

Medicare & You



2007

**This is the official government handbook
with important information about**

- **what's new.**
- **what's covered.**
- **health plans.**
- **prescription drug plans.**
- **your rights.**

Welcome to Medicare & You 2007

Medicare is helping you stay healthy and active. The program offers you more than ever. More of you are taking advantage of the many preventive services that Medicare covers, and an unprecedented number of you have a prescription drug plan.

Medicare is committed to providing information and tools to help you make the best health decisions for your individual needs. www.MyMedicare.gov is an exciting new service on the web. With this tool, you can see your health care claims, track which preventive services you need, and get the most up-to-date details about how to get the most out of your Medicare benefits. If you don't have access to the web, the same information is available by calling 1-800-MEDICARE and through Medicare's many partners in the community.

That's just the start. Medicare is working harder than ever to improve the information you can get. Better information means you can compare and choose better care for better prices. It means helping you access new treatments and innovative practices.

As always, help is available anytime, day or night. You can visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227). Medicare is also present in your local communities to get you the answers you need.

Thank you for taking time to look at this Medicare handbook.



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Medicare Basics

A Brief Look at Medicare

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

Most people get their Medicare health care coverage in one of two ways. Your costs vary depending on your plan, coverage, and the services you use.

Original Medicare Plan	
Part A (Hospital)	Part B (Medical)
Medicare provides this coverage. Part B is optional. You have your choice of doctors. Your costs may be higher than in Medicare Advantage Plans.	



Part D (Prescription Drug Coverage)
You can choose this coverage. Private companies approved by Medicare run these plans. Plans cover different drugs. Medically necessary drugs must be covered.



Medigap (Medicare Supplement Insurance) Policy
You can choose to buy this private coverage (or an employer/union may offer similar coverage) to fill in gaps in Part A and Part B coverage. Costs vary by policy and company.

OR

Medicare Advantage Plans like HMOs and PPOs
Called “Part C,” this option combines your Part A (Hospital) and Part B (Medical)
Private insurance companies approved by Medicare provide this coverage. Generally, you must see doctors in the plan. Your costs may be lower than in the Original Medicare Plan, and you may get extra benefits.



Part D (Prescription Drug Coverage)
Most Part C plans cover prescription drugs. If they don't, you may be able to choose this coverage. Plans cover different drugs. Medically necessary drugs must be covered.

For information about

- The Original Medicare Plan, see pages 25–32.
- Medicare Advantage Plans, see pages 33–42.
- Medicare prescription drug coverage, see pages 43–56.
- Other Medicare plans, see pages 58–59.

Medicare Basics

What's new or important in Medicare for 2007?

- **What You Pay for Medicare**—See the 2007 amounts on pages 101–104.
- **Part B Premium**—If you file an individual tax return and your yearly income is **above** \$80,000 (or \$160,000 for a married couple filing a joint tax return), your monthly Part B premium will be higher than the standard premium amount. For more information, see page 11.
- **Medicare Advantage Plans (Part C) (like HMOs and PPOs)**—Information on these plans starts on page 33.
- **Medicare Prescription Drug Plans (Part D)**—Information on these plans starts on page 43.
- **Outpatient physical and occupational therapy, and speech-language pathology**—There may be limits in 2007, see page 103.
- **Medicare Medical Savings Account (MSA) Plans**—MSAs are a new way to get your Medicare health care, see page 39.



When you see this symbol in this handbook, it means the information in the box is very important.



If you haven't already signed up for Medicare prescription drug coverage, you have another chance each year in the fall. See pages 43–56 for more information.

“Medicare & You 2007” explains the Medicare Program. It isn't a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Medicare Basics

Where can I get help or more information?

- Visit www.medicare.gov on the web.
- Call 1-800-MEDICARE (1-800-633-4227) to get help in English, Spanish, and other languages. TTY users should call 1-877-486-2048.
- Register for MyMedicare.gov on the web. You can access the Medicare information you need on the web at any time. View claims, order forms and publications, and more (see page 89). If you don't have a computer, Medicare's partners can help you access this tool.
- Call your [State Health Insurance Assistance Program](#) for free counseling about choosing plans, buying a [Medigap policy](#), and your Medicare rights, including [appeals](#) (see pages 92–95 for their telephone number).
- Medicare works with many organizations around the country and in your local community. For a more detailed list of telephone numbers and places to get personalized help, see pages 89–95.

How do I find information I need in this handbook?

1. Look at the “Table of Contents,” or
2. Look at the “List of Topics (Index)” that starts on page 1. This alphabetical list of specific topics is the easiest way to find information.

Blue words in the text are defined on pages 97–100.

Medicare Basics

If You're New to Medicare...

"To Do" List

- Decide how you want to get Medicare coverage, see pages 23–24.
- Check pages 63–70 to see about help paying health care costs.
- Check if current insurance works with Medicare, see pages 60–61.
- Schedule a “Welcome to Medicare” physical exam, see page 17.
- Ask your doctor what [preventive services](#) you should get, see page 12.
- Consider Medicare prescription drug coverage, see pages 43–56.
If you have employer or union coverage, see page 50.
- Write important telephone numbers on the inside back cover.
- Register at www.MyMedicare.gov to access personalized information, see page 89.

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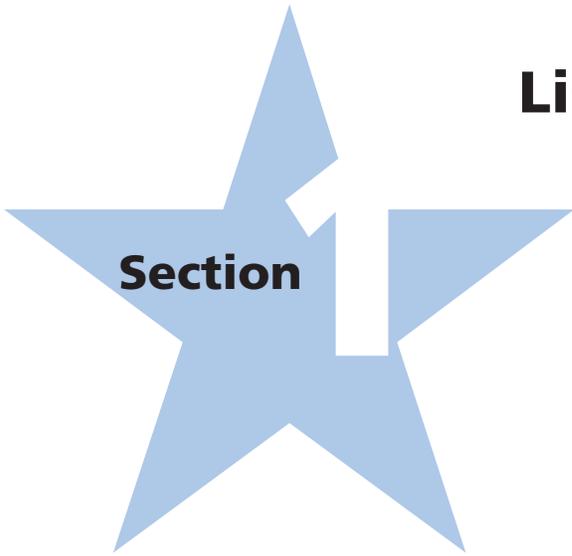
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The information in this handbook was correct when it was printed. Changes may occur after printing. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. **TTY** users should call 1-877-486-2048.

List of Topics (Index)



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What's Covered

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Section

Medicare covers certain medical services and items in hospitals and other settings. Some are covered under Medicare Part A, and some are covered under Medicare Part B. As long as you have both Part A and Part B, these services and items are covered whether you have the [Original Medicare Plan](#), or you belong to a [Medicare Advantage Plan](#) (like an HMO or PPO).

What Is Medicare Part A?

Part A helps cover your inpatient care in hospitals. This includes [critical access hospitals](#) and skilled nursing facilities (not custodial or [long-term care](#)). It also helps cover hospice care and home health care. You must meet certain conditions to get these benefits.

If you aren't sure if you have Part A, look on your red, white, and blue Medicare card (see sample card below). If you have Part A, "HOSPITAL (PART A)" is printed on your card.

Note: Your card may be slightly different. It's still valid.

Blue words in the text are defined on pages 97–100.

A sample Medicare Health Insurance card for Jane Doe. The card is titled "MEDICARE HEALTH INSURANCE" and includes the Social Security Administration logo. It lists the contact number 1-800-MEDICARE (1-800-633-4227). The beneficiary's name is JANE DOE. The Medicare claim number is 000-00-0000-A and the sex is FEMALE. The card indicates entitlement to HOSPITAL (PART A) and MEDICAL (PART B), both with an effective date of 07-01-1986. A signature line at the bottom shows the name Jane Doe.

Do you need to replace your Medicare card?

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

What Is Medicare Part A? (continued)

Cost: Most people automatically get Part A coverage without having to pay a monthly payment, called a **premium**. This is because they or a spouse paid Medicare taxes while working.

If you don't automatically 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 enough Medicare taxes while you worked **and** you are age 65 or older, or
- you are disabled but no longer get premium-free Part A because you returned to work.



For the 2007 Part A premium amount for people who buy Part A, see page 101.

For most people, if you buy Part A coverage, you must also enroll in Part B and pay the Part B premium.

If you have limited income and resources, your state may help you pay for Part A and/or Part B (see page 67). For more information, visit www.socialsecurity.gov on the web or call Social Security at 1-800-772-1213. **TTY** users should call 1-800-325-0778.



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

Medicare Part A Helps Cover Your Medically-Necessary...

Blood	Pints of blood you get at a hospital or skilled nursing facility during a covered stay.
Home Health Services	Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services, and physical therapy, occupational therapy, and speech-language pathology ordered by your doctor and provided by a Medicare-certified home health agency. Also includes medical social services, other services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), and medical supplies for use at home.
Hospice Care	For people with a terminal illness (less than six months to live). 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 (like grief counseling). Hospice care is usually given in your home (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).
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 hospital 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 (only after a three-day inpatient hospital stay for a related illness or injury) for up to 100 days in a benefit period . Note: Medicare doesn't cover long-term care .

For specific costs and other information about these services, see pages 101–104.

What is Medicare Part B?

Part B helps cover medical services like doctors' services, outpatient care, and other medical services that Part A doesn't cover. Part B is optional. Part B helps pay for covered medical services and items when they are **medically necessary** (see pages 12–19). Part B also covers some **preventive services**.

Cost: You pay the Part B **premium** each month (see page 101 for the 2007 amount). In some cases, this amount may be higher if you didn't sign up for Part B when you first became eligible.

You also pay a Part B **deductible** each year before Medicare starts to pay its share. See page 103 for the 2007 amount. You may be able to get help from your state to pay this premium and deductible (see page 67).



If you don't take Part B when you are first eligible, the cost of Part B will 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 100). You may have to pay this **penalty** as long as you have Part B.**

If you didn't sign up for Part B when you first became eligible, call Social Security at 1-800-772-1213 to see when you can apply. **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.

Medicare Part B and TRICARE Coverage

If you have TRICARE, you must have Medicare Part B to keep this coverage. However, if you are an active duty service member, or the spouse or dependent child of an active duty service member, you may not have to get Medicare Part B right away. You can get Part B during a Special Enrollment Period, and in most cases you won't have to pay a late enrollment penalty.

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

Your Part B enrollment rights can be affected if you have coverage through an employer or union, and you or your spouse are still working, or if you have COBRA coverage (see page 61). Your decision about when to sign up for Part B can also affect your rights to buy a [Medigap](#) (Medicare Supplement Insurance) [policy](#). For more information about enrolling in Part B, call Social Security (see previous page). You may also visit www.medicare.gov on the web and view the booklet “Enrolling in Medicare” or call 1-800-MEDICARE (1-800-633-4227) to ask questions. [TTY](#) users should call 1-877-486-2048.

NEW As of January 1, 2007, Your Part B Premium is Based on Your Income

Most people will pay the standard monthly Part B [premium](#). However, some people will pay a higher premium based on their modified adjusted gross income. Your monthly premium will be higher if you file an individual tax return and your annual income is more than \$80,000, or if you are married (file a joint tax return) and your annual income is more than \$160,000. These amounts change each year. For the 2007 premium amount in your income range, see page 101.

If you file an individual tax return and your income is above \$80,000, or if you are married and file a joint tax return and your income is above \$160,000, Social Security will use the income reported two years ago on your IRS income tax return to determine your premium (if unavailable, SSA will use income from three years ago). For example, the income reported on your 2005 tax return will be used to determine your monthly Part B premium in 2007. If your income has decreased since 2005, you can ask that the income from a more recent tax year be used to determine your premium, but you must meet certain criteria. At the end of each year, Social Security will send you a letter if your Part B premium will increase based on the level of your income and to tell you what you can do if you disagree. For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. [TTY](#) users should call 1-800-325-0778.

Part B Helps Cover These Items and Services

Part B covers certain medical items and services no matter how you get your Medicare health care. Costs for these services vary depending on the plan you choose. More specific costs and other information about these services are on page 103. For most of these items and services, you must pay a **copayment** or **coinsurance**, and a **deductible** may apply.

On pages 13–19 is an alphabetical list of common items and services Medicare covers if they are either:

- **Medically necessary**—This means the item or service is needed for the diagnosis or treatment of your medical condition, **or**
- **Medicare-covered preventive services**—like exams, lab tests, and screening shots to help prevent, find, or manage a medical problem. Preventive services may find health problems early when treatment works best. Talk to your doctor about which preventive services you need and if you meet the criteria for coverage.

You can live a healthy lifestyle by exercising, eating well, keeping a healthy weight, not smoking, and using preventive services.

For a list of what isn't covered, see page 21.



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



This symbol identifies the preventive services in the Part B coverage charts on pages 13–19.

Medicare Part B Helps Cover...

Ambulance Services	When you need to be transported to a hospital or skilled nursing facility, and transportation in any other vehicle would endanger your health.
Ambulatory Surgery Center	Facility fees are covered for approved services.
Blood	Pints of blood you get as an outpatient or as part of a Part B-covered service.
 Bone Mass Measurement	To help see if you are at risk for broken bones. This service is covered once every 24 months (more often if medically necessary) for people with Medicare who meet certain medical conditions.
 Cardiovascular Screenings	Every five years to test your cholesterol, lipid, and triglyceride levels to help prevent a heart attack or stroke.
Chiropractic Services (limited)	To correct a subluxation (when one or more of the bones of your spine moves out of position) using manipulation of the spine.
Clinical Laboratory Services	Including blood tests, urinalysis, some screening tests, and more.
Clinical Trials	To help doctors and researchers find better ways to prevent, diagnose, or treat diseases. Clinical trials test new types of medical care, like how well a new cancer drug works. Routine costs are covered if you take part in a qualifying clinical trial (may not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial).

Note: [Coinsurance](#) and/or [deductibles](#) may apply.



Preventive Service

Medicare Part B Helps Cover...



Colorectal Cancer Screenings

To help find precancerous growths, and help prevent or find cancer early, when treatment is most effective. One or more of the following tests may be covered. Talk to your doctor.

1. Fecal Occult Blood Test—Once every 12 months if age 50 or older. You pay nothing for the test, but usually have to pay for the doctor visit.
2. Flexible Sigmoidoscopy—Generally, once every 48 months if age 50 or older, or every 120 months when used instead of a colonoscopy for those not at high risk.
3. Screening Colonoscopy—Once every 120 months (high risk every 24 months). No minimum age.
4. Barium Enema—Once every 48 months if age 50 or older (high risk every 24 months) when used instead of sigmoidoscopy or colonoscopy.

Your risk for colorectal cancer increases if you or a close relative have had colorectal polyps or cancer, or if you have inflammatory bowel disease (like Crohn's disease). In 2007, Medicare covers its share of these costs even if you haven't met the yearly Part B [deductible](#).



Diabetes Screenings

To check for diabetes. These screenings are covered if you have any of the following risk factors: high blood pressure (hypertension), dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar. Tests are covered if you answer yes to two or more of the following questions.

- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, brothers, sisters)?
- Do you have a history of gestational diabetes (diabetes during pregnancy), or did you deliver a baby weighing more than 9 pounds?

Based on the results of these tests, you may be eligible for up to two diabetes screenings every year.

Note: [Coinsurance](#) and/or [deductibles](#) may apply.



Preventive Service

Medicare Part B Helps Cover...

Diabetic Self-management Training	For people with diabetes. Your doctor or other health care provider must provide a written order.
Diabetic Supplies	Including glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes (in some cases). Syringes and insulin are only covered if used with an insulin pump or if you have Medicare prescription drug coverage.
Doctor Services	Doesn't cover routine physical exams except for the one-time "Welcome to Medicare" Physical Exam (see page 17).
Durable Medical Equipment	Items such as oxygen, wheelchairs, walkers, and hospital beds needed for use in the home.
Emergency Room Services	When you believe your health is in serious danger, when every second counts. You may have a bad injury, sudden illness, or an illness that quickly gets much worse.
Eye Exams	For people with diabetes to check for diabetic retinopathy once every 12 months.
Eyeglasses (limited)	One pair of eyeglasses with standard frames after cataract surgery that implants an intraocular lens.
 Flu Shots	To help prevent influenza or flu virus. This is covered once a flu season in the fall or winter. The flu is a serious illness. You need a flu shot for the current virus each year.
Foot Exams and Treatment	If you have diabetes-related nerve damage and/or meet certain conditions.
 Glaucoma Tests	To help find the eye disease glaucoma. This is covered once every 12 months for people at high risk for glaucoma. You are considered high risk for glaucoma if you have diabetes, a family history of glaucoma, are African American and age 50 or older, or are Hispanic and age 65 or older. Tests must be done by an eye doctor legally authorized to perform this service in your state.

Note: [Coinsurance](#) and/or [deductibles](#) may apply.



Preventive Service

Medicare Part B Helps Cover...

<p>Hearing and Balance Exam</p>	<p>If your doctor orders it to see if medical treatment is needed. Hearing aids and exams for fitting hearing aids aren't covered.</p>
<p> Hepatitis B Shots</p>	<p>To help protect people from getting Hepatitis B. This is covered (three shots) for people with Medicare at high or medium (intermediate) risk for Hepatitis B.</p> <p>Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), or a condition that lowers your resistance to infection. Other factors may increase your risk for Hepatitis B. Check with your doctor to see if you are at high or medium risk for Hepatitis B.</p>
<p>Home Health Services</p>	<p>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 pathology that are ordered by your doctor and provided by a Medicare-certified home health agency. Also includes medical social services, other services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), and medical supplies for use at home.</p>
<p>Kidney Dialysis Services and Supplies</p>	<p>Either in a facility or at home.</p>
<p> Mammograms (screening)</p>	<p>To check women for breast cancer before they or their doctor may be able to feel it.</p> <p>Preventive (screening) mammograms are covered once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between age 35 and 39.</p>

Note: [Coinsurance](#) and/or [deductibles](#) may apply.



Preventive Service

Medicare Part B Helps Cover...

Medical Nutrition Therapy Services	Medicare may cover medical nutrition therapy if you have diabetes or kidney disease and you are referred for the service by your doctor.
Mental Health Care (outpatient)	Certain limits and conditions apply.
Occupational Therapy	Services given to help you return to usual activities (such as bathing) after an illness.
Outpatient Hospital Services	Received as an outpatient as part of a doctor's care.
Outpatient Medical and Surgical Services and Supplies	For approved procedures.
 Pap Test and Pelvic Exam (includes clinical breast exam)	To check for cervical and vaginal cancers. Medicare covers these exams for women at low risk for cervical cancer every 24 months. These exams are covered once every 12 months for women at high risk for cervical and vaginal cancer, and those of child bearing age who have had an exam that indicated cancer or other abnormalities in the past three years. Your risk of developing breast cancer increases if you had breast cancer in the past, have a family history of breast cancer (like a mother, sister, daughter, or two or more close relatives who have had breast cancer), had your first baby after age 30, or have never had a baby.
 Physical Exam (one-time "Welcome to Medicare" Physical Exam)	A one-time review of your health, and education and counseling about preventive services , including certain screenings and shots. Getting referrals for other care, if you need it, are also covered. Important: You must have the physical exam within the first six months you have Medicare Part B, and deductibles and coinsurance apply.

Note: Coinsurance and/or deductibles may apply.



Preventive Service

Medicare Part B Helps Cover...

	Physical Therapy	Treatment of injuries and disease by mechanical means, such as heat, light, exercise, and massage.
	Pneumococcal Shot	To help prevent pneumococcal infections. Most people only need this preventive shot once in their lifetime. Talk with your doctor.
	Practitioner Services	Such as those provided by clinical social workers, physician assistants, and nurse practitioners.
	Prescription Drugs	Limited, like certain injectable cancer drugs. For information about additional Medicare prescription drug coverage (Part D), see pages 43–56.
	Prostate Cancer Screening	These tests help find prostate cancer. Medicare covers a preventive digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for all men with Medicare over age 50.
	Prosthetic/Orthotic Items	Including arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); breast prostheses (after mastectomy); prosthetic devices needed to replace an internal body part or function (including ostomy supplies and parenteral and enteral nutrition therapy).
	Second Surgical Opinions	Covered in some cases (and some third surgical opinions are covered) for surgery that isn't an emergency.
	Smoking Cessation (counseling to stop smoking)	Provided at any provider site if ordered by your doctor. It includes up to eight face-to-face visits during a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco.

Note: [Coinsurance](#) and/or [deductibles](#) may apply.



Preventive Service

Medicare Part B Helps Cover...

Speech-language Pathology Services	Treatment given to regain and strengthen speech skills.
Surgical Dressings	For treatment of a surgical or surgically treated wound.
Telemedicine	Services in some rural areas, under certain conditions in a practitioner's office, a hospital, or a federally-qualified health center.
Tests	Including X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests.
Transplant Services	<p>Including heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and in a Medicare-certified facility only. Bone marrow and cornea transplants (under certain conditions). Immunosuppressive drugs are covered if the transplant was paid for by Medicare, or paid by an employer or union group health plan that was required to pay before Medicare (you must have been entitled to Medicare Part A at the time of the transplant and entitled to Medicare Part B at the time you get immunosuppressive drugs, and the transplant must have been performed in a Medicare-certified facility).</p> <p>Note: Medicare drug plans may cover immunosuppressive drugs, even if the transplant wasn't paid for by Medicare or an employer or union group health plan.</p>
Travel (health care needed when traveling outside the United States)	Limited to medical services provided in Canada when you travel on the most direct route through Canada between Alaska and another state. Medicare also covers hospital, ambulance, and doctor services if you are in the United States, but the nearest hospital that can treat you isn't in the United States (the "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). In some cases, Medicare may pay for services that you get while on board a ship within the territorial waters adjoining the land areas of the United States.
Urgently Needed Care	To treat a sudden illness or injury that isn't a medical emergency.

Note: [Coinsurance](#) and/or [deductibles](#) may apply.

For More Information About Medicare Part B Covered Items and Services

If you have the [Original Medicare Plan](#) and need more information about

- any of the listed items or services,
- any items or services you need that aren't listed, or
- information about your share of the costs,

visit www.medicare.gov on the web and select “Search Tools” at the top of the page. Then select “Find Out What Medicare Covers.” Or call 1-800-MEDICARE (1-800-633-4227). [TTY](#) users should call 1-877-486-2048.

For more information about coverage in [Medicare Advantage Plans](#) (like HMOs or PPOs) under Part C, see pages 33–42. For information about Medicare prescription drug coverage (Part D), see pages 43–56.



You may have the right to [appeal](#) decisions about health care payment or services. See [Section 10](#) for more information about your appeal rights.

What isn't covered by Medicare Part A and Part B?

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

- Acupuncture
- Chiropractic services (except as listed on page 13)
- Cosmetic surgery
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home
- **Deductibles**, **coinsurance**, or **copayments** when you get certain health care services (see pages 101–104) (People with limited income or resources may get help paying these costs, see pages 63–70.)
- Dental care and dentures (with only a few exceptions)
- Diabetic supplies (some, like syringes or insulin, unless the insulin is used with an insulin pump or unless you get Medicare coverage for prescription drugs [Part D])
- Eye care (routine exam), eye refractions and most eyeglasses (see page 15)
- Foot care (routine) such as cutting of corns or calluses (with only a few exceptions)
- Hearing aids and hearing exams for the purpose of fitting a hearing aid
- Hearing tests that haven't been ordered by your doctor
- Laboratory tests (screening) except those listed on pages 13–19
- **Long-term care**, such as custodial care in a nursing home
- Orthopedic shoes (with only a few exceptions)
- Physical exams (routine or yearly) (Medicare will cover a one-time physical exam within the first six months you have Part B, see page 17.)
- Prescription drugs—most prescription drugs aren't covered by Medicare Part A or Part B. See Section 6 for information about adding Medicare coverage for prescription drugs (Part D).
- Shots (preventive vaccinations) except those listed on pages 13–19
- Tests (screening) except as listed on pages 13–19
- Travel (Health care you get while traveling outside of the United States, except as listed on page 19.)

Deciding How to Get Your Medicare Benefits

Section 3

You can choose different ways to get the services covered by Medicare. Depending on where you live, you may have different choices. In most cases, when you first get Medicare, you are in the **Original Medicare Plan**. You may want to consider a **Medicare Prescription Drug Plan** to add drug coverage. Or, you may want to consider a **Medicare Advantage Plan** (like an HMO or PPO) that provides all your Part A, Part B, and often Part D coverage. You make a choice when you are first eligible for Medicare. Each year you can review your health and prescription needs and switch to a different plan in the fall. There are things you should consider to help you meet your needs.

Things to Consider for Each Option

- **Cost**—What will you pay out-of-pocket, including **premiums**?
- **Benefits**—Are extra benefits and services, like eye exams or hearing aids covered? (These may be covered by some plans.)
- **Doctor and hospital choice**—Can you see the doctor(s) you want? Are they accepting new patients? Do you need a **referral** to see a specialist? Can you go to the hospital you want? Do you pay less to go to certain doctors or hospitals?
- **Convenience**—Where are the doctors' offices? What are their hours? Is there paperwork?
- **Travel**—Do you spend part of each year in another state? Will the plan cover you there?
- **Prescription drugs**—What will your prescription drugs cost under the plan's **formulary** (list of covered drugs)? What are your drug needs?
- **Pharmacy choice**—What pharmacies can you use?
- **Quality of care**—Quality of care varies among plans, doctors, hospitals, and other health care providers. Giving 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 information to help you make the best choices for your well-being is available at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227).

Blue words in the text are defined on pages 97–100.

For more information about

- the [Original Medicare Plan](#), see pages 25–32.
- [Medicare Advantage Plans](#), see pages 33–42.
- Medicare prescription drug coverage, see pages 43–56.
- other Medicare plans, Government, and private insurance, see pages 57–62.
- joining and switching plans, see pages 71–78.

Do you have other health or prescription drug coverage?

If you have or are eligible for other types of health or prescription coverage, read all the materials you get from your insurer or plan provider. **Talk to your benefits administrator, insurer, or plan provider before you make any changes to your current coverage or you might lose your current coverage.** Other types of coverage include employer or union coverage, TRICARE, the Department of Veterans Affairs (VA) benefits, coverage from a special program, or from a [Medigap](#) (Medicare Supplement Insurance) [policy](#).

Choosing among the Medicare options to get coverage that works for you is an important decision. You can get personalized help.

1. Visit www.medicare.gov on the web, and select “Search Tools” at the top of the page.
2. Call 1-800-MEDICARE (1-800-633-4227). Say “Agent” to speak to a customer service representative. [TTY](#) users should call 1-877-486-2048.
3. Call your [State Health Insurance Assistance Program](#) to get free counseling for your questions about [appeals](#), buying other insurance, choosing a plan, buying a Medigap policy or other insurance, or Medicare rights and protections (see pages 92–95 for their telephone number).
4. Medicare works with many partners in your local community that can help you with these decisions.

Original Medicare Plan

Section

What Is the Original Medicare Plan?

The [Original Medicare Plan](#) is one of your health coverage choices as part of the Medicare Program. You will be in the Original Medicare Plan unless you choose to join a [Medicare Advantage Plan](#) (like an HMO or PPO). Most people get their coverage through the Original Medicare Plan.

How does the Original Medicare Plan work?

The Original Medicare Plan is a fee-for-service plan that is managed by the Federal Government. The general rules for how the Original Medicare Plan works are below:

- You use your red, white, and blue Medicare card when you get health care (see the sample card on page 7).
- If you have Medicare Part A, you get all the [medically-necessary](#) Part A-covered services listed on page 9.
- If you have Medicare Part B, you get all the medically-necessary and preventive Part B-covered services listed on pages 13–19. You usually pay a monthly [premium](#) for Part B (see page 101 for the 2007 amount).
- You can go to any doctor, supplier, hospital, or other facility that is enrolled and accepts Medicare and is accepting new Medicare patients.
- 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](#)) for covered services and supplies.
- You may have a [Medigap policy](#) or other supplemental coverage that may pay deductibles, coinsurance, or other costs that aren't covered by the Original Medicare Plan.

Blue words in the text are defined on pages 97–100.

- Every three months, you get a Medicare Summary Notice (MSN) in the mail if you got a Medicare-covered health care service during that period. The notice lists the details of the services you received and the amount you may be billed. These notices are sent by companies that handle bills for Medicare. If you disagree with the information on the MSN, you can file an [appeal](#). Information on how to appeal is included on the notice. For more information about the MSN, visit www.medicare.gov on the web and select “Medicare Billing.” Or, call 1-800-MEDICARE (1-800-633-4227) and say “Billing.”

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 27).
- how often you need health care.
- what type of health care you need.
- whether you choose to get services or supplies not covered by Medicare. In this case, you would pay all the costs for these services yourself.
- whether you have other health insurance that works with Medicare.
- whether you have [Medicaid](#) or get help paying your Medicare costs (see pages 66–67).

The lists on pages 101–104 shows what you pay in the [Original Medicare Plan](#) for common services in 2007. For details about these covered services, see page 9 for Part A and pages 13–19 for Part B. You can also visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227).

See Sections 7 and 8 for information about help to cover the costs that the Original Medicare Plan doesn’t cover.

What Is “Assignment” and Why Is it Important?

Assignment is an agreement between you (the person with Medicare), doctors, other health care suppliers or providers, and Medicare. You “assign” Medicare to pay your **doctor, supplier, or provider** directly for care. Most doctors, suppliers, and providers accept assignment.

If a doctor, other health care supplier, or provider accepts assignment, it means they

- agree to be paid by Medicare.
- agree to receive only the amount Medicare approves for their services.
- can only charge you, or other insurance you have, the Medicare **deductible** or **coinsurance** amount.

In some cases, doctors, other health care suppliers, and providers must accept assignment. For example, assignment must be accepted if you receive Medicare-covered physician assistant’s services. Doctors, other health care suppliers, and providers have to submit your claim to Medicare directly and can’t charge you for submitting the claim (this includes claims for glucose test strips).

If the doctor, other health care supplier, or provider, doesn’t agree to accept assignment, they may charge you more than the **Medicare-approved amount**; however, for most services, there is a limit to what they can charge you. The highest amount you can be charged is called the “limiting charge.” The limiting charge is 15% over the Medicare-approved amount (but may be lower in your state). The limiting charge applies only to certain services and doesn’t apply to supplies and other durable medical equipment. In addition, you might have to pay the entire charge at the time of service. Medicare will send you payment for its share of the charge when the claim is processed.

To get more information about assignment, visit www.medicare.gov on the web and select “Search Tools” at the top of the page. Then select “Find a Doctor.” You can also call 1-800-MEDICARE (1-800-633-4227).

Adding Prescription Drug Coverage to the Original Medicare Plan

Medicare Prescription Drug Plans (Part D)

People in the Original Medicare Plan can add drug coverage if they join a [Medicare Prescription Drug Plan](#). They are available through private companies that work with Medicare to provide prescription coverage. See pages 43–56 for more details about Medicare prescription drug coverage.

How does the [Original Medicare Plan](#) work with a Medicare Prescription Drug Plan?

- In most cases, you pay a separate monthly [premium](#) for your prescription drug plan. Premiums vary by plan.
- You pay a [copayment](#) or [coinsurance](#) and, in some cases, a yearly [deductible](#) for your prescription drugs. These charges vary by plan.
- You show a prescription card from your Medicare Prescription Drug Plan when you get your prescriptions filled.
- Medicare Prescription Drug Plans have contracts with pharmacies in your area. Check with the plan to make sure plan pharmacies are convenient to you. Some plans may offer a mail-order program that will allow you to have drugs sent directly to your home.
- Each Medicare drug plan has a list of covered drugs ([formulary](#)). The list must include at least two drugs (and in some cases all drugs) in all classes of drugs most commonly prescribed to people with Medicare. This makes sure that people with different medical conditions can get the treatment they need.

What if I can't afford a Medicare Prescription Drug Plan?

People with limited income and resources can qualify for extra help paying their Medicare Prescription Drug Plan costs. See pages 64–65 to find out if you may qualify for extra help.



If you have drug coverage through a previous or current employer or union, contact your benefits administrator before you make any changes to your prescription drug coverage. Joining a Part D plan could cause you to lose your, your spouse's, and your dependent's employer or union health and/or prescription coverage.

Buying a Medigap (Medicare Supplement Insurance) Policy

The [Original Medicare Plan](#) pays for many health care services and supplies, but there are many costs it doesn't cover. To help cover extra health care costs, you might want to buy a [Medigap policy](#). Medicare doesn't pay any of the costs for a Medigap policy.

What is a Medigap policy?

A Medigap policy is health insurance sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Medigap policies help pay your share (coinsurance, copayments, or deductibles) of the costs of Medicare-covered services, and some policies cover certain costs not covered by the Original Medicare Plan. If you are in the Original Medicare Plan and have a Medigap policy, then Medicare and your Medigap policy will both pay their shares of covered health care costs. Insurance companies can only sell you a “standardized” Medigap policy. These Medigap policies must all have specific benefits.

Generally, when you buy a Medigap policy you must have Medicare Part A and Part B. You or someone on your behalf (like a former employer or union) will have to pay the monthly Medicare Part B [premium](#) (see page 101 for the 2007 amount). You will also have to pay a premium to the Medigap insurance company.

In most states, you may be able to choose from up to 12 different standardized Medigap policies (Medigap Plans A through L). Medigap policies must follow Federal and state laws. These laws protect you. A Medigap policy must be clearly identified as “Medicare Supplement Insurance.” Each Medigap Plan A through L has a different set of basic and extra benefits. In Massachusetts, Minnesota, and Wisconsin, plans are standardized in a different way.

It's important to compare Medigap policies because the benefits in any Medigap Plan A through L are the same for any insurance company, but the costs can vary a lot, and may go up as you get older. Each insurance company decides which Medigap policies it wants to sell and the price for each plan (with state review and approval).

What is a Medigap policy? (continued)

Although some Medigap policies sold in the past covered prescription drugs, no new Medigap policies covering prescription drugs are being sold. To cover prescription drug costs, you may want to buy Medicare prescription drug coverage (Part D) offered by private companies approved by Medicare. If you join a [Medicare Prescription Drug Plan](#), and your Medigap policy covers drugs, you must tell your Medigap insurer to remove the prescription drug coverage from your Medigap policy.

If you and your spouse both want [Medigap](#) coverage, you each must buy separate Medigap policies. **Your Medigap policy won't cover any health care costs for your spouse.**

A Medigap policy only works with the [Original Medicare Plan](#). Medigap policies generally provide some of the same kinds of supplemental coverage as [Medicare Advantage Plans](#). If you join a Medicare Advantage Plan (like an HMO or PPO), your Medigap policy won't work. This means it won't pay any [deductibles](#), [copayments](#), or other cost-sharing under your Medicare Advantage Plan. Therefore, you may want to drop your Medigap policy if you join a Medicare Advantage Plan. However, you might not be able to get the same policy back, or in some cases, any policy if you leave the Medicare Advantage Plan. You have a legal right to keep the Medigap policy. Your rights to buy a Medigap policy may vary by state.

If you already have a Medigap policy with prescription drug coverage, you can keep that policy with prescription drug coverage OR join a Medicare Prescription Drug Plan. Keep in mind that Medigap drug coverage is generally not as good as coverage under a Medicare drug plan. You pay all the costs for your Medigap drug coverage, but, if you join a Medicare Prescription Drug Plan, Medicare pays most of the cost for standard coverage. You may have to pay a [premium](#). Medicare prescription drug coverage may cover more than the drug coverage in most Medigap policies. If you kept Medigap prescription drug coverage and didn't join a Medicare drug plan when you were first eligible, you may have to pay a [penalty](#) if you choose to join later. You can't have Medigap prescription drug coverage and Medicare prescription drug coverage at the same time. See page 43 for more information about your drug coverage choices.

What is a Medigap policy? (continued)

For more information about Medigap policies, visit www.medicare.gov and view the booklet “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare,” or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



If you have a limited income, there are programs that might help you pay costs Medicare doesn't cover (see pages 63–70).

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 must pay first includes

- employer or union group health plan coverage when coverage is based on your or a family member's current employment,
- no-fault insurance (including automobile insurance),
- liability insurance (including automobile insurance),
- black lung benefits, and
- workers' compensation.

It's important that you tell your doctor, hospital, and pharmacy that you have other insurance so they know how to handle your bills.

In some cases, if the insurance that is supposed to pay first doesn't pay promptly, the Original Medicare Plan may make a “conditional” payment. This means it must be repaid to Medicare when a payment is made by the insurance that is supposed to pay first.

Section 4: Original Medicare Plan

How Your Bills Get Paid if You Have Other Health Insurance (continued)

If you are in the [Original Medicare Plan](#) and you have questions about who pays first, or you need to update your other health insurance information, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. For more information, visit www.medicare.gov on the web and view the booklet “Medicare and Other Health Benefits: Your Guide to Who Pays First” or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



If you join a [Medicare Prescription Drug Plan](#), you must let your plan know if you have other prescription coverage.

Other Options to Consider

As you’ve read in this section, the Original Medicare Plan is a fee-for-service plan that covers many health care services. You can go to any doctor or hospital that accepts Medicare.

Your Medicare decisions are important because they affect things like how much you pay and what is covered. Before making any decisions, learn as much as you can about the types of plans and coverage available to you. Here are other options you may want to consider:

- [Medicare Advantage Plans](#) (like an HMO or PPO) may offer a lower-cost alternative to the Original Medicare Plan, see pages 33–42.
- Medicare prescription drug coverage can be added to the Original Medicare Plan, see pages 43–56.
- other types of Medicare plans, Government, and private insurance may be available to you, see pages 57–62.

Section

What Are Medicare Advantage Plans (like HMOs and PPOs)?

Medicare Advantage Plans are health plan options that are approved by Medicare and run by private companies. They are part of the Medicare Program, and sometimes called “Part C.” When you join a Medicare Advantage Plan, you are still in Medicare. Some of these plans require referrals to see specialists. In many cases, the **premiums** or the costs of services (co-pays) can be lower in a Medicare Advantage Plan than they are in the **Original Medicare Plan** or the Original Medicare Plan with a **Medigap policy**.

Medicare Advantage Plans provide all of your Part A (hospital) and Part B (medical) coverage and must cover **medically-necessary** services. They generally offer extra benefits, and many include Part D drug coverage. These plans often have networks, which means you may have to see doctors who belong to the plan or go to certain hospitals to get covered services. In many cases, your costs for services can be lower than in the Original Medicare Plan. Some of these plans coordinate your care, using networks and referrals, more than others. This can help manage your overall care and can also result in savings to you.

Medicare pays an amount of money for your care every month to these private health plans, whether or not you use services. Medicare Advantage Plans also include options that provide specialized care for people who need a lot of health care services. Even if you are out of the **service area** of the plan, you are still covered for emergency (see page 15) or urgently needed care (see page 19).

Medicare Advantage Plans include

- Medicare **Preferred Provider Organization (PPO) Plans**, see page 36,
- Medicare **Health Maintenance Organization (HMO) Plans**, see page 37,
- Medicare **Private Fee-for-Service (PFFS) Plans**, see page 37,
- Medicare **Special Needs Plans**, see page 38, and
- Medicare **Medical Savings Account (MSA) Plans**, see page 39.

Blue words in the text are defined on pages 97–100.

Section 5: Medicare Advantage Plans

Who Can Join?

You can generally join if

- you live in the [service area](#) of the plan you want to join. In Medicare [Health Maintenance Organization \(HMO\) Plans](#), the service area is also usually where you get services from the plan. Contact the plan to get more information about its service area.
- you have Medicare Part A **and** Part B. However, if you are already in a [Medicare Advantage Plan](#) and have only Part B, you may stay in your plan.
- you don't have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), except as explained on page 74.



You have a chance to switch plans each year between November 15 and December 31. In certain situations, you may be able to switch plans at other times (see page 72). For more information about joining and switching plans, see pages 71–78.

Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get help learning about and comparing plans in your area. [TTY](#) users should call 1-877-486-2048.

If You Join...

- you are still in the Medicare Program.
- you still have Medicare rights and protections (see pages 79–88).
- you still get complete Medicare Part A and Part B coverage (see pages 9 and 13–19).
- you usually get prescription drug coverage (Part D) through the plan. In most [Medicare Advantage Plans](#), if your plan offers Medicare prescription drug coverage and you want drug coverage, you **must** get it from your plan. In these cases, if you join a stand-alone [Medicare Prescription Drug Plan](#), you will be disenrolled from your Medicare Advantage Plan.

If you have a Medicare [Private Fee-for-Service Plan](#) that doesn't offer Medicare prescription drug coverage, or if you have a [Medicare Medical Savings Account Plan](#), you can also join a stand-alone Medicare Prescription Drug Plan (see page 43).

- you may be able to get extra benefits offered by the plan, such as coverage for vision, hearing, dental, and/or health and wellness programs.
- you still pay the Part B [premium](#). You also pay the Medicare Advantage Plan's premium that includes coverage for Part A and Part B benefits, prescription drug coverage (Part D if offered), and any other extra benefits (if offered).
- you usually will have to pay some other costs (such as [copayments](#) or [coinsurance](#)) for the services you get. Out-of-pocket costs in these plans are generally lower than in the [Original Medicare Plan](#), but vary by the services you use.
- you don't need to buy a [Medigap](#) (Medicare Supplement Insurance) [policy](#).
- in some cases, your costs could be higher than the Original Medicare Plan, like if you see a doctor that doesn't belong to the plan.
- every year in the fall, the plan will send you information about any changes in benefits, costs, or service areas.



If your former employer or union pays for your Medicare Advantage Plan, see page 61.

Compare How Three Types of Medicare Advantage Plans Work

Since each plan can vary, it's important for you to read the plan materials carefully.

	Preferred Provider Organization (PPO) Plan
Are prescription drugs covered?	In most cases. If you want prescription drug coverage, you must get it from the plan. The cost for coverage will be included in the premium.
Do I need to choose a primary care doctor?	No.
Can I get my health care from any doctor or hospital?	Yes. PPOs have network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
Do I have to see a primary care doctor to get a referral to see a specialist?	No.
What else do I need to know about this type of plan?	<ul style="list-style-type: none"> • Contact the plan before you get a service to find out if the service is covered and how much it costs. Follow the plan's rules when needed. • Regional PPOs (which serve an entire state or multi-state area) limit your out-of-pocket costs but may have a higher yearly deductible and/or premium than other PPOs. • Extra benefits are often offered for an extra premium.

Note: If you have limited income and resources, you may qualify for help paying your health care costs (see pages 63–70).

Section 5: Medicare Advantage Plans



Health Maintenance Organization (HMO) Plan	Private Fee-for-Service Plan (PFFS)
In most cases. If you want prescription drug coverage, you must get it from the plan. The cost for coverage will be included in the premium.	Sometimes. If your plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan in your area.
Yes. In most cases you must see a primary care doctor to get a referral before you see any other health care provider.	No.
No. You generally must get your care and services from doctors or hospitals in the plan's network (except emergency or urgent care). If the plan has a Point-of-Service (POS) option, you can go out-of-network, but you will pay more than for services in-network.	In most cases. You can go to any Medicare-approved doctor or hospital that accepts the plan's payment terms for covered services.
In most cases. Women don't need a referral for a yearly screening mammogram or an in-network pap test and pelvic exam (at least every other year).	No.
<ul style="list-style-type: none">• If your doctor leaves, your plan will notify you. You can choose another plan doctor.• If you get health care outside the plan's network, you may have to pay the full cost of the services yourself.• Follow the plan's rules, like getting prior authorization when needed.• Extra benefits are often offered for an extra premium.	PFFS plans are different from the Original Medicare Plan . PFFS plans are offered by private companies. The private company, rather than Medicare, decides how much it will pay and what you pay for the services you get. Extra benefits are often offered for an extra premium.

Section 5: Medicare Advantage Plans

How Medicare Advantage Plans Work (continued)

The following types of health plans are also [Medicare Advantage Plans](#). They are available in some areas to people who meet certain conditions.

Medicare Special Needs Plans

Medicare [Special Needs Plans](#) are specially designed for people with certain chronic diseases and other specialized health needs. These plans must provide all Medicare Part A and Part B health care and services. They also must provide Medicare prescription drug coverage (Part D). Generally, they offer extra benefits and may have lower [copayments](#) than the [Original Medicare Plan](#).

Medicare Special Needs Plans are designed to meet the needs of people

- who live in certain [institutions](#) (like a nursing home) or who continue to live at home, but require the same care as someone living in a nursing home,
- are eligible for both Medicare and [Medicaid](#), or
- have one or more specific chronic or disabling conditions.

The plan may limit membership to people in one of these groups, but may enroll other people as well.

A Medicare Special Needs Plan may help manage and coordinate the many services and providers their members use to help them stay healthy, follow their doctor's orders related to diet and prescription drugs, and help coordinate coverage between Medicare and Medicaid. They may also identify a care coordinator to develop personal care plans to coordinate all health care provider efforts to meet the patient's needs. For example, a Medicare Special Needs Plan for people with diabetes might use a care coordinator to help members monitor blood sugar, follow their diet, get proper exercise, get needed [preventive services](#) such as eye and foot exams, and get the right medicines to prevent complications.

A Medicare Special Needs Plan for people with both Medicare and Medicaid might help members access community resources and coordinate many of their Medicare and Medicaid services.

Visit www.medicare.gov on the web to get help learning about and comparing Medicare Special Needs Plans in your area. Select "Compare Health Plans and Medigap Policies in Your Area." Or, call 1-800-MEDICARE (1-800-633-4227). [TTY](#) users should call 1-877-486-2048.

How Medicare Advantage Plans Work (continued)

NEW

Medicare Medical Savings Account Plans (MSAs)

Medicare Medical Savings Account Plans (MSAs) are similar to Health Savings Account plans available outside of Medicare, and they have two parts. The first part is a Medicare Advantage Plan with a high **deductible**. This health plan won't begin to pay covered costs until you have met the yearly deductible, which varies by plan. The second part is a Medical Savings Account into which Medicare deposits money that you may use to pay health care costs.

For more information about Medicare MSA plans, visit www.medicare.gov on the web and view the booklet "Your Guide to Medicare Medical Savings Account Plans." Or, call 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048.

Medicare Advantage Plans with Prescription Drug Coverage

Most people with a [Medicare Advantage Plan](#) get prescription drug coverage through their plans. If you join a Medicare Advantage Plan and it offers this coverage, you must take the drug coverage your plan offers. Some Medicare Advantage Plans don't include prescription drug coverage. Other options for getting drug coverage include joining another Medicare Advantage Plan that offers prescription drug coverage, or returning to the [Original Medicare Plan](#) and joining a stand-alone [Medicare Prescription Drug Plan](#).



If you belong to a Medicare Advantage HMO or PPO, you can only get Medicare prescription drug coverage from your plan (if offered). If you join a stand-alone Medicare Prescription Drug Plan, you will be automatically disenrolled from your Medicare HMO or PPO and returned to the Original Medicare Plan.

Your out-of-pocket costs depend on

- whether the plan charges a monthly [premium](#) in addition to your Part B premium (see page 101 for the 2007 amount). These plans charge one premium for Part A and Part B benefits, Part D prescription drug coverage (if offered), and extra benefits (if offered).
- whether the plan pays all or part of the monthly Part B premium (see page 41).
- whether the plan has a yearly [deductible](#).
- how much you pay for each visit or service.
- the type of health care services you need and how often you get them.
- whether you follow the plan's rules.
- the types of extra benefits you need, whether the plan covers extra benefits, and what it charges for them.

Extra benefits offered may help lower your overall out-of-pocket costs. To learn more about your costs in specific Medicare Advantage Plans, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227).

Saving on Your Medicare Part B Premium

A few [Medicare Advantage Plans](#) may pay all or part of your Part B [premium](#) for you. You would still get all Part A and Part B-covered services. You can also call your State Medical Assistance ([Medicaid](#)) office to see if you can get help paying your Part B premium costs (see page 67).

Saving on Your Prescription Drug Coverage Premium

Your Medicare Advantage Plan's premium may include the premium for Part B and for Part D (Medicare prescription drug coverage). Some Medicare Advantage Plans may pay all or part of the premium that pays for your prescription drug coverage. Read the plan materials carefully to see if the plan does this. Plans decide each year if they will reduce part or all of your prescription drug coverage [premium](#). If you have limited income and resources, you may also be able to get extra help paying for your prescription drug costs (see pages 64–65).

How Your Bills Get Paid If You Have Other Health Insurance

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

- employer or union group health plan coverage (when coverage is based on your or a family member's current employment),
- no-fault insurance (including automobile insurance),
- liability insurance (including automobile insurance),
- black lung benefits, and
- workers' compensation.

Section 5: Medicare Advantage Plans

How Your Bills Get Paid If You Have Other Health Insurance (continued)

If you have other insurance, tell your doctor, hospital, and pharmacy so your bills get paid correctly. If you have questions about who pays first, or you need to update your other health insurance information, 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, visit www.medicare.gov on the web and view the booklet “Medicare and Other Health Benefits: Your Guide to Who Pays First,” or call 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048.



If you have other insurance, see pages 57–62.

Other Options to Consider

As you’ve read in this section, **Medicare Advantage Plans** are a way to get combined Medicare Part A and Part B benefits, and in most cases, prescription drug coverage (Part D). They may also provide more coordinated health care to help keep you healthy and lower your costs. Some plans (like HMOs) might use networks, where you may only be able to see certain doctors or go to certain hospitals.

Your Medicare decisions are important because they affect things like how much you pay and what is covered. Before making any decisions, learn as much as you can about the types of plans and coverage available to you. Here are other options you may want to consider:

- **Original Medicare Plan** allows you to use any doctor or hospital that accepts Medicare, see pages 25–32.
- Medicare prescription drug coverage can be added to some Medicare Advantage Plans, see pages 43–56.
- other Medicare plans, Government, and private insurance may be available to you, see pages 57–62.

Medicare Prescription Drug Coverage

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Section

6

What is Medicare Prescription Drug Coverage?

Medicare offers prescription drug coverage for everyone with Medicare. This is called “Part D.” This coverage may help lower prescription drug costs and help protect against higher costs in the future. It can give you greater access to drugs that you can use to prevent complications of diseases and stay well.

If you join a Medicare drug plan, you usually pay a monthly **premium**. Part D is optional. If you decide not to enroll in a Medicare drug plan when you are first eligible, you may pay a **penalty** (see pages 47–48) if you choose to join later. These plans are run by insurance companies and other private companies approved by Medicare.

There are two ways to get Medicare prescription drug coverage:

- 1) Join a **Medicare Prescription Drug Plan** that adds drug coverage to the **Original Medicare Plan**, some **Medicare Cost Plans**, some Medicare **Private Fee-for-Service Plans**, and **Medicare Medical Savings Account Plans**.
- 2) Join a Medicare plan (like an HMO or PPO) that includes prescription drug coverage as part of the plan. You get all of your Medicare coverage through these plans, including prescription drugs.

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

Blue words in the text are defined on pages 97–100.



Medicare offers help to employers and unions to help pay for prescription drug coverage. If you have employer or union drug coverage, see page 61. Joining a Part D plan could end the retiree health benefits you and your family get. Talk to your benefits administrator.

How does it work?

After you have joined the Medicare drug plan you want, the plan will mail you membership materials including a plan member card you use when you get your prescriptions filled. When you use the card, you will pay the **copayment**, **coinsurance**, and/or **deductible**, if any.

In **Medicare Advantage Plans** that include Medicare prescription drug coverage (Part D), your health care and drug usage is coordinated, with an emphasis on preventive care to keep you healthy.

How much does it cost?

Most drug plans charge a monthly **premium** that varies by plan. You pay this in addition to the Part B premium. Some drug plans charge no premium. If you have limited income and resources, you may get extra help to cover prescription drugs for little or no cost (see pages 64–65).

Your costs will vary depending on which drugs you use, which Medicare drug plan you choose, and whether you get extra help paying your Part D costs. Having a variety of plans to choose from gives you the chance to pick a plan that meets your unique needs. Choosing a plan that fits your situation allows you to get the coverage you want at the best price possible.

If you belong to a Medicare Advantage Plan (like an HMO or PPO) or a **Medicare Cost Plan** that offers Medicare prescription drug coverage, the monthly premium you pay to the plan includes an amount for prescription drug coverage. Some plans charge no premium.

You may be able to pick a plan with or without a monthly premium, deductible or coverage gap. To find the actual costs of the Medicare drug and health plans in your area, visit www.medicare.gov on the web. Select “Compare Medicare Prescription Drug Plans.” Or, call 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048.

What is a coverage gap?

Medicare drug plans may have a “coverage gap,” which is sometimes called the “donut hole.” A coverage gap means that after you and your plan have spent a certain amount of money for covered drugs (no more than \$2,400), you have to pay out-of-pocket all costs for your drugs while you are in the “gap.” The most you have to pay out-of-pocket in the coverage gap is \$3,051.25. This amount doesn’t include your plan’s monthly **premium** that you must continue to pay even while you are in the coverage gap. Once you’ve reached your plan’s out-of-pocket limit, you will have “catastrophic coverage.” This means that you only pay a **coinsurance** amount (like 5% of the drug cost) or a **copayment** (like \$2.15 or \$5.35 for each prescription) for the rest of the calendar year.

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

The example below shows calendar year costs for covered drugs in a plan that meets Medicare’s standards in 2007:

Mr. Jones joins the ABC Prescription Drug Plan. His coverage begins on January 1, 2007. He pays the plan a monthly premium throughout the year, even during his coverage gap. He doesn’t get “extra help.”

1. Yearly Deductible	2. Copayment/ Coinsurance	3. Coverage Gap (“donut hole”)	4. Catastrophic Coverage
Mr. Jones pays the first \$265 of his drug costs.	Mr. Jones pays a copayment or coinsurance amount, and his plan pays its share for each drug until his total drug costs (including his deductible) reach \$2,400.	Mr. Jones pays everything until he has spent \$3,850 out-of-pocket. (This includes his yearly deductible, coinsurance and copays, and \$3,051.25 while in the coverage gap. This does not include the drug plan’s premium.) Even though he is paying everything, he gets a discount because he belongs to a Medicare drug plan.	Once Mr. Jones has spent \$3,850 out-of-pocket for the year, his coverage gap ends. He only pays a small coinsurance (like 5%) or a small copayment (like \$2.15 or \$5.35) for each prescription until the end of the year.

How to Compare Medicare Drug Plans

Each Medicare drug plan is different. When you choose a Medicare drug plan for the first time, or switch to a different Medicare drug plan, you should compare the plans in your area and choose one that meets your cost and coverage needs.

Get personalized help comparing Medicare prescription drug coverage:

- Visit www.medicare.gov on the web. Select “Compare Medicare Prescription Drug Plans.”
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your [State Health Insurance Assistance Program](#) (see pages 92–95 for their telephone number).

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

Look at the following to compare plans in your area.

- **Drug Coverage.** Plans may have rules about what drugs are covered in different categories. Check to see if the plan covers your prescription drugs. Medicare drug plans will have a list of drugs covered by the plan ([formulary](#)) that must always meet Medicare’s requirements. Even if a drug is on the plan’s list, there may be special rules for filling the prescription. But, the list can change during the year because drug therapies change, and new drugs and medical knowledge become available. If you are affected by the change, your plan will notify you at least 60 days before the formulary changes. If there is a formulary change that affects a drug you take, in most cases, it will still be covered for you until the end of the year.
- **Cost.** Check to see how much your prescription drugs would cost in each plan. If you currently have prescription drug coverage, compare your current costs to those of the Medicare drug plans you are considering. Monthly [premiums](#), [deductibles](#), and your share of the cost of your prescriptions ([copayments](#) and/or [coinsurance](#)) will vary with each plan and by each drug. If you have limited income or resources, you may qualify for “extra help” paying your drug plan costs (see pages 64–65).
- **Convenience.** Medicare drug plans must contract with pharmacies in your area. Check with the plan to make sure the pharmacies in the plan are the ones you want to use. Some plans also allow you to get your prescriptions through the mail. If you spend part of the year in another state, see if the plan will cover you there.

Choosing Medicare Prescription Drug Coverage for the First Time

Like other insurance, Medicare prescription drug coverage will be there when you need it to help you with drug costs. Even if you don't take a lot of prescription drugs now, you still should consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy.

Are you

- new to Medicare, or
- have you lost **creditable prescription drug coverage** (coverage expected to pay at least as much as standard Medicare prescription drug coverage, like that provided by some employer or union plans) within the last 63 days?

If so, joining now means you will pay your lowest possible monthly **premium**. Every year (from November 15—December 31), you can switch to a different Medicare drug plan if your needs change.

You can join a Medicare drug plan from three months before you turn 65 to three months after you turn 65 (called your Initial Enrollment Period). Generally, if you are disabled, you can join three months before and three months after your 25th month of disability. The plan will notify you when your coverage begins.



If you don't join a Medicare drug plan when you are first eligible to join (during your Initial Enrollment Period), and there is a period of 63 continuous days or more during which you don't have creditable prescription drug coverage, you may have to pay a late enrollment **penalty when you do join. This amount changes every year. You will have to pay a penalty as long as you have Medicare prescription drug coverage.**

How much will my penalty be?

Your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national average premium for the year you join (the 2007 amounts are on page 104). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you have a plan. If you qualify for extra help, the penalty will be different. For help figuring your penalty amount, call 1-800-MEDICARE (1-800-633-4227) or your [State Health Insurance Assistance Program](#) (see pages 92–95 for their telephone number).

Switching Medicare Prescription Drug Plans

If you currently have Medicare prescription drug coverage, **you should review your coverage each year in the fall**. You might want to switch Medicare drug plans if another plan better meets your needs. Generally, you can only switch plans from November 15—December 31 of each year (see pages 71–78). Coverage under the new plan will begin January 1 of the following year. It's best to join a plan early in the month once you've made your decision. In certain cases, you may be able to change plans at other times (see page 72). If you are happy with your coverage, and your Medicare drug plan is still offered in your area, you don't have to do anything for your coverage to continue.



Only give personal information to doctors, other providers, and Medicare plans approved by Medicare, and to the people in your community who work with Medicare, like your State Health Insurance Assistance Program or Social Security (SSA). Call 1-800-MEDICARE (1-800-633-4227) if you have questions. TTY users should call 1-877-486-2048.

What if I have full coverage from my state Medicaid program?

If you have full coverage from your state [Medicaid](#) program and you are eligible for Medicare, Medicare will automatically enroll you in Medicare prescription drug coverage if you have not already chosen to do so. Medicare, not Medicaid, will provide your drug coverage and start paying for your prescription drugs. Medicaid will still cover other care that Medicare doesn't cover. In some limited cases, Medicaid will add to Medicare drug coverage. You can switch to another Medicare drug plan each month.

Medicare pays for almost all of the cost of your covered drugs if you join a [Medicare Prescription Drug Plan](#) or a [Medicare Advantage Plan](#) with Medicare prescription drug coverage. In most cases, you will pay only a small amount out-of-pocket for each covered prescription. Your costs and the drugs that are covered vary by plan.

If you have Medicare and full coverage from Medicaid, and you live in certain [institutions](#) (like a nursing home), you will pay nothing for your covered prescription drugs.

What if I get certain benefits or other help to pay Medicare costs?

If you don't join a Medicare drug plan, Medicare will enroll you in one to make sure you get help paying for your prescription drug costs. You will get extensive drug coverage with little or no monthly [premium](#). Generally, you pay only a small amount out-of-pocket for each covered prescription.

- **If you apply and qualify for extra help paying your Medicare costs or get Supplemental Security Income (SSI) benefits** without Medicaid, you can switch plans once by the end of the calendar year, and once each year after between November 15 and December 31.
- **If you belong to a Medicare Savings Program** (your state Medicaid program pays your Medicare premiums), you can switch to another Medicare drug plan at any time.

If you have other prescription drug coverage that's at least as good as Medicare's drug coverage ([creditable prescription drug coverage](#)), you can decline to keep the drug plan Medicare enrolls you in. If you don't want to join this plan or any Medicare drug plan, call 1-800-MEDICARE (1-800-633-4227), or call the plan Medicare enrolls you in.

What if I have prescription drug coverage from a former or current employer or union?

Medicare offers employers and unions help paying for retiree drug coverage. Your (or your spouse's) former or current employer or union must notify you about how your current coverage compares to Medicare's (minimum) standard prescription drug coverage.

Employers or unions may provide this information within a notice or in your benefits handbook. **Keep this notice because it can help you decide whether to join a Medicare drug plan.** It is your proof of [creditable prescription drug coverage](#).

You won't have to pay a [penalty](#) if your employer or union stops offering prescription drug coverage that was creditable coverage if you join a Medicare drug plan before going 63 days without coverage. If your employer or union drug coverage isn't as good as Medicare prescription drug coverage (isn't creditable prescription drug coverage), find out about your options from your benefits administrator. You will have several choices. If you aren't notified, contact your benefits administrator.



If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union *drug* coverage without also dropping your employer or union *health* (doctor and hospital) coverage. If you drop your employer or union coverage for yourself, you may also have to drop coverage for your spouse and dependents. Contact your benefits administrator before you make any change to your drug coverage.

What if I get prescription drug coverage from TRICARE, the Department of Veterans Affairs (VA), or the Federal Employee Health Benefits Program (FEHBP)?

- As long as they still qualify, most people keep their TRICARE, VA, or FEHBP prescription drug coverage.
- Contact your benefits administrator or your insurer for information about your TRICARE, VA, or FEHBP coverage before making any changes. It will almost always be to your advantage to keep your current coverage without any changes. However, in some cases, adding Medicare prescription drug coverage can provide you with extra coverage and, sometimes, lower [copayments](#).
- If you lose your TRICARE, VA, or FEHBP coverage and your Medicare drug coverage begins within 63 days, in most cases, you won't have to pay a [penalty](#).

How do I join a Medicare drug plan?

Once you choose a Medicare drug plan, you may be able to join

- by paper application. Contact the company offering the plan you choose, and ask for an application. Once you fill out the application, mail or fax it back to the company.
- on the plan's website. Visit the drug plan company's website to see if you can join online.
- on Medicare's website. You may also be able to join a Medicare drug plan at www.medicare.gov on the web. Select "Compare Medicare Prescription Drug Plans." Not all Medicare drug plans offer the option to enroll on the web.
- over the telephone. You may be able to join by calling the plan you want or by calling 1-800-MEDICARE (1-800-633-4227). Medicare drug plans aren't allowed to call you to enroll you in a plan.

When you join a Medicare drug plan, you will have to provide your Medicare number. Look on your Medicare card for your number and the date your Part A or Part B coverage started.

For more information on joining or switching plans, see pages 71–78.

Getting the Most out of Your Medicare Prescription Drug Coverage

Once you have joined a Medicare drug plan, there are things you should know so you can get the most out of your Medicare prescription drug coverage. The following information can help answer questions that may come up as you begin to use your coverage.

What if I need to fill a prescription before I get my Medicare drug plan membership card?

You can take any of the following to the pharmacy as proof of membership in your Medicare drug plan:

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

If you enroll early in the month, there is a better chance you will have your membership materials when your coverage starts.

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



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

Why are there rules about whether and when certain drugs are covered?

There are many rules that can vary by plan. There are certain drugs that Medicare drug plans aren't required to provide, such as benzodiazepines, barbiturates, and drugs for weight loss or gain. Some plans may choose to cover these drugs as an added benefit. In addition, drug plans aren't allowed to cover over-the-counter drugs for erectile dysfunction or drugs for relief of colds.

Plans may also exclude certain drugs from coverage. Although your Medicare drug plan may not have a specific drug on their list of covered drugs (**formulary**), a drug that is safe and effective for the same purpose will be available for drugs that are covered by law. This may be in the form of a generic drug or therapeutic alternative (other brand-name drug) that has the same benefit as a more expensive brand-name drug.

Plans have rules that need to be followed before certain prescriptions can be filled. For instance, some drugs may have more side effects or have restrictions on how long they can be taken. Some drugs cost more than others even though some less expensive drugs may work for you just as well.

All plans have an **exceptions** process. If your doctor believes you need a drug that isn't on the plan's list or the plan has rules that should be waived, he or she can request an exception. Not all exceptions are granted. See pages 81–82 for more information.



Specific formulary information isn't included in this handbook because each plan has its own formulary. Formularies can change. Contact your plan for its most current formulary.

All Medicare drug plans have negotiated to get lower prices for the drugs they cover. This means using drugs on your plan's list will generally save you money. You will get lower prices for your prescriptions before you meet the **deductible** and when you are in the coverage gap (the period where you pay all of your costs). Using generic drugs can also save you money. For more information about other drugs you can use, go to www.medicare.gov on the web. Select "Compare Medicare Prescription Drug Plans." Or, call 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048.

What are some of the rules?

To be sure certain drugs are prescribed and used correctly and only when truly necessary, plans may have certain standard rules, including:

- **Prior authorization**—This means before the plan will cover these prescriptions, your doctor must contact the plan. Your doctor must show that the drug is **medically necessary** for it to be covered.
- **Quantity limits**—This means how many pills you can get at a time.
- **Step therapy**—This means one or more similar lower cost drugs must be tried before the step-therapy drug is covered (see example below).

Example of step therapy for a patient who needs a drug for heart failure

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

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

What if I’m taking a drug that isn’t on my plan’s drug list or a step-therapy drug when my drug plan coverage takes effect?

Your drug plan will provide a one-time, temporary supply of your current drug. During your first 90 days in a plan, Medicare requires Medicare drug plans to give you and your doctor time (30 days) to find another drug on the plan’s drug list that would work as well as the drug you are taking. Different rules may apply for people who move into an **institution** (like a nursing home). However, if you have already tried similar drugs and they didn’t work, or if your doctor determines that because of your medical condition it’s necessary for you to take a certain drug, he or she can contact your plan to request an **exception** as soon as you get your initial 30-day supply. If your doctor’s request is approved, the plan will cover the drug. **If the exception isn’t approved, you can **appeal** (see pages 79–82).**

What are “tiers or categories” on a Medicare drug plan’s drug list (formulary)?

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

Tier	You Pay	What is Covered	Cost Example*
1	Lowest copay	Most generic prescription drugs	\$5.00
2	Medium copay	Preferred brand-name prescription drugs	\$28.00
3	Higher copay	Non-preferred brand-name prescription drugs	\$53.00
Specialty Tier	Higher percentage	Unique, very high-cost drugs	25%–33% of drug cost

* These amounts aren’t actual costs. They are examples of [copayments](#) or [coinsurance](#) costs for a 30-day supply. Costs vary by plan and by drug.

Are generic drugs as good as brand-name drugs?

Yes. According to the Food and Drug Administration (FDA), a generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it’s taken, and the way it should be used. Generic drugs use the same active ingredients as brand-name drugs and work the same way. So they have the same risks and benefits as the brand-name drugs.

Because there are usually many drug makers competing to make generic drugs, their costs are 70% lower (on average) than brand-name drug costs. Generic drug makers must prove to the FDA that their product performs in the same way as the brand-name drug. Today, almost half of all prescriptions are filled with generic drugs.

How do I pay my Medicare drug plan premium?

There are three ways to pay your Medicare drug plan premium:

1. You can have your premium automatically deducted from a savings or checking account, or charged to a credit or debit card.
2. You can have the premium deducted from benefits you get from Social Security if your monthly payment covers your necessary deduction.
3. Your Medicare drug plan can send you a bill each month. (For more information about your Medicare drug plan premium or ways to pay for it, call your plan.)

Note: It will take two to three months for your premium deduction to begin after your coverage starts. When you first join a Medicare drug plan, your premiums for your first two or three months of coverage will be combined. For example, if you enroll in or switch Medicare drug plans in December for coverage that begins in January, your first premium payment will probably be due in February. It will include your premium for January and February.

What should I do if I move out of my Medicare drug plan's service area?

You can switch to a Medicare drug plan in your new area as early as the first day of the month before you move. This way, your new coverage will begin the first day of the month in which you move. Or, you can join up to two months after you move. If your previous employer or union pays for your Medicare prescription drug coverage, contact your benefits administrator to learn about your options.

You can get current information on the Medicare drug plans in your new area at www.medicare.gov on the web. Select “Search Tools” at the top of the page. Then select “Compare Medicare Prescription Drug Plans.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



If your income or resources are limited or change during the year, you may qualify for extra help paying your prescription drug costs. For more information about how you can apply for the extra help, see pages 64–65. You might want to consider lower cost prescription drug plans in your area if you aren't taking many drugs.

Other Medicare Plans, Government, and Private Insurance

57

Section

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

These include

1. Other Medicare Plans

- Cost Plans, see page 58
- Demonstrations/Pilot Programs, see page 59
- Programs of All-inclusive Care for the Elderly (PACE), see page 59

2. Other Government Insurance

- Federal Employee Health Benefits Program (FEHBP), see page 59
- Veterans' Benefits, see page 60
- Military Benefits (TRICARE), see page 60

3. Other Private Insurance

- Employer or Union Health Coverage, see page 61
- Long-term Care Insurance, see page 62

For more information, visit www.medicare.gov on the web, call your [State Health Insurance Assistance Program](#) (see pages 92–95 for their telephone number), or call 1-800-MEDICARE (1-800-633-4227). [TTY](#) users should call 1-877-486-2048.

Blue words in the text are defined on pages 97–100.



For information about [Medigap](#) (Medicare Supplement Insurance) [policies](#) that help pay some or all of the deductibles and coinsurance costs that the [Original Medicare Plan](#) doesn't cover, see pages 29–31.

1. Other Medicare Plans

There are some types of Medicare Plans that provide health care coverage that aren't part of [Medicare Advantage](#), but are still part of the Medicare Program. Medicare either pays a set amount of money for your care every month to these plans or reimburses the plan's reasonable cost for your care. They provide your Medicare Part A and Part B coverage, and some provide Part D (Medicare prescription drug coverage) as well.

These plans may work in much the same way, and have some of the same rules, as Medicare Advantage Plans (see pages 36–37 and 71–78). Each type of plan has special rules and exceptions. However, you should contact any plan you may be interested in to get more details. They are explained briefly below, and on page 59.

■ Medicare Cost Plans

[Medicare Cost Plans](#) are a type of HMO that are available in certain areas of the country.

In a Medicare Cost Plan

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

Other Medicare Plans (continued)

■ Demonstrations/Pilot Programs

Demonstrations are special projects that test improvements in Medicare coverage, payment, and quality of care. They are usually for a specific group of people and/or are offered only in specific areas. Some follow [Medicare Advantage](#) rules, but others don't. Check with the demonstration or pilot program for more information about how they work.

Pilot programs are for people with Medicare with one or more chronic illness. These programs are designed to reduce health risks, improve quality of life, and provide savings. For more information, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). [TTY](#) users should call 1-877-486-2048.

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

PACE combines medical, social, and [long-term care](#) services for frail elderly people who live in and get health care in the community. These joint Medicare and [Medicaid](#) programs are available in some states that have chosen to offer PACE as an optional Medicaid benefit. For information about PACE, see page 69.

2. Other Government Insurance

■ Federal Employee Health Benefits Program (FEHBP)

The FEHBP offers health coverage for current and retired Federal employees and covered family members. Generally, plans under FEHBP help pay for the same kind of expenses as Medicare. FEHBP plans also cover prescription drugs, routine physicals, emergency care outside of the United States, and some [preventive services](#) that Medicare doesn't cover. Some FEHBP plans also cover dental and vision care.

If you are covered under FEHBP, you will get information during the open season about your prescription drug coverage. Read this information carefully. Contact the Office of Personnel Management at 1-888-767-6738 or your plan if you have additional questions.

2. Other Government Insurance (continued)

■ Veterans' Benefits

If you are a veteran or have served in the U.S. military, call the U.S. Department of Veterans Affairs (VA) at 1-800-827-1000 or visit www.va.gov on the web for information about veterans' benefits and services available in your area. You may be able to get your prescription drugs through the VA program.

■ Military Benefits (TRICARE)

TRICARE is a health care program for active duty service members, retirees, and their families. TRICARE for Life (TFL) is medical coverage for Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses. TRICARE Prime is a managed care option. TRICARE Standard is a fee-for-service plan in which you can see any TRICARE-certified/authorized provider. TRICARE Extra is mostly an option for people with TRICARE Standard who want to save on out-of-pocket expenses by making an appointment with a TRICARE network provider (doctor, nurse practitioner, lab, etc.). All people with TRICARE are eligible for TRICARE pharmacy benefits.

People with TFL must have Medicare Part A and Part B to get TFL benefits. In general, for services covered by both Medicare and TFL, Medicare pays first for Medicare-covered services and TFL may pay second for services not covered by Medicare. For services covered only by Medicare, Medicare pays its share, and you pay any **deductible**, **copayment**, or **coinsurance**. For services covered only by TFL, TFL pays first. You pay the TFL deductible (\$150 for an individual, \$300 for a family) and your share of the cost. Call the contractor that handles TRICARE claims at 1-866-773-0404 for more information or help with TFL, or visit www.tricare.osd.mil on the web.

3. Other Private Insurance

■ Employer or Union Health Coverage

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

Medicare will help employers or unions continue to provide retiree drug coverage. If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you about how your drug plan will work with Medicare prescription drug coverage. **Keep the notice you get.** You may need to show it as proof of [creditable prescription drug coverage](#) if you join a Medicare drug plan at a later date. In some cases, if you join a Medicare drug plan, it can limit or end your employer or union coverage. Call your employer's or union's benefits administrator before you join a Medicare drug plan. For more information, see page 50.



If you drop your employer or union group health coverage, you may not be able to get it back. You also may not be able to drop *drug* coverage without also dropping all of your *health* coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependents. Call your employer's or union's benefits administrator for more information.

Note about COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) is a law that may allow you to keep health coverage from your or your spouse's employer after the employment ends. When the employment ends, you will get only one [Special Enrollment Period](#) to sign up for Part B without paying a penalty, whether or not you have COBRA coverage.

Part D works a little differently. For Part D, if you leave an employer-sponsored plan (including COBRA), you have a Special Enrollment Period.

Before you elect COBRA, talk with your [State Health Insurance Assistance Program](#) to see if buying a [Medigap policy](#) and/or a Medicare drug plan is better for you than COBRA. See pages 92–95 their telephone number.

3. Other Private Insurance (continued)

- **Long-Term Care Insurance**—It’s important to think about how to get and pay for [long-term care](#) before you need it. You, your family, lawyer, financial advisor, and/or insurance agent should consider your health status, risk factors, finances, preferences, and family situation before you choose an option, since these also affect your costs and coverage.

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.

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 (call 1-800-MEDICARE to get their telephone number), 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 92–95 for their telephone number).



If you decide to buy long-term care insurance, be sure that the company and the agent, if one is involved, is licensed in your state. If you aren’t sure, call your State Insurance Department.

Other options for paying for long-term care are explained below.

- **Reverse Mortgages**—“Reverse mortgages” are a type of loan that allow some homeowners to use the equity in their home as a source of income, without losing ownership. Visit www.medicare.gov on the web for more information.
- **Life Insurance**—Some insurance companies let you use your life insurance policy to pay for long-term care. Ask your insurance agent how this works.
- **Personal Resources**—You can use your savings to pay for long-term care.



For other options and more information about long-term care, visit www.medicare.gov on the web. Select “Search Tools” and then “Plan For Your Long-Term Care Needs.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Help for People with Limited Income and Resources

Section

8

There is extra help to pay for some health care and prescription drug costs if you have limited income and resources. You might qualify for one or more of the programs described in this section. This section covers the following six programs:

1. Extra help paying for Medicare prescription drug coverage, see pages 64–65
2. **Medicaid** (help from your state), see page 66
3. Medicare Savings Programs (help from your state Medicaid program paying Medicare **premiums**), see page 67
4. Supplemental Security Income (SSI) benefits, see page 68
5. The PACE Program (Programs of All-inclusive Care for the Elderly), see page 69
6. Programs for people who live in the U.S. Territories of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, see page 70

Blue words in the text are defined on pages 97–100.

Your state or local area may have other programs that could help you. Contact your State Medical Assistance (Medicaid) office for more information (see page 90).



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

Section 8: Help for People with Limited Income and Resources

1.

Extra help paying for Medicare prescription drug coverage

What is this program?

Medicare provides “extra help” to pay prescription drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan’s monthly **premium**, yearly **deductible**, and prescription **copayments**. In most cases, if you get extra help, you won’t pay a premium. Check with your plan. If you qualify for extra help, you won’t have a coverage gap (see page 45).

2007 Yearly Income and Resource Limits to Qualify for Extra Help
(Amounts will change in early 2008.)

	Income	Resources
Single	Less than \$15,315	Less than \$11,710
Married (living with spouse)	Less than \$20,535	Less than \$23,410

If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa have their own rules for providing extra help to their residents. See page 70 for more information.

How do I qualify for this program?

You automatically qualify for extra help if you have Medicare and

- have or become eligible for **Medicaid** benefits (see page 66),
- get help from your state Medicaid program paying your Medicare premiums (you belong to a Medicare Savings Program, see page 67), or
- get Supplemental Security Income (SSI) benefits without Medicaid (see page 68).

Section 8: Help for People with Limited Income and Resources



What happens if I automatically qualify for extra help?

Medicare mails letters to people who automatically qualify for extra help and don't need to apply for it. If you get one of these letters, keep it for your records. You still need to join a Medicare drug plan to get Medicare prescription drug coverage. If you don't join a Medicare drug plan, Medicare will enroll you in one to make sure you don't miss a day of coverage. Check to see if the plan Medicare enrolled you in covers the drugs you use and if you can go to the pharmacies you prefer. If not, you can change plans.

If Medicare enrolls you in a plan, Medicare will send you a letter letting you know when your coverage begins. If you don't want to join a Medicare drug plan (for example, because you want to keep your employer or union coverage instead), you can call 1-800-MEDICARE (1-800-633-4227) or the plan listed in your letter and tell them you don't want to be in the Part D plan. You must be in a Medicare drug plan to get this extra help.

If you didn't automatically qualify, but think you might qualify for extra help, here's what to do:

- 1. Apply for extra help.** Call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance ([Medicaid](#)) office (see page 90). TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what to do next. Even if you don't qualify, you should consider joining a drug plan.
- 2. Join a Medicare drug plan.** If you apply and qualify for extra help, you can either join a plan on your own or let Medicare enroll you in a plan. Medicare will send you a letter letting you know what plan it will enroll you in and when your coverage begins. If Medicare enrolls you in a drug plan, you can switch plans at least once through the end of the calendar year. You can also switch plans one time between November 15 and December 31 in following years. Your coverage would begin January 1 of the following year.

Call 1-800-MEDICARE (1-800-633-4227) or your [State Health Insurance Assistance Program](#) (see pages 92–95 for their telephone number) to get answers to your questions about extra help paying for your prescription drug costs. [TTY](#) users should call 1-877-486-2048.

Section 8: Help for People with Limited Income and Resources

2.

Medicaid

What is this program?

Medicaid is a joint Federal and state program that helps pay medical costs for some people with limited income and resources. Most of your health care costs are covered if you have Medicare and Medicaid.

Medicaid programs vary from state to state. People with Medicaid may get coverage for services that aren't fully covered by Medicare, such as nursing home and home health care.

Who qualifies for this program?

The income limits for Medicaid vary from state to state. Contact your State Medical Assistance (Medicaid) office to see if you qualify.

How do I apply for this program?

Call your State Medical Assistance (Medicaid) office for more information about Medicaid (see page 90). Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your State Medical Assistance office. **TTY** users should call 1-877-486-2048.



Some Medicare **Special Needs Plans may provide special coverage for people with both Medicare and Medicaid (see page 38).**

3.

Medicare Savings Programs (help from Medicaid paying Medicare premiums)

What is this program?

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

Who qualifies for this program?

- You must have Medicare Part A. The Medicare Savings Program may pay your Part A or Part B premiums.
- You must be an individual with **resources** of \$4,000 or less, or a married couple with resources of \$6,000 or less. Resources include things like money in a checking or savings account, stocks, and bonds, but don't include things like your house or car.
- You must be an individual with a monthly **income** of less than \$1,169, or a married couple with a monthly income of less than \$1,561. Income limits will increase slightly in 2008. If you live in Alaska or Hawaii, income limits are slightly higher.



Individual states may have higher income and/or resource limits. Check with your State Medical Assistance (Medicaid) office. Also, certain types of income and resources aren't counted, so you should still apply even if you think your income and resources are above the limit. It's the only way to be sure if you qualify.

How do I apply for this program?

Call your State Medical Assistance (Medicaid) office (see page 90). Since the names of these programs may vary by state, ask for information on Medicare Savings Programs. It's very important to call if you think you qualify for any of these programs, even if you aren't sure. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state. **TTY** users should call 1-877-486-2048.

4.

Supplemental Security Income Benefits

What is this program?

Supplemental Security Income (SSI) is a monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits provide cash to meet basic needs for food, clothing, and shelter. SSI benefits aren't the same as Social Security benefits. You can make an appointment to apply for SSI benefits on the telephone or in person at your local Social Security office.

Who qualifies for this program?

To qualify for SSI, you must have limited income and resources, and be disabled, blind, or age 65 or older. You also must be a resident of the U.S., not be absent from the country for more than 30 days, and be either a U.S. citizen or national, or in one of certain categories of eligible non-citizens. People who live in Puerto Rico, the Virgin Islands, Guam, and American Samoa generally can't get SSI benefits.

How do I apply for this program?

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

5.

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

What is this program?

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

Who qualifies for this program?

The qualifications for PACE vary from state to state.

How do I apply for this program?

Call your State Medical Assistance (Medicaid) office to find out if you are eligible and if a PACE site is near you. For more information, see page 90.

You can also visit www.cms.hhs.gov/pace/pacesite.asp on the web for PACE locations and telephone numbers.

6.

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

What are these programs?

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

Who qualifies and how do I apply?

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

Section

9

This section gives you information about how to join or switch a [Medicare Advantage Plan](#) or [Medicare Prescription Drug Plan](#). It's important to know that most people can only join or switch plans at certain times. But some people, like those new to Medicare or those with both Medicare and [Medicaid](#), have other options.

Who can join a Medicare Advantage Plan (like an HMO or PPO)?

You can generally join a Medicare Advantage Plan if

- you live in the [service area](#) of the plan you want to join. In a Medicare HMO, the service area is usually where you get services from the plan. The plan can give you more information about its service area. If you live in another state for part of the year, check to see if the plan will cover you there.

AND

- you have Medicare Part A **and** Part B. However, if you are already in a Medicare Advantage Plan and have only Part B, you may stay in your plan.

AND

- you don't have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), except as explained on page 74.

Blue words in the text are defined on pages 97–100.



These rules may be different for Medicare [Special Needs Plans](#) (see page 38), [Medicare Medical Savings Account Plans](#) (see page 39), [Medicare Cost Plans](#) (see page 58), [Demonstrations/Pilot Programs](#) (see page 59), or [Programs of All-Inclusive Care for the Elderly](#) (see page 69).

Section 9: How to Join and Switch Plans

Who can join a Medicare Prescription Drug Plan?

Everyone with the [Original Medicare Plan](#), a Medicare [Private Fee-for-Service Plan](#) that doesn't offer prescription drug coverage, a [Medicare Cost Plan](#), or a [Medicare Medical Savings Account Plan](#) can join a [Medicare Prescription Drug Plan](#) in their area. To get Medicare drug coverage, you must join a Medicare Prescription Drug Plan if you are in the Original Medicare Plan. Or, you must join a [Medicare Advantage Plan](#) that includes drug coverage.



If you have prescription drug coverage from a former or current employer or union, contact your benefits administrator before you make any changes to your drug coverage. If you join a Medicare Prescription Drug Plan or Medicare Advantage Plan, you and your family may lose your employer or union coverage.

When can I join a Medicare Advantage Plan or Medicare Prescription Drug Plan available in my area?

1. You can join when you first become eligible for Medicare (three months before the month you turn age 65 until three months after the month you turn age 65). If you get Medicare due to a disability, you can join from three months before to three months after your 25th month of cash disability payments.
2. If you didn't join when you were first eligible, you can join between November 15 and December 31 of each year. Your coverage will begin on January 1 of the following year. Generally, your next opportunity to make a change will be between November 15 and December 31 of each year.

Note: In certain situations, you may be able to join a Medicare Advantage Plan or Medicare Prescription Drug Plan at other times. For example

- if you move out of the service area of the plan you are in,
- if you have both Medicare and [Medicaid](#),
- if you live in, or move into or out of an [institution](#) (like a nursing home), or
- if you have [creditable prescription drug coverage](#) and that coverage ends.

When can I join a Medicare Advantage Plan or Medicare Prescription Drug Plan available in my area? (continued)

If you are eligible for a [Medicare Advantage Plan](#), you can also join or switch Medicare Advantage Plans from January 1 to March 31 of any year, but you can't join or drop Medicare prescription drug coverage during this time. For instance, if you are in a Medicare Advantage Plan with prescription drug coverage, you could return to the Original Medicare Plan, but you'd have to also join a Medicare Prescription Drug Plan at the same time. If you have questions about whether or not you can join or switch Medicare plans, call 1-800-MEDICARE (1-800-633-4227). [TTY](#) users should call 1-877-486-2048.

Special Note for Joining Medicare Prescription Drug Plans:

If you don't join a Medicare drug plan when you are first eligible, you most likely will have to pay a higher [premium](#) that includes a [penalty](#), unless you have had continuous [creditable prescription drug coverage](#). You will have to pay this penalty as long as you have Medicare prescription drug coverage. The next time you can join is from November 15—December 31 of 2007, and your coverage won't start until January 1, 2008.

How do I join a Medicare Advantage Plan or Medicare Prescription Drug Plan?

Compare the Medicare Advantage Plans and [Medicare Prescription Drug Plans](#) available in your area. To compare plans, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). You can also contact your [State Health Insurance Assistance Program](#) (see pages 92–95 for their telephone number) or one of Medicare's other partners to get help with Medicare options. Once you have decided whether you want to join, contact the plan(s) you are interested in to find out more information and to enroll. After you enroll, you will get a membership card and other plan materials. The plan lets you know when your coverage begins.



See page 51 for more information on how to enroll in a Medicare prescription drug plan (including by paper application, on the plan's website, on Medicare's website, or over the telephone).

Section 9: How to Join and Switch Plans

Special Rules for People with End-Stage Renal Disease

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

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

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

For more information, visit www.medicare.gov and view the booklet "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services." To compare dialysis facilities in your area, visit www.medicare.gov on the web. Select "Search Tools" at the top of the page. Then select "Compare Dialysis Facilities in Your Area." Or, call 1-800-MEDICARE (1-800-633-4227) for more information about ESRD and Medicare plans. TTY users should call 1-877-486-2048.

Can I keep my Medigap (Medicare Supplement Insurance) policy if I join a Medicare Advantage Plan (like an HMO or PPO)?

Yes, you can keep it. However, **you will have to keep paying your premiums and you may get little or no benefit from it while you are in a Medicare Advantage Plan.** If you join a Medicare Advantage Plan, your [Medigap policy](#) can't pay any [deductibles](#), [copayments](#), or [coinsurance](#) under your Medicare plan. Also, if your plan covers prescription drugs and you have a Medigap policy that covers prescription drugs, the drug coverage must be removed from the Medigap policy, and the premium changed. You can't have prescription coverage from both a Medigap policy and a Medicare drug plan. Medigap drug coverage is generally not as good as coverage under a Medicare drug plan. Call your [State Health Insurance Assistance Program](#) if you need help deciding whether to keep your Medigap policy (see pages 92–95 for their telephone number).

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

In most cases, if you drop your [Medigap policy](#), you may not be able to get it back. **However, if this is the first time** you've joined a [Medicare Advantage Plan](#), other Medicare plan, or bought a Medicare SELECT policy (a Medigap policy that requires you to use specific hospitals and, in some cases, specific doctors to get your full insurance benefits), you may have special Medigap protections that give you a right to get your old Medigap policy back or buy a new one if you choose to leave your Medicare Advantage Plan or other Medicare plan within the first year. In either case, the Medigap policy can't include prescription drug coverage. You may also be able to join a [Medicare Prescription Drug Plan](#) if you leave your Medicare Advantage Plan the first year. Check with your [State Health Insurance Assistance Program](#) to see if your state offers other rights to buy Medigap policies. See pages 92–95 for their telephone number.

For more information on Medigap policies and protections, visit www.medicare.gov on the web and view the booklet “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare” or call 1-800-MEDICARE (1-800-633-4227).

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

In some cases, if you join a Medicare Advantage Plan or a Medicare Prescription Drug Plan and also have employer or union coverage, you may still be able to use your employer or union coverage along with the plan you join. In other cases, joining a Medicare plan when you have employer or union coverage might cause you to lose your employer or union 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 rejoin it later.** For more information, see page 61.

When can I switch my Medicare plan?

Generally, if you join a Medicare Advantage Plan or Medicare Prescription Drug Plan, you can only change plans **from November 15 through December 31 of every year**. This change will be effective January 1 of the following year. For more information, see pages 72–73. If you are also eligible for [Medicaid](#), you can switch plans at anytime.

Section 9: How to Join and Switch Plans

How do I switch my Medicare Advantage Plan or Medicare Prescription Drug Plan?

You can switch your plan in one of three ways:

1. Join another plan.
2. Write or call the plan you want to join.
3. Call 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048.

If you want to switch from a Medicare Advantage Plan to the Original Medicare Plan, you need to contact your current plan or call 1-800-MEDICARE (1-800-633-4227).

If you want to buy a [Medigap policy](#), simply signing up for the Medigap policy won't end your Medicare Advantage Plan coverage. You must disenroll. In some cases, you may have certain Medigap protections that give you the right to buy a Medigap policy, but in other cases, you may not be able to buy any Medigap policy. Your rights to buy a Medigap policy can vary by state. If you want to talk to someone who can help you decide what to do, call your [State Health Insurance Assistance Program](#) (see pages 92–95 for their telephone number).

If you want to switch to a new Medicare Advantage Plan, simply join the new Medicare Advantage Plan that you want. You don't need to tell your old Medicare Advantage Plan you are leaving or send them anything. You will be disenrolled automatically from your old Medicare Advantage Plan when your new Medicare Advantage Plan coverage begins. You should get a letter from your new Medicare Advantage Plan telling you when your coverage starts.



Rules for joining and switching Medicare Cost Plans, Demonstrations, Pilot Programs, and PACE plans may be different. See pages 58–59, or call the plan for more information.

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

You can call the plan to see if you can stay in the Medicare plan. If you must switch to another Medicare plan, follow the instructions on page 76 for switching a Medicare plan. Your choices may include joining

- another [Medicare Advantage Plan](#) if one is available in your new area, or
- the [Original Medicare Plan](#), and you will have the right to join a stand-alone [Medicare Prescription Drug Plan](#), and/or buy a [Medigap policy](#) to fill the gaps in Original Medicare Plan coverage (see pages 29–31), or
- another Medicare Prescription Drug Plan.

What can I do if my plan leaves the Medicare Program?

At the end of the year, plans can decide to leave the Medicare Program. If your plan leaves the Medicare Program, the plan will send you a letter about your options. **Note:** In recent years, very few plans have left the Medicare Program.

Special Rules if you are in a Medicare Advantage Plan that leaves the Medicare Program

You will be automatically returned to the Original Medicare Plan if you don't choose to join another Medicare Advantage Plan. You will also have the right to buy a Medigap policy (see pages 29–31). 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.

If your health plan covers prescription drugs and you want to keep getting prescription drug coverage, you need to join another plan that offers this coverage. If you decide to return to the Original Medicare Plan and want to continue to have drug coverage, you will have to join a Medicare Prescription Drug Plan.

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

At the end of the year, [Medicare Advantage Plans](#) can decide to discontinue providing services in certain areas. 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 with that plan. Ask your plan. If your plan has this option, 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 have this option, you will automatically return to the [Original Medicare Plan](#) on January 1. In this case, you will have the right to buy a [Medigap policy](#) (see pages 29–31). If you decide to return to the Original Medicare Plan, and you want to continue to have drug coverage, you will have to join a [Medicare Prescription Drug Plan](#).



Regional Preferred Provider Organizations (PPOs) (see page 36) won't reduce their service area, but they can join or leave the Medicare Program each year.

Section

10

Your Right to Appeal

If you have Medicare, you have certain guaranteed rights. One of these is the right to a fair process to **appeal** decisions about health care payment or services. **No matter what kind of Medicare plan you have, you may have the right to appeal these decisions.**

You may appeal if

- a service or item you got 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.

You can find information on how to file an appeal in

- the box below if you are in the **Original Medicare Plan**,
- your health plan materials if you are in a **Medicare Advantage Plan**, or
- your drug plan materials if you are in a **Medicare Prescription Drug Plan**.



Blue words in the text are defined on pages 97–100.

If you are in the Original Medicare Plan, you can request an appeal by following the instructions below:

- 1. Circle the item(s) on the Medicare Summary Notice you disagree with and explain why you disagree.**
- 2. Sign the Medicare Summary Notice and provide your telephone number.**
- 3. Send the Medicare Summary Notice, or a copy, to the address in the “Appeals Information” section of the Medicare Summary Notice. You can also send any additional information you may have about your appeal.**

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

Your Right to Appeal (continued)

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

If you are in the Original Medicare Plan and you aren't sure if Medicare was billed for the services you got, call or write to the health care provider or supplier and ask for an itemized statement. This statement will list each Medicare item or service you got from them. You should get the statement within 30 days. Also, check your MSN to see if the service was billed to Medicare. If the service was not billed to Medicare, tell the health care provider or supplier to submit the bill to Medicare.

If you are in the Original Medicare Plan, your health care provider or supplier may give you a notice called an "Advance Beneficiary Notice" that says Medicare probably (or certainly) won't pay some Medicare services in certain situations. This helps protect you from unexpected bills in some cases. 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. You can still ask your health care provider or supplier to submit the bill to Medicare.

Medicare plans like HMOs, PPOs, and [Medicare Prescription Drug Plans](#) have other ways of providing this information. If you are in one of these Medicare plans, call your plan to find out if a service or item will be covered.

Your Right to a Fast Appeal

If you are getting Medicare services from an inpatient hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, you may have the right to a fast [appeal](#) if you think your Medicare-covered services are ending too soon. This fast appeal is also called an expedited review or an immediate appeal. You will get a notice from your health care provider, supplier, or health plan that will tell you how to ask for a fast appeal. An independent reviewer will look at your case to decide if your services need to continue. If you decide to file a fast appeal, ask your doctor for any information that may help your case. You can also contact your [State Health Insurance Assistance Program](#) for help filing an appeal (see pages 92–95 for their telephone number). You may have other appeal rights if you miss the timeframe for filing a fast appeal.

Can I appeal my Medicare Prescription Drug Plan's decisions?

Yes. You have the right to get a written explanation from your Medicare Prescription Drug Plan if your request for a drug is denied. Some reasons you might ask for a written explanation are if the pharmacist tells you that your drug plan won't cover a prescription or you are asked to pay more than you think you are required to pay. You also have the right to ask your drug plan for an [exception](#) if you and your doctor believe you need a drug that isn't on your drug plan's list of covered drugs.

If you disagree with the information provided by a pharmacist, you can contact your plan to ask for a [coverage determination](#). The pharmacy will give or show you a notice that explains how to contact your Medicare drug plan.



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

Can I appeal my Medicare Prescription Drug Plan's decisions? (continued)

A standard request must be made in writing unless your plan accepts requests by phone. You or your doctor can call or write your plan for an expedited (fast) request. Once your Medicare drug plan gets your request for a [coverage determination](#), the Medicare drug plan has 72 hours (for a standard request) or 24 hours (for an expedited request) to notify you of its decision. If you are requesting an [exception](#), your prescribing doctor must provide a statement explaining the medical reason why your request should be approved. Your plan generally has 72 hours (for a standard request) or 24 hours (for an expedited request) to notify you of its decision once your plan receives your doctor's statement.

If you disagree with your Medicare drug plan's decision, you have the right to appeal. You must request the appeal within 60 calendar days from the date of the decision. A standard request must be made in writing unless your Medicare drug plan accepts requests by phone. You can call or write your plan for an expedited request. Once your Medicare drug plan receives your request for an appeal, the Medicare drug plan has seven days (for a standard request for coverage) or 72 hours (for an expedited request for coverage) to notify you of its decision.

Other Medicare Rights

In addition, you have rights to

- get information.
- get emergency room or urgently needed care services.
- see doctors, specialists (including women's health specialists), and go to Medicare-certified hospitals.
- participate in treatment decisions.
- know your treatment choices.
- get information in a culturally competent manner in certain circumstances (for example, get information in languages other than English from Medicare, and its providers and contractors).
- file complaints (for example, you may file quality of care complaints).
- nondiscrimination (see page 88).
- have your personal and health information kept private.

Notice of Privacy Practices for the Original Medicare Plan

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

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

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

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

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

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

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

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

Section 10: Your Medicare Rights

By law, Medicare must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that isn’t set out in this notice. You may take back (“revoke”) your written permission at any time, except if Medicare has already acted based on your permission.

By law, you have the right to

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

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

- exercising your rights set out in this notice.
- filing a complaint, if you believe the [Original Medicare Plan](#) has violated these privacy rights. Filing a complaint won’t affect your benefits under Medicare.

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

You may file a complaint with the Secretary of the Department of Health and Human Services. Visit www.hhs.gov/ocr/hipaa on the web or call the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

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

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

The Medicare Beneficiary Ombudsman is Working For You

The Medicare Beneficiary Ombudsman works to ensure that people with Medicare get the information and help they need to understand their Medicare options and to apply their rights and protections. The Medicare Ombudsman may identify issues and problems in payment and coverage policies, but doesn't advocate for any increases in program payments or new coverage of services.

The Medicare Ombudsman works to ensure that existing Medicare information, counseling, and assistance resources work the way they should to help you with your complaints, [appeals](#), grievances, or questions about Medicare.

There are many ways you can get Medicare information or have your Medicare-related problems resolved. The Medicare Ombudsman works with the organizations responsible for meeting these needs to be sure they work effectively.

The Medicare Ombudsman...

- provides these organizations with expected standards for effective and efficient performance.
- gathers information to measure how well your needs are met and whether you have the information you need to make good health care decisions.
- shares information about what works well and what doesn't work well to continuously improve the quality of the services and care you get through Medicare.
- reports problems and makes recommendations for improvement to Congress.
- works to ensure that the needs of all people with Medicare are served by its programs.

Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for more information, to ask questions, and to submit complaints about Medicare to the Office of the Medicare Ombudsman. TTY users should call 1-877-486-2048.

Protect Yourself from Identity Theft and Fraud

Identity theft means someone uses your personal information without your consent to commit fraud or other crimes. Personal information includes things like your name, or your Social Security, Medicare, or credit card numbers.

Keep this information safe. Don't give your information to anyone who calls you (or comes to your home) uninvited selling Medicare-related products. **Only give personal information to doctors, other providers, and Medicare plans approved by Medicare, and to people in the community who work with Medicare, like your [State Health Insurance Assistance Program](#) or Social Security.**

Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a provider is approved by Medicare.



If you think someone is using your personal information, call:

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

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

Note: Medicare plans that are offering demonstrations or pilot programs are allowed to call you to see if you want to enroll. For more information about demonstrations and pilot programs, see page 59.

Protect Yourself and Medicare from Billing Fraud

Most doctors, health care providers, plans, and pharmacies who work with Medicare are honest. There are a few who are dishonest. Medicare is working with other government agencies to protect you and the Medicare Program from such dishonesty.

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.



If you suspect billing fraud, you can call

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

When you get health care in the **Original Medicare Plan**, you get a Medicare Summary Notice from a company that handles bills for Medicare. It shows what services or supplies were charged and how much Medicare paid. Check the notice for mistakes, and 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 that 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.

Fighting fraud can pay

You may get a reward of up to \$1,000 if

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

For more information, call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov on the web and view the booklet "Protecting Medicare and You from Fraud."

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 Department of Health and Human Services, Office for Civil Rights for your state, or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr on the web for more information.

For More Information

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Section

Get Personalized Medicare Information Anytime



The screenshot shows the Medicare website interface. At the top, it says "Official Medicare Website" with a "Live 'Help' Chat!" link. Below that is a navigation menu with "Home", "My Claims", "My Enrollment", "My Preventive Services", "My Messages", "My Profile", and "My Links". A search bar is labeled "Search Medicare.gov". The user is logged in as "JOHN DOE" and the date is "Thursday, May 04, 2006". The page layout includes a "Page Layout" section with "Text Size" options (A, A, A). The main content area is partially obscured by a text box.

Register at www.MyMedicare.gov to

- track your health care claims
- check your Part B deductible status
- view your eligibility information
- track the preventive services you can use
- find your Medicare health or prescription plan, or search for a new one
- keep your Medicare information in one convenient place

Go to www.medicare.gov to

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

1-800-MEDICARE Helpline

At Medicare, we are always working to improve our service to you. The 1-800-MEDICARE (1-800-633-4227) helpline has 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 Medicare card in front of you (see sample card on page 7).

For common questions, use the chart below to help direct your call. If you need help, you can say “Agent” at any time to talk to a customer service representative.

If you are calling about...	Just say...
Medicare prescription drug coverage	“Drug Coverage”
Claim or billing issues, or a specific Medicare claim appeal	“Claims” or “Billing”
Preventive services available to you	“Preventive Services”
Forms or Handbooks	“Publications”
Telephone numbers for your State Medical Assistance (Medicaid) office	“Medicaid”
General questions about Medicare coverage	“General Questions”
Outpatient doctor’s care	“Doctor Service”
Inpatient or outpatient hospital visit or emergency room care	“Hospital Stay”
Oxygen, wheelchairs, walkers, eyeglasses, or diabetic supplies	“Medical Supplies”
Information about your Part B deductible	“Deductible”
General or billing information for nursing homes, home health, or hospice care	“Nursing Home,” “Home Health Care,” or “Hospice Facility”

You can also call 1-800-MEDICARE (1-800-633-4227) to get telephone numbers for your local Quality Improvement Organization (call with questions about the quality of Medicare-covered services) and State Insurance Department (call with general insurance questions). The telephone number for your [State Health Insurance Assistance Program](#) is on pages 92–95. **TTY users should call 1-877-486-2048.**



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

Other Important Contacts

Below are telephone numbers for organizations that provide nationwide services. These numbers were correct at the time of printing. Sometimes these numbers change.

1-800-MEDICARE Helpline
(see page 90)

1-800-633-4227
TTY 1-877-486-2048

Social Security

Call for address or name changes, death notification, enrolling in Medicare, to replace your Medicare card, for information about signing up for extra help with prescription drug costs, and about Social Security benefits.

1-800-772-1213
TTY 1-800-325-0778

State Health Insurance Assistance Program

See pages 92–95

Coordination of Benefits Contractor

1-800-999-1118
TTY 1-800-318-8782

Department of Defense

TRICARE

1-888-363-5433

TRICARE for Life

1-866-773-0404

Department of Health and Human Services

Office of the Inspector General

1-800-447-8477
TTY 1-800-377-4950

Office for Civil Rights

1-800-368-1019
TTY 1-800-537-7697

Department of Veterans Affairs

1-800-827-1000
TTY 1-800-829-4833

Railroad Retirement Board (RRB)
(RRB beneficiaries only)

Local RRB office or
1-800-808-0772



Section 11: For More Information

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.

Section 11: For More Information



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Medicare Publications

Detailed booklets are available on Medicare topics such as

- preventive services,
- hospice care,
- home health care,
- Medicare prescription drug coverage,
- choosing a nursing home,
- skilled nursing care, and
- rights and protections.

To read, print, or download copies of these booklets, or to see what's available,

1. visit www.medicare.gov on the web, then
2. select “Search Tools” at the top of the page, then
3. select “Find a Medicare Publication.”



You can search by keyword (like hospice or rights), or click the “Go” button, and every publication will be listed in alphabetical order.

Section 1

Appeal—A special kind of complaint you make if you disagree with certain kinds of decisions made by Medicare or your health or prescription drug plan. You can appeal if you request a health care service, supply or prescription that you think you should be able to get, or you request payment for health care you already received, and Medicare or a plan denies the request. You can also appeal if you are already receiving coverage and the plan stops paying. There is a specific process your plan must use when you ask for an appeal.

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

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

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

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

- whether or not to provide or pay for a Part D drug
- a formulary exception request you may have made
- what you must pay out-of-pocket for a drug
- whether you have satisfied a prior authorization requirement for a requested drug

If you disagree with the decision, the next step is an appeal.

Creditable Prescription Drug

Coverage—Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

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

Deductible—The amount you must pay for health care or prescriptions, before the Original Medicare Plan, your prescription drug plan, or other insurance begins to pay. For example, in the Original Medicare Plan, you pay a new deductible for each benefit period for Part A and each year for Part B. These amounts can change every year.

Exception—A formulary exception is a decision to cover a drug that's not on the formulary. A tiering exception is a decision to charge you a lower tier amount for a drug that is on a non-preferred drug tier (see page 55). Another exception can be a decision not to apply a limit, like a dose or quantity limit. Your doctor must send a supporting statement with the medical reason for the exception.

Formulary—A list of drugs covered by a plan.

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

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

Lifetime Reserve Days—In the Original Medicare Plan, these are additional days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance (see page 105).

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

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

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

Medicare Advantage Plan (Part C)—A type of Medicare plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called Part C, Medicare Advantage Plans are HMOs, PPOs, Private Fee-for-Service Plans, or Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under the Original Medicare Plan. Some Medicare Advantage Plans offer prescription drug coverage.

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

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

Medicare Medical Savings Account (MSA) Plan—MSA Plans combine a high-deductible Medicare Advantage Plan (like an HMO or PPO) with a Medical Savings Account for medical expenses.

Medicare Prescription Drug Plan (Part D)—A stand-alone drug plan offered by insurers and other private companies to people who get benefits through the Original Medicare Plan, through a Medicare Private Fee-for-Service Plan that doesn’t offer prescription drug coverage, a Medicare Cost Plan, or Medicare Medical Savings Account Plan. Medicare Advantage Plans may also offer prescription drug coverage that must follow the same rules as Medicare Prescription Drug Plans.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, all Medigap policies must be one of 12 standardized Medigap policies labeled Medigap Plan A through Plan L. Medigap policies **only** work with the Original Medicare Plan.

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

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

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

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

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

Preventive Services—Health care to 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 makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Private Fee-for-Service (PFFS) Plan—

A type of Medicare Advantage Plan (Part C) in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare Program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits and may have extra benefits than in the Original Medicare Plan.

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

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

Special Enrollment Period (SEP)—

Under Part B, a period when you can enroll in Medicare Part B if you didn't sign up when first eligible because you or your spouse (or a family member, if disabled) was still working and you were covered under a group health plan from an employer or union. You sign up for Part B at anytime while covered under the group health plan based on that employment, or during the 8-month period that begins the month the employment ends or the group health plan coverage ends, whichever comes first. Usually, if you join Part B in the SEP, you don't pay a penalty.

Under Part D, you may get a SEP to join a plan that provides Medicare prescription drug coverage, or switch to a different plan in certain situations, like if you move out of the service area of a Medicare drug plan, or lose creditable prescription drug coverage.

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

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—Medical or other health services given to a patient using a communications system (like a computer, telephone, or television) by a practitioner located away from the patient.

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

Your 2007 Monthly Premiums for Medicare

Part A (Hospital) Monthly Premium

Most people pay \$0 each month for Part A, because they paid Medicare taxes while working.

You pay up to \$410.00 each month if you don't get [premium-free](#) Part A.

Part B (Medical) Monthly Premium

If Your Yearly Income is		You pay
File Individual Tax Return	File Joint Tax Return	
\$80,000 or less	\$160,000 or less	\$93.50*
\$80,001-\$100,000	\$160,001-\$200,000	\$105.80*
\$100,001-\$150,000	\$200,001-\$300,000	\$124.40*
\$150,001-\$200,000	\$300,001-\$400,000	\$142.90*
Above \$200,000	Above \$400,000	\$161.40*

Part C (Medicare Advantage Plan) Monthly Premium

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

Part D (Medicare Prescription Drug Plan) Monthly Premium

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

*There may be a late-enrollment [penalty](#).

What you pay for the Original Medicare Plan in 2007

Part A Costs for Covered Services and Items

Blood	You pay all costs for the first three pints of blood you get as an inpatient, then 20% of the Medicare-approved amount for additional pints of blood (unless donated to replace what's used).
Home Health Care	You pay <ul style="list-style-type: none"> ■ \$0 for home health care services ■ 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	You pay a copayment of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest).
Hospital Stay	You pay <ul style="list-style-type: none"> ■ \$992 deductible and no coinsurance for days 1-60 each benefit period ■ \$248 per day for days 61-90 each benefit period ■ \$496 per “lifetime reserve day” after day 90 each benefit period (up to 60 days over your lifetime coverage.)
Skilled Nursing Facility Stay	You pay <ul style="list-style-type: none"> ■ \$0 for the first 20 days each benefit period ■ \$124 per day for days 21–100 each benefit period ■ All costs for each day after day 100 in the benefit period

Note: These services must be covered by **Medicare Advantage Plans**. Costs vary by plan, but may be lower than those noted above.

What you pay for the Original Medicare Plan in 2007 (continued)

Part B Costs for Covered Services and Items

Blood	You pay all costs for the first three pints of blood you get as an outpatient, then 20% of the Medicare-approved amount for additional pints of blood (unless donated to replace what's used).
Clinical Laboratory Services	You pay \$0 for Medicare-approved services.
Deductible	You pay the first \$131 yearly for Part B-covered services or items.
Home Health Services	You pay \$0 for Medicare-approved services. You pay 20% of the Medicare-approved amount for durable medical equipment.
Medical and Other Services	You pay 20% of the Medicare-approved amount for most doctor services, outpatient therapy*, most preventive services , and durable medical equipment.
Mental Health Services	You pay 50% for outpatient mental health care.
Other Covered Services	You pay copayment and coinsurance amounts.
Outpatient Hospital Services	You pay a coinsurance or copayment amount that varies by service.

*In 2007, there may be limits on physical therapy, occupational therapy, and speech-language pathology services. If so, there may be exceptions to these limits.

Note: These services must be covered by [Medicare Advantage Plans](#). Costs vary by plan, but may be lower than those noted above.

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

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

Part D Medicare Prescription Drug Plan Costs for Covered Prescription Drugs

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

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

For more information about estimating your penalty amount, see page 48.

	2007
Part D National Average Benchmark Premium	\$27.35
1% Penalty Calculation	\$.27

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

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

To get this handbook on audiotape (English and Spanish), in Braille, large print (English and Spanish), or Spanish, visit www.medicare.gov on the web, or 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.

