). These income limits will change in February 2005. If your state helps pay your Medicare premiums, you may still qualify even if your income is above these limits.

Note: If you don't qualify for the $600 credit, you can still choose a Medicare-approved drug discount card.

How the $600 Credit Works

If you qualify, you can get up to a $600 credit in 2005. To get the $600 credit, you have to apply for a Medicare-approved drug discount card AND for the $600 credit. Follow the directions under "How to Join" on page 8. If you qualify, Medicare will put the credit on your Medicare-approved drug discount card, and you can use it when you get your prescriptions. (While you are using your $600 credit, you will still have to pay a small coinsurance amount for each prescription.) When you have used all of the $600 credit, you can still use your Medicare-approved drug discount card to save money by getting discounted prices on covered prescription drugs.

Section 3: Medicare-Approved Drug Discount Cards

How the $600 Credit Works (continued)

If you enroll, the amount of the credit you get will depend on when you join. The chart below shows how much you will get depending on when you apply:

If you apply between	You will get a
January 1–March 31, 2005	$600 credit
April 1–June 30, 2005	$450 credit
July 1–September 30, 2005	$300 credit
October 1–December 31, 2005	$150 credit

Note: If you live in Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, different rules apply. Call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

For more information about the $600 credit, you can

- look at www.medicare.gov on the web. Select "Prescription Drug and Other Assistance Programs" or
- call 1-800-MEDICARE (1-800-633-4227), and ask about "drug cards." TTY users should call 1-877-486-2048.

You can also get a free copy of the booklet *Guide to Choosing a Medicare-Approved Drug Discount Card* (CMS Pub. No. 11062) from either of the two resources listed above. If you don't have a computer, your local library or senior center might be able to help you find this information.

Who Can't Get the $600 Credit

In addition to people with incomes over the limits shown on page 9, you **can't** get the $600 credit if you already have outpatient prescription drug coverage from any of the following:

- Medicaid
- TRICARE for Life (military health insurance)
- FEHB (health insurance coverage for Federal employees and retirees)
- Employer group health plan or other health insurance (except through Veteran's benefits, Medicare Advantage Plans, or a Medigap policy)
- Medicare Managed Care Plan that isn't a Medicare Advantage Plan, and offers an outpatient prescription drug benefit to its members

Three Simple Steps to Get Information about Medicare-Approved Drug Discount Cards and the $600 Credit

Different people have different drug needs and prefer to get their medicines in different ways. To compare Medicare-approved drug discount cards and choose one that works for you, or to learn more about the $600 credit, you can call 1-800-MEDICARE (1-800-633-4227) and talk to a live person. To better serve you, have the following information ready when you call:

1. Your ZIP code
2. Your medicines and doses (you can find this information on your pill bottles)
3. Your total monthly income

To help narrow down your Medicare-approved drug discount card choices, you can also provide the name of your preferred pharmacy, whether you are interested in low-cost or no-cost Medicare-approved drug discount cards, and the names of any specific Medicare-approved drug discount cards you want more information about.

Section 3: Medicare-Approved Drug Discount Cards

Special Options for People in Skilled Nursing Facilities or Nursing Facilities, or American Indians and Alaska Natives with Medicare

If you are in a skilled nursing facility or a nursing facility, or you get your prescriptions through special pharmacies for American Indians or Alaska Natives, you may have special options. Call 1-800-MEDICARE (1-800-633-4227) to find out more. TTY users should call 1-877-486-2048. Or, look at www.medicare.gov on the web. Select "Prescription Drug and Other Assistance Programs."

Things to Remember About Medicare-Approved Drug Discount Cards

- You can enroll **now**.
- There are many different Medicare-approved drug discount cards. If you want a discount card, **you** must choose one and then enroll. Enrollment **isn't** automatic.
- If you have a low income, you might get a $600 credit in 2005 to help with your prescription drug costs.
- Medicare-approved drug discount cards are temporary. They will begin to phase out January 1, 2006 when the new Medicare prescription drug plans start.

Save Money with Generic Drugs

You may be able to save money on your prescription costs right now by choosing generic drugs instead of more expensive brand names. Generic drugs approved by the Food and Drug Administration (FDA) go through the same rigorous review process as their brand name alternatives. Generic drugs are just as safe and effective as their branded counterparts. From quality and performance to manufacturing and labeling, all drugs that the FDA approves, including generic drugs, must meet the exact same high standards. The key difference is that increased competition means that generic drugs often can cost much less than most brand name drugs.

Section 4

Coming in 2006—Medicare Prescription Drug Plans

On January 1, 2006, Medicare-approved drug discount cards will begin to phase out. The new Medicare prescription drug plans will begin.

Medicare will contract with private companies to offer this drug coverage. These companies will most likely offer a variety of options, with different covered prescriptions, and different costs. Medicare prescription drug plans are voluntary. If you want to participate, **you must choose a plan offering the coverage that best meets your needs and then enroll**. In most cases, there is no automatic enrollment to get a Medicare prescription drug plan.

How to Enroll in a Medicare Prescription Drug Plan

To enroll, you must have Medicare Part A or Part B. You can first enroll from November 15, 2005 through May 15, 2006. This is called the "initial open enrollment period." Enrolling is your choice.

Note: After this initial open enrollment period, you can change your plan during the open enrollment period, which will be from November 15 through December 31 each year. Your Medicare prescription drug plan will begin January 1 of the following year.

Remember, blue words in the text are defined on pages 85–88.

To join, you will need to decide how you want to get your prescriptions. You can

- get all your health care benefits and prescriptions through a Medicare Advantage Managed Care Plan (see page 53) that offers optional coverage for prescription drugs,
- get your health care benefits through the Original Medicare Plan and choose a Medicare prescription drug plan, or
- get your health care benefits through another type of Medicare Advantage health plan or a Medicare Managed Care Plan that isn't a Medicare Advantage Plan. In these kinds of plans, you may be able to choose a Medicare prescription drug plan.

How Plans Work

Medicare prescription drug plans might vary, but in general, this is how they will work. When you join, you will pay a **monthly** premium (varies depending on the plan you choose, but estimated at about $35) in addition to any premiums for Medicare Part A and Part B. You will pay the first $250 per year for your prescriptions. This is called your "deductible."

After you pay the $250 yearly deductible, **here's how the costs work:**

- You pay 25% of your yearly drug costs from $250 to $2,250, and your plan pays the other 75% of these costs, then
- You pay 100% of your drug costs from $2,251 until your out-of-pocket costs reach $3,600, then
- You pay 5% of your drug costs (or a small copayment) for the rest of the calendar year after you have spent $3,600 out-of-pocket and your plan pays the rest.

Medicare prescription drug plans can offer coverage like this or more generous coverage for higher premiums. Joining is your choice. However, **if you don't join when you are first eligible, you may have to pay a higher premium if you choose to join later**. You will have to pay this higher premium for as long as you have a Medicare prescription drug plan.

Note: If you already have prescription coverage from other insurance, you can keep that coverage. If that coverage offers the same or better benefits as described above, you won't have to pay a higher premium if you decide to join later. Check with your other insurance to see how your coverage compares.

Information for People with Lower Incomes

If you have a low income and limited assets, there will be extra help available to you. With income below a certain limit, you will get extra help to pay for your prescriptions. **The exact income limits will be set in early 2005**.

If you have a low income, you can get a head start on enrolling. To help ensure that everyone who qualifies for this assistance will be enrolled on time, the Social Security Administration (SSA) and local Medicaid offices will begin accepting applications from people with low incomes as early as summer 2005. By submitting your application early, you can ensure that the assistance with your Medicare prescription drug plan premiums and deductibles will start when the program begins on January 1, 2006, and you won't miss a single day of your prescription coverage. Look for more details in the mail from Medicare and from SSA during 2005.

Things to Remember About Medicare Prescription Drug Plans

- They start January 1, 2006.
- If you want coverage, **you** must enroll in a plan. Enrollment **isn't** automatic.
- Once you're enrolled, you will pay a monthly premium.
- If you have a low income and limited assets, there will be extra help with your costs.
- If you have a low income, you can start enrolling early (summer 2005).
- You will get more information in the mail during 2005.

Keep Track of Your Prescriptions

This chart may help you keep track of your prescriptions throughout the year. You can use this chart when you are making decisions about your prescription coverage.

Prescription Name	Dosage of prescription (ml, mg)	Number of times a day you take your prescription	Amount you pay each month

Medicare Program Basics

Section 5

Medicare is a health insurance program for

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has

Part A Hospital Insurance, see pages 18–19.
Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

Part B Medical Insurance, see pages 20–28.
Most people pay a monthly premium for Part B.

Medicare Health Plans

Today's Medicare is about choice. Your health plan choices include

- The Original Medicare Plan - Available nationwide (see page 39).
- Medicare Advantage Plans (available in many areas, see page 53), including
  - Medicare Managed Care Plans (see pages 55–56).
  - Medicare Preferred Provider Organization Plans (see page 56).
  - Medicare Private Fee-for-Service Plans (see page 57).
  - Medicare Specialty Plans (see page 57).

Medicare Advantage is the new name for "Medicare + Choice Plans."

Remember, blue words in the text are defined on pages 85–88.

The Medicare health plan that you choose affects many things like out-of-pocket costs, benefits (some have extra benefits such as coverage for extra days in the hospital), choice of doctors and providers, convenience, and quality (see page 35).

For help comparing your health plan choices, use the "Medicare Personal Plan Finder" at www.medicare.gov on the web. See page 38 for details. If you don't have a computer, your local senior center or library may be able to help you get this information. You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. TTY users should call 1-877-486-2048.

What is Medicare Part A?

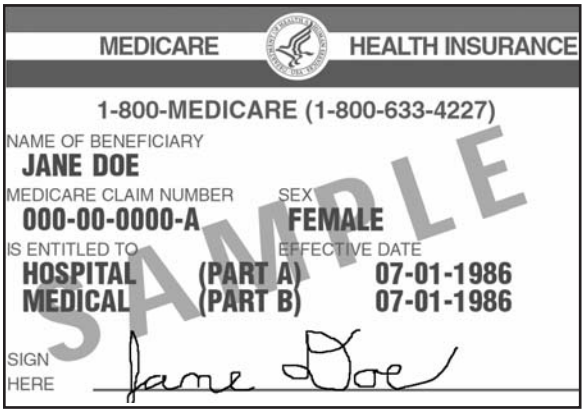
Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. You must meet certain conditions to get these benefits.

Cost: Most people don't have to pay a monthly payment, called a premium, for Part A. This is because they or a spouse paid Medicare taxes while working.

If you don't get premium-free Part A, you may be able to buy it if

- you (or your spouse) aren't entitled to Social Security, because you didn't work or didn't pay Medicare taxes while you worked and are age 65 or older, or
- you are disabled but no longer get free Part A because you have been working for a long time.

If you have limited income and resources, your state may help you pay for Part A (see page 78). For more information, you can look at www.socialsecurity.gov or call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.



If you aren't sure if you have Part A, look on your red, white, and blue Medicare card (see sample card on the left). If you have Part A, "Hospital (Part A)" is printed on the lower left corner of your card.

Note: Earlier versions of this card are slightly different. They are still valid.

Do you need to replace your Medicare card? If your card is lost or damaged, you can order a new Medicare card at www.socialsecurity.gov on the web. In the "Questions about:" box select "Medicare." Then, select number five from the "Subject" list. Or, you can call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772, or look at www.rrb.gov on the web and select "Mainline Services."

Enrolling in (Joining) Part A

If you're already getting benefits from Social Security or the Railroad Retirement Board, you will automatically get Medicare Part A starting the first day of the month you turn age 65. If you're under age 65 and disabled, you will automatically get Medicare Part A after you get disability benefits from Social Security or the Railroad Retirement Board (RRB) for 24 months.* If you're close to age 65 and aren't yet getting Social Security or Railroad Retirement benefits, you must apply for Medicare Part A.

* There is no 24-month waiting period for those who have ALS (Amyotrophic Lateral Sclerosis).

Important: Even if your full retirement age for Social Security or Railroad Retirement benefits is older than age 65, you are still eligible for Medicare at age 65.

Call the Social Security Administration at 1-800-772-1213 for more information. If you get Railroad Retirement benefits, call your local RRB office or 1-800-808-0772.

Medicare Part A Helps Cover Your Medically Necessary

Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care you get in critical access hospitals 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 facility is limited to 190 days in a lifetime.

Skilled Nursing Facility Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related three-day inpatient hospital stay).

Home Health Care: Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language therapy which are ordered by your doctor. Also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice Care: For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in your home (which may include a nursing facility if this is your home). However, Medicare covers some short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).

Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.

What is Medicare Part B?

Medicare Part B (Medical Insurance) helps cover your doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary (see pages 25–33).

Cost: You pay the Medicare Part B premium each month ($78.20 in 2005). In some cases, this amount may be higher if you didn't sign up for Part B when you first became eligible. The cost of 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, except in special cases (see Special Enrollment Period on page 23). You will have to pay this extra amount as long as you have Part B.

You also pay a $110 (in 2005) Part B deductible each year before Medicare starts to pay its share. The Part B deductible will increase each year. You may be able to get help from your state to pay this premium and deductible (see page 78).

Medicare deductible and premium rates may change every year in January. If you get Social Security or Railroad Retirement Board benefits, the new premium and deductible rates are sent to you each December with your cost of living adjustment notice. After December 1, 2004, you can also get the premium and deductible rates for 2005 by looking at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Enrolling in (Joining) Part B

Enrolling in Part B is your choice. If you already get Social Security or Railroad Retirement benefits, you're automatically enrolled in Part B starting the first day of the month you turn age 65. If you are under age 65 and disabled, you are automatically enrolled in Part B after you get Social Security or Railroad Retirement benefits for 24 months.* Your Medicare card (see sample card on page 18) will be mailed to you about three months before your 65th birthday or your 25th month of disability benefits. **If you don't want Medicare Part B, follow the instructions that come with your Medicare card.**

* There is no 24-month waiting period for those who have ALS (Amyotrophic Lateral Sclerosis).

Enrolling in (Joining) Part B (continued)

If you choose to enroll in Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Office of Personnel Management Retirement payment. In these cases, you **won't** get a bill for your premium. If you don't get any of these payments, Medicare sends you a bill for your Part B premium every three months. If you don't get your bill by the 10th of the month, call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

There are three times when you can sign up for Medicare Part B:

1. Initial Enrollment Period (see below)
2. General Enrollment Period (see page 22)
3. Special Enrollment Period (see page 23)

1. Initial Enrollment Period

If you are turning age 65 in the next three months and haven't applied for Social Security or Railroad Retirement benefits, or Medicare Part A, you can sign up for Medicare Part B when you apply for retirement benefits or Medicare Part A. You can sign up for Part B during your Initial Enrollment Period. The Initial Enrollment Period

- begins three months before the month you turn age 65, and
- ends three months after the month you turn age 65.

Note: Your start date for Medicare Part B will be delayed if you sign up the month you turn age 65 or sign up the last three months of your Initial Enrollment Period.

Note: Look at www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to help you make decisions about enrolling in (joining) Medicare Part B.

For more information, call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. If you are a railroad employee or railroad retirement beneficiary, call your local RRB office or 1-800-808-0772 to apply.

Important: Although the eligibility age to get full Social Security or Railroad Retirement benefits now depends on the year you were born, it doesn't affect the Medicare eligibility age (age 65). The eligibility age to get Medicare **isn't** changing.

Enrolling in (Joining) Part B (continued)

2. General Enrollment Period

If you didn't sign up for Medicare Part B when you first became eligible, you may sign up during the General Enrollment Period:

- The General Enrollment Period runs from January 1 through March 31 of each year.
- To apply, call the Social Security Administration 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.
- Your Medicare Part B coverage will start on July 1 of the year you sign up.
- The cost of Medicare Part B will go up 10% for each full 12-month period that you could have had Medicare Part B but didn't take it, except in special cases (see page 23). You will have to pay this extra amount as long as you have Medicare Part B.

Enrolling in (Joining) Part B (continued)

3. Special Enrollment Period

This period is available if you are eligible for Medicare and waited to enroll in Medicare Part B because you or your spouse were working and had group health plan coverage through an employer or union based on this **current** employment. If this applies to you, you can sign up for Medicare Part B

- anytime you are still covered by an employer or union group health plan, through your or your spouse's **current** employment, or
- during the eight months following the month that the employer or union group health plan coverage ends, or when the employment ends (**whichever is first**).

Note: If you are still working and plan to keep your employer's group health plan coverage, you should talk to your benefits administrator or your State Health Insurance Assistance Program (see pages 93–95 for their telephone number) to help you decide the best time to enroll in Medicare Part B. When you sign up for Medicare Part B, you automatically begin your six-month Medigap (Medicare Supplement Insurance) open enrollment period. Once your Medigap open enrollment period begins, it can't be changed or restarted. For more details about Medigap policies, see pages 74–76.

If you are disabled and working (or have group health plan coverage from a working family member), the Medicare Special Enrollment Period rules may also apply. For more information about the Medicare Special Enrollment Period, get a free copy of *Enrolling in Medicare* (CMS Pub. No. 11036). Look on page 83 to see how to get this booklet.

Remember, most people who sign up for Medicare Part B during a Special Enrollment Period don't pay higher premiums. However, if you are eligible but don't sign up for Medicare Part B during the **Special Enrollment Period**, you will only be able to sign up during the **General Enrollment Period** (see page 22), and the cost of Medicare Part B may go up.

For more information about signing up for Medicare Part A and Part B, call the Social Security Administration 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.

Part B and COBRA Coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) is a law that may let you keep your employer group health plan coverage for a limited period of time after your employment ends or after you lose coverage as a dependent of the covered employee. Even if you elect to get COBRA coverage when your employer coverage ends, you should still consider enrolling in Medicare Part B at the same time because you **won't** get another Special Enrollment Period (SEP). The SEP means you will have to sign up for Medicare Part B within eight months after your group health plan coverage ends or when you lose coverage.

If you are age 65 or older and you are covered under COBRA, your employer group health plan may require you to sign up for Medicare Part B. In that case, the best time to sign up for Medicare Part B is **before** your employment ends or you lose your employer's coverage. If you wait to sign up for Medicare Part B during the eight months **after** your employment or coverage ends, your employer could make you pay for services that Medicare would have paid for if you had signed up earlier.

If you don't sign up for Medicare Part B during the eight-month period (SEP) after your employment ends or when you lose coverage, whichever comes first, you will only be able to sign up during the General Enrollment Period (see page 22) and the cost of Medicare Part B may go up.

Remember: Once you're age 65 or older and you enroll in Medicare Part B, your Medigap open enrollment period starts and it can't be changed.

Before you elect COBRA coverage, it may be helpful to talk with your State Health Insurance Assistance Program about whether buying a Medigap policy would be better for you than electing COBRA coverage. See pages 93–95 for their telephone number.

Note: If you have COBRA coverage when you first enroll in Medicare, your COBRA coverage may end. Your employer has the option of canceling your COBRA coverage if your first Medicare enrollment is after the date you elected COBRA coverage.

Part B and Group Health Plan Coverage

If you have Part B and then drop it because you, your spouse, or a family member is working and have group health plan coverage through the employer or union, you can sign up for Part B again during a Special Enrollment Period. It's important to make sure that your group health plan coverage is in effect before you drop Part B. In this case, the cost of Part B won't go up when you get it again. Remember, when you drop Part B, your coverage ends the last day of the next month. Also, if you drop Part B after age 65, you won't get another Medigap open enrollment period when you restart Part B (see pages 74–76).

Medicare Part B Helps Cover Your Medically Necessary

Medical and Other Services: Doctors' services (not routine physical exams)*, outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). It also covers a second, and sometimes a third, surgical opinion for surgery that **isn't** an emergency (in some cases), outpatient mental health care, and outpatient occupational and physical therapy, including speech-language therapy. (These services are also covered for long-term nursing home residents.)

Clinical Laboratory Services: Blood tests, urinalysis, some screening tests, and more.

Home Health Care: Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language therapy which are ordered by your doctor. Also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Outpatient Hospital Services: Hospital services and supplies received as an outpatient as part of a doctor's care.

Blood: Pints of blood you get as an outpatient or as part of a Part B-covered service.

* If your Part B coverage begins on or after January 1, 2005, Medicare will cover a "Welcome to Medicare" one-time physical examination within the first six months you have Part B.

Preventive Services to Help You Stay Healthy

Medicare Part B-Covered Preventive Services	Who is Covered
Bone Mass Measurements: Once every 24 months for qualified individuals and more frequently if medically necessary.	Discuss with your doctor to see if you qualify.
NEW—Cardiovascular Screening Blood Tests: Talk to your doctor about how often you can get these screening tests. Starting January 1, 2005, includes blood tests to check cholesterol, lipid or triglyceride levels, and other tests for early detection of, or to identify a high risk for developing, cardiovascular disease. How frequently these tests are covered had not been decided at the time this handbook was printed.	Discuss with your doctor to see if you qualify.
Colorectal Cancer Screening: Fecal Occult Blood Test (FOBT)—Once every 12 months. Flexible Sigmoidoscopy—Once every 48 months. Colonoscopy—Once every 24 months if you are at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy. Barium Enema—Doctor can use this instead of a flexible sigmoidoscopy or colonoscopy. It's covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.	All people with Medicare age 50 and older. **Note:** There is no minimum age for having a colonoscopy.

Preventive Services to Help You Stay Healthy (continued)

Medicare Part B-Covered Preventive Services	Who is Covered
NEW—Diabetes Services: Diabetes Screening Tests—Talk to your doctor about how often you can get these screening tests. Includes fasting plasma glucose test. How frequently these tests are covered had not been decided at the time this handbook was printed.	Certain people with Medicare who are at risk for diabetes, starting January 1, 2005.
Diabetes Self-Management Training	Certain people with Medicare who are at risk for complications from diabetes. Your doctor or other health care provider must request this service.
Glaucoma Testing: Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.	People with Medicare who are in one of the following groups at high risk for glaucoma: people with diabetes, a family history of glaucoma, or African Americans age 50 and older.
Pap Test and Pelvic Examination (Includes a clinical breast exam): Once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months.	All women with Medicare.

Preventive Services to Help You Stay Healthy (continued)

Medicare Part B-Covered Preventive Services	Who is Covered
Prostate Cancer Screening: Digital Rectal Examination—Once every 12 months. Prostate Specific Antigen (PSA) Test—Once every 12 months.	All men with Medicare age 50 and older (coverage begins the day after your 50th birthday).
Screening Mammograms: Once every 12 months. Medicare also covers digital technologies for mammogram screening.	All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.
Shots (vaccinations):	
Flu Shot*—Once a flu season in the fall or winter.	All people with Medicare.
Pneumococcal Shot—One shot may be all you ever need. Ask your doctor.	All people with Medicare.
Hepatitis B Shots	Certain people with Medicare at medium to high risk for Hepatitis B.
NEW—"Welcome to Medicare" Physical Examination: One time only, within the first six months you have Part B. Includes measurement of height, weight and blood pressure, an EKG, education, and counseling.	People whose Part B coverage begins on or after January 1, 2005.

*** Why should I get a flu shot every year?** The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 65 and older and people of any age with certain chronic medical conditions. You need a flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect you from the flu for about one year. There is a chance that you may still get the flu, but your symptoms will be less severe.

Other Services and Items

The chart below and on pages 30–33 lists specific services and items that Medicare covers. If a service or item isn't listed, call 1-800-MEDICARE (1-800-633-4227) for information about the type of service or item you need. TTY users should call 1-877-486-2048. You can also find more detailed information about what Medicare covers by looking at www.medicare.gov on the web. Select "Your Medicare Coverage."

Some of the topics listed in the charts are discussed in more detail in other booklets. To see a listing of available booklets and information on how to get these booklets, see pages 83–84.

Important: These services and items are covered no matter what kind of Medicare health plan you have. The amount Medicare pays for these services and items depends on the type of health plan you have (see page 36).

Service or Item	What Medicare Covers
Ambulance Services	Ambulance services when it's medically necessary for you to be transported by ambulance to a hospital or skilled nursing facility, and transportation in any other vehicle would endanger your health. Medicare pays for ambulance transport to the nearest hospital or skilled nursing facility that provides the services you need.
Chiropractic Services	Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine moves out of position).
Clinical Trials	Routine costs if you take part in a qualifying clinical trial. Clinical trials test new types of medical care, like how well a new cancer drug works. Clinical trials help doctors and researchers see if the new care works and if it's safe. It's important for you to ask what costs you will have to pay before signing up for a clinical trial. **Note:** Medicare doesn't cover the cost of experimental care, such as the drugs or devices being tested in a clinical trial.

Other Services and Items (continued)

Service or Item	What Medicare Covers
Dental Services	Medicare doesn't cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures. In rare cases, Medicare Part B will pay for certain dental services. In addition, Medicare Part A may pay for certain hospital stays for severe or complicated dental procedures, even when the dental care itself isn't covered. Some Medicare Advantage Plans may offer additional dental coverage.
Diabetic Supplies	Medicare covers glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes (in some cases). There may be limits on supplies or how often you get them. You should ask if the pharmacy or supplier is enrolled in the Medicare program (see page 52). **Note:** Syringes and insulin (unless used with an insulin pump) aren't covered.
Durable Medical Equipment	Items such as oxygen, wheelchairs, walkers, and hospital beds needed for use in the home.
Emergency Room Services (A medical emergency is when you believe that your health is in serious danger—when every second counts. You may have a bad injury, sudden illness, or an illness quickly getting much worse.)	Medicare covers emergency room services.

Other Services and Items (continued)

Service or Item	What Medicare Covers
Eyeglasses	One pair of eyeglasses with standard frames that include an intraocular lens after cataract surgery.
Foot Exams	These exams are covered if you have diabetes-related nerve damage and meet certain conditions.
Hearing and Balance Exams	These exams are covered if your doctor orders them to see if medical treatment is needed. Routine screening exams aren't covered.
Kidney Dialysis Services	Kidney dialysis, and services and supplies, either in a facility or at home.
Long-term Care	Most long-term care, in a nursing home or at home, is custodial care (help with activities of daily living such as bathing, dressing, using the bathroom, and eating). **Medicare doesn't cover long-term care**, since it can't cover custodial care when that is the only kind of care you need. Medicare Part A only covers skilled care given in a certified skilled nursing facility or in your home. You must meet certain conditions for Medicare to pay for skilled care when you get out of the hospital.
Medical Nutrition Therapy Services	These services are covered for people who have diabetes or kidney disease (unless you are on dialysis) with a doctor's referral. Medical nutrition therapy services are covered for three years after a kidney transplant.

Other Services and Items (continued)

Service or Item	What Medicare Covers
Mental Health Care	Medicare Part A covers inpatient mental health care, including room, meals, nursing, and other related services and supplies. Medicare Part B covers mental health services generally given outside a hospital, including visits with a doctor, clinical psychologist, or clinical social worker, and lab tests. Medicare Part B also covers partial hospitalization services for people who need intensive coordinated outpatient care to help them avoid inpatient treatment.
Practitioner Services	Services provided by clinical social workers, physician assistants, and nurse practitioners.
Prescription Drugs	Except in a few cases (like certain cancer drugs), the Original Medicare Plan doesn't cover outpatient prescription drugs. If you are eligible to get drugs that are covered, you should ask if the pharmacy is enrolled in the Medicare program (see page 52). If the pharmacy isn't enrolled, Medicare won't pay. **Note:** Medicare's new prescription drug coverage will start on January 1, 2006. Medicare-approved drug discount cards are available now. See pages 7–15 for more information.

Other Services and Items (continued)

Service or Item	What Medicare Covers
Prosthetic/Orthotic Items	■ 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) **Note:** These items are considered durable medical equipment.
Second Surgical Opinions	Second surgical opinion by a doctor (in some cases). Sometimes, a third opinion may be covered.
Surgical Dressings	Dressings required for the treatment of a wound.
Telemedicine	Services in some rural areas.
Tests	X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests if medically necessary.
Transplant Services	Heart, lung, kidney, pancreas, intestine, and liver transplants (under certain conditions and in Medicare-certified facilities only), and bone marrow and cornea transplants (under certain conditions). Oral immunosuppressive drugs if the transplant was paid for by Medicare, or paid by an employer group health plan that was required to pay before Medicare. 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.
Travel (outside the United States)	Except for some emergency services in Mexico and Canada, the Original Medicare Plan doesn't cover health care when you travel outside the United States. Some Medicare Advantage Plans, Medigap policies, and the Railroad Retirement Board have different rules. Check your insurance coverage before you travel outside the United States.
Urgently Needed Care (care you need for sudden illness or injury that isn't a medical emergency)	Medicare Part B covers urgently needed care.

Using Doctors Who Don't Accept Medicare

Some doctors don't accept Medicare payments. If you want to get care from a doctor who doesn't accept Medicare payment, you may be asked to sign a private contract. A private contract is a written agreement between you and a doctor who has decided not to participate in the Medicare program. The private contract only applies to the services you get from the doctor (such as a physician, dentist, podiatrist, or optometrist) who asked you to sign it. You can't be asked to sign a private contract in an emergency situation or when you get urgently needed care.

If you sign a private contract with your doctor

- you will have to pay whatever this doctor or provider charges you for the services you get. Medicare's limiting charge won't apply.
- no claim should be submitted to Medicare, and Medicare won't pay if one is submitted.
- your Medigap policy, if you have one, won't pay anything for this service.
- Medicare health plans won't pay any amount for the services you get from this doctor.
- your doctor must tell you whether Medicare would 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 opted out of, or been excluded from, the Medicare program.

You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract (see pages 93–95 for their telephone number).

Medicare Health Plan Choices

Section 6

The Medicare Modernization Act of 2003 brought you more choices in how you get your Medicare health care. Just like the choices working Americans have in getting their health care, Medicare gives you choices to meet your individual health care needs.

Things to consider when choosing

- **Cost**—What you pay out-of-pocket.
- **Benefits**—Extra benefits and services, like eye exams or hearing aids may be covered.
- **Doctor choice**—Can you see the doctor(s) you want to see? Do you need a referral to see a specialist?
- **Convenience**—Where are the doctors' offices? What are their hours? Is there paperwork?
- **Quality of care**—All plans must meet quality standards. Medicare measures the quality of the care people like you get in many Medicare health plans.

  This quality information is available at www.medicare.gov on the web. Select "Medicare Personal Plan Finder." Once you have information on plans in your area, select "Quality" at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227) and ask for information about health plan quality. TTY users should call 1-877-486-2048.

These are all important, but some may be more important to you than others. You need to look at which plans are available in your area and what each plan offers. Then make the best choice for you.

Remember, blue words in the text are defined on pages 85–88.

Health plan choices for 2005

The Original Medicare Plan—This is the traditional fee-for-service Medicare plan that is available nationwide. You can see any doctor or provider. No referrals are necessary. For more information about how the Original Medicare Plan works and what your costs are, see pages 39–52.

The Original Medicare Plan covers most health care services and supplies, but it doesn't cover everything. For additional coverage, you can buy a Medigap (Medicare Supplement Insurance) policy (see pages 74–76). Or, you may choose a Medicare Advantage Plan (see below).

Medicare Advantage Plans—Medicare Advantage is the new name for Medicare + Choice. Medicare Advantage Plans are available in most areas of the country. You must have both Medicare Part A **and** Part B to join one of these plans. You may pay lower copayments and get extra benefits, such as coverage for days in the hospital. For more information about how each type of Medicare Advantage Plan works and what your costs are, see the pages shown below.

Medicare Advantage Plans include

- **Medicare Managed Care Plans (see pages 55–56)**—You see doctors in the plan's network. A primary doctor coordinates your health care. Referrals are required for most services and to see doctors out of the plan's network.
- **Medicare Preferred Provider Organization Plans (PPOs) (see page 56)—**You can see any doctor, but it costs less to see doctors in the plan's network. No referrals are necessary.
- **Medicare Private Fee-for-Service Plans (see page 57)**—You can see any doctor that accepts the plan's payment. No referrals are necessary.
- **Medicare Specialty Plans (see page 57)**—A special type of plan that provides more focused health care for specific people.

Your choices may be different if you are enrolled in Medicaid (see page 79), employer or union coverage (see page 73), veterans or military retiree benefits (see page 77), or have End-Stage Renal Disease (permanent kidney failure) (see page 61).

Whether you get your Medicare health care coverage from a Medicare Advantage Plan or the Original Medicare Plan you are still in the Medicare program.

Medicare Advantage Plans and the Original Medicare Plan are all part of the Medicare program. No matter how you choose to get your health care coverage

- Medicare pays for most health care services and supplies, but it doesn't pay for all health care costs.
- you get at least all the Medicare Part A-covered services listed on page 41.
- you get at least all the Medicare Part B-covered services listed on pages 42–43 if you pay the monthly Part B premium ($78.20 in 2005).

Remember, you must have Medicare Part A **and** Part B to join a Medicare Advantage Plan.

For more information to help you make your health care choice

- learn how each type of health plan works (see pages 55–57).
- see what Medicare health plans are available in your area (look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder." See page 38).
- get information on the quality of the health plans in your area (see page 35).
- learn about other types of coverage like Medigap (Medicare Supplement Insurance) policies, coverage from employers and unions, states, special programs, and coverage for military retirees and veterans (see pages 73–80).

Decide what's important to you, and make your best decision. If you are happy with your health care coverage now, you don't have to change.

Medicare provides step-by-step help choosing a Medicare health plan on the web or by telephone (see the next page).

Help for Choosing the Right Plan for You

Choosing the right health care coverage is an important-but sometimes difficult – decision. The "Medicare Personal Plan Finder" helps you narrow down your Medicare health plan choices, and choose the plan that best meets your needs. You can also get important information about special programs that might help you pay health care costs that Medicare doesn't cover.

You can get personalized information two ways:

1. Visit www.medicare.gov on the web for fast results. Select "Medicare Personal Plan Finder."
2. Call 1-800-MEDICARE (1-800-633-4227). Follow the instructions to speak to a Customer Service Representative who will help you with the "Medicare Personal Plan Finder." You will get your results in the mail within three weeks.

When you use the "Medicare Personal Plan Finder," you will get a personalized summary page with information to help you compare plans in your area. You can also get detailed information about all the plans available in your area, or just the ones you are most interested in.

You will need to answer some simple questions, including

- Do you have Medicare Part A and/or Part B?
- Are you over age 65?
- Do you have other health insurance coverage?
- What is your ZIP code?

If you want information about programs that may help with your health care costs, you will need to answer additional questions about your income and resources. Any information you give is always kept private.

If you want more help choosing a Medicare health plan, call your State Health Insurance Assistance Program (see pages 93–95 for their telephone number). You can get help over the telephone or in person.

Original Medicare Plan

What is the Original Medicare Plan?

The Original Medicare Plan is a "fee-for-service" plan. This means you are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care (see the sample card on page 18).
If you are happy getting your health care through the Original Medicare Plan, you don't have to change to another Medicare health plan. You will stay in the Original Medicare Plan unless you choose to join another type of Medicare health plan.

How does the Original Medicare Plan work?

- You may go to any doctor or specialist who accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility. Generally, a fee is charged each time you get a health care service.
- If you have Medicare Part A, you get all the Part A-covered services listed on page 41.
- If you have Medicare Part B, which has a monthly premium of $78.20 in 2005, you get all the Part B-covered services listed on pages 42–43.
- You pay a set amount for your health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment).
- After you get a health care service, each month you get a Medicare Summary Notice in the mail (see pages 46–49). This notice is sent by companies that handle bills for Medicare. The notice lists the amount you may be billed.

Remember, blue words in the text are defined on pages 85–88.

Your costs in the Original Medicare Plan

What you pay out-of-pocket depends on

- whether you have Part A and/or Part B (most people have both).
- whether your doctor or supplier accepts "assignment" (see page 52).
- 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 for these services yourself.
- whether you have other health insurance coverage.

Note: In most cases, Medicare doesn't pay for health care you get while traveling outside of the United States (see page 33).

The charts on the next few pages show what you pay in the Original Medicare Plan. For details about these covered services, see page 19 for Part A and pages 25–33 for Part B.

See pages 73–80 for information about help to cover the costs that the Original Medicare Plan doesn't cover.

Medicare Part A (Hospital Insurance) Helps Pay For:

What YOU Pay in the Original Medicare Plan

(The amounts shown are for 2005. These amounts might change January 1, 2006. For more information on coverage, see page 19.)

Hospital Stays

For each benefit period YOU pay

- A total of $912 for a hospital stay of 1–60 days.
- $228 per day for days 61–90 of a hospital stay.
- $456 per day for days 91–150 of a hospital stay. (See Lifetime Reserve Days on page 86.)
- All costs for each day beyond 150 days.

If you have questions about quality of care in hospitals, call 1-800-MEDICARE (1-800-633-4227).

Skilled Nursing Facility Care

Look on page 83 to see how to get a free booklet for more information.

For each benefit period YOU pay

- Nothing for the first 20 days.
- $114 per day for days 21–100.
- All costs beyond the 100th day in the benefit period.

If you have questions about skilled nursing facility care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227).

Home Health Care

Look on page 83 to see how to get a free booklet for more information.

YOU pay

- Nothing for Medicare-approved services.
- 20% of the Medicare-approved amount for durable medical equipment.

If you have questions about home health care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227).

Hospice Care

Look on page 83 to see how to get a free booklet for more information.

YOU pay a copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (short-term care given to a hospice patient so that the usual caregiver can rest). The amount you pay for respite care can change each year. Medicare generally doesn't pay for room and board except in certain cases. For example, room and board aren't covered if you get general hospice services while a resident of a nursing home or a hospice's residential facility. However, room and board are covered for inpatient respite care and during short-term hospital stays.

If you have questions about hospice care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227).

Blood

YOU pay for the first three pints of blood, unless you or someone else donates blood to replace what you use.

Section 7: Original Medicare Plan

Medicare Part B (Medical Insurance) Helps Pay For:

What YOU Pay in the Original Medicare Plan

(For more information on coverage, see pages 25–33.)

Medical and Other Services

Each year YOU pay

- $110 (in 2005) deductible (once per calendar year). This amount can change each year.
- 20% of the Medicare-approved amount after the deductible (if the doctor, provider, or supplier accepts "assignment," see page 52).
- 20% for all outpatient physical, occupational, and speech-language therapy services.
- 50% for most outpatient mental health care.

Clinical Laboratory Services

YOU pay nothing for Medicare-approved services.

Home Health Care

Look on page 83 to see how to get a free booklet for more information.

YOU pay

- Nothing for Medicare-approved services.
- 20% of the Medicare-approved amount for durable medical equipment.

If you have questions about home health care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227).

Outpatient Hospital Services

Look on page 83 to see how to get a free booklet for more information.

YOU pay a coinsurance or copayment amount, which may vary according to the service.

Blood

YOU pay for the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

Note: Actual amounts you must pay may be higher if the doctor or supplier doesn't accept assignment, **and you may have to pay the entire charge at the time of service**. Medicare will then send you its share of the charge (see page 52).

If you have general questions about Medicare Part B, or durable medical equipment, including diabetic supplies, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Medicare Part B Covered Preventive Services	What YOU pay in the Original Medicare Plan (For more information on coverage, see pages 26–28. Look on page 83 to see how to get a free booklet for more information.)
Bone Mass Measurements	20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.
Cardiovascular Screening Blood Tests	No coinsurance or Part B deductible for lab tests. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible.
Colorectal Cancer Screening	Nothing for the fecal occult blood test (FOBT). For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount after the yearly Part B deductible if the test is done in a hospital outpatient department.
Diabetes Services	No coinsurance or Part B deductible for diabetes screening lab tests. For all other tests and services, 20% of the Medicare-approved amount after the yearly Part B deductible.
Glaucoma Testing	20% of the Medicare-approved amount after the yearly Part B deductible.
Pap Test and Pelvic Examination (includes a clinical breast exam)	Nothing for the Pap lab test. For Pap test collection, and pelvic and breast exams, 20% of the Medicare-approved amount (or a copayment amount) with no Part B deductible.
Prostate Cancer Screening	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA (Prostate Specific Antigen) test.
Screening Mammograms	20% of the Medicare-approved amount with no Part B deductible.
Shots (vaccinations)	Nothing for flu and pneumococcal shots if the health care provider accepts assignment (see page 52). For Hepatitis B shots, 20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.
"Welcome to Medicare" Physical Examination	20% of the Medicare-approved amount after the yearly Part B deductible.

What isn't paid for by Medicare Part A and Part B in the Original Medicare Plan?

The Original Medicare Plan doesn't cover everything. Items and services that aren't covered include, but aren't limited to

- Acupuncture.
- Deductibles, coinsurance, or copayments when you get health care services (see the "What YOU Pay" part of the charts on pages 41–43).
- Dental care and dentures (with only a few exceptions).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- Health care you get while traveling outside of the United States (except in limited cases).
- Hearing aids and hearing exams for the purpose of fitting a hearing aid.
- Hearing exams (screening) unless ordered by your doctor.
- Long-term care, such as custodial care in a nursing home.
- Orthopedic shoes (with only a few exceptions).
- Outpatient prescription drugs (with only a few exceptions).
- Routine foot care (with only a few exceptions).
- Routine eye care and most eyeglasses (see page 31).
- Routine or yearly physical exams. (If your Part B coverage begins on or after January 1, 2005, Medicare will cover a one-time physical examination within the first six months you have Part B.)
- Screening tests and labs except those listed on pages 26–28.
- Shots (vaccinations) except those listed on page 28.
- Some diabetic supplies (like syringes or insulin unless it is used with an insulin pump).

See pages 73–80 for information about help to cover the costs that the Original Medicare Plan doesn't cover.

How are my bills paid in the Original Medicare Plan?

For Part A Services and Some Part B Services

The provider of the covered service such as a hospital or home health agency must send a claim to your Fiscal Intermediary or your Regional Home Health Intermediary.

For Part B Services and Supplies

The provider of the covered service or supply must send a claim to your Medicare Carrier or your Durable Medical Equipment Regional Carrier.

You get a Medicare Summary Notice (MSN) for Part A and for Part B services. The MSN lists all the services or supplies that were billed to Medicare for a 30-day period. Check this notice to be sure you got all the services, medical supplies, or equipment that providers billed to Medicare. **The MSN isn't a bill**. Don't pay unless you get a bill from the provider.

- Questions about the charges? Call the provider of the service or supply.
- Think a service you got should be covered? You can appeal (see page 65).
- Think the provider is being dishonest? Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What is the Electronic Medicare Summary Notice (e-MSN)?

Medicare has a new service in some areas. The electronic Medicare Summary Notice (e-MSN) is a simple and convenient way to get a copy of your MSNs. You can look at your MSNs on the web and print copies right from your own computer, 24 hours a day, seven days a week. The e-MSN **doesn't** replace the paper MSN currently mailed each month when a claim is processed. You will still get a paper copy.

This service is being tested in some areas to evaluate its benefit before Medicare makes it available for all people with Medicare. To see if e-MSNs are available in your area, look at www.medicare.gov on the web. Select "Frequently Asked Questions" and search for "e-MSN."

How do I read the Medicare Summary Notice (MSN)?

Below is a sample MSN for Part B services, and information on how to read it. You could also get a MSN for Part A services and for durable medical equipment.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice

SAMPLE

1–June 16, 2005

CUSTOMER SERVICE INFORMATION — 2

Name —4
Street Address
City, State ZIP Code

3–**Your Medicare Number: 111-11-1111-A**

If you have questions, write or call:
Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Call: 1-800-MEDICARE (1-800-633-4227)
Ask For Doctor Services
TTY users should call 1-877-486-2048.

5
BE INFORMED: Protect your Medicare Number as you would a credit card number.

This is a summary of claims processed from 5/15/05 through 6/15/05.

6
PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 12345-84956-84556 —7						14
Doctor name, Street Address, City, State ZIP Code 8		10	11	12	13	a
		$55.00	$44.35	$0.00	$44.35	b
04/07/05 9	1 Office/Outpatient Visit, ES (99214) 15					

THIS IS NOT A BILL - **Keep this notice for your records.**

See page 48 for the rest of the Medicare Summary Notice.

See next page for an explanation of the numbered items 1-15.

Explanation of Numbered Items on the front of the Medicare Summary Notice (MSN)

1. **Date:** Date the MSN was sent.
2. **Customer Service Information:** Who to contact with MSN questions. Give your Medicare number (3), the date of the MSN (1), and the date of service you have a question about (9).
3. **Medicare Number:** The number on your Medicare card.
4. **Name and Address:** If incorrect, call the Social Security Administration at 1-800-772-1213 immediately. If you get Railroad Retirement Board (RRB) benefits, call your local RRB office or 1-800-808-0772.
5. **Be Informed:** Messages about ways to protect yourself and Medicare from fraud and abuse.
6. **Part B Medical Insurance—Assigned Claims:** Type of service. See back of MSN for information about assignment. (Note: For unassigned services, this section is called **"Part B Medical Insurance—Unassigned Claims."**)
7. **Claim Number:** Number that identifies this specific claim.
8. **Provider's Name and Address:** Doctor (may show clinic, group, and/or referring doctor) or provider's name and billing address.
9. **Dates of Service:** Date service or supply was received. You may use these dates to compare with the dates shown on the bill you get from your doctor.
10. **Amount Charged:** Amount the provider billed Medicare.
11. **Medicare Approved:** Amount Medicare approves for this service or supply.
12. **Medicare Paid Provider:** Amount Medicare paid to the provider. (**Note:** For unassigned claims, this column is called **"Medicare Paid You."**)
13. **You May Be Billed:** Total amount provider may bill you, including deductibles, coinsurance, and non-covered charges. Medigap (Medicare Supplement Insurance) policies may pay all or part of this amount.
14. **See Notes Section:** If letter appears, refer to (16) for explanation.
15. **Services Provided:** Brief description of the service or supply received.

Medicare Summary Notice (continued)

Notes Section: —16

a This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.
b This approved amount has been applied toward your deductible.

Deductible Information: —17

You have now met $44.35 of your $110 Part B deductible for 2005.

General Information: —18

Please notify us if your address has changed or is incorrect as shown on this notice.

Appeals Information - Part B —19

If you disagree with any claims decision on this notice, you can request an appeal by October 16, 2005.

Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1. (You may also send any additional information you may have about your appeal.)

3) Sign here_____Phone Number (___)_____

See next page for an explanation of the numbered items 16-19.

Explanation of Numbered Items on the back of the Medicare Summary Notice (MSN)

16. **Notes Section:** Explains letters in (14) for more detailed information about your claim.

17. **Deductible Information:** How much of your yearly deductible you have met.

18. **General Information:** Important Medicare news and information.

19. **Appeals Information:** How and when to request an appeal.

    Note: See the back of your MSN for more information and how to get help with appeal requests.

Billing Requirements

After October 1, 2005, if Medicare contracts with any new Medicare claim processing companies, the companies will be called Medicare Administrative Contractors (MACs) instead of Fiscal Intermediaries (FI), Medicare Carriers, Durable Medical Equipment Regional Carriers (DMERC), or Regional Home Health Intermediaries (RHHI).

In most cases, doctors, suppliers, and providers must send claims electronically to one of these Medicare claims processing contractors for Medicare-covered services or supplies. If the doctor, supplier, or provider bills you, you should

1. call your doctor or supplier directly and ask the doctor or supplier to file a Medicare claim electronically.

2. call 1-800-MEDICARE (1-800-633-4227) if your doctor or supplier still doesn't file a Medicare claim electronically after you have called and asked. Your Medicare Carrier or MAC will contact the doctor or supplier for you to make the doctor or supplier aware of their responsibility for filing a Medicare claim electronically.

Important: There is a time limit for filing a Medicare claim. If a claim isn't filed within this time limit, Medicare can't pay its share. The time limit may be as short as 15 months or as long as 27 months depending on when you received the service or supply. You can call 1-800-MEDICARE (1-800-633-4227) and ask what the time limit is for your doctor or supplier to file your claim. TTY users should call 1-877-486-2048.

How Medicare Decides What Is Covered

At times, Medicare makes a decision about whether a medical service or medical equipment is covered. Medicare does this after reviewing information about how a service or equipment improves health or helps manage a health problem. If Medicare makes a decision that applies to all people with Medicare, it's called a "National Coverage Determination." You can get a list of all the national coverage determinations Medicare made in the last year. Medicare will also tell you how to get information on each determination. To see all the national coverage determinations, go to www.cms.hhs.gov/mcd on the web.

How Medicare Decides What Is Covered (continued)

If there isn't an existing national coverage determination for a certain service or equipment, the Medicare Fiscal Intermediary, Carrier, or Medicare Administrative Contractor sets rules for the way Medicare claims in your local area are reviewed. These rules are also followed to decide whether a claim will be paid. The local rules can't disagree with any existing national coverage determinations. However, they can be different from one area to another. These rules are called "Local Coverage Determinations." Before December 2003, local coverage determinations used to be called "Local Medical Review Policies." You can find out if there is a local coverage determination or local medical review policy for a specific service or item. Look at www.medicare.gov on the web. Select "Your Medicare Coverage" and the item or service you need. To see all the local coverage determinations or local medical review policies, go to www.cms.hhs.gov/mcd on the web. You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. TTY users should call 1-877-486-2048.

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 pays second. Other insurance that may pay first includes: employer group health plan coverage under certain conditions, no-fault insurance, liability insurance, black lung benefits, and workers' compensation. In most cases, these types of insurance must pay first.

In some cases, if the insurance that is supposed to pay first doesn't pay promptly (that is, within 120 days), the Original Medicare Plan may make a "conditional" payment. The Medicare payment is "conditional" because it must be repaid to Medicare when the insurance that is supposed to pay first makes a payment.

It's important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you have questions about who pays first, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. For more information, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). Look on page 83 to see how to get this booklet.

What is "assignment" in the Original Medicare Plan and why is it important?

Assignment is an agreement between people with Medicare, their doctors and suppliers, and Medicare. The person with Medicare agrees to let the doctor or supplier request direct payment from Medicare for covered Part B services, equipment, and supplies. Doctors or suppliers who agree to (or must by law) accept assignment from Medicare can't try to collect more than the proper Medicare deductible and coinsurance amounts from the person with Medicare, their other insurance, or anyone else.

If assignment isn't accepted, doctors and providers may charge you more than the Medicare-approved amount. For most services, there is a limit on the amount over the Medicare-approved amount your doctors and providers can bill you. The highest amount of money you can be charged for a Medicare-covered service by doctors and other health care providers who don't accept assignment is called the limiting charge. The limiting charge is 15% over Medicare's approved amount. The limiting charge applies only to certain services and doesn't apply to supplies and equipment. **In addition, you may have to pay the entire charge at the time of service**. Medicare will send you its share of the charge when the claim is processed.

In some cases, your health care providers and suppliers must accept assignment. For example, if you get Medicare-covered prescription drugs and biologicals from a pharmacy or supplier that is enrolled in the Medicare program, the pharmacy or supplier must accept assignment.

Caution: If you get your Medicare-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare program, **Medicare won't pay**.

Doctors and suppliers must submit your claim to Medicare. For glucose test strips, all enrolled pharmacies and suppliers must submit the claim and can't charge you for this service. You can't send in the claim yourself.

For more information about assignment, get a free copy of *Does your doctor or supplier accept "assignment?"* (CMS Pub. No. 10134). Look on page 83 to see how to get this booklet. To find physicians and suppliers who participate in Medicare, look at www.medicare.gov on the web. Select "Participating Physician Directory" or "Supplier Directory." You can also call 1-800-MEDICARE (1-800-633-4227) for this information.

Medicare Advantage Plans

Section 8

What is Medicare Advantage?

Medicare Advantage is the new name for Medicare + Choice plans-and it's more than just a new name. Medicare Advantage gives you more health care coverage choices and better health care benefits.

What are Medicare Advantage Plans?

Medicare Advantage Plans are one of your health plan choices as part of the Medicare program. With Medicare Advantage, you may have the following choices

- Medicare Managed Care Plans (see pages 55–56).
  In most of these plans, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. This is called the plan's "network." You may also have to choose a primary care doctor and get referrals to see a specialist. You may pay lower copayments and get extra benefits, such as coverage for extra days in the hospital.
- Medicare Preferred Provider Organization Plans (PPOs) (see page 56).
  In most of these plans, you use doctors, specialists, and hospitals on the plan's list (network). You can go to doctors, specialists, or hospitals not on the plan's list, but it may cost extra. You don't need referrals to see doctors, specialists, or go to hospitals who aren't part of the plan's network. You may pay lower copayments and get extra benefits, such as coverage for extra days in the hospital.
- Medicare Private Fee-for-Service Plans (see page 57).
  If you join one of these plans, you can go to any doctor or hospital that accepts the terms of the plan's payment. The private company, rather than the Medicare program, decides how much it will pay and how much you pay for the services you get. You may get extra benefits, like coverage for extra days in the hospital.
- Medicare Specialty Plans (see page 57).
  These plans, if available, provide more focused health care for specific people. If you join one of these plans, you get all your Medicare health care as well as more focused care to manage a specific disease or condition.

Remember, blue words in the text are defined on pages 85–88.

What are Medicare Advantage Plans? (continued)

Medicare Advantage Plans are available in many areas of the country. They manage the Medicare coverage for their members. Medicare pays a set amount of money for your care every month to these private health plans. If Medicare Advantage Plans are available in your area, and you have Medicare Part A and Part B, you can join one and get your Medicare-covered benefits through the plan (see page 60).

If you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan. You may also have to pay a monthly premium for the extra benefits.

Note: If you have End-Stage Renal Disease, see page 61. The plan may have special rules that you need to follow.

In 2006, new regional plans will be available to everyone with Medicare in the region they serve. Other plans can decide, with Medicare's approval, to be open to everyone with Medicare in a state, or be open only in certain counties or parts of counties.

If you join a Medicare Advantage Plan

- you are still in the Medicare program.
- you still have Medicare rights and protections (see pages 65–66).
- you still get all your regular Medicare-covered services (see pages 19 and 25–33).
- you may be able to get extra benefits, such as coverage for extra days in the hospital.

You can look at www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the most up-to-date and detailed health plan information. TTY users should call 1-877-486-2048.

How does a Medicare Managed Care Plan work?

These are the general rules for how Medicare Managed Care Plans work. For some of these rules, plans may differ slightly, so it's important to read plan materials carefully.

- In most Medicare Managed Care Plans, there are doctors and hospitals that join the plan (called the plan's "network"). You may need to get most of your care and services from the plan's network. Call or get a list from the plan to see which doctors and hospitals are in the plan.

  If you want to see a doctor or use a hospital out-of-network, ask your plan and the doctor or hospital what your costs will be.

- If you join a plan, you may be asked to choose a primary care doctor. If you want to keep seeing your current doctor, call and ask if he or she is in the Medicare Managed Care Plan and can continue to see you if you join the plan. If not, you may want to ask them for a recommendation.

- If you want to change your primary care doctor, you can ask your plan for the names of other plan doctors in your area.

- Doctors can join or leave Medicare Managed Care Plans at any time. If your primary care doctor should leave your plan, your plan will notify you in advance and give you a chance to pick a new doctor.

- If you get health care outside the plan's service area, you may pay more, or it may not be covered. The service area is where the plan accepts members and where plan services are provided.

- Special rules might apply if you need emergency or urgently needed care and you aren't in your managed care plan's service area (see pages 30 and 33).

- You usually need a referral to see a specialist (such as a cardiologist). A referral is a written OK from your primary care doctor for you to see a specialist or get certain services.

- There are special rules for certain services. If you are a woman, you can go once a year, without a referral, to a specialist in the network for Medicare-covered routine and preventive women's care services. If the type of specialist you need isn't available, the plan will arrange for care outside the network.

How does a Medicare Managed Care Plan work? (continued)

- Medicare Managed Care Plans may leave the Medicare program or change their benefits and premiums. However, new plans may be available (see page 64).
- Some Medicare Managed Care Plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who aren't a part of the plan ("out-of-network"), but you may pay more.
- A few Medicare Managed Care Plans aren't Medicare Advantage Plans. Generally, these plans still work as described above and on page 55, but some rules may be different. For instance, you may be able to get non-emergency covered services from doctors and other health care providers that aren't in the plan's network. Look at your plan materials for the rules that apply to you.

How does a Medicare Preferred Provider Organization (PPO) Plan work?

Preferred Provider Organization Plans (PPOs) are among the most common and popular health plans right now for working Americans. Medicare PPOs use many of the same rules as Medicare Managed Care Plans listed above and on page 55. However, in a PPO you

- don't need referrals to see a specialist provider out-of-network. You may need plan approval before you get certain services.
- can see any doctor or provider that accepts Medicare (in most cases). However, if you go to doctors, hospitals, or other providers who aren't part of the plan ("out-of-network" or "non-preferred"), you may pay more.

Every PPO plan is different in terms of what is covered out-of-network and how much you will have to pay. Contact the PPO plan you are interested in to find out more.

NEW

In 2006, the Medicare Modernization Act allows regional PPOs to give all people with Medicare choices for Medicare health care coverage. In a regional PPO, members will have an added protection. PPOs will limit the maximum amount that members pay for care outside the network.

How does a Medicare Private Fee-for-Service Plan work?

Medicare Private Fee-for-Service Plans are fee-for-service plans offered by private companies. The general rules for how Medicare Private Fee-for-Service Plans work are below.

- You can go to any Medicare-approved doctor or hospital that is willing to give you care and accepts the terms of your plan's payment.
- You may get extra benefits not covered under the Original Medicare Plan, such as extra days in the hospital.
- The private company, rather than the Medicare program, negotiates with providers to decide how much it will pay and what you pay for the services you get.
- You may have to pay a premium to join a Medicare Private Fee-for-Service Plan. You may also have to pay other costs (such as a copayment or coinsurance) for the services you get. These costs may be different from those in the Original Medicare Plan.
- At the end of each year, the companies offering Medicare Private Fee-for-Service Plans may decide to join, stay with, or leave Medicare, or change their benefits or premiums.

How does a Medicare Specialty Plan, like a Disease Management Plan, work?

Medicare is working to create specialty plans, which are new ways to provide more focused health care for specific people. For example, these plans may be for people in certain long-term care facilities or people eligible for both Medicare and Medicaid. These Medicare specialty plans are designed to provide Medicare health care, as well as more focused care that is specially designed to treat specific groups of people or people with certain medical conditions. The goal is to provide health care in an efficient, effective, high quality manner to treat the special needs of the specific covered group.

To find out if any Medicare specialty plans are available in your area, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."

Your costs in a Medicare Advantage Plan

What you pay out-of-pocket depends on

- whether the plan charges a monthly premium in addition to your monthly Part B premium ($78.20 in 2005).
- whether the plan reduces the monthly Part B premium (see below).
- how much you pay for each visit or service.
- the type of health care you need and how often you get it.
- the types of extra benefits you need, and whether the plan covers them.

Note: To get information about your out-of-pocket costs in various plans, look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder." You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. TTY users should call 1-877-486-2048.

Saving on Your Medicare Part B Premium

Medicare Advantage Plans may pay all or part of your Medicare Part B premium. If you join a plan that offers this benefit, it may save you money. You would still get all Medicare Part A and Part B-covered services.

You should read the plan materials carefully before joining to see if the Medicare Advantage Plan you are interested in offers lower premiums. Plans decide each year if they will reduce part or all of your Medicare Part B premium.

How Your Bills Get Paid If You Have More Than One Type of Insurance

Sometimes your other insurance pays your health care bills first and your Medicare Advantage Plan pays second. Other insurance that may have to pay first includes: employer group health plan coverage (under certain conditions), no-fault insurance, liability insurance, black lung benefits, and workers' compensation. It's important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you have questions about who pays first, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. For more information about who pays first, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). Look on page 83 to see how to get this booklet.

Can I appeal my Medicare Advantage Plan's decisions?

Yes. Similar to the Original Medicare Plan, you have the right to a fair, efficient, and timely process for resolving issues related to your health plan's provision or payment of a service or item. This process is called an appeal. Your plan must tell you, in writing, how to appeal a plan decision. You have the right to file an appeal if your plan won't pay for, doesn't allow, or stops a service that you think should be covered or provided. After you file an appeal, the plan will review its decision. If waiting for a decision could harm your health, the plan must answer you within 72 hours. If your plan doesn't decide in your favor, it will send your appeal to a review organization that isn't part of the plan. See your plan's membership materials or call your plan for details about your appeal rights and how to file an appeal. You have a right to ask your plan for a copy of your file. It contains your medical history and other information about your appeal.

For more information about your appeal rights, get a free copy of *Your Medicare Rights and Protections* (CMS Pub. No. 10112). Look on page 83 to see how to get this booklet.

Joining a Medicare Advantage Plan

Who can join a Medicare Advantage Plan?

You can join a Medicare Advantage Plan if

- you have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) and continue to pay the monthly Medicare Part B premium ($78.20 in 2005).
- you live in the service area of the plan. The service area is where you must live for the plan to accept you as its member. In the case of a Medicare Managed Care Plan, it's also usually where you get services from the plan. The plan can give you more information about its service areas.
- you don't have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), except as explained on page 61.

Note: If you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan.

When can I join one of these plans?

When you first join Medicare, you can join a Medicare Advantage Plan if one is available in your area and is accepting new members. If you have been in Medicare (the Original Medicare Plan) and later choose to join a Medicare Advantage Plan, you can join

- generally, at any time in 2005. Usually, your coverage begins the first day of the month after the plan gets your enrollment form.
- between November 15 and December 31, if the Medicare Advantage Plan only accepts new members during this election period.

Note: Some Medicare Advantage Plans stop accepting new members when they reach their membership limit. A plan can tell you if it is signing up new members.

Beginning January 1, 2006, you will only be able to join or leave a Medicare Advantage Plan at certain times. More information will be available throughout 2005, and the 2006 version of this handbook will have more detailed information.

Joining a Medicare Advantage Plan (continued)

How do I join a Medicare Advantage Plan?

1. Call the plan and ask for an enrollment form. Fill out the form and mail it to the plan, or

2. Get an enrollment form from a plan representative. Fill out the form and mail it to the plan, or give it to the plan representative. The plan representative can help you fill out the form.

You will get a letter from the plan telling you when your coverage begins.

Caution: You can't join more than one Medicare Advantage Plan at the same time. If you try to join more than one Medicare Advantage Plan with the same starting dates, you may not be enrolled in either plan and may remain in the Original Medicare Plan.

Special Rules for People with End-Stage Renal Disease

If you have End-Stage Renal Disease (ESRD), you usually can't join a Medicare Advantage Plan. However, if you are already in a plan, you can stay in the plan or join another plan offered by the same company in the same state. If you've had a successful kidney transplant, you may be able to join a plan.

Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare health plans. TTY users should call 1-877-486-2048.

If you have ESRD and are in a Medicare Advantage Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan. You don't have to use your one-time right to join a new Medicare Advantage 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 at a later date as long as the plan is accepting new members (described on page 60).

Joining a Medicare Advantage Plan (continued)

Can I keep my Medigap (Medicare Supplement Insurance) policy if I join a Medicare Advantage Plan?

Yes, you can keep it. However, it may cost you a lot and you may get little or no benefit from it while you are in a Medicare Advantage Plan. You can call your State Health Insurance Assistance Program if you need help deciding whether to keep your Medigap policy (see pages 93–95 for their telephone number).

If you drop your Medigap policy, you may not be able to get it back, except in certain situations. If you join a Medicare Advantage Plan when you first become eligible for Medicare at age 65, or if this is the first time you've enrolled in a Medicare Advantage Plan, you may have special Medigap protections that give you a right to buy a Medigap policy later if you choose. For more information on Medigap policies and protections, get a free copy of *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (CMS Pub. No. 02110). Look on page 83 to see how to get this booklet.

Can I join a Medicare Advantage Plan if I have employer or union coverage?

If you join a Medicare Advantage Plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your Medicare Advantage Plan coverage. 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.

How can I tell if I'm in a Medicare Advantage Plan?

When you join a Medicare Advantage Plan, you should get a membership card with the name of the plan on it. If you aren't sure if you are in a Medicare Advantage Plan, you can call the telephone number listed on your membership card. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772. Ask the Customer Service Representative to check if you are in a Medicare Advantage Plan.

Leaving a Medicare Advantage Plan

When can I leave a Medicare Advantage Plan?

In 2005, you may leave a Medicare Advantage Plan at any time for any reason. After you request to leave, your plan will let you know, in writing, the date your coverage ends. Generally, this date will be the first day of the month after you ask the plan to disenroll you.

How do I leave my Medicare Advantage Plan to join a new Medicare Advantage Plan?

You can leave your Medicare Advantage Plan to join a new Medicare Advantage Plan by enrolling in the new plan. You don't need to tell your old plan you are leaving or send them anything. You will be disenrolled automatically from your old plan when your new plan coverage begins. You should get a letter from your new plan telling you when your coverage starts.

How do I leave my Medicare Advantage Plan and return to the Original Medicare Plan?

You can leave your Medicare Advantage Plan and return to the Original Medicare Plan in one of three ways:

1. Write or call your plan
2. Call 1-800-MEDICARE (1-800-633-4227)
3. Visit, call, or write the Social Security Administration

   If you get benefits from the Railroad Retirement Board (RRB) and you want to leave your Medicare Advantage Plan, you should call your local RRB office or 1-800-808-0772.

Tell them you want to leave your Medicare Advantage Plan. The plan should send you a letter with the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

Note: If you want to change to the Original Medicare Plan and buy a Medigap policy, you need to leave your Medicare Advantage Plan in one of the three ways listed above. Simply signing up for the Medigap plan won't end your Medicare Advantage Plan coverage.

Leaving a Medicare Advantage Plan (continued)

What if I move out of the plan's service area?

You may have to leave the plan. However, you can call the health plan to see if you can stay in the plan. If you must leave the plan, follow the instructions on page 63 for leaving a Medicare Advantage Plan. You can choose to join another Medicare Advantage Plan, if one is available in your new area and they are accepting new members, or, you can choose the Original Medicare Plan. You may also have the right to buy a Medigap policy (see pages 74–76).

What can I do if my Medicare Advantage Plan leaves the Medicare program?

If your Medicare Advantage Plan leaves the Medicare program, you will be sent a notification letter. The letter will tell you if there are other Medicare Advantage Plans in your area that you may join, including the Original Medicare Plan. You will be automatically returned to the Original Medicare Plan if you don't choose to join another Medicare Advantage Plan. You may have the right to buy a Medigap policy (see pages 74–76). In this case, you should learn as much as you can about your choices before making a decision. No matter what you choose, you are still in the Medicare program and will get all Medicare-covered services. For more information, get a free copy of *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (CMS Pub. No. 02110). Look on page 83 to see how to get this booklet.

What can I do if I have to leave my Medicare Advantage Plan because my plan reduces its service area?

Your Medicare Advantage Plan may decide not to provide services in all counties or ZIP codes in an area. If your Medicare Advantage Plan reduces its service area and there are no other Medicare Advantage Plans in your area, you may be able to keep your coverage. Ask your plan. In this case, you must agree to travel to the plan's service area to get all your services (except for emergency and urgently needed care). If your plan doesn't offer this option, you will automatically return to the Original Medicare Plan on January 1. In this case, you may have the right to buy a Medigap policy (see pages 74–76).

Your Right to Appeal Denied Services

If you have Medicare, you have certain guaranteed rights. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. **No matter what kind of Medicare health plan you have, you always have the right to appeal**. Some of the reasons you may appeal are when

- a service or item isn't covered, and you think it should be.
- a service or item is denied, and you think it should be paid.
- you question the amount that Medicare paid.

Information on how to file an appeal is on the Medicare Summary Notice (if you are in the Original Medicare Plan) or in your health plan materials (if you are in a Medicare Advantage Plan). If you decide to file an appeal, ask your doctor or provider for any information that may help your case. You can also call your State Health Insurance Assistance Program for help filing an appeal (see pages 93–95 for their telephone number).

If you are in the Original Medicare Plan, you are protected from unexpected bills. A doctor or supplier may give you a notice that says Medicare probably (or certainly) won't pay for a service. If you still want to get the service, you will be asked to sign an agreement that you will pay for the service yourself if Medicare doesn't pay for it. This is called an Advance Beneficiary Notice. Advance Beneficiary Notices are used in the Original Medicare Plan. Medicare Advantage Plans have other ways of providing this information.

If you aren't sure if Medicare was billed for the services that you got, write to the health care provider and ask for an itemized statement. This statement will list each Medicare item or service you got from that provider. You should get it within 30 days. Also, you can check your Medicare Summary Notice to see if the service was billed to Medicare.

If you are in a Medicare Advantage Plan, call your plan to find out if a service or item will be covered. The plan must tell you if you ask.

Remember, blue words in the text are defined on pages 85–88.

Fast-Track Appeals

If you are enrolled in a Medicare Advantage Plan, you have the right to a fast-track appeals process. You can get a quick review whenever you are receiving services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility. You will get a notice from your provider or plan that will tell you how to ask for an appeal if you believe that your services are ending too soon. You will be able to obtain a **quick review** of this decision, with independent doctors looking at your case and deciding if your services need to continue. You may have additional rights if you are in the hospital or a skilled nursing facility, or if your home health care ends. People with Medicare enrolled in the Original Medicare Plan are expected to get fast-track appeal rights during 2005.

Other Medicare Rights

In addition, you have rights to

- get information
- get emergency room 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 culturally competent manner in certain circumstances (for example, get information in languages other than English from Medicare, and its providers and contractors)
- file complaints
- nondiscrimination
- have your personal and health information kept private

For more information about your rights and protections, get a free copy of *Your Medicare Rights and Protections* (CMS Pub. No. 10112). Look on page 83 to see how to get this booklet.

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. For example:

- 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.

Notice of Privacy Practices for the Original Medicare Plan (continued)

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 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.

Notice of Privacy Practices for the Original Medicare Plan (continued)

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.

Look at 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 or contact the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

Notice of Privacy Practices for the Original Medicare Plan (continued)

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 listed above and on pages 67–69 became effective April 14, 2003.

How We Share Information for Research Studies and Clinical Trials

Research studies and clinical trials help doctors and researchers find better ways to operate the Medicare program or to prevent, diagnose, or treat diseases. Medicare may contact you about taking part in a study. Medicare may also share personal medical information with some organizations that conduct these studies to help them find people who qualify to take part in these studies. These organizations must meet all privacy law requirements. They might use the information Medicare gives them to contact you directly about their studies. It is your choice to take part or not. You may want to talk to your doctor about clinical trials (see page 29 for more information about clinical trials).

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 under certain conditions. 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 Office for Civil Rights in your state or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also look at www.hhs.gov/ocr on the web for more information.

Making Health Care Decisions-Advance Directives

As people live longer, the chance that they may not be able to make their own health care decisions increases. To let people know what kind of treatment you want if you are unable to make your own health care decisions, you should fill out a "health care advance directive." This is a written document in which you give directions about who you want to speak for you and what kind of health care you want or don't want if you can't speak for yourself. You might be able to get more information by calling your Area Agency on Aging. To get the telephone number for your Area Agency on Aging, call the Eldercare Locator at 1-800-677-1116, or look at www.aoa.gov on the web.

You Can Help Protect Yourself and Medicare from Fraud

Most doctors and health care providers who work with Medicare are honest. There are a few who aren't honest. Medicare is working very hard with other government agencies to protect the Medicare program.

Medicare fraud happens when Medicare is billed for services 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.

Use this three step approach if you suspect fraud:

1. Call your health care provider.
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).

You Can Help Protect Yourself and Medicare from Fraud (continued)

When you get health care in the Original Medicare Plan, you get a Medicare Summary Notice (see sample on pages 46–49) from a company that handles bills for Medicare. It shows what services or supplies were charged and how much Medicare paid. You should check the notice for mistakes. Make sure that Medicare wasn't charged for any services or supplies that you didn't get. If you see a charge on your bill that may be wrong, call the health care provider and ask about it. The bill may be correct, and the person you speak to may help you to better understand the services or supplies you got. Or, you may have discovered an error in billing which needs to be corrected. If you aren't satisfied after speaking with your provider, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You can also call the Inspector General's hotline 1-800-HHS-TIPS (1-800-447-8477) to report Medicare fraud. Medicare won't use your name if you ask that it not be used.

Fighting fraud can pay. You may get a reward of up to $1,000 if

- you report Medicare fraud,

AND

- your report leads directly to the recovery of at least $100 of Medicare money,

AND

- the fraud you report isn't already being investigated.

For more information about this program, get a free copy of *Pay it Right! Protecting Medicare from Fraud* (CMS Pub. No. 10111). Look on page 83 to see how to get this booklet.

Other Insurance and Ways to Pay Health Care Costs

Section 10

Now is a good time to review your health care coverage. In addition to Medicare, you may already have or be eligible for other health care coverage such as employer or retiree coverage. You also might be able to lower your out-of-pocket costs by buying other supplemental health coverage. The coverage you have will affect how much you pay, what benefits you may have, which doctors you can see, and other things that may be important to you.

For more information about how other kinds of insurance work with Medicare, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). Look on page 83 to see how to get this booklet.

1. Employer or Union Health Coverage

Call the benefits administrator at your or your spouse's current or former employer or union. Ask if you have or can get health care coverage based on your or your spouse's past or current employment.

When you have coverage from an employer or union, they may change the benefits or premiums, and may also cancel the coverage if they choose.

Caution: If you drop your employer or union group health coverage, you may not be able to get it back. For more information, call your employer's or union's benefits administrator.

Remember, blue words in the text are defined on pages 85–88.

Note about COBRA
If you are eligible for COBRA because you have stopped working or because you qualify for other reasons, you should still consider enrolling in Part B (see page 20). You won't get another Special Enrollment Period (see pages 23–24) when your COBRA coverage ends, and you may have to pay more for Part B if you join later.

2. Medigap (Medicare Supplement Insurance) Policies

A Medigap policy is a health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Medigap policies must follow federal and state laws. These laws protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."

In all states, except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of 10 standardized policies so you can compare them easily. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy may be sold as a "Medicare SELECT" policy. Medicare SELECT policies usually cost less because you must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from the policy. In an emergency, you may use any doctor or hospital.

Note: If you live in Massachusetts, Minnesota, or Wisconsin, different standardized plans are sold in your state. See page 91 for important contact information.

NEW

Starting January 1, 2006, when Medicare prescription drug plans are available you won't be able to buy Medigap policies covering prescription drugs. Plans H, I, or J may still be sold, but without drug benefits. If you already have a Medigap policy that covers prescription drugs, you may be able to keep it under certain circumstances. In addition, new types of Medigap policies might be available. More information about these changes will be available during 2005.

Medigap (Medicare Supplement Insurance) Policies (continued)

For more information about Medigap policies, costs, and choices, call 1-800-MEDICARE (1-800-633-4227) and speak with a Customer Service Representative. TTY users should call 1-877-486-2048. Or, call your State Health Insurance Assistance Program (see pages 93–95 for their telephone number). You may also find information about Medigap policies on www.medicare.gov on the web. Select "Medicare Personal Plan Finder."

Do I need to buy a Medigap policy?

Whether you need a Medigap policy is a decision that only you can make. You may want to buy a Medigap policy if you choose to enroll in the Original Medicare Plan, because it doesn't pay for all of your health care. There are "gaps" or costs you must pay in the Original Medicare Plan. Depending on your health care needs and finances, you may want to continue your employee or retiree coverage, or join a Medicare Advantage Plan.

You don't need to buy a Medigap policy if you are in a Medicare Advantage Plan. In fact, it's illegal for anyone to sell you a Medigap policy if they know you are in one of these health plans. If you have Medicaid, it's illegal for an insurance company to sell you a Medigap policy except in certain situations.

Medigap (Medicare Supplement Insurance) Policies (continued)

When is the best time to buy a Medigap policy?

For most people, the best time to buy a Medigap policy is during your Medigap open enrollment period. Your Medigap open enrollment period lasts for six months. It starts on the first day of the month in which you are both age 65 or older and are enrolled in Medicare Part B. Once the six-month Medigap open enrollment period starts, it can't be changed.

Note: If you are age 65 or older, and you or your spouse are working, and you have health coverage through an employer or union based on your or your spouse's current employment, you may want to wait to enroll in Medicare Part B so that you delay your Medigap open enrollment period.

During this period, an insurance company can't deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or charge you more for a policy because of your past or present health problems. They must also shorten the waiting period for pre-existing conditions based on your previous health coverage.

Important: If you don't buy a Medigap policy during your open enrollment period, you may not be able to buy the one you want later, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back. (However, special rules may apply if you have been in a Medicare Advantage Plan, (see page 62) or have employer-sponsored insurance.)

For information about buying a Medigap policy, get a free copy of *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (CMS Pub. No. 02110). Look on page 83 to see how to get this booklet.

3. Veterans' Benefits

If you are a veteran or have had any U.S. military service, call the U.S. Department of Veterans Affairs at 1-800-827-1000 for information about veterans' benefits and services available in your area.

4. Military Retiree Benefits

TRICARE is a health care program for active duty and retired uniformed services members and their families. It includes TRICARE Prime, TRICARE Extra, TRICARE Standard, and TRICARE for Life (TFL). Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses have access to expanded medical coverage known as TRICARE for Life. You must have Medicare Part A and Part B to get TFL benefits. See page 22 if you aren't enrolled in Medicare Part B and want to access TFL benefits.

In general, Medicare pays first for Medicare-covered services. If Medicare doesn't pay all of the bill, TRICARE might pay some of the costs as the second payer. TRICARE will also pay the Medicare deductible and coinsurance amounts, and for any services not covered by Medicare that TRICARE covers. You are also eligible for pharmacy benefits through the TRICARE Senior Pharmacy Program.

For more information about the TRICARE programs, call 1-800-538-9552 or look at www.tricare.osd.mil on the web.

5. Medicare Savings Programs (Help from Your State as Part of the State Medical Assistance Program)

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

You can apply for these programs if

- you have Medicare Part A. (If you are paying a premium for Medicare Part A, the Medicare Savings Program may pay the Medicare Part A premium for you.)

and

- you are an individual with resources of $4,000 or less, or are a couple with resources of $6,000 or less. Resources include things like money in a checking or savings account, stocks, or bonds.

and

- you are an individual with a monthly income of less than $1,068, or are a couple with a monthly income of less than $1,426. Income limits will change slightly in 2005. If you live in Alaska or Hawaii, income limits are slightly higher.

Call your State Medical Assistance Office (see page 89). 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 Medicare Savings Programs, even if you aren't sure.

Note: Individual states may have more generous income and/or resource requirements.

Medicare Savings Programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

6. Medicaid

If your income and resources are limited, you may qualify for Medicaid. Most of your health care costs are covered if you have Medicare and Medicaid. Medicaid is a joint Federal and State program that helps pay medical costs for some people with limited incomes and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for things like nursing home care, home health care, and outpatient prescription drugs that aren't covered by Medicare. For more information about Medicaid, call your State Medical Assistance Office (see page 89).

7. Assistance Programs

There are programs that may offer you discounts or free medication. For more information, look at www.medicare.gov on the web. Select "Prescription Drug and Other Assistance Programs." If you don't have a computer, your local senior center or library may be able to help you get this information. Or, call 1-800-MEDICARE (1-800-633-4227), and ask for information about these programs. TTY users should call 1-877-486-2048.

8. The PACE Program (Program of All-inclusive Care for the Elderly)

PACE combines medical, social, and long-term care services for frail people. PACE might be a better choice for you instead of getting care through a nursing home. PACE is available only in states that have chosen to offer it under Medicaid.

To find out if you are eligible and if there is a PACE site near you, or for more information, call your State Medical Assistance Office (see page 89). You can also look at www.medicare.gov/Nursing/Alternatives/PACE.asp on the web for PACE locations and telephone numbers.

If you are currently enrolled in PACE and have questions about Medicare-approved drug discount cards, contact your PACE organization.

9. Long-Term Care Insurance

Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care to help you with your personal care needs, such as bathing, dressing, using the bathroom, and eating. Generally, Medicare doesn't pay for long-term care.

It's very important to think about long-term care before you may need care or before a crisis occurs. You will have more control over your decisions. For more information about the types of long-term care, get a free copy of *Choosing Long-Term Care: A Guide for People with Medicare* (CMS Pub. No. 02223). Look on page 83 to see how to get this booklet.

For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State Insurance Department (see page 90) or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600. Or, call your State Health Insurance Assistance Program (see pages 93-95 for their telephone number).

For More Information

Section 1

www.medicare.gov on the web

Need quick answers and information now?

Go to the Medicare website. It's updated regularly, so visit often.

Here are some of the tools you can use to get quick answers to your questions.

Medicare Personal Plan Finder

Compare health plan options (including Medicare Advantage and supplemental insurance plans) in your area.

Prescription Drug and Other Assistance Programs

Identify programs that may help with your prescription drug and other health care costs, including information on Medicare-approved drug discount cards.

Participating Physician Directory

Locate Medicare participating doctors in your area.

Medicare Eligibility Tool

Determine your Medicare eligibility and enrollment status.

Publications

View, order, or download Medicare publications.

Frequently Asked Questions

Locate answers to your questions about Medicare.

Your Medicare Coverage

Learn about your health care coverage in the Original Medicare Plan.

Compare Quality

Get information about the quality of care provided by certain types of health care providers, anywhere in the country. Look at Nursing Home Compare, Home Health Compare, Dialysis Facility Compare, and the Medicare Personal Plan Finder.

Section 11: For More Information

1-800-MEDICARE Helpline

Medicare is always working to improve its service to you. The 1-800-MEDICARE helpline has replaced the touch-tone system with a speech-automated system to make it easier for you to get the information you need 24 hours a day, including weekends.

The system will ask you questions that you answer with your voice to direct your call automatically.

Remember to

- speak clearly,
- call from a quiet area, and
- have your red, white, and blue Medicare card in front of you.

You can direct your call faster if you say what you need, after listening to the instructions.

If you are calling about...	Just say...
Medicare-Approved Drug Discount Card	"Drug Card"
Doctor's bills, x-rays, or outpatient doctor's care	"Doctor's Service"
Inpatient or outpatient hospital visit or emergency room care	"Hospital Stay"
Oxygen, wheelchairs, walkers, eyeglasses, diabetic supplies, or Medicare-covered prescription drugs	"Medical Supplies"
Plan choices under Medicare, including Medicare Advantage	"Plan Choices"
Frequently asked questions like "What does Medicare cover?" or "Who is eligible for Medicare?" and other important questions	"Answers"
Ordering Medicare publications	"Publications"
If you want to talk to a Customer Service Representative	**"Agent"**

TTY users should call 1-877-486-2048.

Free Booklets About Medicare and Related Topics

Medicare tries to give you information to help you make good health care decisions. You can look at or order free booklets from Medicare to learn more about the topics that are of interest to you. We are always adding new booklets with detailed information about important subjects.

How do I get these booklets?

1. Look at www.medicare.gov on the web, and select "Publications." You can read, print, or order some booklets. This is the fastest way to get a copy.

2. Call 1-800-MEDICARE (1-800-633-4227). Follow the instructions to get a publication. TTY users should call 1-877-486-2048. You will get your copy within three weeks.

3. Put your name on the web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select "Mailing List" at the top of the page.

Many booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish). Look at www.medicare.gov on the web for a list of available Medicare publications.

Note: Some booklets may not be available in print, but all of the most up-to-date versions will be available at www.medicare.gov on the web. If you don't have a computer, your local library or senior center may be able to help you find these publications.

Turn to the next page to see a list of some of the available booklets that have more detailed information about some of the topics discussed in this handbook.

Section 11: For More Information

Available Medicare Booklets

Below is a list of detailed booklets covering some of the topics discussed in this handbook. Booklets on other topics may be available.

- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (CMS Pub. No. 02110)

NEW
- *Enrolling in Medicare* (CMS Pub. No. 11036)

NEW
- *Guide to Answering your Medicare Questions on the Web* (CMS Pub. No. 11063)
- *Getting a Second Opinion Before Surgery* (CMS Pub. No. 02173)

NEW
- *Guide to Choosing a Medicare-Approved Drug Discount Card* (CMS Pub. No. 11062)
- *Medicare & Clinical Trials* (CMS Pub. No. 02226)
- *Medicare and Home Health Care* (CMS Pub. No. 10969)
- *Medicare and Your Mental Health Benefits* (CMS Pub. No. 10184)
- *Medicare Coverage of Ambulance Services* (CMS Pub. No. 11021)
- *Medicare Coverage of Diabetes Supplies & Services* (CMS Pub. No. 11022)
- *Medicare Coverage of Durable Medical Equipment* (CMS Pub. No. 11045)
- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* (CMS Pub. No. 10128)
- *Medicare Coverage of Skilled Nursing Facility Care* (CMS Pub. No. 10153)
- *Medicare Coverage Outside the U.S.* (CMS Pub. No. 11037)
- *Medicare Hospice Benefits* (CMS Pub. No. 02154)
- *Guide to Medicare's Preventive Services* (CMS Pub. No. 10110)

NEW
- *The Facts About Medicare Advantage* (CMS Pub. No. 11061)
- *Your Medicare Benefits* (CMS Pub. No. 10116)
- *Your Medicare Rights and Protections* (CMS Pub. No. 10112)

Words to Know

Appeal—An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for or provide an item or service you think you should be able to get. There is a specific process that your Medicare Advantage Plan or the Original Medicare Plan must use when you ask for an appeal.

Benefit Period—The way that Medicare 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 hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Carrier—A private company that contracts with Medicare to pay Part B bills.

Coinsurance—The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Comprehensive Outpatient Rehabilitation Facility (CORF)—A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

Copayment—In some Medicare health plans, the amount that you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay for a service. For example, this could be $10 or $20 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Critical Access Hospital—A hospital facility to which Medicare has given specific status to provide outpatient and certain inpatient services to people in rural areas.

Custodial Care—Nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and 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, before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

Section 12: Words to Know

Durable Medical Equipment Regional Carrier—A private company that contracts with Medicare to pay bills for durable medical equipment.

Fiscal Intermediary—A private company that contracts with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

Inpatient Care—Health care that you get when you are admitted to a hospital.

Lifetime Reserve Days—In the Original Medicare Plan, 60 days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($438 in 2004).

Limiting Charge—In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

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.

Managed Care Plan—In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extra benefits, like extra days in the hospital. In most cases, a type of Medicare Advantage Plan that is available in some areas of the country. Your costs may be lower than in the Original Medicare Plan.

Medicaid—A joint Federal and State program that helps with medical costs for some people with low incomes and limited 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 proper and needed for the diagnosis or treatment of your medical condition,
- are provided for the diagnosis, direct care, and treatment of your medical condition,
- meet the standards of good medical practice in the local area, and
- aren't mainly for the convenience of you or your doctor.

Medicare Advantage Plan—A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

Medicare-approved Amount—In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medigap Policy—A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Original Medicare Plan—A pay-per-service health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Outpatient Care—Medical or surgical care that doesn't include an overnight hospital stay.

Point-of-Service (POS)—A Medicare Managed Care Plan option that lets you use doctors and hospitals outside the plan for an additional cost.

Preferred Provider Organization (PPO) Plan—A type of Medicare Advantage Plan in which 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.

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

Preventive Services—Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and screening mammograms).

Primary Care Doctor—A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Managed Care Plans, you must see your primary care doctor before you can see any other health care provider.

Private Fee-for-Service Plan—A type of Medicare Advantage Plan 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.

Section 12: Words to Know

Quality—Quality of care is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person--and getting the best possible results.

Quality Improvement Organization—Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service Plans, and ambulatory surgical centers.

Referral—A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare Managed Care Plans, 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.

Regional Home Health Intermediary—A private company that contracts with Medicare to pay home health and hospice bills and check on the quality of home health care.

Skilled Nursing Facility Care—A level of care that requires daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can't be provided on an outpatient basis. Examples of skilled nursing facility care include intravenous injections and physical therapy. Needing custodial care, such as help with bathing and dressing, can't, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for skilled nursing or rehabilitation care, Medicare covers all of your care needs in the facility.

Specialty Plan—A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease.

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

Telemedicine—Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site.

TTY—A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. 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.

Section 13 Important Contacts

Check the list below to see whom you can call for help with your questions. Telephone numbers are provided for organizations that provide nationwide services. For local organizations, information is provided for how you can get their telephone number.

For questions about:	Call:	At:
Address/name changes	Social Security Administration Railroad Retirement Board (RRB beneficiaries only)	1-800-772-1213 TTY 1-800-325-0778 1-800-808-0772
Appeals	State Health Insurance Assistance Program (SHIP)	See pages 93–95
Appeal rights (inpatient)	Quality Improvement Organization	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Assistance Programs—programs (including Medicaid) to help people with limited incomes and resources pay medical bills and help with prescription drug coverage	State Medical Assistance Office	Get local number from 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Bills—help with questions about your bills for durable medical equipment like prosthetics, orthotics, and other supplies help with questions about your bills for other services	Durable Medical Equipment Regional Carrier State Health Insurance Assistance Program (SHIP)	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048 See pages 93–95
Complaints—about the quality of Medicare-covered services; review options may include mediation	Quality Improvement Organization Centers for Medicare & Medicaid Services Regional Offices	Get local number from 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048 See above

Section 13: Important Contacts

For questions about:	Call:	At:
Death notification	Social Security Administration Railroad Retirement Board (RRB Beneficiaries only)	1-800-772-1213 TTY 1-800-325-0778 1-800-808-0772
Discrimination	Office for Civil Rights	1-800-368-1019 TTY 1-800-537-7697
Enrolling in Medicare	Social Security Administration Railroad Retirement Board (RRB Beneficiaries only)	1-800-772-1213 TTY 1-800-325-0778 1-800-808-0772
Fraud and abuse—general Part A (Hospital) Part B (Medical)	Department of Health and Human Services, Office of the Inspector General Fiscal Intermediary Medicare Carrier	1-800-447-8477 TTY 1-800-377-4950 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048 See above
Home health care	Regional Home Health Intermediary	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Hospice care	Regional Home Health Intermediary	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Hospital outpatient services	Fiscal Intermediary	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Initial enrollment questionnaire (Medicare)	Coordination of Benefits Contractor	1-800-999-1118 TTY 1-800-318-8782
Insurance—general questions	State Insurance Department	Get local number from 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Long-term care insurance	State Health Insurance Assistance Program (SHIP)	See pages 93–95

For questions about:	Call:	At:
Medical services	Medicare Carrier	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Medicare (in general)	The Medicare Helpline	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Medicare card (replacement)	Social Security Administration Railroad Retirement Board (RRB Beneficiaries only)	1-800-772-1213 TTY 1-800-325-0778 1-800-808-0772
Medicare health plans—general questions and for list of plans in your area choosing a health plan	The Medicare Helpline State Health Insurance Assistance Program (SHIP)	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048 See pages 93–95
Medicare rights and protections	State Health Insurance Assistance Program (SHIP)	See pages 93–95
Medigap policies—general questions and for list of policies in your area choosing a Medigap policy	The Medicare Helpline State Health Insurance Assistance Program (SHIP)	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048 See pages 93–95
Military retiree health benefits	Department of Defense	1-888-DOD-LIFE (1-888-363-5433) 1-800-538-9552
Other insurance (which pays first)	Coordination of Benefits Contractor	1-800-999-1118 TTY 1-800-318-8782
Part A (hospital) bills and services	Fiscal Intermediary	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048

Section 13: Important Contacts

For questions about:	Call:	At:
Part B (medical) bills and services	Medicare Carrier	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
	Railroad Retirement Board (RRB Beneficiaries only)	1-800-808-0772
Payment denials	Fiscal Intermediary Medicare Carrier	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
help filling out appeal forms	State Health Insurance Assistance Program (SHIP)	See pages 93–95
Privacy Medicare privacy rights and protections	The Medicare Helpline	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
privacy complaints	The Medicare Helpline	See above
	Department of Health and Human Services (Office for Civil Rights)	1-866-627-7748 TTY 1-800-537-7697
Publications (Medicare – related)	The Medicare Helpline	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Railroad Retirement benefits	Railroad Retirement Board (RRB)	Local RRB Office or 1-800-808-0772
Skilled Nursing Care	Fiscal Intermediary	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Social Security benefits	Social Security Administration	1-800-772-1213 TTY 1-800-325-0778
TRICARE for Life	Department of Defense	1-888-DOD-LIFE (1-888-363-5433) 1-800-538-9552
Veteran's benefits	Department of Veterans Affairs	1-800-827-1000 TTY 1-800-829-4833

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

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Section 13: Important Contacts

Notes

Important Telephone Numbers

Name	Telephone Number
Your Doctor	
Your Doctor	
Your Doctor	
Your Dentist	
Your Pharmacy	
Medicare Helpline For help with questions about Medicare.	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Social Security Administration For help with questions about eligibility for and enrolling in Medicare, Social Security retirement benefits, or disability benefits.	1-800-772-1213 TTY 1-800-325-0778

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

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

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CENTERS for MEDICARE & MEDICAID SERVICES

To get this handbook on Audiotape (English and Spanish), in Braille, Large Print (English and Spanish), or Spanish, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

¿Necesita usted una copia en español? También está disponible en audiocasete y letra grande. Llame gratis al 1-800-MEDICARE (1-800-633-4227). Las personas que usan TTY deben llamar al 1-877-486-2048.