

Large Print Edition

Medicare & You 2019

This is the **official U.S. government**
Medicare handbook.



Centers for Medicare & Medicaid Services

You're getting a new Medicare card!

We've been mailing new Medicare cards since April 2018.

Your new card has a Medicare Number that's unique to you, **instead of your Social Security Number**. We did this to protect your information and help prevent Medicare fraud.

When you get your new card:

- **Destroy your old Medicare card.** Make sure you destroy your old card so no one can get your personal information.
- **Start using your new Medicare card right away!**
Your doctors, other health care providers, and facilities will ask for your new number, so carry your new card with you when you need care.
- **Keep your other plan cards.** If you're in a Medicare Advantage Plan (like an HMO or PPO) or a Medicare drug plan, keep using that Plan ID card whenever you need care or prescriptions. However, you should carry your new Medicare card too—you may be asked to show it.

- **Protect your Medicare Number like you do your Social Security Number.** Only give your new Medicare Number to doctors, pharmacists, other health care providers, your insurer, or people you trust to work with Medicare on your behalf.

Still waiting for your new card?

Your new Medicare card should have arrived in the mail by now. If you didn't get it, here's what to do next:

- Look around the house for any old or unopened mail. Your new Medicare card will come in a plain white envelope from the Department of Health and Human Services.
- If you still can't find it, **call us at 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.** We may not have your correct address on file. Our call center representatives can help you check your address and fix it if needed.
- In the meantime, **use your current Medicare card to get health care services.**

Get started

If you're new to Medicare:

- **Learn about your Medicare choices.** There are 2 different ways to get your Medicare coverage—see the next few pages to learn more.
- **Find out how and when you can sign up.** If you don't have Medicare Part A or Part B, see Section 1, which starts on page 19. If you don't have Medicare prescription drug coverage (Part D), see Section 6, which starts on page 175. There may be penalties if you don't sign up when you're first eligible.
- **If you have other health insurance,** see pages 31 – 32 to find out how it works with Medicare.

If you already have Medicare:

- **You don't need to sign up for Medicare each year.** However, you can **review your Medicare health and prescription drug coverage** and make changes each year.
- **Mark your calendar with these important dates!** This may be the only chance you have each year to make changes to your coverage.

October 1, 2018

Start comparing your coverage with other options. You may be able to save money. Visit **[Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)**.

October 15 to December 7, 2018

Change your Medicare health or prescription drug coverage for 2019, if you decide to. This includes returning to Original Medicare or joining a Medicare Advantage Plan.

January 1, 2019

New coverage begins if you made a change. If you kept your existing coverage and your plan's costs or benefits changed, those changes will also start on this date.

January 1 to March 31, 2019

If you're in a Medicare Advantage Plan, you can make one change to a different plan or switch back to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan) once during this time. Any changes you make will be effective the first of the month after the plan gets your request. See page 136.

Pages 6 – 16 provide an overview of your Medicare options.

What are the parts of Medicare?

Part A (Hospital Insurance)

Helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

See pages 42 – 51.

- End of Page

Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment and supplies)
- Many preventive services (like screenings, shots, and yearly “Wellness” visits)

See pages 52 – 117.

Part D (Prescription drug coverage)

Helps cover:

- Cost of prescription drugs

Part D plans are run by private insurance companies that follow rules set by Medicare.

See pages 175 – 204.

Your Medicare options

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- If you want drug coverage, you can join a separate Part D plan.
- To help pay your out-of-pocket costs in Original Medicare (like your deductible and 20% coinsurance), you can also shop for and buy supplemental coverage. (Some examples include coverage from a Medicare Supplement Insurance (Medigap) policy, or coverage from a former employer or union.)

Medicare Advantage (also known as Part C)

- Medicare Advantage is an “all in one” alternative to Original Medicare. These “bundled” plans include Part A, Part B, and usually Part D.
 - Some plans may have lower out-of-pocket costs than Original Medicare.
 - Some plans offer extra benefits that Original Medicare doesn’t cover—like vision, hearing, or dental.
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- End of Page

At a glance: Original Medicare vs. Medicare Advantage

Doctor and hospital choice

Original Medicare

- You can go to **any doctor that accepts Medicare**.
- In most cases you **don't need** a referral to see a specialist.

Medicare Advantage

- In most cases, you'll need to use **doctors who are in the plan's network** (for non-emergency or non-urgent care). Ask your doctor if they participate in any Medicare Advantage Plans.
- You **may need** to get a referral to see a specialist.

Cost

Original Medicare

- For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible.
- You **pay a premium (monthly payment) for Part B**. If you choose to buy prescription drug coverage, you'll pay that premium separately.
- There's **no yearly limit** on what you pay out-of-pocket.
- You **can buy** supplemental coverage to help pay your out-of-pocket costs (like your deductible and 20% coinsurance).

Medicare Advantage

- **Out-of-pocket costs vary**—some plans have low or no out-of-pocket costs.
- You may pay a premium for the plan (most include prescription drug coverage) and a premium for Part B. Some plans have a \$0 premium or will help pay all or part of your Part B premium.

Medicare Advantage (continued)

- Plans have a **yearly limit** on what you pay out-of-pocket for Medicare Part A and B covered services. Once you reach your plan's limit, you'll pay nothing for Part A- and Part B- covered services for the rest of the year.
- You **can't buy or use** separate supplemental coverage—but some plans have lower out-of-pocket costs than Original Medicare.

Coverage

Original Medicare

- Original Medicare covers medical services and supplies in hospitals, doctors' offices, and other health care settings.
- You can join a **separate Medicare Prescription Drug Plan** to get drug coverage.
- In most cases, you don't have to get a service or supply approved ahead of time for it to be covered.

Medicare Advantage

- Plans must cover all of the services that Original Medicare covers. Some plans **offer extra benefits that Original Medicare doesn't cover**—like vision, hearing, or dental.
- **Prescription drug coverage is included** in most plans.
- In some cases, you have to get a service or supply approved ahead of time for it to be covered by the plan.

Travel

Original Medicare

- Original Medicare generally **doesn't cover care outside the U.S.** You may be able to buy supplemental coverage that covers care outside the U.S.

Medicare Advantage

- Plans usually **don't cover care outside the U.S.** **Also, plans usually don't cover non-emergency care you get outside of your plan's network.**

These topics are explained in more detail throughout this book.

- Original Medicare: See Section 3 (starting on page 121).
- Medicare Advantage: See Section 4 (starting on page 129).
- End of Page

Get the most out of Medicare

Get help choosing the coverage option that's right for you:

- Get free, personalized counseling from your State Health Insurance Assistance Program (SHIP)—see pages 275 – 281 for the phone number.
- Call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.
- Visit the Medicare Plan Finder at [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan).

Get free help with your Medicare questions

For general Medicare questions, visit [Medicare.gov](https://www.medicare.gov), or call 1 800 633 - 4227. See pages 255 – 261 to learn about other resources.

Get preventive services

Ask your doctor or other health care provider which preventive services (like screenings, shots, and tests) you need to get. Medicare covers many common preventive services at no cost to you. See pages 52 – 117 to learn more.

Get help paying for health care

Find out if you can get help paying your health and prescription drug costs. Go to Section 7, which starts on page 205, to see if you qualify.

Go paperless

Help save tax dollars by choosing to access future “Medicare & You” handbooks electronically. See page 256 to find out how. To access and manage your personalized Medicare information online, visit **MyMedicare.gov**. See pages 259 – 261 for details.

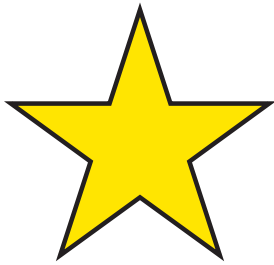
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Notes

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Section 1: Signing up for Medicare

Some people get Part A and Part B automatically

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

If you're under 65 and have a disability, you'll automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months.

If you live in Puerto Rico, you don't automatically get Part B. You must sign up for it. See page 22 for more information.

Underlined words are defined on pages 283 - 291.

If you have ALS (amyotrophic lateral sclerosis, also called Lou Gehrig's disease), you'll get Part A and Part B automatically the month your Social Security disability benefits begin.

If you're automatically enrolled, you'll get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday or 25th month of disability benefits. If you do nothing, you'll keep Part B and will have to pay Part B **premiums**. You can choose not to keep Part B, but if you decide you want Part B later, you may have to wait to enroll and pay a penalty for as long as you have Part B. See page 36.

Note: If you don't get your card in the mail, call Social Security at 1 800 772 - 1213 and let them know. TTY users can call 1 800 325 - 0778. If you get RRB benefits, call 1 877 772 - 5772. TTY users can call 1 312 751 - 4701.

Underlined words are defined on pages 283 – 291.

Some people have to sign up for Part A and/or Part B

If you're close to 65, but not getting Social Security or Railroad Retirement Board (RRB) benefits, you'll need to sign up for Medicare. Contact Social Security 3 months before you turn 65. You can also apply for Part A and Part B at [socialsecurity.gov/retirement](https://www.socialsecurity.gov/retirement). If you worked for a railroad, contact the RRB. In most cases, if you don't sign up for Part B when you're first eligible, you may have a delay in getting Medicare coverage in the future, and you may have to pay a late enrollment penalty for as long as you have Part B.

If you have End-Stage Renal Disease (ESRD) and you want Medicare, you'll need to sign up. Contact Social Security to find out when and how to sign up for Part A and Part B. For more information, visit [Medicare.gov/publications](https://www.Medicare.gov/publications) to view the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

Important!

If you live in Puerto Rico and get benefits from Social Security or the RRB, you'll automatically get Part A the first day of the month you turn 65 or after you get disability benefits for 24 months. **However, if you want Part B, you'll need to sign up for it by completing an "Application for Enrollment in Part B Form" (CMS - 40B).** If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Visit [CMS.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms017339.html](https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms017339.html) to get Form CMS-40B in English or Spanish. Contact your local Social Security office or RRB for more information.

Where can I get more information?

Call Social Security at 1 800 772 - 1213 for more information about your Medicare eligibility and to sign up for Part A and/or Part B. TTY users can call 1 800 325 - 0778. If you worked for a railroad or get RRB benefits, call the RRB at 1 877 772 - 5772. TTY users can call 1 312 751 - 4701.

Underlined words are defined on pages 283 – 291.

You can also get free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). See pages 275 – 281 for the phone number.

No matter how you enroll in Medicare, you'll need to decide how to get your Medicare coverage. You can choose between Original Medicare or a **Medicare Advantage Plan**. See pages 8 – 15 for more information.

If I'm not automatically enrolled, when can I sign up?

If you're not automatically enrolled in **premium**-free Part A, you can sign up for Part A once your Initial Enrollment Period starts. Your Part A coverage will start 6 months back from the date you apply for Medicare (or Social Security/RRB benefits), but no earlier than the first month you were eligible for Medicare. However, you can only sign up for Part B (or Part A if you have to buy it) during the times listed below. **Remember, in most cases, if you don't sign up for Part A (if you have to buy it) and Part B when you're first eligible, you may have to pay a late enrollment penalty.**

Initial Enrollment Period

You can first sign up for Part A and/or Part B during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

If you sign up for Part A and/or Part B during the first 3 months of your Initial Enrollment Period, in most cases, your coverage starts the first day of your birthday month. However, if your birthday is on the first day of the month, your coverage will start the first day of the prior month.

If you enroll in Part A and/or Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, the start date for your Medicare coverage will be delayed.

Underlined words are defined on pages 283 – 291.

Special Enrollment Period

After your Initial Enrollment Period is over, you may have a chance to sign up for Medicare during a Special Enrollment Period. If you didn't sign up for Part B (or Part A if you have to buy it) when you were first eligible because you're covered under a group health plan based on current employment (your own, a spouse's, or a family member's (if you have a disability)), you can sign up for Part A and/or Part B:

- Anytime you're still covered by the group health plan
- During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first

Usually, you don't pay a late enrollment penalty if you sign up during a Special Enrollment Period. This Special Enrollment Period doesn't apply to people who are eligible for Medicare based on End-Stage Renal Disease (ESRD). It also doesn't apply if you're still in your Initial Enrollment Period.

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Note: If you have a disability, and the group health plan coverage is based on the current employment of a family member, the employer offering the group health plan must have 100 or more employees for you to get a Special Enrollment Period.

Important!

COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, retiree health plans, and individual health coverage (like through the Health Insurance Marketplace) aren't considered coverage based on current employment. You aren't eligible for a Special Enrollment Period to sign up for Medicare when that coverage ends. To avoid paying a higher **premium**, make sure you sign up for Medicare when you're first eligible. See page 199 for more information about COBRA coverage.

To learn more about enrollment periods, visit **Medicare.gov**, or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Underlined words are defined on pages 283 – 291.

General Enrollment Period

If you didn't sign up for Part A (if you have to buy it) and/or Part B (for which you must pay premiums) during your Initial Enrollment Period, and you don't qualify for a Special Enrollment Period, you can sign up between January 1 – March 31 each year. **Your coverage won't start until July 1 of that year, and you may have to pay a higher Part A and/or Part B premium for late enrollment.** See pages 21 – 28.

Should I get Part B?

This information can help you decide if you should get Part B:

Employer or union coverage

If you or your spouse (or family member if you have a disability) **is still working** and you have health coverage through that employer or union, contact your employer or union benefits administrator to find out how your coverage works with Medicare. This includes federal or state employment and active-duty military service. It might be to your advantage to delay Part B enrollment.

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Note: Remember, coverage based on current employment doesn't include:

- COBRA
- Retiree coverage
- VA coverage
- Individual health coverage (like through the Health Insurance Marketplace)

TRICARE

If you have TRICARE (health care program for active-duty and retired service members and their families), **you generally must enroll in Part A and Part B when you're first eligible to keep your TRICARE coverage.** However, if you're an active-duty service member or an active-duty family member, you don't have to enroll in Part B to keep your TRICARE coverage. For more information, contact TRICARE. See page 203.

If you have CHAMPVA coverage, you must enroll in Part A and Part B to keep it. Call 1 800 733 - 8387 for more information about CHAMPVA.

Underlined words are defined on pages 283 – 291.

Health Insurance Marketplace

If you have coverage through an individual Marketplace plan (not through an employer), you may want to end your Marketplace coverage and enroll in Medicare during your Initial Enrollment Period to avoid the risk of a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty. It's important to terminate your Marketplace coverage in a timely manner to avoid an overlap in coverage. Once you're considered eligible for Part A, you won't qualify for help paying your Marketplace plan **premiums** or other medical costs.

If you continue to get help paying your Marketplace plan premium after you have Medicare, you may have to pay back the help you got when you file your taxes.

Visit **HealthCare.gov** to connect to the Marketplace in your state and learn more. You can also find out how to terminate your Marketplace plan or Marketplace financial help when your Medicare enrollment begins. You can also call the Marketplace Call Center at 1 800 318 - 2596.

TTY users can call 1 855 889 - 4325.

Health savings accounts (HSAs)

You can't contribute to your HSA once your Medicare coverage begins. However, you may use money that's already in your HSA after you enroll in Medicare to help pay for **deductibles**, premiums, **copayments**, or **coinsurance**. If you contribute to your HSA after your Medicare coverage starts, you may have to pay a tax penalty. If you'd like to continue contributing to your HSA, you shouldn't apply for Medicare, Social Security, or Railroad Retirement Board (RRB) benefits.

Remember, premium-free Part A coverage begins 6 months back from the date you apply for Medicare (or Social Security/RRB benefits), but no earlier than the first month you were eligible for Medicare. To avoid a tax penalty, you should stop contributing to your HSA at least 6 months before you apply for Medicare.

A Medicare Advantage Medical Savings Account (MSA) Plan might be an option if you'd like to continue to get health benefits through an HSA-like benefit structure. See page 131 for more information.

Underlined words are defined on pages 283 – 291.

How does my other insurance work with Medicare?

When you have other insurance and Medicare, there are rules for whether Medicare or your other insurance pays first.

- If you have **retiree** insurance (insurance from your or your spouse's former employment) Medicare pays first.
- If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **20 or more employees** your group health plan pays first.
- If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **fewer than 20 employees** Medicare pays first.
- If you're under 65 and have a disability, have group health plan coverage based on your family member's **current** employment, and the employer has **100 or more employees** your group health plan pays first.

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- If you're under 65 and have a disability, have group health plan coverage based on your or a family member's **current** employment, and the employer has **fewer than 100 employees** Medicare pays first.
- If you have Medicare because of End-Stage Renal Disease (ESRD) your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period.

Note: In some cases, your employer may join with other employers or unions to form or sponsor a multiple-employer plan. If this happens, the size of the largest employer/union determines whether Medicare pays first or second.

Here are some important facts to remember:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.

Underlined words are defined on pages 283 – 291.

- If your employer insurance is the secondary payer, you might need to enroll in Part B before your insurance will pay.
- Medicaid pays after Medicare.

For more information, visit **Medicare.gov/publications** to view the booklet “Medicare & Other Health Benefits: Your Guide to Who Pays First.”

If you have other insurance or changes to your insurance, you need to let Medicare know by calling Medicare’s Benefits Coordination & Recovery Center (BCRC) at 1 855 798 - 2627. TTY users can call 1 855 797 - 2627.

Important!

If you have Medicare Part A (including coverage in a **Medicare Advantage Plan**), you meet the requirement for having health coverage. You’ll have to report this on your federal income tax return, and you won’t have to pay a penalty for not having health coverage.

If you have Part A, you may get a Health Coverage form (IRS Form 1095-B) from Medicare by early 2019. This form verifies that you had health coverage in 2018. Keep the form for your records. Not everyone will get this form. If you don’t get Form 1095-B, don’t worry, you don’t need to have it to file your taxes.

How much does Part A coverage cost?

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working for a certain amount of time. This is sometimes called premium-free Part A. If you aren't eligible for premium-free Part A, you may be able to buy Part A.

In most cases, if you choose to **buy** Part A, you must also have Part B and pay monthly premiums for both. If you choose NOT to buy Part A, you can still buy Part B.

The **2019** Part A premium amounts weren't available at the time of printing. To get the most up-to-date cost information, visit [Medicare.gov](https://www.medicare.gov) later this fall.

What's the Part A late enrollment penalty?

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

Example: If you were eligible for Part A for 2 years but didn't sign up, you'll have to pay a 10% higher premium for 4 years.

Underlined words are defined on pages 283 – 291.

How much does Part B coverage cost?

The standard Part B premium amount for **2018** is \$134. However, some people who get Social Security benefits will pay less than this amount (\$130 on average). You'll pay the standard premium amount if:

- You enroll in Part B for the first time in 2018.
- You don't get Social Security benefits.
- You're directly billed for your Part B premiums.
- You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of \$134 in 2018.)

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

The **2019** Part B premium amount wasn't available at the time of printing. To get the most up-to-date cost information, visit **Medicare.gov** later this fall.

What's the Part B late enrollment penalty?

If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Your monthly premium for Part B may go up 10% for each full 12-month period that you could've had Part B, but didn't sign up for it. If you're allowed to sign up for Part B during a Special Enrollment Period, you usually don't pay a late enrollment penalty. See page 25.

Example: Mr. Smith's Initial Enrollment Period ended December 2016. He waited to sign up for Part B until March 2019 during the General Enrollment Period. His coverage starts July 1, 2019. His Part B premium penalty is 20%, and he'll have to pay this penalty for as long as he has Part B. (Even though Mr. Smith wasn't covered a total of 27 months, this included only 2 full 12-month periods.)

Underlined words are defined on pages 283 – 291.

How can I pay my Part B premium?

If you get Social Security or Railroad Retirement Board (RRB) benefits, your Medicare Part B (Medical Insurance) **premium** will be deducted from your benefit payment.

If you're a federal retiree with an annuity from OPM and not entitled to RRB or SSA benefits, you may request to have your Part B premiums deducted from your annuity. Call 1 800 633 - 4227 to make your request. TTY users can call 1 877 486 - 2048.

If you don't get these benefit payments, you'll get a bill. If you choose to buy Medicare Part A (Hospital Insurance), you'll always get a bill for your premium. There are 4 ways to pay these bills:

- 1. Pay by check or money order.** Write your Medicare Number on your payment, and mail it with your payment coupon to:

Medicare Premium Collection Center
P.O. Box 790355
St. Louis, MO 63179-0355

- 2. Pay by credit/debit card.** To do this, complete the bottom portion of the payment coupon on your Medicare Premium Bill, and mail it to the address above. Payments submitted without the bottom portion of the payment coupon may not be processed.
- 3. Sign up for Medicare Easy Pay.** This is a free service that automatically deducts your premium payments from your savings or checking account each month. Visit **Medicare.gov** or call 1 800 633 - 4227 and to find out how to sign up.
- 4. Make an online bill payment.** This is a more secure and faster way to make your payment without sending your personal information in the mail. Ask your financial institution if it allows customers to pay bills online. Not all financial institutions offer this service and some may charge a fee. You'll need to give your financial institution this information:
 - **Account number:** This is your Medicare Number. It's important that you use the exact number on your red, white, and blue Medicare card, but without the dashes.
 - **Biller name:** CMS Medicare Insurance

Underlined words are defined on pages 283 – 291.

- **Remittance address:**

Medicare Premium Collection Center
P.O. Box 790355
St. Louis, MO 63179-0355

Note to RRB Annuitants: If you get a bill from the RRB, mail your premium payments to:

RRB Medicare Premium Payments
P.O. Box 979024
St. Louis, MO 63197-9000

If you have questions about your **premiums** or need to change your address on your bill, call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778. If your bills are from the RRB, call 1 877 772 - 5772. TTY users can call 1 312 751 - 4701.

If you'd like more information about paying your Medicare premiums, visit **Medicare.gov** to view the brochure "Understanding the Medicare Premium Bill Form (CMS-500)."

If you need help paying your Part B premium, see pages 212 – 220.

Notes

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Section 2:

Find out if Medicare covers your test, service, or item

What services does Medicare cover?

Medicare Part A and Part B cover certain medical services and supplies in hospitals, doctors' offices, and other health care settings. Prescription drug coverage is provided through Medicare Part D.

If you have both Part A and Part B, you can get all of the Medicare-covered services listed in this section, whether you have Original Medicare or a Medicare health plan.

Important

To get Medicare-covered Part A and/or Part B services, you must be a U.S. citizen or be lawfully present in the U.S.

Underlined words are defined on pages 283 – 291.

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What does Part A cover?

Part A (Hospital Insurance) helps cover:

- Inpatient care in a hospital
- Inpatient care in a skilled nursing facility (not **custodial** or **long-term care**)
- Hospice care
- Home health care
- Inpatient care in a religious nonmedical health care **institution**

You can find out if you have Part A by looking at your red, white, and blue Medicare card. If you have it, it will be listed as “HOSPITAL” and will have an effective date. If you have Original Medicare, you’ll use this card to get your Medicare-covered services. If you join a Medicare health plan, in most cases, you must use the card from the plan to get your Medicare-covered services.

Underlined words are defined on pages 283 – 291.

What do I pay for Part A-covered services?

Copayments, coinsurance, or deductibles may apply for each service listed on the following pages. Visit **Medicare.gov**, or call 1 800 633 - 4227 to get specific cost information. TTY users can call 1 877 486 - 2048.

If you're in a Medicare Advantage Plan or have other insurance (like a Medicare Supplement Insurance (Medigap) policy, or employer or union coverage), your copayments, coinsurance, or deductibles may be different. Contact the plans you're interested in to find out about the costs, or visit the Medicare Plan Finder at **Medicare.gov/find-a-plan**.

Part A-covered services

Blood

If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

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Home health services

You can use your home health benefits under Part A and/or Part B. See page 90 for more information about home health benefits.

Hospice care

To qualify for hospice care, a hospice doctor and your doctor (if you have one) must certify that you're terminally ill, meaning you have a life expectancy of 6 months or less. You must accept palliative care (for comfort) instead of care to cure your illness. You also must sign a statement choosing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions. Coverage includes:

- All items and services needed for pain relief and symptom management
- Medical, nursing, and social services
- Drugs
- Certain durable medical equipment
- Aide and homemaker services
- Other covered services, as well as services Medicare usually doesn't cover, like spiritual and grief counseling

A Medicare-certified hospice usually gives hospice care in your home or other facility where you live, like a nursing home.

Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, like a hospice facility, hospital, or skilled nursing facility that contracts with the hospice. Medicare also covers inpatient respite care, which is care you get in a Medicare-approved facility so that your usual caregiver (family member or friend) can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness or related conditions. After 6 months, you can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies (at a face-to-face meeting) that you're terminally ill.

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Hospice care (continued):

- You pay nothing for hospice care.
- You pay a **copayment** of up to \$5 per prescription for outpatient prescription drugs for pain and symptom management. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D.
- You pay 5% of the **Medicare-approved amount** for inpatient respite care.

Original Medicare will cover your hospice care, even if you're in a **Medicare Advantage Plan**.

Underlined words are defined on pages 283 – 291.

Hospital care (inpatient care)

Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, **critical access hospitals**, **inpatient rehabilitation facilities**, **long-term care hospitals**, inpatient care as part of a qualifying clinical research study, and inpatient mental health care given in a psychiatric hospital or other hospital. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless **medically necessary**. If you have Part B, it generally covers 80% of the Medicare-approved amount for doctor's services you get while you're in a hospital.

- You pay a **deductible** and no **coinsurance** for days 1 – 60 of each **benefit period**.
- You pay coinsurance per day for days 61 – 90 of each benefit period.
- You pay coinsurance per **“lifetime reserve day”** after day 90 of each benefit period (up to 60 days over your lifetime).

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Hospital care (inpatient care) (continued):

- You pay all costs for each day after you use all the lifetime reserve days.
- Inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a lifetime.

Am I an inpatient or outpatient?

Staying overnight in a hospital doesn't always mean you're an inpatient. Your doctor must order your hospital admission and the hospital must formally admit you for you to be inpatient. Without the formal inpatient admission, you're still an outpatient, even if you stay overnight in a regular hospital bed, and/or you're getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays. **You or a family member should always ask the hospital and/or your doctor if you're an inpatient or an outpatient each day during your stay, since it affects what you pay and can affect whether you'll qualify for Part A coverage in a skilled nursing facility.**

Underlined words are defined on pages 283 – 291.

A “Medicare Outpatient Observation Notice” (MOON) is a document that lets you know you’re an outpatient in a hospital or **critical access hospital**. You must receive this notice if you’re getting observation services as an outpatient for more than 24 hours. The MOON will tell you why you’re an outpatient receiving observation services, rather than an inpatient. It will also let you know how this may affect what you pay while in the hospital, and for care you get after leaving the hospital.

Religious non-medical health care institution (inpatient care)

In these facilities, religious beliefs prohibit conventional and unconventional medical care. If you qualify for hospital or **skilled nursing facility care**, Medicare will only cover the inpatient, non-religious, non-medical items and services. Examples are room and board, or any items and services that don’t require a doctor’s order or prescription, like unmedicated wound dressings or use of a simple walker.

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Skilled nursing facility care

Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other **medically necessary** services and supplies furnished in a skilled nursing facility after a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital formally admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged. You may get coverage of skilled nursing care or skilled therapy care if it's necessary to help improve or maintain your current condition.

To qualify for skilled nursing facility care coverage, your doctor must certify that you need daily skilled care (like intravenous injections or physical therapy) which, as a practical matter, can only be provided in a skilled nursing facility if you're an inpatient.

Underlined words are defined on pages 283 – 291.

Section 2: Find out if Medicare covers your test, service, or item **51**

You pay:

- Nothing for the first 20 days of each **benefit period**
- **Coinsurance** per day for days 21 – 100 of each benefit period
- All costs for each day after day 100 in a benefit period

Visit **Medicare.gov** later this fall to find out what you'll pay for inpatient hospital stays and skilled nursing facility care in 2019.

Note: Medicare doesn't cover long-term care or **custodial care**.

Medicare Advantage Plans can't charge more than Original Medicare for **skilled nursing facility** care services.

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What does Part B cover?

Medicare Part B (Medical Insurance) helps cover **medically necessary** doctors' services, outpatient care, home health services, durable medical equipment, mental health services, and other medical services. Part B also covers many **preventive services**. You can find out if you have Part B by looking at your red, white, and blue Medicare card. If you have it, it will be listed as "MEDICAL" and will have an effective date. See pages 55 – 117 for a list of common Part B-covered services and general descriptions. Medicare may cover some services and tests more often than the timeframes listed if needed to diagnose or treat a condition. To find out if Medicare covers a service not on this list, visit **Medicare.gov/coverage**, or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. For more details about Medicare covered services, visit **Medicare.gov/publications** to view the booklet "Your Medicare Benefits." Call 1 800 633 - 4227 to find out if a copy can be mailed to you.

Underlined words are defined on pages 283 – 291.

What do I pay for Part B-covered services?

The alphabetical list on the following pages gives general information about what you pay if you have Original Medicare and see doctors or other health care providers who accept **assignment**. See page 126. You'll pay more if you see doctors or providers who don't accept assignment. **If you're in a Medicare health plan or have other insurance, your costs may be different. Contact your plan or benefits administrator directly to find out about the costs.**

Under Original Medicare, if the Part B **deductible** (\$183 in 2018) applies, you must pay all costs (up to the **Medicare-approved amount**) until you meet the yearly Part B deductible. After your deductible is met, Medicare begins to pay its share and you typically pay 20% of the Medicare-approved amount of the service, if the doctor or other health care provider accepts assignment. There's no yearly limit for what you pay out-of-pocket. Visit **Medicare.gov**, or call 1 800 633 - 4227 to get specific cost information.

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**What do I pay for Part B-covered services?
(continued)**

You pay nothing for most covered preventive services if you get the services from a doctor or other qualified health care provider who accepts assignment. However, for some preventive services, you may have to pay a deductible, **coinsurance**, or both. These costs may also apply if you get a preventive service in the same visit as a non-preventive service.

See pages 143 – 144 to find out what affects your Medicare Advantage Plan costs.

Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services.
See page 137.

Underlined words are defined on pages 283 – 291.

Part B-covered services

Abdominal aortic aneurysm screening — This is a preventive service.

Medicare covers a one-time abdominal aortic aneurysm screening ultrasound for people at risk. You must get a **referral** from your doctor or other qualified health care practitioner. You pay nothing for the screening if the doctor or other qualified health care practitioner accepts **assignment**.

Note: If you have a family history of abdominal aortic aneurysms, or you're a man 65 – 75 and you've smoked at least 100 cigarettes in your lifetime, you're considered at risk.

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Advance care planning

Medicare covers voluntary advance care planning as part of the yearly “Wellness” visit. This is planning for care you would want to get if you become unable to speak for yourself. You can talk about an advance directive with your health care professional, and he or she can help you fill out the forms, if you want to. An advance directive is an important legal document that records your wishes about medical treatment at a future time, if you’re not able to make decisions about your care. You pay nothing if it’s provided as part of the yearly “Wellness” visit and the doctor or other qualified health care provider accepts assignment.

Note: Medicare may also cover this service as part of your medical treatment. When advance care planning isn’t part of your yearly “Wellness” visit, the Part B **deductible** and **coinsurance** apply.

Underlined words are defined on pages 283 – 291.

Alcohol misuse screening and counseling — This is a preventive service.

Medicare covers one alcohol misuse screening per year for adults with Medicare (including pregnant women) who use alcohol, but don't meet the medical criteria for alcohol dependency. If your health care provider determines you're misusing alcohol, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling). You must get counseling in a primary care setting (like a doctor's office). You pay nothing if the doctor or other qualified health care provider accepts assignment.

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Ambulance services

Medicare covers ground ambulance transportation when you need to be transported to a hospital, **critical access hospital**, or skilled nursing facility for **medically necessary** services, and transportation in any other vehicle could endanger your health. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide.

In some cases, Medicare may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is medically necessary. An example may be a medically necessary ambulance transport to a dialysis facility for someone with End-Stage Renal Disease (ESRD).

Medicare will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need.

You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies.

Underlined words are defined on pages 283 – 291.

Ambulatory surgical centers

Medicare covers the facility service fees related to approved surgical procedures provided in an ambulatory surgical center (facility where surgical procedures are performed, and the patient is expected to be released within 24 hours). Except for certain **preventive services** (for which you pay nothing if the doctor or other health care provider accepts **assignment**), you pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you, and the Part B deductible applies. You pay all of the facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.

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Behavioral health integration services

If you have a behavioral health condition (like depression, anxiety, or another behavioral health condition), Medicare may pay for a health care provider's help to manage that condition if your provider offers the Psychiatric Collaborative Care Model. The Psychiatric Collaborative Care Model is a set of integrated behavioral health services that includes care management support if you have a behavioral health condition. This care management support may include care planning for behavioral health conditions, ongoing assessment of your condition, medication support, counseling, or other treatments that your provider recommends. Your health care provider will ask you to sign an agreement for you to get this set of services on a monthly basis. You pay a monthly fee, and the Part B deductible and **coinsurance** apply.

Underlined words are defined on pages 283 – 291.

Blood

If the provider gets blood from a blood bank at no charge, you won't have to pay for it or replace it. However, you'll pay a **copayment** for the blood processing and handling services for each unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year, or have the blood donated by you or someone else.

Bone mass measurement (bone density) — This is a preventive service.

This test helps to see if you're at risk for broken bones. It's covered once every 24 months (more often if **medically necessary**) for people who have certain medical conditions or meet certain criteria. You pay nothing for this test if the doctor or other qualified health care provider accepts **assignment**.

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**Breast cancer screening (mammograms) —
This is a preventive service.**

Medicare covers screening mammograms to check for breast cancer once every 12 months for all women with Medicare who are 40 and older. Medicare covers one baseline mammogram for women between 35–39. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

Note: Part B also covers diagnostic mammograms more frequently than once a year when medically necessary. You pay 20% of the **Medicare-approved amount** for diagnostic mammograms, and the Part B **deductible** applies.

Underlined words are defined on pages 283 – 291.

Cardiac rehabilitation

Medicare covers comprehensive programs that include exercise, education, and counseling for patients who meet at least one of these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)
- A heart or heart-lung transplant
- Stable, chronic heart failure

Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. Services are covered in a doctor's office or hospital outpatient setting. You pay 20% of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you also pay the hospital a **copayment**. The Part B deductible applies.

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**Cardiovascular disease (behavioral therapy) —
This is a preventive service.**

Medicare will cover one visit per year with a **primary care doctor** in a primary care setting (like a doctor's office) to help lower your risk for cardiovascular disease. During this visit, the doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you eat well. You pay nothing if the doctor or other qualified health care provider accepts assignment.

**Cardiovascular disease screenings —
This is a preventive service.**

These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. Medicare covers these screening tests once every 5 years to test your cholesterol, lipid, lipoprotein, and triglyceride levels. You pay nothing for the tests if the doctor or other qualified health care provider accepts **assignment**.

Underlined words are defined on pages 283 – 291.

Cervical and vaginal cancer screenings — This is a preventive service.

Part B covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare also covers a clinical breast exam to check for breast cancer. Medicare covers these screening tests once every 24 months. Medicare covers these screening tests once every 12 months if you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months.

Part B also covers Human Papillomavirus (HPV) tests (when received with a Pap test) once every 5 years if you're age 30 – 65 without HPV symptoms.

You pay nothing for the lab Pap test or for the lab HPV with Pap test if your doctor or other qualified health care provider accepts assignment. You also pay nothing for the Pap test specimen collection and pelvic and breast exams if the doctor or other qualified health care provider accepts assignment.

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Chemotherapy

Medicare covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting for people with cancer. You pay a **copayment** for chemotherapy in a hospital outpatient setting.

For chemotherapy given in a doctor's office or freestanding clinic, you pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies.

For chemotherapy in a hospital inpatient setting covered under Part A, see Hospital care (inpatient care) on pages 47 – 48.

Visit the Eldercare Locator at **eldercare.acl.gov** to get help with advance directives.

Underlined words are defined on pages 283 – 291.

Chiropractic services (limited coverage)

Medicare covers manipulation of the spine if **medically necessary** to correct a subluxation (when one or more of the bones of your spine move out of position) when provided by a chiropractor or other qualified provider. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Note: Medicare doesn't cover other services or tests ordered by a chiropractor, including X-rays, massage therapy, and acupuncture. If you think your chiropractor is billing Medicare for services that aren't covered, you can report suspected Medicare fraud by calling 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

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Chronic care management services

If you have 2 or more serious, chronic conditions (like arthritis, asthma, diabetes, hypertension, heart disease, osteoporosis, and other conditions) that are expected to last at least a year, Medicare may pay for a health care provider's help to manage those conditions. This includes a comprehensive care plan that lists your health problems and goals, other health care providers, medications, community services you have and need, and other information about your health. It also explains the care you need and how your care will be coordinated. Your health care provider will ask you to sign an agreement to provide this service. If you agree, he or she will prepare the care plan, help you with medication management, provide 24/7 access for urgent care needs, give you support when you go from one health care setting to another, review your medicines and how you take them, and help you with other chronic care needs. You pay a monthly fee, and the Part B **deductible** and **coinsurance** apply.

Underlined words are defined on pages 283 – 291.

Clinical research studies

Clinical research studies test how well different types of medical care work and if they're safe. Medicare covers some costs, like office visits and tests, in qualifying clinical research studies. You may pay 20% of the **Medicare-approved amount**, and the Part B deductible may apply.

Note: If you're in a **Medicare Advantage Plan** (like an HMO or PPO), some costs may be covered by Original Medicare and some may be covered by your Medicare Advantage Plan.

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**Colorectal cancer screenings —
This is a preventive service.**

Medicare covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. One or more of these tests may be covered:

- **Multi-target stool DNA test:** This lab test is generally covered once every 3 years if you meet all of these conditions:
- Are between ages 50 – 85.
- Show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test.

Underlined words are defined on pages 283 – 291.

- At average risk for developing colorectal cancer, meaning:
 - Have no personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
 - Have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

You pay nothing for the test if the doctor or other qualified health care provider accepts **assignment**.

- **Screening fecal occult blood test:** This test is covered once every 12 months if you're 50 or older. You pay nothing for the test if the doctor or other qualified health care provider accepts **assignment**.
- **Screening flexible sigmoidoscopy:** This test is generally covered once every 48 months if you're 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

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Colorectal cancer screenings (continued):

- **Screening colonoscopy:** This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There's no minimum age. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.
Note: If a polyp or other tissue is found and removed during the colonoscopy, you may have to pay 20% of the **Medicare-approved amount** for the doctor's services and a **copayment** in a hospital outpatient setting. The Part B **deductible** doesn't apply.
- **Screening barium enema:** This test is generally covered once every 48 months if you're 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy. You pay 20% of the Medicare-approved amount for the doctor services. In a hospital outpatient setting, you also pay the hospital a copayment. The Part B deductible doesn't apply.

Underlined words are defined on pages 283 – 291.

Continuous Positive Airway Pressure (CPAP) therapy

Medicare covers a 3-month trial of CPAP therapy if you've been diagnosed with obstructive sleep apnea. Medicare may cover it longer if you meet with your doctor in person, and your doctor documents in your medical record that the CPAP therapy is helping you.

You pay 20% of the Medicare-approved amount for rental of the machine and purchase of related supplies (like masks and tubing), and the Part B deductible applies. Medicare pays the supplier to rent the machine for 13 months if you've been using it without interruption. After you've rented the machine for 13 months, you own it.

Note: If you had a CPAP machine before you got Medicare, Medicare may cover rental or a replacement CPAP machine and/or CPAP accessories if you meet certain requirements.

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Defibrillator (implantable automatic)

Medicare covers these devices for some people diagnosed with heart failure. If the surgery takes place in an outpatient setting, you pay 20% of the Medicare-approved amount for the doctor's services. If you get the device as a hospital outpatient, you also pay the hospital a copayment. In most cases, the copayment amount can't be more than the Part A hospital stay deductible. The Part B deductible applies. Part A covers surgeries to implant defibrillators in a hospital inpatient setting. See Hospital care (inpatient care) on pages 47 – 48.

Underlined words are defined on pages 283 – 291.

Depression screening — This is a preventive service.

Medicare covers one depression screening per year. The screening must be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and **referrals**. You pay nothing for this screening if the doctor or other qualified health care provider accepts **assignment**.

Diabetes screenings — This is a preventive service.

Medicare covers these screenings if your doctor determines you're at risk for diabetes or diagnosed with prediabetes. You may be eligible for up to 2 diabetes screenings each year. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.

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New!

Medicare Diabetes Prevention Program

Prediabetes is a serious health condition where blood sugar levels are higher than normal, but not high enough yet to be diagnosed as having type 2 diabetes. Fortunately, type 2 diabetes can sometimes be delayed or prevented with health behavior changes. If you have prediabetes, losing even a small amount of weight if you're overweight and getting regular exercise can lower your risk for developing type 2 diabetes.

If you have Medicare Part B, have prediabetes, and meet other criteria, Medicare covers a proven health behavior change program to help you prevent diabetes. The program begins with at least 16 core sessions offered in a group setting over a 6-month period. After the core sessions, you may be eligible for additional monthly sessions will help you maintain healthy habits.

Underlined words are defined on pages 283 – 291.

The diabetes prevention program sessions will include:

- Training to make realistic, lasting lifestyle changes
- Tips on how to get more exercise
- Strategies for controlling your weight
- A lifestyle coach, specially trained to help keep you motivated
- Support from people with similar goals and challenges

If you think you're at risk, ask your doctor to be tested for prediabetes to find out if you have the condition. If you qualify for the program, you can join a program at no out-of-pocket cost without a referral from your doctor. If you're in a **Medicare Advantage Plan**, contact your plan for more information.

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**Diabetes self-management training —
This is a preventive service.**

Medicare covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks. You must have diabetes and a written order from your doctor or other qualified health care provider who's treating your diabetes. You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies.

Underlined words are defined on pages 283 – 291.

Diabetes supplies

Medicare covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Medicare only covers insulin if it's **medically necessary** and you use an external insulin pump to administer the insulin. You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies.

Note: Medicare prescription drug coverage (Part D) may cover insulin, certain medical supplies used to inject insulin (like syringes), and some oral diabetes drugs. Check with your plan for more information.

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Doctor and other health care provider services

Medicare covers medically necessary doctor services (including outpatient services and some doctor services you get when you're a hospital inpatient) and covered **preventive services**. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical social workers, physical therapists, and clinical psychologists. Except for certain preventive services (for which you may pay nothing), you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Underlined words are defined on pages 283 – 291.

Durable medical equipment (DME)

Medicare covers items like oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Make sure your doctors and DME suppliers are enrolled in Medicare. Doctors and suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If your doctors or suppliers aren't enrolled, Medicare won't pay the claims they submit. It's also important to ask your suppliers if they participate in Medicare before you get DME. If suppliers are participating suppliers, they must accept **assignment** (that is, they're limited to charging you only **coinsurance** and the Part B deductible for the **Medicare-approved amount**). If suppliers aren't participating and don't accept assignment, there's no limit on the amount they can charge you.

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Durable medical equipment (DME) (continued):

To find suppliers who accept assignment, visit

Medicare.gov/supplierdirectory or call 1 800 633 - 4227.

TTY users can call 1 877 486 - 2048. You can also call 1 800 633 - 4227 if you're having problems with your DME supplier, or you need to file a complaint.

For more information, visit **Medicare.gov/publications** to view the booklet "Medicare Coverage of Durable Medical Equipment and Other Devices."

EKG or ECG (electrocardiogram) screening

Medicare covers a one-time screening EKG/ECG if referred by your doctor or other health care provider as part of your one-time "Welcome to Medicare" preventive visit. See page 115. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. An EKG/ECG is also covered as a diagnostic test. See page 109. If you have the test at a hospital or a hospital-owned clinic, you also pay the hospital a copayment.

Underlined words are defined on pages 283 – 291.

Emergency department services

These services are covered when you have an injury, a sudden illness, or an illness that quickly gets much worse. You pay a specified **copayment** for the hospital emergency department visit, and you pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. The Part B **deductible** applies. However, your costs may be different if you're admitted to the hospital as an inpatient.

Eyeglasses (after cataract surgery)

Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. You pay 20% of the **Medicare-approved amount**, and the Part B deductible applies.

Note: Medicare will only pay for contact lenses or eyeglasses provided by a supplier enrolled in Medicare, no matter who submits the claim (you or your provider).

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Federally Qualified Health Center (FQHC) services

FQHCs provide many outpatient primary care and preventive health services. There's no deductible, and generally, you're responsible for paying 20% of the charges. You pay nothing for most **preventive services**. All FQHCs offer discounts if your income is limited. To find an FQHC near you, visit **findahealthcenter.hrsa.gov**.

Flu shots — This is a preventive service.

Medicare covers one flu shot per flu season. You pay nothing for the flu shot if the doctor or other qualified health care provider accepts **assignment** for giving the shot.

Foot exams and treatment

Medicare covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. You pay 20% of the **Medicare-approved amount**, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Underlined words are defined on pages 283 – 291.

Glaucoma tests — This is a preventive service.

These tests are covered once every 12 months for people at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African American and 50 or older, or are Hispanic and 65 or older. An eye doctor who's legally allowed by the state must do the tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Hearing and balance exams

Medicare covers these exams if your doctor or other health care provider orders them to see if you need medical treatment. You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies. In a hospital outpatient setting, you also pay the hospital a **copayment**.

Note: Original Medicare doesn't cover hearing aids or exams for fitting hearing aids.

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Hepatitis B shots — This is a preventive service.

Medicare covers these shots for people at medium or high risk for Hepatitis B. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, if you live with someone who has Hepatitis B, or if you're a health care worker and have frequent contact with blood or body fluids. Check with your doctor to see if you're at medium or high risk for Hepatitis B. You pay nothing for the shot if the doctor or other qualified health care provider accepts assignment.

Hepatitis B Virus (HBV) infection screening — This is a preventive service.

Medicare covers HBV infection screenings if you meet one of these conditions:

- You're at high risk for HBV infection.
- You're pregnant.

Medicare will only cover HBV infection screenings if they're ordered by a primary care provider.

Underlined words are defined on pages 283 – 291.

HBV infection screenings are covered:

- Annually only for those with continued high risk who don't get a Hepatitis B vaccination.
- For pregnant women:
- At the first prenatal visit for each pregnancy.
- At the time of delivery for those with new or continued risk factors.
- At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative HBV screening results.

You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment.

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**Hepatitis C screening test —
This is a preventive service.**

Medicare covers one Hepatitis C screening test if you meet one of these conditions:

- You're at high risk because you have a current or past history of illicit injection drug use.
- You had a blood transfusion before 1992.
- You were born between 1945 – 1965.

Medicare also covers yearly repeat screenings for certain people at high risk.

Medicare will only cover Hepatitis C screening tests if they're ordered by your health care provider. You pay nothing for the screening test if the doctor or other qualified health care provider accepts **assignment**.

Underlined words are defined on pages 283 – 291.

HIV (Human Immunodeficiency Virus) screening — This is a preventive service.

Medicare covers HIV screenings once every 12 months if you're:

- Between the ages of 15 – 65.
- Younger than 15 and older than 65, and at increased risk.

Note: Medicare also covers this test up to 3 times during a pregnancy.

You pay nothing for the HIV screening if the doctor or other qualified health care provider accepts assignment.

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Home health services

You can use your home health benefits under Part A and/or Part B to pay for home health services. Medicare covers **medically necessary** part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, or continued occupational therapy services. A doctor, or certain health care professionals who work with a doctor, must see you face-to-face before a doctor can certify that you need home health services. A doctor must order your care, and a Medicare-certified home health agency must provide it.

Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, which means:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.

Underlined words are defined on pages 283 – 291.

- Leaving your home isn't recommended because of your condition.
- You're normally unable to leave your home because it's a major effort.

You pay nothing for covered home health services. You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies, for Medicare-covered medical equipment.

Kidney dialysis services and supplies

Generally, Medicare covers 3 dialysis treatments per week if you have End-Stage Renal Disease (ESRD). This includes most ESRD-related drugs and biologicals, and all laboratory tests, home dialysis training, support services, equipment, and supplies. The dialysis facility is responsible for coordinating your dialysis services (at home or in a facility). You pay 20% of the Medicare-approved amount, and the Part B **deductible** applies.

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Kidney disease education services

Medicare covers up to 6 sessions of kidney disease education services if you have Stage IV chronic kidney disease, and your doctor or other health care provider refers you for the service. You pay 20% of the **Medicare-approved amount**, and the Part B deductible applies.

Laboratory services

Medicare covers laboratory services including certain blood tests, urinalysis, certain tests on tissue specimens, and some screening tests. You generally pay nothing for these services.

Underlined words are defined on pages 283 – 291.

Lung cancer screening — This is a preventive service.

Medicare covers a lung cancer screening with Low Dose Computed Tomography (LDCT) once per year if you meet all of these conditions:

- You're 55–77.
- You're asymptomatic (don't have signs or symptoms of lung cancer).
- You're either a current smoker or have quit smoking within the last 15 years.
- You have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years).
- You get a written order from a doctor or other qualified health care provider.

You generally pay nothing for this service if the health care provider accepts **assignment**.

Note: Before your first lung cancer screening, you'll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.

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**Medical nutrition therapy services —
This is a preventive service.**

Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you've had a kidney transplant in the last 36 months, and your doctor or other health care provider refers you for the service. You pay nothing for these services if the doctor or other qualified health care provider accepts assignment.

Underlined words are defined on pages 283 – 291.

Mental health care (outpatient)

Medicare covers mental health care services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor's or other health care provider's office, hospital outpatient department, or community mental health center), including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist, or clinical social worker. Laboratory tests are also covered. Certain limits and conditions may apply.

Generally, you pay 20% of the **Medicare-approved amount** and the Part B **deductible** applies for mental health care services.

Note: Inpatient mental health care is covered under Part A.

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Obesity screening and counseling — This is a preventive service.

If you have a body mass index (BMI) of 30 or more, Medicare covers face-to-face individual behavioral therapy sessions to help you lose weight. This counseling may be covered if you get it in a primary care setting (like a doctor's office), where it can be coordinated with your other care and a personalized prevention plan. You pay nothing for this service if the doctor or other qualified health care provider accepts assignment.

Occupational therapy

Medicare covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) to maintain current capabilities or slow decline when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Underlined words are defined on pages 283 – 291.

Outpatient hospital services

Medicare covers many diagnostic and treatment services in hospital outpatient departments. Generally, you pay 20% of the **Medicare-approved amount** for the doctor's or other health care provider's services. You may pay more for services you get in a hospital outpatient setting than you'll pay for the same care in a doctor's office. In addition to the amount you pay the doctor, you'll also usually pay the hospital a **copayment** for each service you get in a hospital outpatient setting, except for certain **preventive services** that don't have a copayment. In most cases, the copayment can't be more than the Part A hospital stay deductible for each service. The Part B deductible applies, except for certain preventive services. If you get hospital outpatient services in a **critical access hospital**, your copayment may be higher and may exceed the Part A hospital stay deductible.

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Outpatient medical and surgical services and supplies

Medicare covers approved procedures like X-rays, casts, stitches, or outpatient surgeries. You pay 20% of the **Medicare-approved amount** for the doctor's or other health care provider's services. You generally pay the hospital a **copayment** for each service you get in a hospital outpatient setting. In most cases, for each service provided, the copayment can't be more than the Part A hospital stay **deductible**. The Part B deductible applies, and you pay all costs for items or services that Medicare doesn't cover.

Physical therapy

Medicare covers evaluation and treatment for injuries and diseases that change your ability to function, or to maintain current function or slow decline, when your doctor or other health care provider certifies your need for it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Underlined words are defined on pages 283 – 291.

Pneumococcal shots — This is a preventive service.

Medicare covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). The two shots protect against different strains of the bacteria. Medicare covers the first shot at any time, and also covers a different second shot if it's given one year (or later) after the first shot. Talk with your doctor or other health care provider to see if you need one or both of the pneumococcal shots. You pay nothing for these shots if the doctor or other qualified health care provider accepts **assignment** for giving the shots.

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Prescription drugs (limited)

Medicare covers a limited number of drugs like injections you get in a doctor's office, certain oral anti-cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump), immunosuppressant drugs (see pages 111 – 112), and, under very limited circumstances, certain drugs you get in a hospital outpatient setting. You pay 20% of the **Medicare-approved amount** for these covered drugs, and the Part B deductible applies.

If the covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay a copayment for the services. However, other types of drugs in a hospital outpatient setting (sometimes called “self-administered drugs” or drugs you'd normally take on your own) aren't covered by Part B. What you pay depends on whether you have Part D or other prescription drug coverage, whether your drug plan covers the drug, and whether the hospital's pharmacy is in your drug plan's network. Contact your prescription drug plan to find out what you pay for drugs you get in a hospital outpatient setting that aren't covered under Part B.

Underlined words are defined on pages 283 – 291.

Section 2: Find out if Medicare covers your test, **101** service, or item

Other than the examples above, you pay 100% for most prescription drugs, unless you have Part D or other drug coverage. See pages 175 – 203 for more information about Part D.

Prostate cancer screenings — This is a preventive service.

Medicare covers a Prostate Specific Antigen (PSA) test and a digital rectal exam once every 12 months for men over 50 (beginning the day after your 50th birthday). You pay nothing for the PSA test. For the digital rectal exam, you pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies. In a hospital outpatient setting, you also pay the hospital a **copayment**.

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Prosthetic/orthotic items

Medicare covers arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after a mastectomy); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a doctor or other health care provider enrolled in Medicare.

For Medicare to cover your prosthetic or orthotic, you must go to a supplier that's enrolled in Medicare. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Underlined words are defined on pages 283 – 291.

Pulmonary rehabilitation

Medicare covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a **referral** from the doctor treating this chronic respiratory disease. You pay 20% of the Medicare-approved amount if you get the service in a doctor's office. You also pay the hospital a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible applies.

Rural Health Clinic (RHC) services

RHCs furnish many outpatient primary care and preventive health services. RHCs are located in rural and underserved areas. Generally, you're responsible for paying 20% of the charges, and the Part B deductible applies. You pay nothing for most **preventive services**.

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Second surgical opinions

Medicare covers second surgical opinions for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Sexually transmitted infection (STI) screening and counseling — This is a preventive service.

Medicare covers STI screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered if you're pregnant or at increased risk for an STI when the tests are ordered by a primary care provider. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Underlined words are defined on pages 283 – 291.

Section 2: Find out if Medicare covers your test, **105** service, or item

Medicare also covers up to 2 individual, 20–30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a **primary care doctor** or other primary care practitioner and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a **preventive service**.

You pay nothing for these services if the primary care doctor or other qualified health care provider accepts **assignment**.

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Shots

Part B covers:

- Flu shots. See page 84.
- Hepatitis B shots. See page 86.
- Pneumococcal shots. See page 99.

Note about the shingles shot: The shingles shot isn't covered by Part A or Part B. Generally, Medicare Prescription Drug Plans (Part D) cover the shingles shot, as well as all commercially available vaccines needed to prevent illness. Contact your Medicare drug plan for more information about coverage.

Underlined words are defined on pages 283 – 291.

Smoking and tobacco-use cessation (counseling to stop smoking or using tobacco products) — This is a preventive service.

Medicare covers up to 8 face-to-face visits in a 12-month period. All people with Medicare who use tobacco are covered. You pay nothing for the counseling sessions if the doctor or other qualified health care provider accepts assignment.

Speech-language pathology services

Medicare covers evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, or to maintain current function or slow decline, when your doctor or other health care provider certifies you need it. You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies.

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Surgical dressing services

Medicare covers **medically necessary** treatment of a surgical or surgically treated wound. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You pay a fixed **copayment** for these services when you get them in a hospital outpatient setting. The Part B deductible applies. You pay nothing for the supplies.

Telehealth

Medicare covers services like office visits, psychotherapy, consultations, and certain other medical or health services provided using an interactive, two-way telecommunications system (like real-time audio and video) by an eligible provider who isn't at your location. These services are available in rural areas, under certain conditions, but only if you're located at: a doctor's office, hospital, **critical access hospital**, Rural Health Clinic, Federally Qualified Health Center, hospital-based dialysis facility, skilled nursing facility, or community mental health center. For most of these services, you'll pay the same amount that you would if you got the services in person.

Underlined words are defined on pages 283 – 291.

Tests (other than lab tests)

Medicare covers X-rays, MRIs, CT scans, EKG/ECGs, and some other diagnostic tests. You pay 20% of the **Medicare-approved amount**, and the Part B **deductible** applies. If you get the test at a hospital as an outpatient, you also pay the hospital a **copayment** that may be more than 20% of the **Medicare-approved amount**, but, in most cases, this amount can't be more than the Part A hospital stay deductible. See Laboratory services on page 92 for other Part B-covered tests.

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Transitional care management services

Medicare may cover this service if you're returning to your community after a stay at certain facilities, like a hospital or skilled nursing facility. The health care provider who's managing your transition back into the community will work to coordinate and manage your care for the first 30 days after you return home. He or she will work with you, your family, and caregiver(s), as appropriate, and other health care providers. You'll also be able to get an in-person office visit within 2 weeks of your return home. The health care provider may also review information on the care you received in the facility, provide information to help you transition back to living at home, work with other care providers, help you with **referrals** or arrangements for follow-up care or community resources, assist you with scheduling, and help you manage your medications. The Part B deductible and **coinsurance** apply.

Underlined words are defined on pages 283 – 291.

Transplants and immunosuppressive drugs

Medicare covers doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions but only in Medicare-certified facilities.

Medicare also covers bone marrow and cornea transplants under certain conditions.

Note: The transplant surgery may be covered as a hospital inpatient service under Part A. See pages 47 – 48 for more information.

Medicare covers immunosuppressive drugs if the transplant was covered by Medicare or an employer or union group health plan was required to pay before Medicare paid for the transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. You pay 20% of the Medicare-approved amount for the drugs, and the Part B **deductible** applies.

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Transplants and immunosuppressive drugs (continued):

If you're thinking about joining a **Medicare Advantage Plan** (like an HMO or PPO) and are on a transplant waiting list or believe you need a transplant, check with the plan before you join to make sure your doctors, other health care providers, and hospitals are in the plan's network. Also, check the plan's coverage rules for prior authorization.

Note: Medicare drug plans (Part D) may cover immunosuppressive drugs if they aren't covered by Original Medicare.

Medicare pays the full cost of care for your kidney donor. You and your donor won't have to pay a deductible, **coinsurance**, or any other costs for their hospital stay.

Underlined words are defined on pages 283 – 291.

Travel (health care needed when traveling outside the U.S.)

Medicare generally doesn't cover health care while you're traveling outside the U.S. (The "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.) There are some exceptions, including cases where Medicare may pay for services you get while on board a ship within the territorial waters adjoining the land areas of the U.S. Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in these rare cases:

- You're in the U.S. when an emergency occurs, and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.
- You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another U.S. state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.

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Travel (health care needed when traveling outside the U.S.) (continued):

- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.

Medicare may cover medically necessary ambulance transportation to a foreign hospital only with admission for medically necessary covered inpatient hospital services. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Urgently needed care

Medicare covers urgently needed care to treat a sudden illness or injury that isn't a medical emergency. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Underlined words are defined on pages 283 – 291.

“Welcome to Medicare” preventive visit — This is a preventive service.

During the first 12 months that you have Part B, you can get a “Welcome to Medicare” preventive visit. This visit includes a review of your medical and social history related to your health, and education and counseling about **preventive services**, including certain screenings, flu and pneumococcal shots, and **referrals** for other care, if needed. When you make your appointment, let your doctor’s office know that you’d like to schedule your “Welcome to Medicare” preventive visit. You pay nothing for the “Welcome to Medicare” preventive visit if the doctor or other qualified health care provider accepts **assignment**.

Important!

If your doctor or other health care provider performs additional tests or services during the same visit that aren’t covered under this preventive benefit, you may have to pay **coinsurance**, and the Part B deductible may apply.

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Yearly “Wellness” visit — This is a preventive service.

If you’ve had Part B for longer than 12 months, you can get a yearly “Wellness” visit to develop or update a personalized plan to prevent disease or disability based on your current health and risk factors. This visit is covered once every 12 months.

Your provider will ask you to fill out a questionnaire, called a “Health Risk Assessment,” as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit. When you make your appointment, let your doctor’s office know that you’d like to schedule your yearly “Wellness” visit.

Note: Your first yearly “Wellness” visit can’t take place within 12 months of your enrollment in Part B or your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” preventive visit to qualify for a yearly “Wellness” visit.

Underlined words are defined on pages 283 – 291.

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You pay nothing for the yearly “Wellness” visit if the doctor or other qualified health care provider accepts **assignment**.

Important!

If your doctor or other health care provider performs additional tests or services during the same visit that aren’t covered under this preventive benefit, you may have to pay **coinsurance**, and the Part B **deductible** may apply.

What’s NOT covered by Part A and Part B?

Medicare doesn’t cover everything. If you need certain services that aren’t covered under Medicare Part A or Part B, you’ll have to pay for them yourself unless:

- You have other coverage (including Medicaid) to cover the costs.
- You’re in a **Medicare Advantage Plan** that covers these services.

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

- Most dental care.
- Eye examinations related to prescribing glasses.
- Dentures.
- Cosmetic surgery.
- Massage therapy.
- Acupuncture.
- Hearing aids and exams for fitting them.
- Long-term care. See the next page for more information about paying for long-term care.
- Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care).

Some Medicare Advantage Plans may choose to cover these services. See page 153.

Underlined words are defined on pages 283 – 291.

Paying for long-term care

Long-term care (sometimes called “long-term services and supports”) includes non-medical care for people who have a chronic illness or disability. This includes non-skilled personal care assistance, like help with everyday activities, including dressing, bathing, and using the bathroom. **Medicare and most health insurance plans, including Medicare Supplement Insurance (Medigap) policies, don’t pay for this type of care, sometimes called “custodial care.” You may be eligible for this type of care through Medicaid, or you can choose to buy private long-term care insurance.** Long-term care can be provided at home, in the community, in an assisted living facility, or in a nursing home. It’s important to start planning for long-term care now to maintain your independence and to make sure you get the care you may need, in the setting you want, in the future.

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Long-term care resources

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

- Visit **[longtermcare.gov](https://www.longtermcare.gov)** to learn more about planning for long-term care.
- Call your State Insurance Department to get information about long-term care insurance. Visit **[Medicare.gov/contacts](https://www.Medicare.gov/contacts)**, or call 1 800 633 - 4227 to get the phone number. TTY users can call 1 877 486 - 2048.
- Call the National Association of Insurance Commissioners at 1 866 470 - 6242 to get a copy of “A Shopper’s Guide to Long-Term Care Insurance.”
- Call your State Health Insurance Assistance Program (SHIP). See pages 275 – 281 for the phone number.
- Visit the Eldercare Locator, a public service of the U.S. Administration on Aging, at **[eldercare.acl.gov](https://www.eldercare.acl.gov)** to find help in your community.



Section 3: Original Medicare

How does Original Medicare work?

Original Medicare is one of your health coverage choices as part of Medicare. You'll have Original Medicare unless you choose a **Medicare Advantage Plan** or other type of **Medicare health plan**.

Original Medicare is coverage managed by the federal government. You generally have to pay a portion of the cost for each service covered by Original Medicare. See the next page for the general rules about how it works.

Underlined words are defined on pages 283 – 291.

Original Medicare

Can I get my health care from any doctor, other health care provider, or hospital?

In most cases, yes. You can go to any doctor, other health care provider, hospital, or other facility that's enrolled in Medicare and accepting Medicare patients. Visit **Medicare.gov** to search for and compare health care providers, hospitals, and facilities in your area.

Are prescription drugs covered?

No, with a few exceptions (see pages 43 – 44, 91, and 100), most prescriptions aren't covered. You can add drug coverage by joining a Medicare Prescription Drug Plan (Part D). See pages 175 - 204.

Do I need to choose a primary care doctor?

No.

Do I have to get a referral to see a specialist?

In most cases, no, but the specialist must be enrolled in Medicare.

Underlined words are defined on pages 283 – 291.

Should I get a supplemental policy?

You may already have employer or union coverage that may pay costs that Original Medicare doesn't. If not, you may want to buy a Medicare Supplement Insurance (Medigap) policy if you're eligible. See pages 165 – 173.

What else do I need to know about Original Medicare?

- You generally pay a set amount for your health care (**deductible**) before Medicare pays its share. Then, Medicare pays its share, and you pay your share (**coinsurance/copayment**) for covered services and supplies. There's no yearly limit for what you pay out-of-pocket.
- You usually pay a monthly **premium** for Part B. See pages 212 – 220 for information about help paying your Part B premium.
- You generally don't need to file Medicare claims. The law requires providers (like doctors, hospitals, skilled nursing facilities, and home health agencies) and suppliers to file your claims for the covered services and supplies you get.

What do I pay?

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

- Whether you have Part A and/or Part B. Most people have both.
- Whether your doctor, other health care provider, or supplier accepts “**assignment**.” See the next page for more information.
- The type of health care you need and how often you need it.
- Whether you choose to get services or supplies Medicare doesn’t cover. If you do, you pay all costs unless you have other insurance that covers them.
- Whether you have other health insurance that works with Medicare.
- Whether you have Medicaid or get help from your state paying your Medicare costs.
- Whether you have a Medicare Supplement Insurance (Medigap) policy.

Underlined words are defined on pages 283 – 291.

- Whether you and your doctor or other health care provider sign a private contract. See page 128.

How do I know what Medicare paid?

If you have Original Medicare, you'll get a "Medicare Summary Notice" (MSN) in the mail every 3 months that lists all the services billed to Medicare. The MSN shows what Medicare paid and what you may owe the provider. The MSN isn't a bill. Review your MSNs to be sure you got all the services, supplies, or equipment listed.

If you need to change your address on your MSN, call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778. If you get Railroad Retirement Board (RRB) benefits, call the RRB at 1 877 772 - 5772. TTY users can call 1 312 751 - 4701.

New!

Your MSN will tell you if you're enrolled in the Qualified Medicare Beneficiary Program (QMB). If you have QMB, Medicare providers aren't allowed to bill you for Medicare Part A and/or Part B **deductibles**, **coinsurance**, or **copayments**. For more information about QMB and steps to take if you get billed for these costs, see page 212 – 213.

Important!

Get your Medicare Summary Notices electronically

Go paperless and get your “Medicare Summary Notices” electronically (also called “eMSNs”). You can sign up by visiting **MyMedicare.gov**. If you sign up for eMSNs, we’ll send you an email each month when they’re available in your **MyMedicare.gov** account. The eMSNs contain the same information as paper MSNs. You won’t get printed copies of your MSNs in the mail if you choose eMSNs.

What’s assignment?

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the **Medicare-approved amount** as full payment for covered services.

If your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less.
- They agree to charge you only the Medicare deductible and coinsurance amount and usually wait for Medicare to pay its share before asking you to pay your share.

Underlined words are defined on pages 283 – 291.

- They have to submit your claim directly to Medicare and can't charge you for submitting the claim.

Non-participating providers haven't signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services. These providers are called "non-participating." Here's what happens if your doctor, provider, or supplier doesn't accept assignment:

- **You might have to pay the entire charge at the time of service.** Your doctor, provider, or supplier is supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. If they don't submit the Medicare claim once you ask them to call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.
- **They can charge you more than the Medicare-approved amount, but there's a limit called "the limiting charge."**

To find out if someone accepts assignment or participates in Medicare, visit [**Medicare.gov/physician**](https://www.medicare.gov/physician) or [**Medicare.gov/supplier**](https://www.medicare.gov/supplier). Or, you can call 1 800 633 - 4227.

Certain doctors and other health care providers who don't want to enroll in the Medicare program may "opt out" of Medicare. You can still see these providers, but they must enter into a private contract with you (unless you're in need of emergency or urgently needed care). Medicare won't pay for any services you get under a private contract, so you'll pay the provider's entire charge out of your own pocket. You and your provider will set up your own payment terms through the private contract.

You can contact your State Health Insurance Assistance Program (SHIP) to get free help with these topics. See pages 275 – 281 for the phone number.



Section 4: Medicare Advantage Plans & other options

What are Medicare Advantage Plans?

A Medicare Advantage Plan (like an HMO or PPO) is another way to get your Medicare coverage. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by Medicare-approved private companies that must follow rules set by Medicare. If you join a Medicare Advantage Plan, you’ll still have Medicare but you’ll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare. In most cases, you’ll need to use health care providers who participate in the plan’s network. Some plans offer out-of-network coverage. Remember, in most cases, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Keep your Medicare card in a safe place because you’ll need it if you ever switch back to Original Medicare.

Underlined words are defined on pages 283 – 291.

What are the different types of Medicare Advantage Plans?

- **Health Maintenance Organization (HMO) plans:**
See pages 145 - 146.
- **Preferred Provider Organization (PPO) plans:**
See pages 147 - 148.
- **Private Fee-for-Service (PFFS) plans:**
See pages 149 – 150.
- **Special Needs Plans (SNPs):**
See pages 151 – 152.
- **HMO Point-of-Service (HMOPOS) plans:** These are HMO plans that may allow you to get some services out-of-network for a higher copayment or coinsurance.

Underlined words are defined on pages 283 – 291.

- **Medical Savings Account (MSA) Plans:** These plans combine a high-**deductible** health plan with a bank account that the plan selects. The plan deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year. MSA Plans don't offer Medicare drug coverage. If you want drug coverage, you have to join a Medicare Prescription Drug Plan. For more information on MSA Plans, visit Medicare.gov. To find out if an MSA Plan is available in your area, visit **Medicare.gov/find-a-plan**.

Medicare Advantage Plans cover all Medicare Part A and Part B services

In all types of **Medicare Advantage Plans**, you're always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers. However, if you're in a Medicare Advantage Plan, Original Medicare will still cover the cost for hospice care, some new Medicare benefits, and some costs for clinical research studies.

Some Medicare Advantage Plans offer coverage for things that aren't covered by Original Medicare, like vision, hearing, dental, and other health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to your Part B **premium**, you might have to pay a monthly premium for the Medicare Advantage Plan.

Underlined words are defined on pages 283 – 291.

Organization determinations

You (or a provider acting on your behalf) can request to see if an item or service will be covered by the plan in advance. Sometimes you must do this for the service to be covered. This is called an “organization determination.” If your plan denies coverage, the plan must tell you in writing.

You don’t have to pay more than the plan’s usual cost-sharing for a service or supply if a network provider didn’t get an organization determination and either of these is true:

- The provider gave you or referred you for services or supplies that you reasonably thought would be covered.
- The provider referred you to an out-of-network provider for plan-covered services.

Contact your plan for more information.

Medicare Advantage Plans must follow Medicare's rules

Medicare pays a fixed amount for your coverage each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a **referral** to see a specialist or if you have to go to doctors, facilities, or suppliers that belong to the plan's network for non-emergency or non-urgent care). These rules can change each year. The plan must notify you about any changes before the start of the next enrollment year. Remember, you have the option each year to keep your current plan, choose a different plan, or switch to Original Medicare. See pages 153 – 154.

In most cases, you don't need a referral to see a specialist if you have Original Medicare. See page 121.

Underlined words are defined on pages 283 – 291.

Important!

Read the information you get from your plan

If you're in a **Medicare Advantage Plan**, review the “Annual Notice of Change” (ANOC) and “Evidence of Coverage” (EOC) from your plan each year:

- **The ANOC:** Includes any changes in coverage, costs, **service area**, and more that will be effective starting in January. Your plan will send you a printed copy by September 30.
- **The EOC:** Gives you details about what the plan covers, how much you pay, and more. Your plan will send you a notice (or printed copy) by October 15, which will include information on how to access the EOC electronically or request a printed copy.

If you don't get these important documents, contact your plan.

What else should I know about Medicare Advantage Plans?

- You have Medicare rights and protections, including the right to appeal. See pages 221 – 236.
- You must follow plan rules. It's important to check with the plan for information about your rights and responsibilities.
- If you go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan's network for non-emergency or non-urgent care services, your services may not be covered, or your costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs.
- Providers can join or leave a plan's provider network anytime during the year. Your plan can also change the providers in the network anytime during the year. If this happens, you may need to choose a new provider. You generally can't change plans during the year if this happens.
- Plans may offer supplemental benefits, like fitness or wellness benefits.

Underlined words are defined on pages 283 – 291.

- Medicare Advantage Plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and **skilled nursing facility care**.
- Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you'll pay nothing for covered services. Each plan can have a different limit, and the limit can change each year. You should consider this when choosing a plan.

Joining and leaving

- You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease (ESRD), for which there are special rules. See page 141.
- **You can only join or leave a Medicare Advantage Plan at certain times during the year.** See pages 153 – 158.
- Each year, Medicare Advantage Plans can choose to leave Medicare or make changes to the services they cover and what you pay. If the plan decides to stop participating in Medicare, you'll have to join another Medicare Advantage Plan or return to Original Medicare. See page 223.
- Medicare Advantage Plans must follow certain rules when giving you information about how to join their plan. See page 246 for more information about these rules and how to protect your personal information.

Underlined words are defined on pages 283 – 291.

Prescription drug coverage

You usually get prescription drug coverage (Part D) through the **Medicare Advantage Plan**. In certain types of plans that can't offer drug coverage (like MSA plans) or choose not to offer drug coverage (like some PFFS plans), you can join a separate Medicare Prescription Drug Plan. **If you're in a Medicare Advantage HMO or PPO, and you join a separate Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.**

Who can join?

You must meet these conditions to join a Medicare Advantage Plan:

- You have Part A and Part B.
- You live in the plan's **service area**.
- You're a U.S. citizen, U.S. national, or lawfully present in the U.S.
- You don't have End-Stage Renal Disease (ESRD), except as explained on page 141.

What if I have other coverage?

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

A Medicare Advantage Plan with drug coverage is an option if you're interested in enrolling in Part D but can't afford a separate premium for prescription drug coverage. See page 205.

What if I have a Medicare Supplement Insurance (Medigap) policy?

You can't enroll in (and don't need) a Medicare Supplement Insurance (Medigap) policy while you're in a Medicare Advantage Plan. You can't use it to pay for any expenses (**copayments**, **deductibles**, and premiums) you have under a Medicare Advantage Plan. If you already have a Medigap policy and join a Medicare Advantage Plan, you'll probably want to drop your Medigap policy. **If you drop your Medigap policy, you may not be able to get it back.** See page 172.

What if I have End-Stage Renal Disease (ESRD)?

If you have End-Stage Renal Disease (ESRD), you can only join a **Medicare Advantage Plan** in certain situations:

- If you're already in a Medicare Advantage Plan when you develop ESRD, you can stay in your plan or you may be able to join another Medicare Advantage Plan offered by the same company.
- If you're in a Medicare Advantage Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan.

**What if I have End-Stage Renal Disease (ESRD)?
(continued)**

- If you have an employer or union health plan or other health coverage through a company that offers one or more Medicare Advantage Plan(s), you may be able to join one of that company's Medicare Advantage Plans.
- If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan.
- You may be able to join a Medicare Special Needs Plan (SNP) that covers people with ESRD if one is available in your area.

For more information, visit **[Medicare.gov/publications](https://www.medicare.gov/publications)** to view the booklet “Medicare Coverage of Kidney Dialysis & Kidney Transplant Services.”

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

Underlined words are defined on pages 283 – 291.

What do I pay?

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

- Whether the plan charges a monthly **premium**. You pay this in addition to the Part B premium.
- Whether the plan pays any of your monthly Medicare premiums. Some Medicare Advantage Plans will help pay all or part of your Part B premium. This benefit is sometimes called a “Medicare Part B premium reduction.”
- Whether the plan has a yearly **deductible** or any additional deductibles for certain services.
- How much you pay for each visit or service (**copayments** or **coinsurance**).
- The type of health care services you need and how often you get them.
- Whether you get services from a network provider or a provider that doesn’t contract with the plan.

What do I pay? (continued)

- Whether you go to a doctor or supplier who accepts **assignment** (if you're in a Preferred Provider Organization, Private Fee-for-Service Plan, or Medical Savings Account Plan and you go out-of-network). See page 126 for more information about assignment.
- Whether the plan offers extra benefits (in addition to Original Medicare benefits) and if you need to pay an extra premium for them.
- The plan's yearly limit on your out-of-pocket costs for all medical services. Once you reach this limit, you'll pay nothing for covered services.
- Whether you have Medicaid or get help from your state.

To learn more about your costs in specific Medicare Advantage Plans, visit **[Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)**.

Underlined words are defined on pages 283 – 291.

Types of Medicare Advantage Plans

Health Maintenance Organization (HMO) plan

Can I get my health care from any doctor, other health care provider, or hospital?

No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option.

Are prescription drugs covered?

In most cases, yes. If you want Medicare drug coverage, you must join an HMO plan that offers prescription drug coverage.

Do I need to choose a primary care doctor?

In most cases, yes.

Health Maintenance Organization (HMO) plan (continued)

Do I have to get a referral to see a specialist?

In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

What else do I need to know about this type of plan?

- If your doctor or other health care provider leaves the plan's network, your plan will notify you. You may choose another doctor in the plan's network.
- If you get health care outside the plan's network, you may have to pay the full cost.
- It's important that you follow the plan's rules, like getting prior approval for a certain service when needed.
- If you need more information than what's listed on this page, check with the plan.

Underlined words are defined on pages 283 – 291.

Preferred Provider Organization (PPO) plan

Can I get my health care from any doctor, other health care provider, or hospital?

In most cases, yes. PPO plans have network doctors, other health care providers, and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.

Are prescription drugs covered?

In most cases, yes. If you want Medicare drug coverage, you must join a PPO plan that offers prescription drug coverage.

Do I need to choose a primary care doctor?

No.

Do I have to get a referral to see a specialist?

In most cases, no.

Preferred Provider Organization (PPO) plan (continued)

What else do I need to know about this type of plan?

- PPO plans aren't the same as Original Medicare or Medigap.
- Medicare PPO plans usually offer more benefits than Original Medicare, but you may have to pay extra for these benefits.
- If you need more information than what's listed on this page, check with the plan.

Underlined words are defined on pages 283 – 291.

Private Fee-for-Service (PFFS) plan

Can I get my health care from any doctor, other health care provider, or hospital?

You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. If you join a PFFS plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but you may pay more.

Are prescription drugs covered?

Sometimes. If your PFFS plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan to get coverage.

Do I need to choose a primary care doctor?

No.

Do I have to get a referral to see a specialist?

No.

Private Fee-for-Service (PFFS) plan (continued)

What else do I need to know about this type of plan?

- PFFS plans aren't the same as Original Medicare or Medigap.
- The plan decides how much you pay for services.
- Some PFFS plans contract with a network of providers who agree to always treat you, even if you've never seen them before.
- Out-of-network doctors, hospitals, and other providers may decide not to treat you, even if you've seen them before.
- For each service you get, make sure to show your plan member card before you get treated.
- In a medical emergency, doctors, hospitals, and other providers must treat you.
- If you need more information than what's listed on this page, check with the plan.

Underlined words are defined on pages 283 – 291.

Special Needs Plan (SNP)

Can I get my health care from any doctor, other health care provider, or hospital?

You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).

Are prescription drugs covered?

Yes. All SNP plans must provide Medicare prescription drug coverage.

Do I need to choose a primary care doctor?

Generally, yes.

Do I have to get a referral to see a specialist?

In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

Special Needs Plan (SNP) (continued)

What else do I need to know about this type of plan?

- A plan must limit membership to these groups: 1) people who live in certain **institutions** (like nursing homes) or who require nursing care at home, or 2) people who are eligible for both Medicare and Medicaid, or 3) people who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease, HIV/AIDS, chronic heart failure, or dementia). Plans may further limit membership.
- Your plan will coordinate the services and providers you need to help you stay healthy and follow doctors' or other health care providers' orders.
- Visit **Medicare.gov/find-a-plan** to see if there are SNPs available in your area.
- If you need more information than what's listed on this page, check with the plan.

Underlined words are defined on pages 283 – 291.

When can I join, switch, or drop a Medicare Advantage Plan?

- When you first become eligible for Medicare, you can sign up during your Initial Enrollment Period. See page 24.
- If you have Part A coverage and you get Part B for the first time during the General Enrollment Period, you can also join a **Medicare Advantage Plan** at that time. Your coverage may not start until July 1. See page 27.
- Between October 15 – December 7, anyone with Medicare can join, switch, or drop a Medicare Advantage Plan. Your coverage will begin on January 1, as long as the plan gets your request by December 7.

If you drop a Medigap policy to join a Medicare Advantage Plan, you might not be able to get it back. Rules vary by state and your situation. See page 141 for more information.

Always review the materials your plan sends you (like the “Annual Notice of Change” and “Evidence of Coverage”), and make sure your plan will still meet your needs for the following year.

New!

Can I make changes to my coverage after December 7?

Starting in 2019, between January 1 – March 31 each year, you can make these changes during the **Medicare Advantage Open Enrollment Period**:

- If you’re in a Medicare Advantage Plan (with or without drug coverage), you can switch to another Medicare Advantage Plan (with or without drug coverage).
- You can disenroll from your Medicare Advantage Plan and return to Original Medicare. If you choose to do so, you’ll be able to join a Medicare Prescription Drug Plan.

Underlined words are defined on pages 283 – 291.

- If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months you have Medicare.

During this period, you **can't**:

- Switch from Original Medicare to a Medicare Advantage Plan.
- Join a Medicare Prescription Drug Plan if you're in Original Medicare.
- Switch from one Medicare Prescription Drug Plan to another if you're in Original Medicare.

You can only make one change during this period, and any changes you make will be effective the first of the month after the plan gets your request.

Important!

Thinking about joining a Medicare Advantage Plan between October 15 – December 7, but aren't sure?

The Medicare Advantage Open Enrollment Period (January 1 – March 31) gives you an opportunity to switch back to Original Medicare depending on which coverage works better for you.

Special Enrollment Periods

In most cases, you must stay enrolled for the calendar year starting the date your coverage begins. However, in certain situations, you may be able to join, switch, or drop a **Medicare Advantage Plan** during a Special Enrollment Period. Some examples are:

- You move out of your plan's **service area**.
- You have (or lose) Medicaid.
- You qualify for (or lose) **Extra Help**. See pages 209 – 211.
- You live in an **institution** (like a nursing home).

Underlined words are defined on pages 283 – 291.

5-star Special Enrollment Period

You can switch to a Medicare Advantage Plan or Medicare Cost Plan (see page 179) that has **5 stars for its overall star rating** from December 8, 2018 – November 30, 2019. You can only use this Special Enrollment Period once during this timeframe. The overall star ratings are available at **[Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)**. See pages 264 – 265 for more information.

Important!

You may lose your prescription drug coverage if you move from a Medicare Advantage Plan that has drug coverage to a 5-star Medicare Advantage Plan that doesn't. You'll have to wait until your next enrollment opportunity to get drug coverage, and you may have to pay a Part D late enrollment penalty. See pages 210 – 211.

How do I switch?

Follow these steps if you're already in a Medicare Advantage Plan and want to switch:

- **To switch to a new Medicare Advantage Plan,** simply join the plan you choose during one of the enrollment periods explained on page 153. You'll be disenrolled automatically from your old plan when your new plan's coverage begins.
- **To switch to Original Medicare,** contact your current plan, or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. If you don't have drug coverage, you should consider joining a Medicare Prescription Drug Plan to avoid paying a penalty if you decide to join later. You may also want to consider joining a Medicare Supplement Insurance (Medigap) policy if you're eligible. See page 165 for more information about buying a Medigap policy.

For more information on joining, dropping, and switching plans, visit **Medicare.gov** or call 1 800 633 - 4227.

Underlined words are defined on pages 283 – 291.

Are there other types of Medicare health plans and projects?

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

Medicare Cost Plans

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

- You can join even if you only have Part B.
- If you have Part A and Part B and go to a non-network provider, the services are covered under Original Medicare. You'll pay the Part A and Part B **coinsurance** and **deductibles**.
- You can join anytime the Cost Plan is accepting new members.
- You can leave anytime and return to Original Medicare.
- You can either get your Medicare prescription drug coverage from the Cost Plan (if offered) or you can join a Medicare Prescription Drug Plan. Even if the Cost Plan offers prescription drug coverage, you can choose to get drug coverage from a different plan.

Note: You can add or drop Medicare prescription drug coverage only at certain times. See pages 177 – 179.

Underlined words are defined on pages 283 – 291.

For more information about Medicare Cost Plans, visit the Medicare Plan Finder at **[Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)**. Your State Health Insurance Assistance Program (SHIP) can also give you more information. See pages 275 – 281 for the phone number.

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

PACE is a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community. To qualify for PACE, you must meet these conditions:

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

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PACE provides coverage for many services, including prescription drugs, doctor or other health care practitioner visits, transportation, home care, hospital visits, and even nursing home stays whenever necessary.

If you have Medicaid, you won't have to pay a monthly **premium** for the long-term care portion of the PACE benefit. If you have Medicare but not Medicaid, you'll be charged a monthly premium to cover the **long-term care** portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE, there's never a **deductible** or **copayment** for any drug, service, or care approved by the PACE team of health care professionals.

Visit **[Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)**, to see if there's a PACE organization that serves your community.

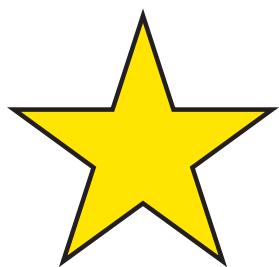
Underlined words are defined on pages 283 – 291.

Medicare Innovation Projects

Medicare develops innovative models, **demonstrations**, and pilot projects to test and measure the effect of potential changes in Medicare. These projects help to find new ways to improve health care quality and reduce costs. Usually, they operate only a limited time for a specific group of people and/or are offered only in specific areas. Examples of current models, demonstrations, and pilot projects include innovations in primary care, care related to specific procedures (like hip and knee replacements), cancer care, and care for people with End-Stage Renal Disease. To learn more about the current Medicare models, demonstrations, and pilot projects, visit **innovation.cms.gov**. You can also call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Notes

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Section 5: Medicare Supplement Insurance (Medigap) policies

Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. Medicare Supplement Insurance policies, sold by private companies, can help pay some of the remaining health care costs for covered services and supplies, like copayments, coinsurance, and deductibles. **Medicare Supplement Insurance policies are also called Medigap policies.**

Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. Generally, Medigap policies don't cover long-term care (like care in a nursing home), vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Underlined words are defined on pages 283 – 291.

Medigap policies are standardized

Every Medigap policy must follow federal and state laws designed to protect you, and they must be clearly identified as “Medicare Supplement Insurance.” Insurance companies can sell you only a “standardized” policy identified in most states by letters A through D, F through G, and K through N. All policies offer the same basic benefits, but some offer additional benefits so you can choose which one meets your needs. In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

Important!

Starting January 1, 2020, Medigap plans sold to new people with Medicare won’t be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people new to Medicare starting on January 1, 2020. If you already have either of these 2 plans (or the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, you’ll be able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.

Underlined words are defined on pages 283 – 291.

How do I compare Medigap policies?

Medicare Supplement Insurance (Medigap) plans Benefits

Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used) covered 100% in plans A, B, C, D, F*, G, K, L, M, N.

Medicare Part B coinsurance or copayment covered 100% in plans A, B, C, D, F*, G, M and N. Covered 50% in plan K and 75% in plan L. **Plan N***** pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don't result in an inpatient admission.

Blood (first 3 pints) covered 100% in plans A, B, C, D, F*, G, M, and N. Covered 50% in plan K and 75% in Plan L.

Part A hospice care coinsurance or copayment covered 100% in plans A, B, C, D, F*, G, M, and N. Covered 50% in plan K and 75% in plan L.

Skilled nursing facility care coinsurance covered 100% in plans C, D, F*, G, M, and N. Covered 50% in plan K and 75% in plan L.

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(Medigap) policies

Part A deductible covered 100% in plans B, C, D, F*, G, and N. Covered 50% in plan K and M and 75% in plan L.

Part B deductible covered 100% in plans C and F*.

Part B excess charges covered 100% in plans F* and G.

Foreign travel emergency (up to plan limits) covered 80% in plans C, D, F*, G, M and N.

Out - of - pocket limit for plan K** in 2018 is \$5,240.

Out - of - pocket limit for plan L** in 2018 is \$2,620.

- * Plan F also offers a high-deductible plan in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of \$2,240 in 2018 before your policy pays anything.
- ** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$183 in 2018), the Medigap plan pays 100% of covered services for the rest of the calendar year.

Underlined words are defined on pages 283 – 291.

- *** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don't result in an inpatient admission.

What else should I know about Medicare Supplement Insurance (Medigap)?

Important facts

- You must have Part A and Part B.
- You pay the private insurance company a monthly **premium** for your Medigap policy in addition to your monthly Part B premium that you pay to Medicare. Also, if you join a Medigap policy and a Medicare drug plan offered by the same company, you may need to make 2 separate premium payments for your coverage. Contact the company to find out how to pay your premiums.
- A Medigap policy only covers one person. Spouses must buy separate policies.

- You can't have prescription drug coverage in both your Medigap policy and a Medicare drug plan. See page 197. The same insurance company may offer Medigap policies and Medicare Prescription Drug Plans.
- It's important to compare Medigap policies since the costs can vary between insurance companies for exactly the same coverage, and may go up as you get older. Some states limit Medigap premium costs.
- In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. If you buy a Medicare SELECT policy, you have rights to change your mind within 12 months and switch to a standard Medigap policy.

When to buy

- The best time to buy a Medigap policy is during your Medigap Open Enrollment Period. This 6-month period begins on the first day of the month in which you're 65 or older **and** enrolled in Part B. (Some states have additional Open Enrollment Periods.) After this enrollment period, you may not be able to buy a Medigap policy. If you're able to buy one, it may cost more.

Underlined words are defined on pages 283 – 291.

Section 5: Medicare Supplement Insurance 171 (Medigap) policies

- If you delay enrolling in Part B because you have group health coverage based on your (or your spouse's) current employment, your Medigap Open Enrollment Period won't start until you sign up for Part B.
- Federal law generally doesn't require insurance companies to sell Medigap policies to people under 65. If you're under 65, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. However, some states require Medigap insurance companies to sell Medigap policies to people under 65. If you're able to buy one, it may cost more.

How does Medigap work with Medicare Advantage Plans?

- If you have a **Medicare Advantage Plan** (like an HMO or PPO), it's illegal for anyone to sell you a Medigap policy unless you're switching back to Original Medicare. If you're not planning to leave your Medicare Advantage Plan, and someone tries to sell you a Medigap policy, report it to your State Insurance Department.

- If you have a Medigap policy and join a Medicare Advantage Plan, you may want to drop your Medigap policy. Your Medigap policy **can't** be used to pay your Medicare Advantage Plan **copayments**, **deductibles**, and **premiums**. If you want to cancel your Medigap policy, contact your insurance company. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you won't be able to get it back.
- If you join a Medicare Advantage Plan for the first time, and you aren't happy with the plan, you'll have special rights under federal law to buy a Medigap policy if you return to Original Medicare within 12 months of joining.
- If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.
- If you joined a Medicare Advantage Plan when you were first eligible for Medicare, you can choose from any Medigap policy within the first year of joining.

Underlined words are defined on pages 283 – 291.

Section 5: Medicare Supplement Insurance **173** (Medigap) policies

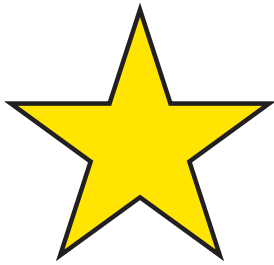
- You may be able to join a Medicare Prescription Drug Plan.
- Some states provide additional special rights.

Where can I get more information?

- Visit **Medicare.gov** to find policies in your area.
- Visit **Medicare.gov/publications** to view the booklet “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.”
- Call your State Insurance Department. Visit **Medicare.gov/contacts**, or call 1 800 633 - 4227 to get the phone number. TTY users can call 1 877 486 - 2048.
- Call your State Health Insurance Assistance Program (SHIP). See pages 275 – 281 for the phone number.

Notes

[illegible]



Section 6: Medicare prescription drug coverage (Part D)

How does Medicare prescription drug coverage (Part D) work?

Medicare prescription drug coverage is an optional benefit. Medicare offers drug coverage to everyone with Medicare. Even if you don't take prescriptions now, you should consider joining a Medicare drug plan. If you decide not to join a Medicare drug plan when you're first eligible, and you don't have other **creditable prescription drug coverage** or get **Extra Help**, you'll likely pay a late enrollment penalty if you join a plan later. Generally, you'll pay this penalty for as long as you have Medicare prescription drug coverage. See pages 185 – 187. To get Medicare prescription drug coverage, you must join a plan approved by Medicare that offers Medicare drug coverage. Each plan can vary in cost and specific drugs covered. Visit the Medicare Plan Finder at **Medicare.gov/find-a-plan** for more information about plans in your area.

Underlined words are defined on pages 283 – 291.

There are 2 ways to get Medicare prescription drug coverage:

- 1. Medicare Prescription Drug Plans.** These plans (sometimes called “PDPs”) add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) plans, and Medicare Medical Savings Account (MSA) plans. You must have Part A **and/or** Part B to join a Medicare Prescription Drug Plan.
- 2. Medicare Advantage Plans (like HMOs or PPOs) or other Medicare health plans that offer Medicare prescription drug coverage.** You get all of your Part A, Part B, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called “MA-PDs.” Remember, you must have Part A **and** Part B to join a Medicare Advantage Plan, and not all of these plans offer drug coverage.

In either case, you must live in the service area of the Medicare drug plan you want to join. **Both types of plans are called “Medicare drug plans” in this handbook.**

Underlined words are defined on pages 283 – 291.

Important!

If you have employer or union coverage

Call your benefits administrator before you make any changes, or sign up for any other coverage. Signing up for other coverage could cause you to lose your employer or union health and drug coverage for you and your dependents. If you lose your employer or union coverage, you may not be able to get it back. If you want to know how Medicare prescription drug coverage works with other drug coverage you may have, see page 140.

When can I join, switch, or drop a Medicare drug plan?

- When you first become eligible for Medicare, you can join during your Initial Enrollment Period. See page 24.
- If you get Part B for the first time during the General Enrollment Period, you can also join a Medicare drug plan from April 1 – June 30. Your coverage will start on July 1. See page 27.
- You can join, switch, or drop between October 15 – December 7 each year. Your changes will take effect on January 1 of the following year, as long as the plan gets your request before December 7.

New!

- If you're enrolled in a Medicare Advantage Plan, you can join, switch, or drop a plan during the Medicare Advantage Open Enrollment Period, between January 1 – March 31 each year. See page 153 for more information.
- If you qualify for a Special Enrollment Period. See the next page.

Underlined words are defined on pages 283 – 291.

Special Enrollment Periods

Special Enrollment Periods are times when you can join, switch, or drop your Medicare drug coverage if you meet certain requirements. Generally you must stay enrolled in your Medicare drug plan for the entire year, but you can change your coverage mid-year if you qualify for a Special Enrollment Period. Some examples are if you:

- Move out of your plan's **service area**.
- Lose other **creditable prescription drug coverage**.
- Live in an **institution** (like a nursing home).
- Have (or lose) Medicaid.
- Qualify for (or lose) **Extra Help**. See pages 209 – 211.

5-star Special Enrollment Period

You can switch to a Medicare Prescription Drug Plan that has **5 stars for its overall star rating** from December 8, 2018 – November 30, 2019. You can only use this Special Enrollment Period once during this timeframe. The overall star ratings are available at **Medicare.gov/find-a-plan**.

Important!

If you have a Medicare Advantage Plan

If your Medicare Advantage Plan includes prescription drug coverage, and you use an enrollment period to join a Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan, including the health benefit. You'll be returned to Original Medicare for coverage of your health services.

How do I switch?

You can switch to a new Medicare drug plan simply by joining another drug plan during one of the times listed on pages 178 – 179. **You don't need to cancel your old Medicare drug plan.** Your old Medicare drug plan coverage will end when your new drug plan coverage begins. You should get a letter from your new Medicare drug plan telling you when your coverage with the new plan begins. You can switch plans by calling 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Underlined words are defined on pages 283 – 291.

How do I drop a Medicare drug plan?

If you want to drop your Medicare drug plan and don't want to join a new plan, you can only do so during certain times. See pages 178 – 179. You can disenroll by calling 1 800 633 - 4227. You can also send a letter to the plan to tell them you want to disenroll. If you drop your plan and want to join another Medicare drug plan later, you have to wait for an enrollment period. You may have to pay a late enrollment penalty if you don't have **creditable prescription drug coverage**. See pages 185 – 192.

Read the information you get from your plan

Review the “Evidence of Coverage” (EOC) and “Annual Notice of Change” (ANOC) your plan sends you each year. The EOC gives you details about what the plan covers, how much you pay, and more. The ANOC includes any changes in coverage, costs, provider networks, **service area**, and more that will be effective in January. If you don't get these important documents in the early fall, contact your plan.

How much do I pay?

Below and continued on the next page are descriptions of what you pay in your Medicare drug plan. **Your actual drug plan costs will vary depending on:**

- Your prescriptions and whether they're on your plan's **formulary** (list of covered drugs) and depending on what "tier" the drug is in. See page 193.
- Which phase of your drug benefit that you're in (some examples include whether or not you met your **deductible**, if you're in the coverage gap, etc.)
- The plan you choose. Remember, plan costs can change each year.
- Which pharmacy you use (whether it offers preferred or standard cost sharing, is out-of-network, or is mail order). Your out-of-pocket prescription drug costs may be less at a preferred pharmacy because it has agreed with your plan to charge less.
- Whether you get **Extra Help** paying your Part D costs. See pages 205 – 211.

Underlined words are defined on pages 283 – 291.

Monthly premium

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

Note: Contact your drug plan (not Social Security or the Railroad Retirement Board (RRB)) if you want your premium deducted from your monthly Social Security or RRB payment. If you want to stop premium deductions and get billed directly, contact your drug plan.

Important!

If you have a higher income, you might pay more for your Part D coverage. If your income is above a certain limit (\$85,000 if you file individually or \$170,000 if you're married and file jointly), you'll pay an extra amount in addition to your plan premium (sometimes called "Part D-IRMAA"). This doesn't affect everyone, so most people won't have to pay a higher amount. You'll also have to pay this extra amount if you're in a Medicare Advantage Plan that includes drug coverage.

Usually, the extra amount will be deducted from your Social Security check. If you get benefits from the Railroad Retirement Board (RRB), the extra amount will be deducted from your RRB check. **If you're billed the amount by Medicare or the RRB, you must pay the extra amount to Medicare or the RRB and not your plan.** If you don't pay the extra amount, you could lose your Part D coverage. You may not be able to enroll in another plan right away, and you may have to pay a late enrollment penalty for as long as you have Part D.

If you have to pay an extra amount and you disagree (for example, you have a life event that lowers your income), visit **[socialsecurity.gov](https://www.socialsecurity.gov)** or call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778.

Yearly deductible

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

Underlined words are defined on pages 283 – 291.

Copayments or coinsurance

These are the amounts you pay for your covered prescriptions after the deductible (if the plan has one). You pay your share and your drug plan pays its share for covered drugs. If you pay a coinsurance, these amounts may vary throughout the year due to changes in the drug's total cost.

Coverage gap

Most Medicare drug plans have a coverage gap (also called the “donut hole”). The coverage gap begins after you and your drug plan together have spent a certain amount for covered drugs. In 2019, once you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 37% of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Not everyone will enter the coverage gap because their drug costs won't be high enough.

Coverage gap (continued)

These costs (sometimes called true out-of-pocket, or “TrOOP,” costs) all **count** toward you getting out of the coverage gap:

- Your yearly **deductible**, **coinsurance**, and **copayments**
- The discount you get on covered brand-name drugs in the coverage gap
- What you pay in the coverage gap

The drug plan **premium** and what you pay for drugs that aren’t covered **don’t count** toward getting you out of the coverage gap.

Some plans offer additional cost-sharing reductions in the gap beyond the standard benefits and discounts on brand-name and generic drugs, but they may charge a higher monthly premium. Check with the plan first to see if your drugs would have additional cost-sharing reductions while you’re in the gap.

Underlined words are defined on pages 283 – 291.

Catastrophic coverage

Once you've met the out-of-pocket cost requirements of the coverage gap (or threshold), you automatically get "catastrophic coverage." With catastrophic coverage, you only pay a reduced coinsurance amount or copayment for covered drugs for the rest of the year.

Note: If you get **Extra Help**, you won't have some of these costs. See pages 205 – 211.

Important!

Visit **[Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)** to get specific Medicare drug plan costs, and call the plans you're interested in to get more details. For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP). See pages 275 – 281 for the phone number.

What's the Part D late enrollment penalty?

The late enrollment penalty is an amount that's permanently added to your Part D premium. You may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Part D or other **creditable prescription drug coverage**. You'll generally have to pay the penalty for as long as you have Part D coverage.

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

3 ways to avoid paying a penalty:

- 1. Join a Medicare drug plan when you're first eligible.** Even if you don't take prescriptions now, you should consider joining a Medicare drug plan or a **Medicare Advantage Plan** that offers drug coverage to avoid a penalty. You may be able to find a plan that meets your needs with little to no monthly **premiums**. See pages 6 – 16 to learn more about your choices.

Underlined words are defined on pages 283 – 291.

- 2. Enroll in a Medicare drug plan if you lose other creditable coverage.** Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, the Department of Veterans Affairs, or individual health insurance coverage. Your plan must tell you each year if your drug coverage is creditable coverage. If you go 63 days or more in a row without a Medicare drug plan or other creditable prescription drug coverage, you may have to pay a penalty if you join later.

- 3. Keep records showing when you had creditable drug coverage, and tell your plan if they ask about it.** If you don't tell the plan about your creditable prescription drug coverage, you may have to pay a penalty for as long as you have Part D coverage.

How much more will I pay?

The cost of the late enrollment penalty depends on how long you didn't have creditable prescription drug coverage. Currently, the late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" (\$35.02 in 2018) by the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest \$.10 and added to your monthly premium. Since the "national base beneficiary premium" may increase each year, the penalty amount may also increase each year. After you join a Medicare drug plan, the plan will tell you if you owe a penalty and what your premium will be.

Example: Mrs. Martin didn't join when she was first eligible—by June 2015. She doesn't have prescription drug coverage from any other source. She joined a Medicare drug plan during November 2017, and her coverage began on January 1, 2018.

Underlined words are defined on pages 283 – 291.

Since Mrs. Martin was without creditable prescription drug coverage from July 2015 – December 2017, her penalty in 2018 is 30% (1% for each of the 30 months) of \$35.02 (the national base beneficiary premium for 2018), which is \$10.50. She'll be charged \$10.50 each month in addition to her plan's monthly premium in 2018. She'll continue to pay a penalty for as long as she has Part D coverage, and the amount may go up each year.

Here's the math:

.30 (30% penalty) × **\$35.02** (2018 base beneficiary premium) = **\$10.50**

\$10.50 = Mrs. Martin's monthly late enrollment penalty for 2018

What if I don't agree with the penalty?

If you disagree with your penalty, you can ask for a review or reconsideration. Generally, you must request this review within 60 days from the date on the first letter you get stating you have to pay a late enrollment penalty. You'll need to fill out a reconsideration request form (that your Medicare drug plan will send you) by the date listed in the letter. You can provide proof that supports your case, like information about previous **creditable prescription drug coverage**. If you need help, call your plan.

Underlined words are defined on pages 283 – 291.

Which drugs are covered?

Information about a plan's list of covered drugs (called a "**formulary**") isn't included in this handbook because each plan has its own formulary. Many Medicare drug plans place drugs into different "tiers" on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier. In some cases, if your drug is in a higher tier and your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) thinks you need that drug instead of a similar drug in a lower tier, you or your prescriber can ask your plan for an exception to get a lower **coinsurance** or **copayment** for the drug in the higher tier. See page 229 for more information on exceptions.

Formularies are subject to change and can be changed by the plan. Your plan will notify you of any formulary changes that affect drugs you're taking.

Contact the plan for its current formulary, or visit the plan's website. You can also visit the Medicare Plan Finder at **[Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)**, or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. Your plan will notify you of any formulary changes.

Important!

Each month that you fill a prescription, your drug plan mails you an “Explanation of Benefits” (EOB) notice. Review your notice and check it for mistakes. Contact your plan if you have questions or find mistakes. If you suspect fraud, call the Medicare Drug Integrity Contractor (MEDIC) at 1 877 772 - 3379. See page 246 for more information about the MEDIC.

Plans may have these coverage rules:

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

Underlined words are defined on pages 283 – 291.

Before your prescriptions are filled, your Medicare drug plan will also perform additional safety checks, like checking for unsafe amounts of opioid pain medications.

If you or your prescriber believe that one of these coverage rules should be waived, you can ask for an exception. See page 229.

Do you get automatic prescription refills in the mail?

Some people with Medicare get their prescription drugs by using an “automatic refill” service that automatically delivers prescription drugs when they’re about to run out. To make sure you still need a prescription before they send you a refill, prescription drug plans should get your approval to deliver a new or refilled prescription before each delivery, except when you ask for the refill or new prescription. If you get a prescription automatically by mail that you don’t want, and you weren’t contacted to see if you wanted it before it shipped, you may be eligible for a refund.

Medication Therapy Management (MTM) Program

Plans with Medicare prescription drug coverage must offer additional Medication Therapy Management (MTM) services to plan members who meet certain requirements. Members who qualify can get these MTM services to help them understand how to manage their medications and use them safely. The MTM services offered may vary in some plans. MTM services are free and usually include a discussion with a pharmacist or health care provider to review your medications. The pharmacist or health care provider may talk with you about:

- How well your medications are working
- Whether your medications have side effects
- If there might be interactions between the drugs you're taking
- Whether your costs can be lowered
- Other problems you're having

Underlined words are defined on pages 283 – 291.

Visit **[Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)** to get general information about program eligibility for your Medicare drug plan or for other plans that interest you. Contact each drug plan for specific details.

Drug Management Programs

Medicare drug plans may also have Drug Management Programs to monitor the safe use of prescription drugs that are frequently abused. Medicare drug plans can limit drug coverage if you may be at risk of abusing certain drugs. If you use opioid medications from several doctors and/or pharmacies, your plan may communicate with the doctors who prescribed these medications to make sure this use is appropriate and **medically necessary**. Your plan will give you a letter in advance if coverage of your opioid or benzodiazepine medications will be limited, or if you'll be required to get your opioid or benzodiazepine prescriptions from certain doctors or pharmacies. If you disagree with the plan's decision, you and your prescriber have the right to appeal the determination that you're an at-risk beneficiary by contacting your plan. Also, you may be exempt from a Drug Management Program if, for example, you have cancer and/or you're in hospice or long-term care facility.

How do other insurance and programs work with Part D?

The next 2 pages provide information about how other insurance you have works with, or is affected by, Medicare prescription drug coverage (Part D).

Employer or union health coverage

This is health coverage from your, your spouse's, or other family member's current or former employer or union. If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your prescription drug coverage is creditable. **Keep the information you get.** Call your benefits administrator for more information before making any changes to your coverage.

Note: If you join a Medicare drug plan, you, your spouse, or your dependents may lose your employer or union health coverage.

Underlined words are defined on pages 283 – 291.

COBRA

This is a federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. As explained on page 27, there may be reasons why you should take Part B instead of, or in addition to, COBRA coverage. However, if you take COBRA and it includes **creditable prescription drug coverage**, you'll have a Special Enrollment Period to join a Medicare drug plan without paying a penalty when the COBRA coverage ends. Talk with your State Health Insurance Assistance Program (SHIP) to see if COBRA is a good choice for you. See pages 275 – 281 for the phone number.

Medicare Supplement Insurance (Medigap) policy with prescription drug coverage

You may choose to join a Medicare drug plan because most Medigap drug coverage isn't creditable, and you may pay more if you join a drug plan later. See pages 185 – 191. Medigap policies can no longer be sold with prescription drug coverage, but if you have drug coverage under a current Medigap policy, you can keep it. If you join a Medicare drug plan, tell your Medigap insurance company so they can remove the prescription drug coverage under your Medigap policy and adjust your **premiums**. Call your Medigap insurance company for more information.

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

Underlined words are defined on pages 283 – 291.

How does other government insurance work with Part D?

The types of insurance on the next page are all considered creditable prescription drug coverage, and in most cases, it will be to your advantage to keep this coverage if you have it.

Federal Employee Health Benefits (FEHB) Program

This is health coverage for current and retired federal employees and covered family members. FEHB plans usually include prescription drug coverage, so you don't need to join a Medicare drug plan. However, if you decide to join a Medicare drug plan, you can keep your FEHB plan, and in most cases, the **Medicare plan** will pay first. For more information for retirees, visit **[opm.gov/healthcare-insurance/healthcare](https://www.opm.gov/healthcare-insurance/healthcare)**, or call the Office of Personnel Management at 1 888 767 - 6738. TTY users can call 1 800 878 - 5707. If you're an active federal employee, contact your Benefits Officer. Visit **apps.opm.gov/abo** for a list of Benefits Officers. You can also call your plan if you have questions.

Veterans' benefits

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

TRICARE (military health benefits)

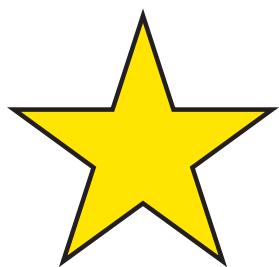
This is a health care plan for active-duty service members, military retirees, and their families. **Most people with TRICARE who are entitled to Part A must have Part B to keep TRICARE prescription drug benefits.** If you have TRICARE, you don't need to join a Medicare Prescription Drug Plan. However, if you do, your Medicare drug plan pays first, and TRICARE pays second.

If you join a **Medicare Advantage Plan** (like an HMO or PPO) with prescription drug coverage, your Medicare Advantage Plan and TRICARE may coordinate their benefits if your Medicare Advantage Plan network pharmacy is also a TRICARE network pharmacy. Otherwise, you can file your own claim to get paid back for your out-of-pocket expenses. For more information, visit **tricare.mil**, or call the TRICARE Pharmacy Program at 1 877 363 - 1303. TTY users can call 1 877 540 - 6261.

Indian Health Service (IHS)

The IHS is the primary health care provider to the American Indian/Alaska Native Medicare population. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services through a network of hospitals, clinics, and other entities. Many Indian health facilities participate in the Medicare prescription drug program. If you get prescription drugs through an Indian health facility, you'll continue to get drugs at no cost to you, and your coverage won't be interrupted. Joining a Medicare drug plan may help your Indian health facility because the drug plan pays the Indian health facility for the cost of your prescriptions. Talk to your local Indian health benefits coordinator who can help you choose a plan that meets your needs and tell you how Medicare works with the Indian health care system.

Note: If you're getting care through an IHS or tribal health facility or program without being charged, you can continue to do so for some or all of your care. Getting Medicare doesn't affect your ability to get services through the IHS and tribal health facilities.



Section 7: Get help paying your health & prescription drug costs

What if I need help paying my Medicare prescription drug costs?

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

Note: Extra Help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa. See page 220 for information about programs that are available in those areas.

Underlined words are defined on pages 283 – 291.

206 Section 7: Get help paying your health & prescription drug costs

Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs. You may qualify for Extra Help if your yearly income and resources are below these limits in 2018:

- **Single person:** If your yearly income is less than \$18,210 per year and your Other resources are less than \$14,100 per year
- **Married person living with a spouse and no other dependents:** If your yearly income is less than \$24,690 and your Other resources are less than \$28,150 per year

Underlined words are defined on pages 281 – 289.

Section 7: Get help paying your health & **207** prescription drug costs

These amounts may change in 2019. You may qualify even if you have a higher income (like if you still work, live in Alaska or Hawaii, or have dependents living with you). Resources include money in a checking or savings account, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs). Resources **don't** include your home, car, household items, burial plot, up to \$1,500 for burial expenses (per person), or life insurance policies.

If you qualify for Extra Help and join a Medicare drug plan, you'll:

- Get help paying your Medicare drug plan's costs.
- Have no coverage gap.
- Have no late enrollment penalty.

208 Section 7: Get help paying your health & prescription drug costs

Most people with Medicare can only make changes to their drug coverage certain times of the year. If you newly get, lose, or have a change in your Medicaid or **Extra Help** status, you'll get a Special Enrollment Period to change plans.

If you have Medicaid or get Extra Help, you'll also be able to make changes to your coverage one time during each of these periods:

- January – March
- April – June
- July – September

If you made a change during one of these periods, it will take effect on the first day of the following month. You'll have to wait for the next period to make another change. You can't use this Special Enrollment Period from October – December. However, all people with Medicare can make changes to their coverage from October 15 – December 7, and the changes will take effect on January 1.

Underlined words are defined on pages 281 – 289.

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

- You have full Medicaid coverage.
- You get help from your state Medicaid program paying your Part B **premiums** (in a Medicare Savings Program). See pages 212 – 218.
- You get Supplemental Security Income (SSI) benefits.

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

- If you aren't already in a Medicare drug plan, you must join one to use this Extra Help.
- If you don't join a Medicare drug plan, Medicare may enroll you in one so that you'll be able to use the Extra Help. If Medicare enrolls you in a plan, you'll get a yellow or green letter letting you know when your coverage begins, and you'll have a Special Enrollment Period to change plans.

210 Section 7: Get help paying your health & prescription drug costs

- Different plans cover different drugs. Check to see if the plan you're enrolled in covers the drugs you use and if you can go to the pharmacies you want. Visit **Medicare.gov/find-a-plan**, or call 1 800 633 - 4227 to compare with other plans in your area. TTY users can call 1 877 486 - 2048.
- If you have Medicaid and live in certain **institutions** (like a nursing home) or get home- and community-based services, you pay nothing for your covered prescription drugs.

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

Underlined words are defined on pages 281 – 289.

Section 7: Get help paying your health & **211** prescription drug costs

Important!

If you have employer or union coverage and you join a Medicare drug plan, you may lose your employer or union coverage (for you and your dependents) even if you qualify for Extra Help. Call your employer's benefits administrator before you join a Medicare drug plan.

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

- Visit [socialsecurity.gov/i1020](https://www.socialsecurity.gov/i1020) to apply online.
- Call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778.

Drug costs in 2019 for people who qualify will be no more than \$3.40 for each generic drug and \$8.50 for each brand-name drug. Look on the Extra Help letters you get, or contact your plan to find out your exact costs.

To get answers to your questions about Extra Help and help choosing a drug plan, call your State Health Insurance Assistance Program (SHIP). See pages 275 – 281 for the phone number. You can also call 1 800 633 - 4227.

What if I need help paying my Medicare health care costs?

Medicare Savings Programs

If you have limited income and resources, you may be able to get help from your state to pay your Medicare costs if you meet certain conditions.

There are 4 kinds of Medicare Savings Programs:

- 1. Qualified Medicare Beneficiary (QMB) Program:** If you're eligible, the QMB Program helps pay for Part A and/or Part B premiums. In addition, Medicare providers aren't allowed to bill you for Medicare deductibles, coinsurance, and copayments when you get services and items Medicare covers, except outpatient prescription drugs.

Underlined words are defined on pages 281 – 289.

Section 7: Get help paying your health & **213** prescription drug costs

To make sure your provider knows you have QMB, show both your Medicare and Medicaid or QMB card each time you get care. If you get a bill for medical care Medicare covers, call your provider about the charges. If you have Original Medicare, show your provider your Medicare Summary Notice (see page 125). It will show you have QMB and that you shouldn't be billed. Tell them that you have QMB and can't be charged for Medicare deductibles, coinsurance, and copayments. If this doesn't resolve the billing problem, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. Medicare will ask the provider to stop improper billing, and refund any incorrect payments you made. If you're in a **Medicare Advantage Plan**, call your plan.

- 2. Specified Low-Income Medicare Beneficiary (SLMB) Program:** Helps pay Part B premiums only.
- 3. Qualifying Individual (QI) Program:** Helps pay Part B premiums only. You must apply each year for QI benefits and the applications are granted on a first-come, first-served basis.

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4. Qualified Disabled and Working Individuals (QDWI)

Program: Helps pay Part A premiums only. You may qualify for this program if you have a disability and are working.

If you qualify for a QMB, SLMB, or QI Program, you automatically qualify to get **Extra Help** paying for Medicare prescription drug coverage. See pages 205 – 211.

Important!

The names of these programs and how they work may vary by state. Medicare Savings Programs aren't available in Puerto Rico and the U.S. Virgin Islands.

How do I qualify?

In most cases, to qualify for a Medicare Savings Program, you must have income and resources below a certain limit.

Many states figure your income and resources differently, so you should check with your state to see if you qualify.

Underlined words are defined on pages 281 – 289.

Section 7: Get help paying your health & **215** prescription drug costs

For more information

- Call or visit your Medicaid office, and ask for information about Medicare Savings Programs. To get the phone number for your state, visit **[Medicare.gov/contacts](https://www.medicare.gov/contacts)**. You can also call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.
- Contact your State Health Insurance Assistance Program (SHIP). See pages 275 – 281 for the phone number.

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Medicaid

Medicaid is a joint federal and state program that helps pay medical costs if you have limited income and/or resources and meet other requirements. Some people qualify for both Medicare and Medicaid.

What does Medicaid cover?

- If you have Medicare and full Medicaid coverage, most of your health care costs are covered. You can get your Medicare coverage through Original Medicare or a **Medicare Advantage Plan** (like an HMO or PPO).
- If you have Medicare and/or full Medicaid coverage, Medicare covers your Part D prescription drugs. Medicaid may still cover some drugs and other care that Medicare doesn't cover.
- People with Medicaid may get coverage for services that Medicare may not or may partially cover, like nursing home care, personal care, and home- and community-based services.

Underlined words are defined on pages 281 – 289.

How do I qualify?

- Medicaid programs vary from state to state. They may also have different names, like “Medical Assistance” or “Medi-Cal.”
- Each state has different income and resource requirements.
- In some states, you may need to be enrolled in Medicare, if eligible, to get Medicaid.
- Call your Medicaid office (State Medical Assistance Office) for more information and to see if you qualify. Visit **[Medicare.gov/contacts](https://www.medicare.gov/contacts)**, or call 1 800 633 - 4227.

Demonstration plans for people who have both Medicare and Medicaid

Medicare is working with some states and health plans to offer **demonstration** plans for certain people who have both Medicare and Medicaid, called Medicare-Medicaid Plans. If you’re interested in joining a Medicare-Medicaid Plan, visit **[Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)** to see if one is available in your area and if you qualify. Call your Medicaid office for more information.

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State Pharmacy Assistance Programs (SPAPs)

Many states have SPAPs that help certain people pay for prescription drugs based on financial need, age, or medical condition. To find out if there's an SPAP in your state and how it works, call your State Health Insurance Assistance Program (SHIP). See pages 275 – 281 for the phone number.

Pharmaceutical Assistance Programs (also called Patient Assistance Programs)

Many major drug manufacturers offer assistance programs for people with Medicare drug coverage who meet certain requirements. Visit [**Medicare.gov/pharmaceutical-assistance-program**](https://www.medicare.gov/pharmaceutical-assistance-program) to learn more about Pharmaceutical Assistance Programs.

Underlined words are defined on pages 281 – 289.

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

PACE is a Medicare and Medicaid program offered in many states that allows people who need a nursing home-level of care to remain in the community. See page 161 for more information.

Supplemental Security Income (SSI) benefits

SSI is a cash benefit paid by Social Security to people with limited income and resources who are blind, 65 or older, or have a disability. SSI benefits aren't the same as Social Security retirement benefits.

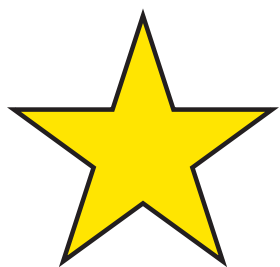
You can visit [**benefits.gov/ssas**](https://benefits.gov/ssas), and use the “Benefit Eligibility Screening Tool” to find out if you're eligible for SSI or other benefits. Call Social Security at 1 800 772 - 1213 or contact your local Social Security office for more information. TTY users can call 1 800 325 - 0778.

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

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Programs for people who live in the U.S. territories

There are programs in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your Medicaid office (State Medical Assistance Office) to learn more. Visit **[Medicare.gov/contacts](https://www.medicare.gov/contacts)**, or call 1 800 633 - 4227 to get the phone number. TTY users can call 1 877 486 - 2048.



Section 8: Know your rights & protect yourself from fraud

What are my Medicare rights?

No matter how you get your Medicare, you have certain rights and protections. All people with Medicare have the right to:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Have personal and health information kept private
- Get information in a way they understand from Medicare, health care providers, and Medicare contractors
- Have questions about Medicare answered
- Have access to doctors, other health care providers, specialists, and hospitals

Underlined words are defined on pages 283 – 291.

- Learn about their treatment choices in clear language that they can understand, and participate in treatment decisions
- Get Medicare-covered services in an emergency
- Get a decision about health care payment, coverage of services, or prescription drug coverage
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage
- File complaints (sometimes called “grievances”), including complaints about the quality of their care

What are my rights if my plan stops participating in Medicare?

Medicare health and prescription drug plans can decide not to participate in Medicare for the coming year. In these cases, your coverage under the plan will end after December 31. Your plan will send you a letter explaining your options. If this happens:

- You can choose another plan between October 15 – December 7. Your coverage will begin January 1.
- **You'll also have a special right to join another Medicare plan until February 28, 2019.**
- You may have the right to buy certain Medigap policies within 63 days after your plan coverage ends.

What's an appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision by Medicare or your Medicare plan. For example, you can appeal if Medicare or your plan denies:

- A request for a health care service, supply, item, or prescription drug that you think should be covered by Medicare.
- A request for payment of a health care service, supply, item, or prescription drug you already got.
- A request to change the amount you must pay for a health care service, supply, item, or prescription drug.

You can also appeal:

- If Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.
- An at-risk determination made under a drug management program that limits access to coverage for frequently abused drugs (see page 197).

Underlined words are defined on pages 283 – 291.

If you decide to file an appeal, you can ask your doctor, supplier, or other health care provider for any information that may help your case. This will make your appeal stronger. Keep a copy of everything related to your appeal, including what you send to Medicare or your plan.

How do I file an appeal?

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

If you have Original Medicare

- Get the “Medicare Summary Notice” (MSN) that shows the item or service you’re appealing. See page 125 for more information about MSNs.
- Circle the item(s) on the MSN you disagree with. Write an explanation of why you disagree with the decision. You can write on the MSN or on a separate piece of paper and attach it to the MSN.
- Include your name, phone number, and Medicare Number on the MSN, and sign it. Keep a copy for your records.

- Send the MSN, or a copy, to the company that handles bills for Medicare (Medicare Administrative Contractor or MAC) listed on the MSN. You can include any other additional information you have about your appeal. Or, you can use CMS Form 20027. To view or print this form, visit **CMS.gov/cmsforms/downloads/cms20027.pdf**, or call 1 800 633 - 4227 to have a copy mailed to you. TTY users can call 1 877 486 - 2048.
- You must file the appeal within 120 days of the date you get the MSN in the mail.
- You'll generally get a decision from the Medicare Administrative Contractor (MAC) within 60 days after they get your request. If Medicare will cover the item(s) or service(s), it will be listed on your next MSN.

Underlined words are defined on pages 283 – 291.

If you have a Medicare health plan

The time frame for filing an appeal may be different than Original Medicare. Learn more by looking at the materials your plan sends you, calling your plan, or visiting

Medicare.gov/appeals.

In some cases, you can file a fast appeal. See materials from your plan and page 230.

If you have a Medicare Prescription Drug Plan

You have the right to do all of these (even before you buy a certain drug):

- Get a written explanation (called a “coverage determination”) from your Medicare drug plan. A coverage determination is the first decision your Medicare drug plan (not the pharmacy) makes about your benefits. This can be a decision about if your drug is covered, if you met the plan’s requirements to cover the drug, or how much you pay for the drug. You’ll also get a coverage determination decision if you ask your plan to make an exception to its rules to cover your drug.

- Ask for an exception if you or your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) believes you need a drug that isn't on your plan's **formulary**.
- Ask for an exception if you or your prescriber believes that a coverage rule (like prior authorization) should be waived.
- Ask for an exception if you think you should pay less for a higher tier (more expensive) drug because you or your prescriber believes you can't take any of the lower tier (less expensive) drugs for the same condition.

How do I ask for a coverage determination or exception?

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

If you're asking for prescription drug benefits you haven't gotten yet, you or your prescriber may make a standard request by phone or in writing. If you're asking to get paid back for prescription drugs you already bought, your plan can require you or your prescriber to make the standard request in writing.

You or your prescriber can call or write your plan for an expedited (fast) request. Your request will be expedited if you haven't gotten the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting.

Important!

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

What are my rights if I think my services are ending too soon?

If you're getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your Medicare-covered services are ending too soon (or that you're being discharged too soon), you can ask for a fast appeal. Your provider will give you a notice before your services end that will tell you how to ask for a fast appeal. The notice might call it an "immediate appeal" or an "expedited appeal." You should read this notice carefully. If you don't get this notice, ask your provider for it. With a fast appeal, an independent reviewer will decide if your services should continue.

How can I get help filing an appeal?

You can appoint a representative to help you. Your representative can be a family member, friend, advocate, attorney, financial advisor, doctor or someone else who will act on your behalf. For more information, visit **[Medicare.gov/appeals](https://www.medicare.gov/appeals)**. You can also get help filing an appeal from your State Health Insurance Assistance Program (SHIP). See pages 275 – 281 for the phone number.

What's an “Advance Beneficiary Notice of Noncoverage” (ABN)?

If you have Original Medicare, your doctor, other health care provider, or supplier may give you a notice called an “Advance Beneficiary Notice of Noncoverage” (ABN) if they think the care they'll provide isn't covered by Medicare. This notice says Medicare probably (or certainly) won't pay for some services in certain situations.

What happens if I get an ABN?

- You'll be asked to choose whether to get the items or services listed on the ABN.
- If you choose to get the items or services listed on the ABN, you're agreeing to pay if Medicare doesn't.
- You'll be asked to sign the ABN to say that you've read and understood it.
- Doctors, other health care providers, and suppliers don't have to (but still may) give you an ABN for services that Medicare never covers. See page 231.
- An ABN isn't an official denial of coverage by Medicare. If Medicare denies payment, you can still file an appeal. However, you'll have to pay for the items or services if Medicare decides that the items or services aren't covered (and no other insurer is responsible for payment).

Can I get an ABN for other reasons?

You may get a “Skilled Nursing Facility ABN” when the facility believes Medicare will no longer cover your stay or other items and services.

What if I didn’t get an ABN?

If your provider was required to give you an ABN but didn’t, in most cases, your provider must give you a refund for what you paid for the item or service.

Where can I get more information about appeals and ABNs?

- Visit **[Medicare.gov/appeals](https://www.medicare.gov/appeals)**.
- Visit **[Medicare.gov/publications](https://www.medicare.gov/publications)** to view the booklet “Medicare Appeals.”
- If you’re in a **Medicare plan**, call your plan to find out if a service or item will be covered.

Your right to access your personal health information

By law, you or your legal representative generally has the right to view and/or get copies of your personal health information from health care providers who treat you, or by health plans that pay for your care, including Medicare. In most cases, you also have the right to have a provider or plan send copies of your information to a third party that you choose, like other providers who treat you, a family member, a researcher, or a mobile application (or “app”) you use to manage your personal health information.

This includes:

- Claims and billing records
- Information related to your enrollment in health plans, including Medicare
- Medical and case management records (except psychotherapy notes)
- Any other records that contain information that doctors or health plans use to make decisions about you

Section 8: Know your rights & protect **235** yourself from fraud

You may have to fill out a health information “request” form, and pay a reasonable, cost-based fee for copies. Your providers or plans should tell you about the fee when you make the request. If they don’t, you should ask. The fee can only be for the labor to make the copies, copying supplies, and postage (if needed). In most cases, you shouldn’t be charged for viewing, searching, downloading, or sending your information through an electronic portal.

Generally, you can get your information on paper or electronically. If your providers or plans store your information electronically, they generally must give you electronic copies, if that’s your preference.

You have the right to get your information in a timely manner, but it may take up to 30 days to fill the request.

For more information, visit **[hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html](https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html)**.

How does Medicare use my personal information?

Medicare protects the privacy of your health information. The next 2 pages describe how your information may be used and given out, and explain how you can get this information.

Notice of Privacy Practices for Original Medicare

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The law requires Medicare to protect the privacy of your personal medical information. It also requires us to give you this notice so you know how we may use and share (“disclose”) the personal medical information we have about you.

Underlined words are defined on pages 283 – 291.

Section 8: Know your rights & protect **237** yourself from fraud

We must provide your information to:

- You, to someone you name (“designate”), or someone who has the legal right to act for you (your personal representative)
- The Secretary of the Department of Health and Human Services, if necessary
- Anyone else that the law requires to have it

We have the right to use and provide your information to pay for your health care and to operate Medicare.

For example:

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

We may use or share your information under these limited circumstances:

- To state and other federal agencies that have the legal right to get Medicare data (like to make sure Medicare is making proper payments and to help federal/state Medicaid programs)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like investigating fraud and abuse)
- For judicial and administrative proceedings (like responding to a court order)
- For law enforcement purposes (like providing limited information to find a missing person)
- For research studies that meet all privacy law requirements (like research to prevent a disease or disability)
- To avoid a serious and imminent threat to health or safety

Section 8: Know your rights & protect **239** yourself from fraud

- To contact you about new or changed Medicare benefits
- To create a collection of information that no one can trace to you
- To practitioners and their contractors for care coordination and quality improvement purposes, like Accountable Care Organizations (ACOs).
- We must have your written permission (an “authorization”) to use or share your information for any purpose that isn’t described in this notice. We don’t sell or use and share your information to tell you about health products or services (“marketing”). You may take back (“revoke”) your written permission at any time, unless we’ve already shared information because you gave us permission.

You have the right to:

- See and get a copy of the information we have about you.
- Have us change your information if you think it's wrong or incomplete, and we agree. If we disagree, you may have a statement of your disagreement added to your information.
- Get a list of people who get your information from us. The listing won't cover information that we gave to you, your personal representative, or law enforcement, or information that we used to pay for your care or for our operations.
- Ask us to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask us to limit how we use your information and how we give it out to pay claims and run Medicare. We may not be able to agree to your request.

Section 8: Know your rights & protect **241** yourself from fraud

- Get a letter that tells you about the likely risk to the privacy of your information (“breach notification”).
- Get a separate paper copy of this notice.
- Speak to a Customer Service Representative about our privacy notice. Call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

If you believe your privacy rights have been violated, you may file a privacy complaint with:

- The Centers for Medicare & Medicaid Services (CMS). Visit **Medicare.gov**, or call 1 800 633 - 4227.
- The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR). Visit **hhs.gov/hipaa/filing-a-complaint**.
- Filing a complaint won’t affect your coverage under Medicare.
- The law requires us to follow the terms in this notice. We have the right to change the way we use or share your information. If we make a change, we’ll mail you a notice within 60 days of the change.

The Notice of Privacy Practices for Original Medicare became effective September 23, 2013.

How can I protect myself from identity theft?

Identity theft happens when someone uses your personal information without your consent to commit fraud or other crimes. Personal information includes things like your name and your Social Security, Medicare, credit card, or bank account numbers. Guard your cards and protect your Medicare and Social Security Numbers. **Keep this information safe.**

Only give personal information, like your Medicare Number, to doctors, insurers or plans acting on your behalf, or trusted people in the community who work with Medicare like your State Health Insurance Assistance Program (SHIP). Don't share your Medicare Number or other personal information with anyone who contacts you by phone, email, or in person. Medicare, or someone representing Medicare, will only call you in limited situations:

Underlined words are defined on pages 283 – 291.

Section 8: Know your rights & protect **243** yourself from fraud

- A Medicare health or drug plan can call you if you're already a member of the plan. The agent who helped you join can also call you.
- A customer service representative from 1 800 633 - 4227 can call you if you've called and left a message, or a representative said that someone would call you back. If you suspect identity theft, or feel like you gave your personal information to someone you shouldn't have, call your local police department and the Federal Trade Commission's ID Theft Hotline at 1 877 438 - 4338. TTY users can call 1 866 653 - 4261. Visit **[ftc.gov/idtheft](https://www.ftc.gov/idtheft)** to learn more about identity theft.

How can I protect myself and Medicare from fraud?

Medicare fraud and abuse can cost taxpayers billions of dollars each year. One common form of Medicare fraud is when a provider bills Medicare for services you never got. When you get health care services, record the dates on a calendar and save the receipts and statements you get from providers to check for mistakes. If you think you see an error or are billed for services you didn't get, take these steps to find out what was billed:

- Check your “Medicare Summary Notice” (MSN) if you have Original Medicare to see if the service was billed to Medicare. If you're in a **Medicare health plan**, check the statements you get from your plan.
- If you know the health care provider or supplier, call and ask for an itemized statement. They should give this to you within 30 days.

Underlined words are defined on pages 283 – 291.

Section 8: Know your rights & protect **245** yourself from fraud

- Visit **MyMedicare.gov** to view your Medicare claims if you have Original Medicare. Your claims are generally available online within 24 hours after processing. You can also download your claims information by using Medicare's Blue Button. See page 261. You can also call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

If you've contacted the provider and you suspect that Medicare is being charged for a service or supply that you didn't get, or you don't know the provider on the claim, call 1 800 633 - 4227.

For more information on protecting yourself from Medicare fraud and tips for spotting and reporting fraud, visit **Medicare.gov**, or contact your local Senior Medicare Patrol (SMP) Program. For more information about the SMP program, visit **smpresource.org** or call 1 877 808 - 2468.

You can also visit **oig.hhs.gov** or call the fraud hotline of the Department of Health and Human Services Office of the Inspector General at 1 800 447 - 8477. TTY users can call 1 800 377 - 4950.

Plans must follow rules

Medicare plans must follow certain rules when marketing their plans and getting your enrollment information. They can't ask you for credit card or banking information over the phone or via email, unless you're already a member of that plan. Medicare plans can't enroll you into a plan over the phone unless you call them and ask to enroll, or you've given them permission to contact you.

Important!

Call 1 800 633 - 4227 to report any plans that:

- Ask for your personal information over the phone or email
- Call to enroll you in a plan
- Use false information to mislead you

You can also call the Medicare Drug Integrity Contractor (MEDIC) at 1 877 772 - 3379). The MEDIC helps prevent inappropriate activity and fights fraud, waste, and abuse in Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) Programs.

Underlined words are defined on pages 283 – 291.

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Fighting fraud can pay

You may get a reward if you help us fight fraud and meet certain conditions. For more information, visit **Medicare.gov**, or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Investigating fraud takes time

Every tip counts. Medicare takes all reports of suspected fraud seriously. When you report fraud, you may not hear of an outcome right away. It takes time to investigate your report and build a case, but rest assured that your information is helping us protect Medicare.

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What's the Medicare Beneficiary Ombudsman?

An “ombudsman” is a person who reviews questions, concerns, and challenges with how a program is administered, and helps to resolve them when possible.

There are several resources to get answers to your Medicare questions and to get assistance with your Medicare, like **Medicare.gov**, 1 800 633 - 4227, and State Health Insurance Assistance Programs (SHIPs). The Medicare Beneficiary Ombudsman works closely with those resources and Medicare to help make sure information and assistance are available for you, and works to improve your experience with Medicare.

Visit **Medicare.gov** for information on how the Medicare Beneficiary Ombudsman can help you.

Underlined words are defined on pages 283 – 291.

Notice of Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides auxiliary aids and services to help us better communicate with people with disabilities. Auxiliary aids include materials in Braille, audio/data CD or other accessible formats.

Note: You can get this handbook electronically in standard print, large print, or as an eBook.

For general Medicare inquiries and Medicare publications, call us at 1 800 633 - 4227. TTY: 1 877 486 - 2048.

For all other CMS publications and documents in accessible formats, you can contact our Customer Accessibility Resource Staff:

- Call 1 844 258 - 3676. TTY: 1 844 716 - 3676.
- Send a fax to 1 844 530 - 3676.
- Send an email to **AltFormatRequest@cms.hhs.gov**.
- Send a letter to:

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop S1 - 13 - 25
Baltimore, MD 21244 - 1850
Attn: Customer Accessibility Resource Staff

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You can also contact the Customer Accessibility Resource staff:

- To inquire about a request for accessible formats.
- To submit concerns and issues about accessible communications, including the quality and timeliness of your request.

Note: Your request for a CMS publication or document should include:

- Your name, phone number, and the mailing address where we should send the publications or documents.
- The publication title and CMS Product No., if known.
- The format you need, like Braille, large print, or data/audio CD.

Note: If you're enrolled in a Medicare Advantage or Prescription Drug Plan, you can contact your plan to request their documents in an accessible format.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

Underlined words are defined on pages 283 – 291.

How to file a complaint

If you believe you've been subjected to discrimination in a CMS program or activity, there are 3 ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- 1. Online at:** hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
- 2. By phone:** Call 1 800 368 - 1019. TTY users can call 1 800 537 - 7697.
- 3. In writing:** Send information about your complaint to:

Office for Civil Rights

U.S. Department of Health and Human Services

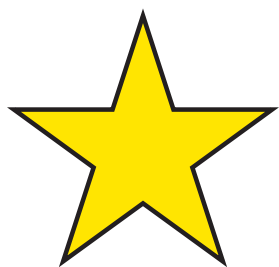
200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

Notes

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Section 9: Get more information

Where can I get personalized help?

1 800 633 - 4227

TTY users call 1 877 486 - 2048

Get information 24 hours a day, including weekends

- Speak clearly and follow the voice prompts to pick the category that best meets your needs.
- Have your Medicare card in front of you, and be ready to give your Medicare Number.
- When prompted for your Medicare Number, speak the numbers and letters clearly one at a time.
- If you need help in a language other than English or Spanish, or need to request a Medicare publication in an accessible format (like large print or Braille), let the customer service representative know.

Underlined words are defined on pages 283 – 291.

Important!

**Do you need someone to be able to call
1 800 633 - 4227 on your behalf?**

You can fill out a “Medicare Authorization to Disclose Personal Health Information” form so Medicare can give your personal health information to someone other than you. You can find the form by visiting **Medicare.gov/medicareonlineforms** or get a copy of the form by calling 1 800 633 - 4227. You may want to do this now in case you become unable to do it later.

**Did your household get more than one copy of
“Medicare & You?”**

If you want to get only one copy in the future, call 1 800 633 - 4227. If you want to stop getting paper copies in the mail, visit **Medicare.gov/gopaperless**.

Underlined words are defined on pages 283 – 291.

What are State Health Insurance Assistance Programs (SHIPs)?

SHIPs are state programs that get money from the federal government to give local health insurance counseling to people with Medicare at no cost to you. SHIPs aren't connected to any insurance company or health plan. SHIP volunteers work hard to help you with these Medicare questions or concerns:

- Your Medicare rights.
- Billing problems.
- Complaints about your medical care or treatment.
- Plan choices.
- How Medicare works with other insurance.
- Finding help paying for health care costs.

See pages 275 – 281 for the phone number of your local SHIP. If you would like to become a volunteer SHIP counselor, contact the SHIP in your state to learn more.

Where can I find general Medicare information online?

Visit Medicare.gov

- Get information about the Medicare health and prescription drug plans in your area, including what they cost and what services they provide.
- Find doctors or other health care providers and suppliers who participate in Medicare.
- See what Medicare covers, including **preventive services**.
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospices, **inpatient rehabilitation facilities**, and **long-term care hospitals**.
- Look up helpful websites and phone numbers.

Underlined words are defined on pages 283 – 291.

Where can I find personalized Medicare information online?

Register at MyMedicare.gov

- Manage your personal information (like medical conditions, allergies, and implanted devices).
- Sign up to get your “Medicare Summary Notices” (eMSNs) and this handbook electronically. You won’t get printed copies if you choose to get them electronically.
- Manage your personal drug list and pharmacy information.
- Search for, add to, and manage a list of your favorite providers and access quality information about them.

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- Select your primary clinician from your list of favorite providers. Your primary clinician is the practitioner who you want responsible for coordinating your overall care, regardless of where you choose to get services. By choosing a primary clinician, your doctor may have access to more tools or services for your care available to patients of doctors participating in an Accountable Care Organization or certain other Medicare alternative payment models. (This is also known as “voluntary alignment.”)
- Track Original Medicare claims and your Part B **deductible** status.
- Print an official copy of your new Medicare card once it’s mailed to you.

Underlined words are defined on pages 283 – 291.

MyMedicare.gov's Blue Button®

MyMedicare.gov's Blue Button makes it easy for you to download your personal health information to a file. Having access to your information can help you make more informed decisions about your health care. Blue Button is safe, secure, reliable, and easy to use. By getting your information through Blue Button, you can:

- Download and save a file of your personal health information on your computer or other device, including your Part A, Part B, and Part D claims.
- Print or email the information to share with others after you've saved the file.
- Import your saved file into other computer-based personal health management tools.

Visit **MyMedicare.gov** to use Blue Button today.

How do I compare the quality of health care providers?

Medicare collects information about the quality and safety of medical care and services given by most health care providers (and facilities).

Visit **Medicare.gov/quality-care-finder** and use the Compare tools to get a snapshot of the quality of care health care providers (and facilities) give their patients. Some of these tools feature a star rating system to help you compare quality measures that are important to you. Find out more about the quality of care by:

- Asking what your health care provider does to ensure and improve the quality of care. Each health care provider should have someone you can talk to about quality.
- Asking your doctor or other health care provider what he or she thinks about the quality of care other providers give. You can also ask your doctor or other health care provider about the quality of care information you find on the **Medicare.gov** Compare tools.

Underlined words are defined on pages 283 – 291.

How do I compare the quality of Medicare health and drug plans?

The Medicare Plan Finder at [**Medicare.gov/find-a-plan**](https://www.medicare.gov/find-a-plan) features a star rating system for Medicare health and drug plans. The Overall Star Rating gives an overall rating of the plan's quality and performance for the types of services each plan offers.

For plans covering health services, this is an overall rating for the quality of many medical/health care services that fall into 5 categories:

- 1. Staying healthy—screening tests and vaccines:** Includes whether members got various screening tests, vaccines, and other check-ups to help them stay healthy.
- 2. Managing chronic (long-term) conditions:** Includes how often members with certain conditions got recommended tests and treatments to help manage their condition.
- 3. Member experience with the health plan:** Includes member ratings of the plan.

4. **Member complaints and changes in the health plan's performance:** Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
5. **Health plan customer service:** Includes how well the plan handles member appeals.

For plans covering drug services, this is an overall rating for the quality of prescription-related services that fall into 4 categories:

1. **Drug plan customer service:** Includes how well the plan handles member appeals.
2. **Member complaints and changes in the drug plan's performance:** Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
3. **Member experience with plan's drug services:** Includes member ratings of the plan.

Underlined words are defined on pages 283 – 291.

- 4. Drug safety and accuracy of drug pricing:** Includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that's safer and clinically recommended for their condition.

For plans covering both health and drug services, the overall rating for quality and performance covers all of the topics above.

You can compare the quality of care and services given by health care providers and **Medicare plans** nationwide by visiting **Medicare.gov** or by calling your State Health Insurance Assistance Program (SHIP). See pages 275 – 281 for the phone number.

What's Medicare doing to better coordinate my care?

Medicare continues to look for ways to better coordinate your care and to make sure that you get the best health care possible.

Here are examples of how your **health care providers** can better coordinate your care:

Electronic Health Records (EHRs)

EHRs are records that your doctor, other health care provider, medical office staff, or hospital keeps on a computer about your health care or treatments.

- EHRs can help lower the chances of medical errors, eliminate duplicate tests, and may improve your overall quality of care.
- Your doctor's EHR may be able to link to a hospital, lab, pharmacy, or other doctors, so the people who care for you can have a more complete picture of your health.

Underlined words are defined on pages 283 – 291.

Electronic prescribing

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

Accountable Care Organizations (ACOs)

An ACO is a group of doctors, hospitals, and other health care providers who agree to work together with Medicare to give you more coordinated service and care.

If you have Original Medicare and your doctor has decided to participate in an ACO, you'll be notified. A poster with information about your doctor's participation in an ACO may be displayed at the office, or your doctor may give you this information in writing.

To help you get better, more coordinated care, Medicare will share certain health information with ACOs working with your doctors and other health care providers about the care you get from your doctors and other providers. Just like Medicare, ACOs must put important safeguards in place to make sure your health care information is safe.

Your doctor may ask you to select them as your primary clinician on **MyMedicare.gov**. Medicare may use your selection to hold your doctor's ACO accountable for the quality of your care and overall medical costs. See pages 259 – 260 for more information.

You can ask Medicare not to share certain information with the ACO about the care you got from your doctors and other health care providers. To do this, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048 and tell us you don't want us to share this information. You can also change your data sharing preferences at any time by calling 1 800 633 - 4227. Even if you ask Medicare not to share your information, Medicare will still use your information for some purposes, like assessing the financial and quality of care performance of providers participating in ACOs. Also, Medicare may share some of your information with ACOs when measuring the quality of care given by health care providers participating in those ACOs.

Underlined words are defined on pages 283 – 291.

Your Medicare benefits, services, costs, and protections won't change if your doctor participates in an ACO or if you ask that Medicare not share your information. You still have the right to visit and get care from any doctor or hospital that accepts Medicare at any time, the same way you do now.

The poster in your doctor's office (or written notification) should let you know whether the doctor or ACO has asked Medicare for access to your information about the care you get through Medicare. With the information Medicare shares, the doctors and other health care providers in the ACO can have a complete picture of your health and be better able to coordinate your care.

For more information about ACOs, visit **Medicare.gov**, or call 1 800 633 - 4227.

Are there other ways to get Medicare information?

Publications

Visit **Medicare.gov/publications** to view, print, or download copies of publications on different Medicare topics. You can also call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048. Accessible formats are available at no cost. See page 249 for more information.

Social media

Stay up to date and connect with other people with Medicare by following us on Facebook (**facebook.com/Medicare**) and Twitter (**twitter.com/MedicareGov**).

Videos

Visit **YouTube.com/cmshhs.gov** to see videos covering different health care topics on Medicare's YouTube channel.

Underlined words are defined on pages 283 – 291.

Blogs

Visit **blog.medicare.gov** for up-to-date information on important topics.

Other helpful contacts

Social Security

Find out if you're eligible for Part A and/or Part B and how to enroll, make changes to your Part A and/or Part B coverage, get a replacement Social Security card, report a change to your address or name, apply for **Extra Help** with Medicare prescription drug costs, ask questions about Part A and Part B **premiums**, and report a death.

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

socialsecurity.gov

Benefits Coordination & Recovery Center (BCRC)

Contact the BCRC to report changes in your insurance information or to let Medicare know if you have other insurance.

1 855 798 - 2627 TTY: 1 855 797 - 2627

Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO)

Contact a BFCC-QIO to ask questions or report complaints about the quality of care you got for a Medicare-covered service (and you aren't satisfied with the way your provider has responded to your concern). Or, you can contact the BFCC-QIO if you think Medicare coverage for your service is ending too soon (for example, if your hospital says that you must be discharged and you disagree). Visit **[Medicare.gov/contacts](https://www.medicare.gov/contacts)**, or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048 to get the phone number of your BFCC-QIO.

Department of Defense

Get information about TRICARE for Life (TFL) and the TRICARE Pharmacy Program.

- **TFL:**

1 866 773 - 0404 TTY: 1 866 773 - 0405

tricare.mil/tfl

- **Tricare Pharmacy Program:**

1 877 363 - 1303 TTY: 1 877 540 - 6261

tricare.mil/pharmacy

express-scripts.com/tricare

tricare4u.com

Department of Veterans Affairs

Contact the VA if you're a veteran or have served in the U.S. military and you have questions about VA benefits.

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

va.gov

vets.gov

eBenefits.va.gov

Office of Personnel Management

Get information about the Federal Employee Health Benefits (FEHB) Program for current and retired federal employees.

Retirees: 1 888 767 - 6738, TTY: 1 800 878 - 5707

[opm.gov/healthcare-insurance](https://www.opm.gov/healthcare-insurance)

Active federal employees: Contact your Benefits Officer. Visit **apps.opm.gov/abo** for a list of Benefits Officers.

Railroad Retirement Board (RRB)

If you get benefits from the RRB, call them to change your address or name, check eligibility, enroll in Medicare, replace your Medicare card, or report a death.

1 877 772 - 5772, TTY: 1 312 751 - 4701

[rrb.gov](https://www.rrb.gov)

State Health Insurance Assistance Programs (SHIPs)

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

Alabama State Health Insurance Assistance Program (SHIP) 1 800 243 - 5463

Alaska Medicare Information Office
1 800 478 - 6065 TTY: 1 800 770 - 8973

Arizona Arizona State Health Insurance Assistance Program (SHIP) 1 800 432 - 4040

Arkansas Senior Health Insurance Information Program (SHIIP) 1 800 224 - 6330

California California Health Insurance Counseling & Advocacy Program (HICAP) 1 800 434 - 0222

Colorado State Health Insurance Assistance Program (SHIP) 1 888 696 - 7213

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Connecticut Connecticut program for Health insurance assistance, Outreach, Information & referral, Counseling and Eligibility Screening (CHOICES) 1 800 994 - 9422

Delaware Delaware Medicare Assistance Bureau
1 800 336 - 9500

Florida SHINE (Serving Health Insurance Needs of Elders) 1 800 963 - 5337 TTY: 1 800 955 - 8770

Georgia GeorgiaCares Program 1 866 552 - 4464

Guam Guam Medicare Assistance Program (GUAM MAP) 1 671 735 - 7415

Hawaii Hawaii SHIP 1 888 875 - 9229
TTY: 1 866 810 - 4379

Idaho Senior Health Insurance Benefits Advisors (SHIBA) 1 800 247 - 4422

Illinois Senior Health Insurance Program (SHIP)
1 800 252 - 8966 TTY: 1 888 206 - 1327

Indiana State Health Insurance Assistance Program
(SHIP) 1 800 452 - 4800 TTY: 1 866 846 - 0139

Iowa Senior Health Insurance Information Program
(SHIIP) 1 800 351 - 4664 TTY: 1 800 735 - 2942

Kansas Senior Health Insurance Counseling for Kansas
(SHICK) 1 800 860 - 5260

Kentucky State Health Insurance Assistance Program
(SHIP) 1 877 293 - 7447

Louisiana Senior Health Insurance Information
Program (SHIIP) 1 800 259 - 5300

Maine Maine State Health Insurance Assistance
Program (SHIP) 1 800 262 - 2232

Maryland State Health Insurance Assistance Program
(SHIP) 1 800 243 - 3425

Massachusetts Serving Health Insurance Needs
of Everyone (SHINE) 1 800 243 - 4636
TTY: 1 877 610 - 0241

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Michigan MMAP, Inc. 1 800 803 - 7174

Minnesota Minnesota State Health Insurance
Assistance Program/ Senior LinkAge Line
1 800 333 - 2433

Mississippi MS State Health Insurance Assistance
Program (SHIP) 844 822 - 4622

Missouri CLAIM 1 800 390 - 3330

Montana Montana State Health Insurance Assistance
Program (SHIP) 1 800 551 3191

Nebraska Nebraska Senior Health Insurance
Information Program (SHIIP) 1 800 234 - 7119

Nevada State Health Insurance Assistance Program
(SHIP) 1 800 307 - 4444

New Hampshire NH SHIP - ServiceLink Resource
Center 1 866 634 - 9412

New Jersey State Health Insurance Assistance
Program (SHIP) 1 800 792 - 8820

New Mexico New Mexico ADRC/SHIP

1 800 432 - 2080

New York Health Insurance Information Counseling
and Assistance Program (HIICAP) 1 800 701 - 0501

North Carolina Seniors' Health Insurance
Information Program (SHIIP) 1 855 408 - 1212

North Dakota State Health Insurance Counseling
(SHIC) 1 888 575 - 6611 TTY: 1 800 366 - 6888

Ohio Ohio Senior Health Insurance Information
Program (OSHIIP) 1 800 686 - 1578

Oklahoma Oklahoma Medicare Assistance
Program (MAP) 1 800 763 - 2828

Oregon Senior Health Insurance Benefits
Assistance (SHIBA) 1 800 722 - 4134

Pennsylvania APPRISE 1 800 783 - 7067

Puerto Rico State Health Insurance Assistance
Program (SHIP) 1 877 725 - 4300
TTY: 1 787 919 - 7291

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Rhode Island Senior Health Insurance Program (SHIP)
1 888 884 - 8721

South Carolina (I-CARE) Insurance Counseling
Assistance and Referrals for Elders 1 800 868 - 9095

South Dakota Senior Health Information & Insurance
Education (SHIINE) 1 800 536 - 8197

Tennessee TN SHIP 1 877 801 - 0044
TTY: 1 800 848 - 0299

Texas Health Information Counseling and Advocacy
Program (HICAP) 1 800 252 - 9240

Utah Senior Health Insurance Information Program
(SHIP) 1 800 541 - 7735

Vermont State Health Insurance Assistance Program
(SHIP) 1 800 642 - 5119

Virgin Islands Virgin Islands State Health Insurance
Assistance Program (VI SHIP) (STX) 1 340 772 - 7368

Virginia Virginia Insurance Counseling and Assistance
Program (VICAP) 1 800 552 - 3402

Washington Statewide Health Insurance Benefits
Advisors (SHIBA) 1 800 562 - 6900
TTY: 1 360 586 - 0241

Washington D.C. Health Insurance Counseling Project
(HICP) 1 202 994 - 6272

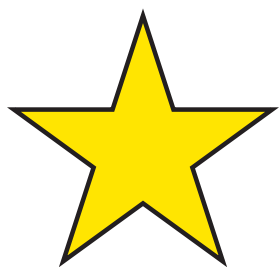
West Virginia West Virginia State Health Insurance
Assistance Program (WV SHIP) 1 877 987 - 4463

Wisconsin Wisconsin SHIP 1 800 242 - 1060
TTY: 1 888 758 - 6049

Wyoming Wyoming State Health Insurance Information
Program (WSHIIP) 1 800 856 - 4398

Notes

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Section 10: Definitions

Assignment

An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period

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

Coinsurance

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

Copayment

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

Creditable prescription drug coverage

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

Critical access hospital

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

Custodial care

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

Deductible

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

Demonstrations

Special projects, sometimes called “pilot programs” or “research studies,” that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and/or in specific areas.

Extra Help

A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Formulary

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

Inpatient rehabilitation facility

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

Institution

For the purposes of this publication, an institution is a facility that provides short-term or long-term care, like a nursing home, skilled nursing facility (SNF), or rehabilitation hospital. Private residences, like an assisted living facility or group home, aren't considered institutions for this purpose.

Lifetime reserve days

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

Long-term care hospital

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

Medically necessary

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organization
- Private Fee-for-Service Plan
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Medicare services aren't paid for by Original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount

In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan

Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private companies and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare plan

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

Premium

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

Preventive services

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

Primary care doctor

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

Referral

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

Service area

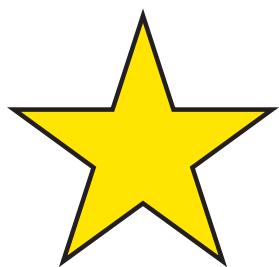
A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out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

Skilled nursing facility (SNF) care

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

Notes

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Help in other languages

If you, or someone you're helping, has questions about Medicare, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1 800-MEDICARE (1 800 633-4227).

العربية (Arabic) إن كان لديك أو لدى شخص تُساعده أسئلة بخصوص Medicare فإن من حقك الحصول على المساعدة و المعلومات بلغتك من دون أي تكلفة. للتحدث مع مترجم إتصل بالرقم Medicare (1-800-633-4227).

հայերեն (Armenian) Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Medicare-ի մասին, ապա Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք 1-800-MEDICARE (1-800-633-4227) հեռախոսահամարով:

中文 (Chinese-Traditional) 如果您，或是您正在協助的個人，有關於聯邦醫療保險的問題，您有權免費以您的母語，獲得幫助和訊息。與翻譯員交談，請致電 1-800-MEDICARE (1-800-633-4227)。

فارسی (Farsi) اگر شما، یا شخصی که به او کمک می‌رسانید سوالی در مورد اعلامیه مختصر مدیکردارید، حق این را دارید که کمک و اطلاعات به زبان خود به طور رایگان دریافت نمایید. برای مکالمه با مترجم با این شماره زیر تماس بگیرید 1-800-MEDICARE (1-800-633-4227).

310 Help in other languages

Français (French) Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions au sujet de l'assurance-maladie Medicare, vous avez le droit d'obtenir de l'aide et de l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le 1-800-MEDICARE (1-800-633-4227)

Deutsch (German) Falls Sie oder jemand, dem Sie helfen, Fragen zu Medicare haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-MEDICARE (1-800-633-4227) an.

Kreyòl (Haitian Creole) Si oumenm oswa yon moun w ap ede, gen kesyon konsènan Medicare, se dwa w pou jwenn èd ak enfòmasyon nan lang ou pale a, san pou pa peye pou sa. Pou w pale avèk yon entèprèt, rele nan 1-800-MEDICARE (1-800-633-4227).

Italiano (Italian) Se voi, o una persona che state aiutando, vogliate chiarimenti a riguardo del Medicare, avete il diritto di ottenere assistenza e informazioni nella vostra lingua a titolo gratuito. Per parlare con un interprete, chiamate il numero 1-800-MEDICARE (1-800-633-4227).

日本語 (Japanese) Medicare (メディケア) に関するご質問がある場合は、ご希望の言語で情報を取得し、サポートを受ける権利があります (無料)。通訳をご希望の方は、1-800-MEDICARE (1-800-633-4227) までお電話ください。

한국어(Korean) 만약 귀하나 귀하가 돕는 어느 분이 메디케어에 관해서 질문을 가지고 있다면 비용 부담이 없이 필요한 도움과 정보를 귀하의 언어로 얻을 수 있는 권리가 귀하에게 있습니다. 통역사와 말씀을 나누시려면 1-800-MEDICARE(1-800-633-4227)로 전화하십시오.

Polski (Polish) Jeżeli Państwo lub ktoś komu Państwo pomagają macie pytania dotyczące Medicare, mają Państwo prawo do uzyskania bezpłatnej pomocy i informacji w swoim języku. Aby rozmawiać z tłumaczem, prosimy dzwonić pod numer telefonu 1-800-MEDICARE (1-800-633-4227).

Português (Portuguese) Se você (ou alguém que você esteja ajudando) tiver dúvidas sobre a Medicare, você tem o direito de obter ajuda e informações em seu idioma, gratuitamente. Para falar com um intérprete, ligue para 1-800-MEDICARE (1-800-633-4227).

Русский (Russian) Если у вас или лица, которому вы помогаете, возникли вопросы по поводу программы Медикэр (Medicare), вы имеете право на бесплатную помощь и информацию на вашем языке. Чтобы воспользоваться услугами переводчика, позвоните по телефону 1-800-MEDICARE (1-800-633-4227).

312 Help in other languages

Tagalog (Tagalog) Kung ikaw, o ang isang tinutulungan mo, ay may mga katanungan tungkol sa Medicare, ikaw ay may karapatan na makakuha ng tulong at impormasyon sa iyong lengguwahe ng walang gastos. Upang makipag-usap sa isang tagasalin ng wika, tumawag sa 1-800-MEDICARE (1-800-633-4227).

Tiếng Việt (Vietnamese) Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Medicare, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện qua thông dịch viên, gọi số 1-800-MEDICARE (1-800-633-4227).

The information in “Medicare & You” describes the Medicare Program at the time it was printed. Changes may occur after printing. Visit **Medicare.gov** or call 1 800 633 - 4227 to get the most current information. TTY users can call 1 877 486 - 2048.

“Medicare & You” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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Moving? Visit [socialsecurity.gov](https://www.socialsecurity.gov), or call Social Security at 1 800 772 - 1213. TTY users can call 1 800 325 - 0778. If you get RRB benefits, contact the RRB at 1 877 772 - 5772. TTY users can call 1 312 751 - 4701.

¿Necesita usted una copia de este manual en Español?

Llame al 1 800 633 - 4227). Los usuarios de TTY pueden llamar al 1 877 486 - 2048.

General comments about this handbook are welcome. Email us at medicareandyou@cms.hhs.gov. We can't respond to every comment, but we'll consider your feedback when writing future handbooks.