Medicare & You 2002

This handbook has important information about:

- **Your Medicare benefits.**
- **Choosing a health plan that's right for you.**
- **New ways to get information.**

How do you find what you need? See page 67.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Welcome to *Medicare & You!*

Your Medicare health care coverage is one of the most important assets you have. This handbook is designed to help you learn about the health care choices you have as a person with Medicare. It also tells you about new benefits and new ways to get information.

We're making it easier for you to learn about your choices with...

- ✓ **Expanded phone services**. Call 1-800-MEDICARE (1-800-633-4227) for fast answers to your questions. You can speak with a customer service representative 24 hours a day, including weekends (see pages 6-7).
- ✓ **Information on the Web**. Look on www.medicare.gov for information you can trust. You can get the most up-to-date Medicare news and answers to your questions right now (see page 8).
- ✓ **New tool to help you decide**. Choosing the Medicare health plan that's right for you is an important decision. The new "Medicare Personal Plan Finder" can help you make your health plan choice. This new service is on www.medicare.gov on the Web. Or, call 1-800-MEDICARE (1-800-633-4227). Ask about the "Medicare Personal Plan Finder." Details are on pages 28-29.
- ✓ **Help paying Medicare expenses.** States have programs for people with limited income and resources that pay some or all of Medicare's premiums. Some programs may also pay Medicare deductibles and coinsurance. For more information, see page 58.

No matter which Medicare health plan you pick, you are still in Medicare. You will get all the Medicare services and protections you know and trust.

Tommy G. Thompson
Secretary
Health and Human Services

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

Table of Contents

What's NEW in Medicare

New coverage for:

- Glaucoma screening, see page 16.
- Clinical trials, see page 21.
- Macular degeneration of the eye (age-related) treatment, see page 15.
- Medical nutrition therapy services, see page 15.

New rules for:

- Joining and leaving Medicare health plans, see pages 49-51.
- People with ALS (Lou Gehrig's Disease), see page 21.
- Immunosuppressive drug coverage, see page 15.

If you have Employer or Union Health Coverage:

Call your employer or union before you make any changes to your health coverage. Your employer or union may offer different plans than those described in this book. See page 57 and questions on pages 19-20, and 22 for important information.

If you are a Railroad Retiree:

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

If you need help paying health care costs:

See page 58 for information about state programs that may help pay your Medicare premiums, coinsurance, or deductibles.

If your address changes:

Call the Social Security Administration at 1-800-772-1213.

Medicare & You 2002 explains the Medicare program. It is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Section 1

Medicare Basics

About This Handbook:

✓ **Finding Information:** The index starts on page 67. This is an alphabetical list of what is in this handbook, with page numbers.

✓ **Words in Blue:** Important words shown in blue are defined on pages 63-66.

✓ **Sharing "Medicare & You 2002:"** Households with up to four people with Medicare will get one handbook to share. The handbook will be addressed to one person. This will help save Medicare money. The other people with Medicare in these households will get a postcard. It will tell them how to get an extra handbook if they need it. If your household gets more than one handbook, you can choose to share one copy in the future. If you want to share, call and tell a customer service representative at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Please have your red, white, and blue Medicare card with you when you call.

✓ **Please Keep this Handbook:** This handbook is good (valid) from January 1, 2002 through December 31, 2002. Use it in place of any older version you have now. Keep it where you can find it if you need it.

✓ **Local Health Plan Information:** Details about the Medicare health plan choices in your area begin on page 79.

Did You Know…

…you can get even more details about Medicare Health Plans, including quality information? This information can help you choose the plan that's best for you. It includes a personal listing of plans in your ZIP code. It's important to learn as much as you can before you choose a plan.

To get your free information today, call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov on the Web.

Section 1
Medicare Basics

Medicare is a health insurance program for:

- People age 65 or older.
- Some people with disabilities under age 65.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare Has Two Parts

Part A Hospital Insurance, see pages 11-12.
Most people do not have to pay for Part A.

Part B Medical Insurance, see pages 13-17.
Most people pay monthly for Part B.

Medicare Health Plans

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

The Original Medicare Plan - Available nationwide.
For more information, see page 31.

or

Medicare + Choice Plans (pronounced "Medicare plus Choice"), including:

- Medicare Managed Care plans (like HMOs, see page 46).
- Medicare Private Fee-for-Service plans (see page 47).

Available in many areas.

The Medicare health plan that you choose affects many things, like cost, doctor choice, benefits (some have extra benefits, like prescription drugs), convenience, and quality (see pages 26-27).

NEW! For help comparing your health plan choices, use the new "Medicare Personal Plan Finder." See pages 28-29 for details.

Section 1

Medicare Basics

Need answers and information now? Medicare is here for you.

- I'm thinking about joining a Medicare HMO. Which one's best for me?
- I want to buy a Medigap policy. Which one has the extra coverage I need?
- How can I get prescription drug coverage?
- How do I get another Medicare card?
- How do I keep up with what's new in Medicare?
- I can't afford my health care. Can I get help?

Answers to these questions and more are as close as your phone or computer.

- Call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, including weekends. TTY users should call 1-877-486-2048. See pages 6-7 to learn how to use this free service.
- Visit www.medicare.gov on the Web for quick answers to your questions. See page 8 for more details about Medicare's website.
- Read new booklets about Medicare. See pages 9-10 for details about getting free booklets to help you learn more.

Section 1

Medicare Basics

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

We're here when you need us, 24 hours a day, including weekends.

When you call, you will hear:

Thank you for calling 1-800-MEDICARE.

We offer service in English and Spanish.

• For **English**, press (1). • Para **Español**, oprima dos (2).

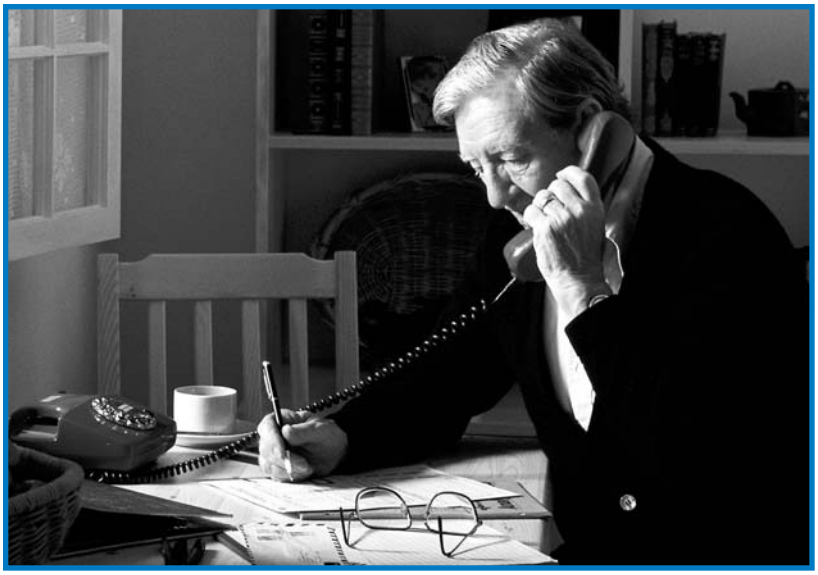
Please listen carefully as our options may change.
Choose from the following **Main Menu** options:

To sign up for Medicare, change your address, or replace your Medicare Card...	For information on State programs that may help those with low incomes pay Medicare premiums and copayments...	To find out how your doctor or hospital bill is paid...
Press **1** now	Press **2** now	Press **3** now

Tip: You don't have to call for options 1-3. The information is printed on pages 71-78.

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

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



To order Medicare publications... (Please have the publication number ready, see pages 9-10.)	For answers to frequently asked questions, including information about Medicare Health Plan choices...	To speak with a customer service representative...
Press **4** now	Press **5** now	Press **0** now

Section 1

Medicare Basics

Need answers and information now? Visit our website, www.medicare.gov

How do I get another Medicare card? I need a copy of a Medicare publication – What's the fastest way to get it? How do I keep up with what's new in Medicare?

Answers to these questions and more are as close as a computer. Go to Medicare's website for quick answers to your questions. The site is updated regularly, so visit often.

★ Publications

Read all of the Medicare publications on your computer or print out a copy to use now.

★ Compare Medicare Health Plans

Find the Medicare health plan that's best for you at "Medicare Health Plan Compare." Compare information about costs, benefits, and quality of care. To shop for health plans, use the new "Medicare Personal Plan Finder" to find the plans that best meet your needs.

★ Compare Nursing Homes

Trying to find a nursing home? Check out "Nursing Home Compare" for details on nursing homes in your area, including state inspection results and nursing staff information. You can get a copy of the Guide to Choosing a Nursing Home and a Nursing Home Checklist to help as you make your decision.

★ Answers to your Questions

Find basic information on Medicare, including coverage, eligibility, enrollment, and answers to frequently-asked questions. Let www.medicare.gov be your first stop for the answers you need now.

★ Look for a Physician

Select the "Participating Physician Directory" for a list of physicians who participate in Medicare. This directory includes physician names, addresses, and specialties.

★ And more...

Medicare's website helps you find the answers you need. See pages 28-29 for more information on our new "Medicare Personal Plan Finder." There's also health information, phone numbers for helpful contacts, details on prescription drug help, and more. Some information is available in Spanish and Chinese.

Section 1

Medicare Basics

Free Booklets About Medicare and Related Topics

Health care decisions are important. Medicare tries to give you information to help you make good decisions. You can order free booklets from Medicare to learn more about the topics that are of interest to you. We are always adding new booklets with detailed information about important subjects. The list below highlights some of the booklets that are available.

How do I get these booklets?

You can:

1. Look at www.medicare.gov on the Web and select "Publications." You can read, print, or order these booklets. This is the fastest way to get a copy.
2. Call 1-800-MEDICARE (1-800-633-4227), and select option "4" to order a free copy of the booklet you want. TTY users should call 1-877-486-2048. Have the publication number (listed below) ready when you call. You will get your copy within three weeks.
3. Put your name on the Web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select "Subscribe to Our Mailing List" at the bottom of the page. Then, select the topic "Publications," type your e-mail address in the box at the bottom, and select "Subscribe."

What booklets are available?

- Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy (CMS Pub. No. 02110)
- Does Your Doctor or Supplier Accept Assignment? (CMS Pub. No. 10134)
- Guide to Choosing a Nursing Home (CMS Pub. No. 02174)

NEW! ■ Health Care Coverage Directory for People with Medicare (CMS Pub. No. 02231)

- Medicare Appeals and Grievances (Complaints) (CMS Pub. No. 10119)

continued on next page

Free Booklets About Medicare and Related Topics (continued)

- NEW! Medicare & Clinical Trials (CMS Pub. No. 02226)
- Medicare and Other Health Benefits: Your Guide to Who Pays First (CMS Pub. No. 02179)
- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (CMS Pub. No. 10128)
- Medicare Coverage of Skilled Nursing Facility Care (CMS Pub. No. 10153)
- Medicare Home Health Care (CMS Pub. No. 10969)
- Medicare Hospice Benefits (CMS Pub. No. 02154)
- Medicare Preventive Services (CMS Pub. No. 10110)
- NEW! Medicare Savings Programs (CMS Pub. No. 10126)
- NEW! New Rules for Switching Medicare Health Plans (CMS Pub. No. 02241)
- Pay it Right! Protecting Medicare from Fraud (CMS Pub. No. 10111)
- NEW! What Kind of Doctor is a Hospitalist? (CMS Pub. No. 02244)
- NEW! Where To Get Your Medicare Questions Answered (CMS Pub. No. 02246)
- NEW! Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam, and Clinical Breast Exam (CMS Pub. No. 02248)
- Your Medicare Benefits (CMS Pub. No. 10116)
- NEW! Your Medicare Rights and Protections (CMS Pub. No. 10112)

Many of these booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish). Some booklets are also available in Chinese.

For a catalog of Medicare booklets, call 1-800-MEDICARE (1-800-633-4227). Select option "4" to order a free copy of this catalog (CMS Publication No. 02240). TTY users should call 1-877-486-2048.

Section 2

The Medicare Program

Medicare has two parts. Medicare Part A is hospital insurance. Most people do not have to pay for Part A. Medicare Part B is medical insurance. Most people pay monthly for Part B.

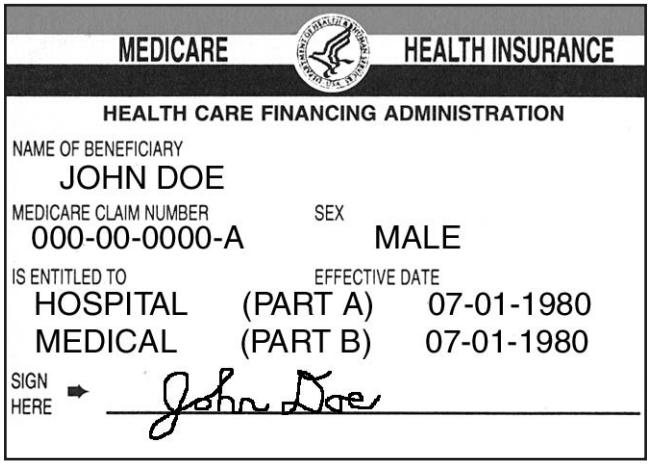
What is Medicare Part A?

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care (not room and board) and some home health care. You must meet certain conditions.

Cost: Most people do not have to pay a monthly payment, called a premium, for Part A because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. If you are not 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 the lower left corner of your card. You can also call the Social Security Administration at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Do you need a new Medicare card?
Look at www.ssa.gov on the Web or call the Social Security Administration at 1-800-772-1213.



Section 2

The Medicare Program

Medicare Part A Helps Cover Your:

Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes care you get in critical access hospitals and inpatient mental health care. This does not include private duty nursing, or a television or telephone in your room. It also does not include a private room, unless medically necessary.

Skilled Nursing Facility Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related 3-day hospital stay).

Home Health Care: Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and medical supplies, and other services.

Hospice Care: Medical and support services from a Medicare-approved hospice for people with a terminal illness, drugs for symptom control and pain relief, and other services not otherwise covered by Medicare. Hospice care is given in your home. However, short-term hospital and inpatient respite care (care given to a hospice patient by another caregiver so that the usual caregiver can rest) are covered when needed, however room and board are not covered.

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

Section 2

The Medicare Program

What is Medicare Part B?

* The new Part B premium amount will be available by January 1, 2003. You may be able to get help from your state to pay this premium (see page 58).

Medicare Part B (Medical Insurance) helps cover your doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary (see pages 14-17).

Cost: You pay the Medicare Part B premium of $54* per month in 2002. This may change January 1, 2003. In some cases, this amount may be higher if you did not sign up for Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it. You will have to pay this extra amount as long as you have Part B, except in special cases (see Q3 on pages 19-20).

Enrolling in (Joining) Part B

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

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

Enrolling in (Joining) Part B (continued)

If you are close to age 65 and are not yet getting either Social Security or Railroad Retirement benefits or Medicare, you can apply for both at the same time. You can also apply for Medicare only. You can sign up for Part B during your Initial Enrollment Period. Your Initial Enrollment Period begins three months before the month you turn 65 and ends three months after you turn age 65. If you wait until you are 65, or sign up during the last three months of your Initial Enrollment Period, your Medicare Part B start date will be delayed. To apply, you can call or visit your local Social Security office, or call Social Security at 1-800-772-1213. You may be able to apply at www.ssa.gov on the Web if you meet certain rules.

Medicare Part B Helps Cover Your:

Medical and Other Services: Doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, and outpatient physical and occupational therapy, including speech-language therapy.

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

Home Health Care: Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and medical supplies, and other services.

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

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

Medicare Also Helps Cover:

- Ambulance services (when other transportation would endanger your health).
- Artificial eyes.
- Artificial limbs that are prosthetic devices, and their replacement parts.
- Braces - arm, leg, back, and neck.
- Chiropractic services (limited), for manipulation of the spine to correct a subluxation.
- Emergency care.
- Eyeglasses - one pair of standard frames after cataract surgery with an intraocular lens.
- Immunosuppressive drug therapy for transplant patients as long as you are covered by Medicare (in some cases).
- Kidney dialysis.
- Macular degeneration of the eye (age-related) treatment, using ocular photodynamic therapy with verteporfin.
- Medical nutrition therapy services for people with diabetes or kidney disease (unless you are on dialysis) with a doctor's referral. Coverage ends 3 years after a kidney transplant.
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.
- Outpatient prescription drugs (very limited). For example, some oral drugs for cancer.
- Preventive services (see pages 16-17).
- Prosthetic devices, including breast prosthesis after mastectomy.
- Second opinion by a doctor (in some cases).
- Services of practitioners such as clinical social workers, physician assistants, and nurse practitioners.
- Telemedicine services in some rural areas.
- Therapeutic shoes for people with diabetes (in some cases).
- Transplants - heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions and when performed at approved facilities).
- X-rays, MRIs, CAT scans, EKGs, and some other diagnostic tests.

Medicare Part B Covered Preventive Services	Who is Covered
Bone Mass Measurements: Frequency of testing varies with your health status.	Certain people with Medicare at risk for losing bone mass (see Q5 on page 44).
Colorectal Cancer Screening: Fecal Occult Blood Test - Once every 12 months. Flexible Sigmoidoscopy - Once every 48 months. Colonoscopy - Once every 24 months if you are at high risk for colon cancer. If you are not at high risk for colon cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy. Barium Enema - Doctor can use this instead of a flexible sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no minimum age for having a colonoscopy.
Diabetes Services and Supplies: Coverage for glucose monitors, test strips, and lancets.	All people with Medicare who have diabetes (insulin users and non-users).
Diabetes self-management training.	Certain people with Medicare who are at risk for complications from diabetes, if requested by your doctor or other provider.
Glaucoma Screening: Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.	People with Medicare who are at high risk for glaucoma, including people with diabetes or a family history of glaucoma.

Medicare Part B Covered Preventive Services	Who is Covered
Mammogram Screening: Once every 12 months. Medicare also covers new digital technologies for mammogram screening.	All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.
Pap Test and Pelvic Examination: (Includes a clinical breast exam) Once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months.	All women with Medicare.
Prostate Cancer Screening: Digital Rectal Examination - Once every 12 months. Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older.
Shots (vaccinations): Flu Shot - Once a year in the fall or winter.	All people with Medicare.
Pneumococcal Pneumonia Shot - One shot may be all you ever need. Ask your doctor.	All people with Medicare.
Hepatitis B Shot	Certain people with Medicare at medium to high risk for Hepatitis B.

Section 2

The Medicare Program

Your Medicare Rights

If you have Medicare, you have certain guaranteed rights to help protect you. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. No matter how you get your Medicare health care, you always have the right to appeal. You may appeal if:

- You don't agree with the amount that is paid.
- A service isn't covered and you think it should be.
- A service is stopped before you think it should be.

You must be given instructions for filing an appeal. These instructions are either on the notice that explains what Medicare pays (see page 37) or in your health plan materials, depending on how you get your Medicare health care. If you decide to file an appeal, ask your doctor or provider for any information that may help your case.

In addition to your appeal rights, you also have certain rights to:

- Information
- Get Emergency Services
- See Doctors, Specialists, including Women's Health Specialists, and Hospitals
- Participate in Treatment Decisions
- Know Your Treatment Choices
- Culturally Competent Services
- File Complaints
- Nondiscrimination
- Privacy of Personal Information
- Privacy of Health Information

You may have additional rights if you are in the hospital or a skilled nursing facility, or if your home health care ends.

For more detailed information about your rights and protections, call 1-800-MEDICARE (1-800-633-4227) to get a free copy of *Your Medicare Rights and Protections*. Look on page 9 for details about how to get this booklet.

Section 2

The Medicare Program

Common Questions and Answers

Q1: How do I get a new Medicare card if my card is lost, stolen, or damaged?

A: To get a new red, white, and blue Medicare card, call the Social Security Administration (SSA) at 1-800-772-1213. You can also get a new card from SSA at www.ssa.gov on the Web. Select "Medicare information." SSA will send you a new card. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

Q2: When do the Medicare premiums and coinsurance rates change? How will I know what they are?

A: New Medicare premium and coinsurance rates come out each fall and become effective in January. If you get Social Security or Railroad Retirement benefits, new rates are sent to you each year with your cost of living adjustment notice in December. You can also get the new Medicare rates for 2003 after December 1, 2002, by looking at www.medicare.gov on the Web, or by calling 1-800-MEDICARE (1-800-633-4227).

Q3: What if I didn't sign up for Medicare Part B when I first became eligible?

A: If you didn't sign up for Medicare Part B when you first became eligible (for example, because you were still working), you may sign up during the General Enrollment Period or the Special Enrollment Period.

1. **General Enrollment Period**

   If you did not take Part B when you were first eligible for Medicare, you may sign up during a General Enrollment Period. This period runs from January 1 through March 31 each year. Remember, the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it, and you will have to pay this extra amount as long as you have Part B, except in special cases (see page 20).

   You can sign up for Part B at your local Social Security office. If you get benefits from the Railroad Retirement Board, you can sign up at your local RRB office. Your Part B coverage will start on July 1 of the year you sign up.

Q3: What if I didn't sign up for Part B when I first became eligible? (continued)

A: (continued)

2. **Special Enrollment Period**

If you didn't enroll in Part B when you were first eligible because you or your spouse were working and had group health coverage through your or your spouse's employer or union, you can sign up for Part B during a Special Enrollment Period.

You can sign up:

- Any time you are still covered by the employer or union group health plan, through your or your spouse's current or active employment, or
- During the 8 months following the month that the employer or union group plan coverage ends, **or** when the employment ends (whichever is first).

If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply.

Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums. However, if you are eligible but do not sign up during the Special Enrollment Period, you will only be able to sign up during the General Enrollment Period, and the cost of Part B may go up.

For more information about Medicare Part B, or to sign up for it, call the Social Security Administration at 1-800-772-1213, or call your local Social Security office. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Q4: I am under age 65 and have ALS (Amyotrophic Lateral Sclerosis), known as Lou Gehrig's disease. When can I get Medicare?

A: If you are under age 65 and have Lou Gehrig's disease (ALS), you get your Medicare benefits the first month you get disability benefits from Social Security or the Railroad Retirement Board. For more information about disability benefits, look at www.ssa.gov on the Web. Or, call the Social Security Administration at 1-800-772-1213.

Q5: Does Medicare pay for prescription drugs?

A: The Original Medicare Plan does not cover prescription drugs except in a few cases, like certain cancer drugs. Many Medicare + Choice plans cover prescription drugs, up to certain dollar limits (sometimes for an extra cost). Some Medigap policies and states also cover prescription drugs. For information about "Prescription Drug Assistance Programs," look at www.medicare.gov on the Web (see page 8). You can use this to learn about different prescription drug coverage options, including Medicare + Choice plans and Medigap policies.

Q6: Does Medicare cover dental services?

A: Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures. In rare cases, Medicare Part B will pay for certain dental services. In addition, Medicare Part A will pay for certain dental services that you get when you are in the hospital. Call your local Medicare Carrier for more information (see page 75). Some Medicare health plans may offer additional dental coverage.

Q7: Does Medicare cover my costs if I am in a clinical trial?

A: Yes. Medicare pays for routine costs if you take part in an approved clinical trial. Clinical trials test new types of medical care, like how well a new cancer drug works. Clinical trials help doctors and researchers see if the new care works and if it is safe. For more information about clinical trials, get a free copy of *Medicare & Clinical Trials*. Look on page 9 for details about how to get this booklet.

Q8: What diabetic supplies and services does Medicare cover?

A: **Diabetic Supplies**: Medicare covers the same supplies for people with diabetes whether or not you use insulin. These include a glucose testing monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions. Medicare also covers therapeutic shoes for people with diabetes. There may be some limits on supplies or how often you get them. For more information about diabetic supplies, call your Durable Medical Equipment Regional Carrier (see page 73).

Diabetic Services: If your doctor thinks you are at risk for complications from diabetes, you are covered for diabetes self-management training. Medical nutrition therapy services are also covered for people with diabetes (or kidney disease) when referred by a doctor. These services can be given by a registered dietician or nutrition professional and include diet counseling and therapy services to help you manage your diabetes. Medicare also covers glaucoma screening for people with diabetes or a family history of glaucoma. For more information about diabetic services, call your Medicare Carrier (see page 75).

Q9: I have more than one insurance. How do I know who pays first?

A: Sometimes your other insurance pays your health care bills first and Medicare pays second. This is called Medicare Secondary Payer. Other insurance that may have to pay first includes: employer group health plan coverage under certain conditions, no-fault insurance, any liability insurance, black lung benefits, and workers' compensation. It is important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you have questions about who pays first, call the Coordination of Benefits Contractor at 1-800-999-1118 (TTY users should call 1-800-318-8782). For more information, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First*. Look on page 9 for details about how to get this booklet.

Q10: What is a "private contract," and how does it work?

A: A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. If you sign a private contract with your doctor:

- Medicare won't pay any amount for the services you get from this doctor.
- You will have to pay whatever this doctor or provider charges you for the services you get. Medicare's limiting charge will not apply.
- Medicare + Choice plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is submitted.
- Your Medigap policy, if you have one, will not pay anything for this service. Call your Medigap insurance company before you get the service if you have any questions.
- Many other insurance plans will not pay for the service either.
- Your doctor must tell you whether Medicare would pay for the service if you get it from another doctor who participates in Medicare.
- Your doctor must tell you if he or she has been excluded from the Medicare program.

The private contract only applies to the services you get from the doctor who asked you to sign it. You cannot be asked to sign a private contract in an emergency or urgent health situation.

You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract (see page 77).

Q11: Can I pay for a service myself, even if it is not covered by Medicare?

A: You can always choose to get services not covered under Medicare and pay for these services yourself. In this case, you do not have to sign a private contract, and your doctor does not have to stop giving services through Medicare.

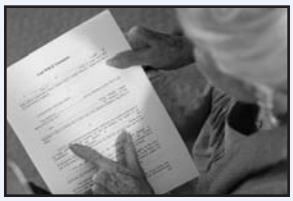
Q12: How is the privacy of my medical records protected?

A: You have the right to talk with health care providers in private and to have your personal health care information kept private as protected under federal and state laws.

There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used by your health care provider or your health plan. This rule will be fully effective on April 14, 2003.

If you have any questions about this privacy rule, look at www.hhs.gov/ocr/hipaa on the Web.

If you are in a Medicare + Choice plan, you also have the right to timely access to your medical records.



Section 3

Introduction to Medicare Health Plans

What are Medicare Health Plans?

Medicare offers you different ways to get your Medicare benefits. These different options are called Medicare health plans. Medicare health plans contract with and are managed by the Medicare program. How you get your health care in the Medicare program depends on which plan you choose. Depending on where you live, you may have more than one plan to choose from.

What types of Medicare health plans are available?

In 2002, Medicare offers the following types of Medicare health plans:

- **The Original Medicare Plan** (sometimes called fee-for-service) - Everyone with Medicare can join the Original Medicare Plan. This plan is available nationwide. Many people in the Original Medicare Plan also have a Medigap (Medicare Supplement Insurance) policy to help pay health care costs that this plan does not cover (see page 60).

- **Medicare + Choice (pronounced "Medicare plus Choice") plans** - Medicare + Choice plans provide care under contract to Medicare. They may provide benefits like coordination of care or reduce out-of-pocket expenses. Some plans may offer additional benefits, such as prescription drugs. There are two types of Medicare + Choice plans. They are available in many parts of the country.

  Medicare + Choice plans include:

  - **Medicare managed care plans** (like HMOs), and
  - **Medicare Private Fee-for-Service plans**.

Section 3

Introduction to Medicare Health Plans

Choosing the Best Medicare Health Plan for You

How you get your Medicare health benefits affects many things. You need to think about things like cost, doctor choice, extra benefits, convenience, and quality when choosing your Medicare health plan. They are all important, but some may be more important to you than others. You need to look at what each plan offers and make the best choice for you.

Your choice will affect:

Cost — What will my out-of-pocket costs be? More information about your out-of-pocket costs starts on page 32.

Doctor Choice — Can I see the doctor(s) I want to see?

Benefits — Do I need extra benefits and services, like prescription drugs, eye exams, hearing aids, or routine physical exams?

Convenience — Where are the doctors' offices and what are their hours? What about paperwork? Do I have to file claims myself? Is there a telephone hotline for medical advice from a nurse or other medical staff?

Quality Data to Help You Choose

Research shows that Medicare health plans differ on quality. The Medicare program measures the quality of care that people like you get. This information is available to everyone. To compare the quality of Medicare health plans in your area, go to www.medicare.gov on the Web and select "Medicare Health Plan Compare." Or, call 1-800-MEDICARE (1-800-633-4227) and ask for health plan quality information.

Section 3

Introduction to Medicare Health Plans

What is important to you?

Think about what is most important to you in a health plan. Then look at this chart. It can help you see which types of plans have the things that are most important to you. The next two sections of this handbook give more details about these types of plans. Using the "Medicare Personal Plan Finder" can help you make your best health plan choice (see pages 28-29).

		Medicare + Choice Plans	
	Original Medicare Plan	**Managed Care Plan (like an HMO)**	**Private Fee-for-Service Plan**
Cost Total Out-of-Pocket Costs	**High**	**Low to Medium**	**Medium to High**
Doctor Choice	**Widest** Choose any doctor or specialist who accepts Medicare.	**Some** Usually must see a doctor or specialist who belongs to your plan.	**Wide** Choose any doctor or specialist who accepts the plan's payment.
Extra Benefits In addition to Medicare covered benefits.	**None**	**Most** Like prescription drugs, eye exams, hearing aids, or routine physical exams.	**Some** Like foreign travel or extra days in the hospital.
Convenience	**Varies** Available nationwide.	**Varies** Available in some areas. May require less paperwork and have phone hotline for medical advice.	**Varies** Available in some areas. May require less paperwork and have phone hotline for medical advice.

Section 3

Introduction to Medicare Health Plans

NEW this Year! Step-by-Step Help for Choosing a Health Plan

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

You can get this information two ways:

1. Visit www.medicare.gov on the Web for fast results. Select "Medicare Personal Plan Finder."

2. Call 1-800-MEDICARE (1-800-633-4227). For English, press "1" or for Spanish, press "2" (para Español, oprima dos "2"). Select option "0." A customer service representative will help you. You will get your results in the mail within three weeks.

You will need to answer some simple questions, including:

- What parts of Medicare you have (Part A and/or Part B).
- Your age.
- What your general health is.

If you want information about programs that may help with your health care costs, you will need to answer questions about your income and resources.

Any information you give is always kept private.

"Medicare Personal Plan Finder" Results

When you use the "Medicare Personal Plan Finder," you will get a personalized summary page (see sample on page 29) with general information to help you compare plans in your area. You can also get detailed information about all the plans available in your area, or just the ones you are most interested in.

Section 3

Introduction to Medicare Health Plans

Sample Summary Page

You may be interested in:

❑ State Prescription Drug Assistance Program (1-555-555-5555)

❑ "Medicare Basics" Seminar - 9/27/02 (1-555-555-5555)

Below is a summary of the plans that are available in your ZIP code. The out-of-pocket costs column compares average costs for a person of your self-reported age and health status. The chart also includes information on doctor choice, and whether the plan offers any of the following extra benefits: outpatient prescription drugs, routine physical exams, vision services, and dental services.

Original Medicare Plan Only - Approximately xx% of people with Medicare have chosen this option. With this option, the Federal Government pays approximately $xxx each month for beneficiaries.

Medicare Health Plans	Out-of-Pocket Costs	Doctor Choice (Can you go to any doctor?)	Outpatient Prescription Drugs	Routine Physical Exams	Vision Services	Dental Services
Original Medicare	$$$	✓				

Original Medicare with a Medigap Plan - Approximately xx% of people with Medicare have chosen this option. With this option, the Federal Government pays approximately $xxx each month for beneficiaries.

Medicare Health Plans	Out-of-Pocket Costs	Doctor Choice (Can you go to any doctor?)	Outpatient Prescription Drugs	Routine Physical Exams	Vision Services	Dental Services
Medigap Plan C	$$	✓				
Medigap Plan H	$$$	✓	✓			

Medicare + Choice Plans - Approximately xx% of people with Medicare have chosen this option. With this option, the Federal Government pays approximately $xxx each month for beneficiaries.

Medicare Health Plans	Out-of-Pocket Costs	Doctor Choice (Can you go to any doctor?)	Outpatient Prescription Drugs	Routine Physical Exams	Vision Services	Dental Services
HMO Plan #1	$$	Usually must see a doctor or specialist who belongs to your plan.	✓	✓	✓	

Section 3

Introduction to Medicare Health Plans

Whether you get your Medicare health care coverage from the Original Medicare Plan or a Medicare + Choice plan:

You must have Medicare Part A and Part B to enroll in a Medicare + Choice plan.

- You are still in the Medicare program. The Original Medicare Plan and Medicare + Choice plans are all part of the Medicare program.
- You get at least all the Medicare Part A covered services listed on page 12.
- If you pay the monthly Part B premium ($54 in 2002), you get all the Medicare Part B covered services listed on pages 14-17.
- The Medicare program helps you get quality health care.
- The Medicare program still pays for part of your health care.

What if I have other health insurance or coverage that isn't listed here?

Many people with Medicare also have health coverage in addition to Medicare. You may have or qualify for:

- A Medigap (Medicare Supplement Insurance) policy (see page 60),
- Employer or union health coverage (see page 57),
- Help from your state (see Medicare Savings Programs and Medicaid on pages 58-59),
- TRICARE for Life (for military retirees and their spouses and survivors, see page 58),
- Veterans' benefits (see page 57), or
- Other insurance, like long-term care insurance (see page 62).

The way these types of insurance work with Medicare varies. See the page numbers shown above for more information.

Section 4

Original Medicare Plan

What is the Original Medicare Plan?

The Original Medicare Plan is a "fee-for-service" plan. You are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care (see the sample card on page 11). If you are happy getting your health care this way, you do not have to change. You will stay in the Original Medicare Plan unless you choose to join a Medicare + Choice plan.

How does the Original Medicare Plan work?

- You may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service.
- If you have Part A, you get all the Medicare Part A covered services listed on page 12.
- If you pay the monthly Part B premium ($54 in 2002), you get all the Medicare Part B covered services listed on pages 14-17.
- You pay a set amount for your health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment).
- After you get a health care service, you get a Medicare Summary Notice or an Explanation of Medicare Benefits in the mail (see page 37). These notices are sent by companies that handle bills for Medicare. The notice lists the amount you may be billed.

Remember, words in blue are defined on pages 63-66.

Section 4

Original Medicare Plan

Your costs in the Original Medicare Plan

What you pay out-of-pocket depends on:

- Whether your doctor or supplier agrees to accept assignment (see page 42).
- How often you need health care.
- What type of health care you need.
- Whether you get services or supplies not covered by Medicare.
- Whether you have Part B.

Note: In most cases, you pay for any health care you get while traveling outside of the United States.

The charts on the next few pages show what you pay in the Original Medicare Plan. For details about these covered services, see page 12 for Part A and pages 14-17 for Part B.

To help cover the costs that the Original Medicare Plan does not cover, you can:

- Keep or get employer or union health coverage (see page 57), or
- Buy a Medigap (Medicare Supplement Insurance) policy (see page 60), or
- Check if you can get help from your state (see pages 58-59).

Section 4
Original Medicare Plan

Medicare Part A (Hospital Insurance) Helps Pay For:

What YOU Pay in 2002 in the Original Medicare Plan (see note on page 34)

(For more information on coverage, see page 12.)

Hospital Stays

For each benefit period YOU pay:

- A total of $812 for a hospital stay of 1-60 days.
- $203 per day for days 61-90 of a hospital stay.
- $406 per day for days 91-150 of a hospital stay. (See Lifetime Reserve Days on page 64.)
- All costs for each day beyond 150 days.

Skilled Nursing Facility (SNF) Care

Look on page 9 for details about how to get a free booklet for more information.

For each benefit period YOU pay:

- Nothing for the first 20 days.
- Up to $101.50 per day for days 21-100.
- All costs beyond the 100th day in the benefit period.

If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary (see page 74).

Home Health Care

Look on page 9 for details about how to get a free booklet for more information.

YOU pay:

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

If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see page 77).

Hospice Care

Look on page 9 for details about how to get a free booklet for more information.

YOU pay a copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (short-term care given to a hospice patient by another caregiver, so that the usual caregiver can rest). The amount you pay for respite care can change each year. You also pay for room and board for inpatient hospice care.

If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary (see page 77).

Blood

YOU pay for the first 3 pints of blood, unless you or someone else donates blood to replace what you use.

Section 4
Original Medicare Plan

Medicare Part B (Medical Insurance) Helps Pay For:	What YOU Pay in 2002 in the Original Medicare Plan (see Note below) **(For more information on coverage, see pages 14-17.)**
Medical and Other Services	**Each year YOU pay:** ■ $100 deductible (once per calendar year). ■ 20% of Medicare-approved amount after the deductible (see "assignment" on page 42). ■ 20% for all outpatient physical, occupational, and speech-language therapy services. ■ 50% for outpatient mental health care. (See Q1 on page 43.)
Clinical Laboratory Services	**YOU pay** nothing for Medicare-approved services.
Home Health Care Look on page 9 for details about how to get a free booklet for more information.	**YOU pay:** ■ Nothing for Medicare-approved services. ■ 20% of the Medicare-approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see page 77).
Outpatient Hospital Services	**YOU pay** a coinsurance or copayment amount, which may vary according to the service. Look on page 9 for details about how to get a free booklet for more information.
Blood	**YOU pay** for the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

Note: New Medicare Part A and B amounts will be available by January 1, 2003. Actual amounts you must pay may be higher if the doctor or supplier does not accept assignment, **and you may have to pay the entire charge at the time of service**. Medicare will then send you its share of the charge (see page 42).

If you have general questions about Medicare Part B, call your Medicare Carrier (see page 75). If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (see page 73).

Medicare Part B Covered Preventive Services	What YOU pay in the Original Medicare Plan (For more information on coverage, see pages 16-17.)
Bone Mass Measurements	20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.
Colorectal Cancer Screening	Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount if the test is done in an ambulatory surgical center or hospital outpatient department.
Diabetes Services and Supplies	20% of the Medicare-approved amount after the yearly Part B deductible.
Glaucoma Screening	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening	20% of the Medicare-approved amount with no Part B deductible.
Pap Test and Pelvic Examination (includes a clinical breast exam)	Nothing for the Pap lab test. For Pap test collection, and pelvic and breast exams, 20% of the Medicare-approved amount (or a copayment amount) with no Part B deductible.
Prostate Cancer Screening	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA (Prostate Specific Antigen) Test.
Shots (vaccinations)	Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment (see page 42). For Hepatitis B shots, 20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.

What is not paid for by Medicare Part A and Part B in the Original Medicare Plan?

The Original Medicare Plan does not cover everything. Health care costs not covered by Medicare will include, but are not limited to:

- Acupuncture.
- Deductibles, coinsurance, or copayments when you get health care services (see the "What YOU Pay" part of the charts on pages 33-35).
- Dental care and dentures (in most cases).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- Health care you get while traveling outside of the United States (except in limited cases).
- Hearing aids and hearing exams.
- Orthopedic shoes.
- Outpatient prescription drugs (with only a few exceptions).
- Routine foot care (with only a few exceptions).
- Routine eye care and most eyeglasses (see page 15).
- Routine or yearly physical exams.
- Screening tests except those listed on pages 16-17.
- Shots (vaccinations) except those listed on page 17.

To help cover the costs the Original Medicare Plan does not cover, see page 32.

Section 4

Original Medicare Plan

How are my bills paid in the Original Medicare Plan?

For Part A Services and some Part B Services:

The provider of the covered service sends a claim to your Fiscal Intermediary.

For Part B Services and Supplies:

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

You get a Medicare Summary Notice (MSN) or an Explanation of Medicare Benefits (EOMB). Soon, everyone will get MSNs as EOMBs are phased out. The MSN lists all the services or supplies that were billed to Medicare for that month. Check this notice to be sure you got all the services, medical supplies, or equipment that providers billed to Medicare.

If you have questions about your bills, see pages 73-75 for important phone numbers.

- Questions about the charges? Call the provider of the service or supply.
- Disagree with what was paid? You can appeal (see page 18).
- Think the provider is being dishonest? Call the company that sent you the notice. Their phone number is on the notice.

Note: You should not need to file any Medicare claims. Providers and suppliers are required by law to file Medicare claims for the covered services and supplies you get. If your doctor or supplier does not file the Medicare claim in a timely manner, contact your Medicare Carrier.

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

Pages 38-39 have a sample MSN for Part B services, followed by information on how to read it. You could also get an MSN for Part A services and for durable medical equipment. Remember that the MSN is not a bill. DO NOT send money to Medicare or to the provider until you get a bill.

Medicare Summary Notice

1

June 16, 2002

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

4

5

HELP STOP FRAUD: Protect your Medicare Number as you would a credit card number.

CUSTOMER SERVICE INFORMATION 2

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

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

Phone number: (XXX) XXX-XXXX
1-800-XXX-XXXX
TTY for Hearing Impaired: 1-800-XXX-XXXX

6 This is a summary of claims processed from 5/15/02 through 6/15/02.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 12345-84956-84556 (8)						14
Doctor name, Street Address, City, State ZIP Code (15)		10	11	12	13	a
		$55.00	$44.35	$0.00	$44.35	b
03/07/02 (7)	1 Office/Outpatient Visit, ES (99214) (9)					

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

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

See pages 40-41 for an explanation of the numbered items.

Section 4
Original Medicare Plan

Notes Section: (16)

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

Deductible Information: (17)

You have now met $44.35 of your $100 Part B deductible for 2002.

General Information: (18)

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

Appeals Information - Part B (19)

If you disagree with any claims decision on this notice, you can request an appeal by December 16, 2002.

Follow the instructions below:

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

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.

3) Sign here_____Phone Number (___)_____

See pages 40-41 for an explanation of the numbered items.

Section 4

Original Medicare Plan

Explanation of numbered items on Medicare Summary Notice (MSN)

1. The **Date** the MSN was sent.

2. The **Customer Service Information** box. Write or call using the information in this box if you have questions about your MSN. For all inquiries, include your Medicare number, the date of the notice, and the specific date of service you have questions about.

3. Your **Medicare Number**. It should match the number on your Medicare card.

4. Your **Name and Address**. If these are incorrect on your MSN, please contact both the company shown in the customer service information section and the Social Security Administration immediately.

5. Read the **Help Stop Fraud** message for information on ways to protect yourself and Medicare against fraud and abuse.

6. **Part B Medical Insurance - Assigned Claims/Unassigned Claims**. This line describes the category of services received. It tells you if it is a Medicare Part A or B service or durable medical equipment. See the back of your MSN for an explanation of Medicare assignment.

7. **Dates of Service**. This shows when your doctor or supplier provided the service(s) listed. You may use these dates to compare with the dates shown on your doctor or supplier bill.

8. Each claim is assigned a **Claim Number**, which you may be asked to provide when calling regarding your MSN.

9. **Services Provided** is a brief description of the service or supply, the number of services and the service code.

10. **Amount Charged** is the charge submitted to Medicare by the provider of service(s).

11. **Medicare Approved** is the amount Medicare approved for the service(s) you received.

12. **Medicare Paid Provider**. In most situations, Medicare pays 80 percent of the approved amount after subtracting any unmet portion of the yearly deductible. For unassigned service(s), this column is titled Medicare Paid You.

13. **You May Be Billed**. This is the total amount the provider is allowed to bill you. It combines the deductibles, the coinsurance and any non-covered charges. If you have supplemental insurance, it may pay all or part of this amount. There may be other laws in your state that limit doctors' charges.

14. **See Notes Section**. If a letter appears in this column, refer to the Notes Section. Please see item 16.

15. **Provider's Name and Address**. More than one name may be shown. If you were treated by a clinic or group medical practice, the clinic or group name will be shown, followed by the name of the doctor who performed the service. If the service was ordered or referred by another doctor, the referring doctor's name may also be listed. The address shown is the billing address which may be different from where you received the service(s).

16. The **Notes Section** gives more detailed information about your claim.

17. The **Deductible Information** section shows how much of your yearly deductible has been met.

18. The **General Information** section provides important Medicare news and information.

19. **Appeals Information**, such as how and when to request an appeal, is shown here. See the back of your MSN for more information and how to get help with appeal requests.

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

Assignment is an agreement between Medicare, and doctors, other health care providers, and suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies). Doctors, providers, and suppliers who agree to accept assignment accept the Medicare-approved amount as payment in full for Part B services and supplies. You pay the coinsurance and deductible amounts. In some cases (such as if you have both Medicare and Medicaid), your health care providers and suppliers must accept assignment.

Look at www.medicare.gov on the Web to find doctors in your area who always accept assignment. Select "Participating Physician Directory."

If assignment is not accepted, charges are often higher. This means you may pay more. In addition, you may have to pay the entire charge at the time of service. Medicare will then send you its share of the charge.

There is a limit on the amount your doctors and providers can bill you. The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment is called the limiting charge. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

For more information about assignment, get a free copy of *Does Your Doctor or Supplier Accept Assignment*? Look on page 9 for details about how to get this booklet.

Section 4

Original Medicare Plan

Common Questions and Answers

Q1: Does the Original Medicare Plan cover mental health care?

A: Yes. If you are in the Original Medicare Plan, Part A covers inpatient mental health care, including room, meals, nursing, and other related services and supplies. Part B covers mental health services generally given outside a hospital, including visits with a doctor, clinical psychologist, clinical social worker, and lab tests. For certain outpatient mental health services, Medicare payment is reduced. For more information about Medicare coverage for mental health care, get a free copy of *Medicare and Your Mental Health Benefits*. Look on page 9 for details about how to get this booklet.

Q2: Does the Original Medicare Plan pay for care in a nursing home?

A: Usually, no. Most nursing home care is custodial care (help with bathing, dressing, using the bathroom, and eating). This care is not covered by Medicare. Medicare Part A only covers skilled care given in a certified skilled nursing facility. You must meet certain conditions and coverage is limited. For more information about Medicare skilled nursing care, get a free copy of *Medicare Coverage of Skilled Nursing Facility Care*. Look on page 9 for details about how to get this booklet.

Q3: Does the Original Medicare Plan cover me when I travel outside of the United States?

A: The Original Medicare Plan does not cover health care when you travel outside the United States, except for some emergency situations in Mexico and Canada. Some Medigap policies do cover care outside the United States (see page 60). Check your insurance coverage before you travel outside the country.

Q4: Why are some of my bills for outpatient services higher than they were before July 2000?

A: Medicare changed the way it pays for outpatient services in July 2000. Depending on which services you get and the hospital where you get these services, your out-of-pocket costs may be different than they were before, for the same service. For more information about this new payment system, get a free copy of *Your Guide to the Outpatient Prospective Payment System*. Look on page 9 for details about how to get this booklet.

Q5: Why didn't Medicare pay for my bone mass measurement? I thought this service was covered.

A: Medicare covers bone mass measurement for "certain people with Medicare who are at risk for losing bone mass."

These people are at risk of losing bone mass:

- A woman who is estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and findings (as determined by the doctor or a qualified non-physician practitioner), or
- A person with vertebral abnormalities seen on x-ray and that shows osteoporosis, osteopenia (low bone mass), or vertebral fracture, or
- A person getting (or expecting to get) glucocorticoid (steroid) therapy that is equal to at least 7.5 mg of prednisone per day, for more than three months, or
- A person with primary hyperparathyroidism, or
- A person being monitored to see how well an FDA-approved osteoporosis drug therapy is working.

Section 5

Medicare + Choice Plans

What is a Medicare + Choice plan?

Medicare + Choice plans provide care under contract to Medicare. They may provide benefits like coordination of care or reduce out-of-pocket expenses. Some plans may offer additional benefits.

Medicare + Choice plans currently include:

- Medicare managed care plans (like HMOs), and
- Medicare Private Fee-for-Service plans.

Medicare + Choice plans are available in many areas of the country. For information about the Medicare + Choice plans available in your area, look on pages 79-83, look at www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227).

Remember, words in blue are defined on pages 63-66.

Medicare pays a set amount of money for your care every month to these private health plans. In turn, the Medicare + Choice plan manages the Medicare coverage for its members. If Medicare + Choice plans are available in your area, you can join one and get your Medicare covered benefits. By joining a Medicare + Choice plan, you can often get extra benefits, like prescription drugs. The Medicare + Choice plan may have additional rules that you need to follow. You may also have to pay a monthly premium for the extra benefits.

If you join a Medicare + Choice plan:

- You are still in the Medicare program.
- You must have Medicare Part A **and** Part B, and continue to pay the monthly Medicare Part B premium ($54 in 2002). If you are already in a Medicare managed care plan and have only Part B, you may stay in your plan.
- You still get all your regular Medicare-covered services (see pages 12-17). You may be able to get extra benefits like prescription drugs or additional days in the hospital.
- You have Medicare rights to protect you (see page 18).

Section 5

Medicare + Choice Plans

How does a Medicare managed care plan work?

- In most managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan. Call the plan you are interested in to see which doctors are in the plan.
- Doctors can join or leave managed care plans at any time. If your doctor leaves your plan, ask your plan for the names of other plan doctors in your area.
- Generally, you need a referral to see a specialist (like a cardiologist), which means your primary care doctor tells you and the specialist it is OK for you to go.
- You may pay more if you get health care outside the service area of the plan, unless you have an emergency or need urgent care (see Q7 and Q8 on page 55). The service area is where the plan accepts members and where you get services from the plan.
- Each year, the companies offering Medicare + Choice plans can decide to join, stay with, or leave Medicare.
- Some managed care plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who are not a part of the plan. Most of the time this costs you more, but this option gives you more choices.
- Exceptions to these rules might apply in emergencies or certain cases when care is urgently needed (see Q7 and Q8 on page 55).

Section 5

Medicare + Choice Plans

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

- The private company, rather than the Medicare program, decides how much it pays, and how much you pay, for the services you get.
- You can go to any doctor or hospital that accepts the terms of the plan's payment.
- The private company provides health care coverage to people with Medicare who join this plan. The private company pays a fee for each doctor visit or service you get, and you may also pay a fee.
- The private company may have a "pre-notification" requirement. For example, it may require that you tell the plan of any planned inpatient hospital stays.
- You may pay more if the plan lets doctors, hospitals, and other providers bill you more than the plan pays for services. If this is allowed, there may be a limit to what they can charge, and you must pay the difference.

Your costs in a Medicare + Choice plan

What you pay out-of-pocket depends on:

- Whether the plan charges a monthly premium in addition to your monthly Part B premium ($54 in 2002).
- How much you pay for each visit or service ("copayments").
- The type of health care you need and how often you get it.
- The types of extra benefits you use, and whether the plan covers them.

Section 5

Medicare + Choice Plans

Joining a Medicare + Choice plan

Who can join a Medicare + Choice plan?

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

If you have Medicare, you can join a Medicare + Choice plan if:

- You have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).
- You live in the service area of the plan. The service area is where you must live for the plan to accept you as its member. In the case of a Medicare managed care plan, it's also where you get services from the plan. The plan can give you more information about its service areas.
- You do not have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Special Rules for People with End-Stage Renal Disease:

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

Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare + Choice plans.

If you have ESRD and are in a Medicare + Choice plan, and the plan leaves Medicare or no longer provides coverage in your area, you can join another Medicare + Choice plan if one is available in your area. This is true for people whose plans left Medicare or stopped providing coverage in their area on or after December 31, 1998.

Joining a Medicare + Choice plan (continued)

When can I join one of these plans?

There are three main times when you can join. They are:

1. When you first become eligible for Medicare.
2. November. Medicare + Choice plans must accept new members from November 1 through November 30 of each year. In 2001, Medicare + Choice plans must also accept new members in December. In most cases, if you join a Medicare health plan in November (or December 2001), your coverage begins on January 1 of the next year.
3. January 1 through June 30, 2002 (if a plan is accepting new members).

Note: Some Medicare + Choice plans limit the number of members in their plans. These plans may not accept new members all of the time. A plan can tell you if it is signing up new members.

How do I join a Medicare + Choice plan?

1. Call the plan and ask for an enrollment form. Fill out the form and mail it to the plan, or
2. Get an enrollment form from a plan representative. Fill out the form and mail it to the plan, or give it to the plan representative.

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

Caution: You can't join more than one Medicare health plan at the same time. If you try to join more than one Medicare health plan with the same starting dates, you may end up enrolled in the plan you didn't want to be in.

Joining a Medicare + Choice plan (continued)

Can I keep my Medigap (Medicare Supplement Insurance) policy if I join a Medicare + Choice plan?

Yes, you can keep it. However, it may cost you a lot and you may get little benefit from it while you are in a Medicare + Choice plan.

If you drop your Medigap policy, you may not be able to get it back, except in certain situations. If you join a Medicare + Choice plan when you first become eligible for Medicare at age 65, or if this is the first time you've enrolled in a Medicare + Choice plan, you may have special Medigap protections that give you another chance to buy a Medigap policy. For more information on Medigap policies and protections, get a free copy of the *Guide to Health Insurance For People with Medicare: Choosing a Medigap Policy*. Look on page 9 for details about how to get this booklet.

How can I tell if I am in a Medicare + Choice plan?

If you joined a Medicare + Choice plan, you should have a membership card with the name of the plan on it. If you are not sure if you are in a Medicare + Choice plan, you can call the number listed on your membership card. You can also call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772. Ask the customer service representative to check if you are in a Medicare + Choice plan.

Section 5

Medicare + Choice Plans

Leaving a Medicare + Choice plan

When can I leave a Medicare + Choice plan?

Starting January 1, 2002, you can leave a Medicare + Choice plan and join another plan only one time from January 1 through June 30, 2002. After you have made one change (including changing to the Original Medicare Plan), you must stay in that plan for the rest of the year.

Example: Mrs. Smith belongs to the Alpha managed care plan. She leaves the Alpha managed care plan in May 2002 to join the Beta managed care plan. She now must stay with the Beta plan for the rest of the year.

For more information on leaving a Medicare + Choice plan, get a free copy of *New Rules for Switching Medicare Health Plans*. Look on page 9 for details about how to get this booklet.

How do I leave a Medicare + Choice plan?

Write to the plan or to the Social Security Administration, or call 1-800-MEDICARE (1-800-633-4227). Tell them you want to leave the plan. The plan should send you a letter with the date your plan coverage ends. If you don't get a letter, call the plan and ask for the date. When you leave a plan, you are automatically returned to the Original Medicare Plan, unless you join another Medicare + Choice plan. If you join another Medicare + Choice plan, you should get a letter telling you when your coverage starts. You will be disenrolled from your old plan automatically.

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

You will need to call the health plan to see if you can stay in the plan if you move out of the plan's service area. If you must leave the plan, you must disenroll. If there are no Medicare + Choice plans available in your new location, you will be covered by the Original Medicare Plan. You can choose to join another Medicare + Choice plan, if one is available in your new area and they are accepting new members. Or, you can choose the Original Medicare Plan.

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Medicare + Choice Plans

For more information about Medicare + Choice plans:

- Look on pages 79-83.
- Look at www.medicare.gov on the Web. Select "Medicare Health Plan Compare" or "Publications" to look at or print plan information or booklets.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can get:
  - A free copy of detailed health plan information for Medicare health plans in your ZIP code. This information includes health plan names, contact phone numbers, costs, extra benefits, quality ratings, and disenrollment information to help you compare health plans.
  - A free copy of *Your Guide to Private Fee-for-Service Plans* (CMS Pub. No. 10144).

Section 5

Medicare + Choice Plans

Common Questions and Answers

Q1: How do I find out if my doctor or hospital belongs to a plan?

A: If you want to keep seeing your doctor when you join a Medicare + Choice plan, call and ask if he or she is in the Medicare + Choice plan and would continue to see you if you joined the plan. You can also get a list from your plan of doctors and hospitals that belong to the plan.

Q2: Can I join a Medicare + Choice plan if I have employer or union coverage?

A: If you join a Medicare + Choice plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your Medicare health plan coverage. Talk to your employer's or union's benefits administrator about the rules that apply. Remember, if you drop your employer or union coverage, you may not be able to get it back.

Q3: Do Medicare + Choice plans cover me when I travel outside the United States?

A: Some Medicare + Choice plans cover you when you travel outside of the United States. Check with your plan before you leave the country.

Q4: Is mental health care covered in a Medicare + Choice plan?

A: If you are in a Medicare + Choice plan, read your plan materials or call the plan to learn about its coverage of mental health care. You must get at least the same coverage as provided by Medicare Part A and Medicare Part B of the Original Medicare Plan.

Section 5
Medicare + Choice Plans

Q5: Who decides where Medicare + Choice plans will be available?

A: Medicare + Choice plans are offered by private companies. A company can decide that a plan will be available to everyone with Medicare in a state, or be open only in certain counties. A company may also choose to offer more than one plan in an area, with different benefits and costs. Each year, companies offering Medicare + Choice plans can decide to stay in or leave Medicare.

Companies may decide to offer plans in your area in the future. For the most up-to-date information about Medicare + Choice plans in your area:

- Look at www.medicare.gov on the Web. Select "Medicare Health Plan Compare."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Q6: How long do Medicare + Choice plans contract with Medicare?

A: When a Medicare + Choice plan decides to contract with (join or stay in Medicare), it agrees to stay for the entire year, January 1 through December 31. Private companies offer Medicare + Choice plans. Each year, they make a business decision to stay in or leave the Medicare program. Costs and extra benefits can also change each year.

Section 5
Medicare + Choice Plans

Q7: What is a "medical emergency"?

How do I get emergency care in a Medicare + Choice plan?

A: A medical emergency is when you believe that your health is in serious danger — when every second counts. You may have a bad injury, sudden illness, or an illness quickly getting much worse.

All Medicare + Choice plans must allow you to get emergency care whenever you need it from any provider in the United States. You do not need to get permission from a primary care doctor first. Your plan must pay for emergency care (you may have to pay a copayment). If you get a bill, give it to the plan to pay. If your plan does not pay for your emergency care, you have the right to appeal (see Q9 on page 56).

Q8: What is "urgently needed care"?

How do I get urgent care in a Medicare + Choice plan?

A: Urgently needed care is care you need for a sudden illness or injury that is not a medical emergency.

In a Medicare managed care plan, you get urgently needed care from your primary care doctor. However, if you are in the United States but out of the plan's service area and cannot wait until you return home, your plan must pay for urgently needed care (you will have to pay a copayment). If it does not, you have the right to appeal (see Q9 on page 56).

In a Private Fee-for-Service plan, you can get urgently needed care from any doctor who accepts the terms of the plan's payment.

Section 5
Medicare + Choice Plans

Q9: Can I appeal my Medicare + Choice plan's payment decisions?

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

Q10: What can I do if my Medicare + Choice plan doesn't stay in the Medicare program?

A: If your Medicare + Choice plan leaves the Medicare program, you will be sent a notification letter. The letter will tell you if there are other Medicare + Choice plans in your area that you can join. You can always choose the Original Medicare Plan. You will be automatically returned to the Original Medicare Plan if you don't choose another Medicare + Choice plan. You may be able to buy a Medigap policy (see page 60). 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.

Q11: What can I do if my Medicare + Choice plan reduces its service area and I lose my coverage?

A: If your Medicare + Choice plan reduces its service area and you lose coverage, the Medicare + Choice plan may have an option that lets you keep your coverage. In order to keep your coverage, you must: have no other Medicare + Choice plans in your area you can join, and agree to get all your services (except in an emergency or urgent situation) from providers in the reduced service area. If your Medicare + Choice plan does not offer this option, you will automatically return to the Original Medicare Plan. If your plan reduces its service area and you want to know if you can keep your coverage, call your plan.

Section 6

Other Insurance and Ways to Pay Health Care Costs

Do you know what health care insurance you have and what it helps pay for? Now is a good time to review your coverage. Medicare may not be the only health care coverage you have or can get. You might be able to get more health care coverage, help to lower your out-of-pocket costs, or more benefits than you get with Medicare alone.

Whether or not you can get employer, union, military, or other health care coverage, you should learn about all of the different kinds of health care coverage. What coverage you have will affect how much you pay, what benefits you may have, which doctors you can see, and other things that may be important to you.

For more information about how these kinds of insurance work with Medicare, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First*. Look on page 9 for details about how to get this booklet.

1. Employer or Union Health Coverage

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

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

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

2. Veterans' Benefits

If you are a Veteran, call the U.S. Department of Veterans Affairs at 1-800-827-1000 for information about Veterans' benefits and services available in your area.

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Other Insurance and Ways to Pay Health Care Costs

3. Military Retiree Benefits

TRICARE for Life (TFL) provides expanded medical coverage for: Medicare-eligible retirees, including retired guard members and reservists; Medicare-eligible family members and widow/widowers; and certain former spouses if they were eligible for TRICARE before age 65. You must have Medicare Part B to be eligible for TFL.

If eligible, you get all Medicare-covered benefits under the Original Medicare Plan, plus all TFL-covered benefits. If you use a Medicare provider, Medicare will be the first payer for all Medicare-covered services, and TFL will be the second payer. TFL will pay all Medicare copayments and deductibles and cover most of the costs of certain care not covered by Medicare.

For more information on TFL, call 1-888-DOD-LIFE (1-888-363-5433) or look at www.TRICARE.osd.mil on the Web. Call 1-800-538-9552 for other military retiree benefit questions.

4. Medicare Savings Programs (Help From Your State)

There are programs that help millions of people with Medicare save money each year. States have programs for people with limited income and resources that pay some or all of Medicare's premiums. Some programs may also pay Medicare deductibles and coinsurance.

You can apply for these programs if:

- You have Medicare Part A. (If you have Medicare Part A but don't think you can afford it, there is a program that may pay the Medicare Part A premium for you.)

and

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

4. Medicare Savings Programs (continued)

and

- You are an individual with a monthly income of less than $1,273,* or are a couple with a monthly income of less than $1,714.*

  Call your state medical assistance office (see page 78) and ask for information on Medicare Savings Programs. It's very important to call if you think you qualify for any of these Medicare Savings Programs, even if you aren't sure.

* Income limits will change slightly in 2002. If you live in Alaska or Hawaii, income limits are slightly higher.

5. Medicaid

If your income and assets are even more limited than those described above, you may qualify for Medicaid. Most of your health care costs are covered if you have Medicare and you qualify for Medicaid. Medicaid is a joint federal and state program that helps pay medical costs for some people with limited incomes and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for nursing home care and outpatient prescription drugs that are not covered by Medicare. For more information about Medicaid, call your state medical assistance office (see page 78).

6. Prescription Drug Assistance Programs

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

Section 6

Other Insurance and Ways to Pay Health Care Costs

7. Medigap (Medicare Supplement Insurance) Policies

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

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

For more information about Medigap policies, costs and choices, call 1-800-MEDICARE (1-800-633-4227) and speak with a customer service representative.

Do I need to buy a Medigap policy?

Medigap policies help pay health care costs only if you have the Original Medicare Plan. Whether you need a Medigap policy is a decision that only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree coverage, or join a Medicare + Choice plan.

You do not need to buy a Medigap policy if you are in a Medicare + Choice plan. In fact, it may be illegal for anyone to sell you a Medigap policy if they know you are in one of these health plans. If you have Medicaid, it is generally illegal for an insurance company to sell you a Medigap policy.

When is the best time to buy a Medigap policy?

The best time to buy a Medigap policy is during your Medigap open enrollment period. It starts on the first day of the month in which you are both age 65 or older and are enrolled in Medicare Part B. Your Medigap open enrollment period lasts for 6 months. Once the 6-month Medigap open enrollment period starts, it cannot be changed.

During this period, an insurance company cannot deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or change the price of a policy because of your past or present health problems. They must also shorten the waiting period for pre-existing conditions by the amount of previous health coverage you have.

Important: If you don't buy a Medigap policy during your open enrollment period, you may not be able to buy the one you want, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back.

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

For information about buying a Medigap policy, get a free copy of the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy.* Look on page 9 for details about how to get this booklet.

Section 6

Other Insurance and Ways to Pay Health Care Costs

8. Long-Term Care Insurance

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

For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State Insurance Department (see page 78) or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600.

Insure Kids Now

Free or low-cost health insurance is available now in your state for uninsured children under age 19. Call 1-877-KIDS-NOW (1-877-543-7669) toll-free for more information.

Section 7

Words To Know

Appeal - An appeal is a special kind of complaint you make if you disagree with any decision about your health care services. For example, if Medicare doesn't pay or doesn't pay enough for a service you got or would like to get. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint.

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go to the hospital after 60 days, a new benefit period begins. You must pay an inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

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

Copayment - In some Medicare health plans, the amount that you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5 or $10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Critical Access Hospitals - A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Deductible - The amount you must pay for health care, before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

Health Maintenance Organization (HMO), Medicare - A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. In an HMO, you usually must get all your care from the providers that are part of the plan.

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

Section 7
Words To Know

Lifetime Reserve Days - Sixty days that Medicare will pay for when you are in a hospital for more than 90 days in a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance amount ($406 in 2002).

Limiting Charge - The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

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

Medically Necessary - Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition;
- are used for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the local community; and
- are not mainly for the convenience of you or your doctor.

Medicare + Choice Plan - A health plan, such as an HMO or Private Fee-for-Service plan offered by a private company and approved by Medicare. An alternative to the Original Medicare Plan.

Medicare-Approved Amount - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "approved charge."

Medicare Managed Care Plan - These are health care choices in some areas of the country. In most plans, except in emergencies or certain cases when care is urgently needed, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Private Fee-for-Service Plan - A private insurance plan that accepts people with Medicare. 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 for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Section 7
Words To Know

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

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

Preventive Services - Care to keep you healthy or to prevent illness, such as colorectal cancer screening, yearly mammograms, and flu shots.

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 managed care plans, you must see your primary care doctor before you can see any other health care provider.

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

Quality Improvement Organization (QIO) - Groups of practicing doctors and other health care experts paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service plans, and ambulatory surgical centers.

Referral - An OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

Section 7
Words To Know

Skilled Nursing Facility Care* - A level of care that must be given or supervised by licensed nurses. All of your needs are taken care of with this type of service. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average nonmedical person (or one's self) without the supervision of a licensed nurse is not covered.

State Health Insurance Assistance Program (SHIP) - A state program that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

Telemedicine - The use of medical information exchanged from one site to another using electronic communications for the health and education of patients or providers and to improve patient care.

* This definition in whole or in part was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology 2000.

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The phone numbers listed on the following pages were correct at the time of printing. Sometimes phone numbers change. You can find the most up-to-date phone numbers by looking at www.medicare.gov on the Web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You are protected from discrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, or religion under certain conditions. If you think that you have not been treated fairly for any of these reasons, call the Office for Civil Rights in your state (see page 76).

NOTES

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
(Formerly the Health Care Financing Administration)
7500 Security Boulevard
Baltimore, Maryland 21244-1850

PRSRT STD
POSTAGE & FEES PAID
CMS
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Official Business
Penalty for Private Use, $300

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