Medicare

for Railroad Workers
and Their Families

U.S. Railroad Retirement Board
Chicago, IL 60611-2092

U.S. Railroad Retirement Board Mission Statement

The Railroad Retirement Board's mission is to administer retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement Act and the Railroad Unemployment Insurance Act. These programs provide income protection during old age and in the event of disability, death or temporary unemployment and sickness. The Railroad Retirement Board also administers aspects of the Medicare program and has administrative responsibilities under the Social Security Act and the Internal Revenue Code.

In carrying out its mission, the Railroad Retirement Board will pay benefits to the right people, in the right amounts, in a timely manner, and will take appropriate action to safeguard our customers' trust funds. The Railroad Retirement Board will treat every person who comes into contact with the agency with courtesy and concern, and respond to all inquiries promptly, accurately and clearly.

Why you should read this booklet . . .

Railroad workers are covered under the Federal Medicare program just like workers covered under social security, and railroad retirement payroll taxes include a Medicare hospital insurance tax just like social security payroll taxes.

Even though you're paying into the Medicare program during your working years, and will probably rely on its services in the future, you may not be aware of what benefits the program offers--and what it doesn't offer. The basic information in this booklet will give you an overview of the Medicare program.

What's Inside . . .

More detailed information on Medicare's benefits, costs, and health service options is available from the Centers for Medicare & Medicaid Services publication *Medicare & You* which is mailed to Medicare beneficiary households each fall and to new Medicare beneficiaries when they become eligible for the coverage. It is also available by calling the **Medicare toll-free number, 1-800-MEDICARE (1-800-633-4227), TTY/TDD 1-877-486-2048**.

This booklet is issued for the purpose of general information. Certain limitations, exceptions and special cases are not covered.

WHAT'S NEW IN MEDICARE?

On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003. This law adds new prescription drug and preventive benefits and provides extra help to people with low incomes.

Medicare-Approved Drug Discount Cards are being made available starting June 2004 to help you save on prescription drugs. Medicare is contracting with private companies to offer the drug discount cards which will bear a Medicare-approved seal. Voluntary enrollment began May 2004 and continues through December 31, 2005.

People in the greatest need will have the greatest help available to them. If your income in 2004 was less than $12,569 for a single person or less than $16,862 for a married couple, you might also qualify for a $600 credit on your discount card to help pay for your prescription drugs. (You can't qualify for the $600 if you already have drug coverage from Medicaid, TRICARE for Life or an employer group health plan.)

Beginning in 2006, the drug discount cards will be replaced by a voluntary prescription drug benefit under which all persons eligible for Medicare would pay a monthly premium for cover-

age in helping them purchase prescription drugs.

Also, Medicare Advantage has become the new name for Medicare + Choice plans, which provide optional health service plans. Whether you choose to enroll in the Original Medicare Plan or in these new options, you are still in the Medicare program.

Preventive benefits coverage will expand in 2005 to include: a one-time initial wellness physical examination; screening blood tests for early detection of cardiovascular diseases; and diabetes screening tests for people at risk of diabetes.

For the latest information about changes to the Medicare program, visit www.medicare.gov on the Internet or call 1-800-MEDICARE (1-800-633-4227).

WHAT IS MEDICARE?

Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under age 65, and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care.

Medicare is financed by a portion of railroad retirement tier I and social security payroll taxes paid by employees and employers. It is also financed in part by monthly premiums paid by enrollees.

The Centers for Medicare & Medicaid Services (CMS) is the agency in charge of the Medicare program. But the Railroad Retirement Board enrolls railroad retirement beneficiaries in the program, deducts Medicare medical insurance premiums from monthly benefit payments, and assists in certain other ways.

Medicare Has Two Parts

- Hospital Insurance (also called Medicare "Part A"), which helps pay for inpatient care in hospitals and skilled nursing facilities, some home health care, and hospice care; and

- Medical Insurance (also called Medicare "Part B"), which helps pay for doctors' services, outpatient hospital care, and other medical services such as diagnostic tests and outpatient occupational and physical therapy.

A Word About Medicaid

You may think that Medicaid and Medicare are two different names for the same program. Actually, they are two different programs. Medicaid is a State-run program designed primarily to help those with low income and little or no resources. The Federal Government

helps pay for Medicaid, but each State has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid.

For more information about the Medicaid program, contact your State medical assistance office. You can get the telephone number for your State medical assistance office by calling the Medicare toll-free number, 1-800-MEDICARE (1-800-633-4227), TTY/TDD 1-877-486-2048 for the hearing and/or speech impaired. You can also go to www.medicare.gov on the Internet, click on "Helpful Contacts," and search for your State medical assistance office under "Other Health Insurance Programs."

WHO CAN GET MEDICARE?

Hospital Insurance (Part A)

If you are age 65 or older. Most people age 65 or older who are citizens or permanent residents of the United States are eligible for Medicare hospital insurance (Part A) without paying a monthly premium based on their own--or their spouse's--employment. You are eligible at age 65 if you receive or are eligible to receive railroad retirement or social security benefits. (Although the age requirements for some unreduced railroad retirement benefits are rising just like

the social security requirements, beneficiaries are still eligible for Medicare at age 65.)

If you are under age 65. Before age 65, you are eligible for premium-free Medicare hospital insurance if you have been entitled to monthly benefits based on **a total disability** for at least 24 months. (Special rules apply for disabled individuals diagnosed with Amyotrophic Lateral Sclerosis.)

Eligibility for family members. Under certain conditions, your spouse, divorced spouse, surviving divorced spouse, widow or widower, or a dependent parent may be eligible for hospital insurance when he or she turns age 65, based on your work record.

Also, disabled widows and widowers under age 65, disabled surviving divorced spouses under age 65, and disabled children may be eligible for Medicare, usually after a 24-month qualifying period.

If you have permanent kidney failure. If you have permanent kidney failure, you are eligible for free Medicare hospital insurance at any age. This is true if you receive maintenance dialysis or a kidney transplant and you are eligible for or are receiving monthly benefits under the railroad retirement or social security system.

In addition, your spouse, divorced spouse or child may be eligible, based on your work record, if she or he has permanent kidney failure and receives maintenance dialysis or a kidney transplant.

Medical Insurance (Part B)

Anyone who is eligible for Medicare hospital insurance (Part A) can enroll in Medicare medical insurance (Part B) by paying a monthly premium. The basic monthly premium in 2004 is $66.60 and will increase from year to year.

How Much Does Medicare Cost?

In addition to the monthly premiums you pay, there are other "out-of-pocket" costs for Medicare, which may also change each year. These are the amounts you pay when you actually receive medical services, known as "deductibles" and "coinsurance."

For example, if you are hospitalized, you will be required to pay a deductible amount, and may have to pay coinsurance amounts, depending on how long you stay. In 2004, the hospital insurance deductible amount is $876. If you receive medical services from a doctor, you pay a yearly deductible amount as well as a coinsurance amount for each visit. In 2004, the medical insurance deductible is $100.

You can find more information on these Medicare charges by calling the Medicare tool-free number 1-800-MEDICARE (1-800-633-4227).

SIGNING UP FOR MEDICARE

If you're already getting railroad retirement or social security benefits, you will be contacted a few months before you become eligible for Medicare and given information about the Medicare program. You will automatically be enrolled in Medicare Parts A and B. However, because you must pay a premium for Part B coverage, you have the option of turning it down.

If you aren't already getting benefits, you should contact your local Board office about 3 months before your 65th birthday to sign up for Medicare. You can sign up for Medicare even if you don't plan to retire at age 65.

You should also contact us about applying for Medicare if:

- you're a disabled widow or widower between age 50 and age 65 but haven't applied for disability benefits because you're already getting another kind of benefit;

- you had Medicare medical insurance in the past but dropped the coverage;

- you turned down Medicare medical insurance when you became entitled to hospital insurance; or

- you, your spouse, or your dependent child has permanent kidney failure. (Contact a social security office in these cases to see if you are eligible.)

Initial Enrollment Period

When you first become eligible for hospital insurance (Part A), you have a 7-month period to sign up for medical insurance (Part B). This is called your "initial enrollment period." If you are eligible at age 65, your initial enrollment period begins 3 months before your 65th birthday, includes the month you turn age 65, and ends 3 months after that birthday. If you are eligible for Medicare based on disability or permanent kidney failure, your initial enrollment period depends on the date your disability or treatment began.

If you already receive retirement or disability benefits, you will be automatically enrolled in Part B when you become entitled to Part A. However, because you must pay a premium for Part B coverage, you have the option of paying for the coverage or turning it down.

When does my enrollment in Part B become effective? If you accept the automatic enrollment in Medicare Part B, or if you enroll in Medicare Part B during the first 3 months of your

initial enrollment period, your medical insurance protection will start with the month you are first eligible. If you enroll during the last 4 months, your protection will start from 1 to 3 months after you enroll.

General Enrollment Period

If you don't enroll in Medicare Part B during your initial enrollment period, you have another chance each year to sign up during a "general enrollment period" from January 1 through March 31. Your coverage begins the following July. **However, your monthly premium increases 10 percent for each 12-month period you were eligible but didn't enroll.**

Special Enrollment Period

For People Who Have Employer Group Health Plans. A "special enrollment period" is available if you are eligible for Medicare and waited to enroll in Medicare Part B because you or your spouse were working and had group health plan coverage, through an employer or union, based on this current employment. If this applies to you, you can sign up for Medicare Part B:

- any time you are still covered by an employer or union group health plan, through your or your spouse's current employment, or

- during the eight months following the month that the employer or union group health plan coverage ends, or when the employment ends (whichever is first).

If you are disabled and working (or have group health plan coverage from a working family member), the Medicare special enrollment period rules may also apply.

If you are still working and plan to keep your employer's group health plan coverage or your employment has ended, but you can keep your employer's group health plan coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), *you should talk to your benefits administrator or your State Health Insurance Assistance Program to help you decide the best time to enroll in Medicare Part B*. You can get the telephone number of the program in your State from the Medicare toll-free number, 1-800-MEDICARE (1-800-633-427). Or you can go to www.medicare.gov, click on "Helpful Contacts" and then "General Medicare Information."

Special Enrollment Period and Medigap. When you sign up for Medicare Part B, you automatically begin your “Medigap open enrollment period.” (A “Medigap” or Medicare Supplemental Insurance policy is sold by a private insurance company to fill in the gaps in

Medicare coverage. For more details about Medigap policies, see pages 18-19.)

During this 6-month period, you have a right to buy the Medigap policy of your choice regardless of any health problems you may have. The company cannot refuse you a policy or charge you more than other open enrollment applicants. Once your Medigap open enrollment period begins, it can't be changed or restarted.

Remember, most people who sign up for Medicare Part B during a special enrollment period don't pay higher premiums. However, if you are eligible but don't sign up for Medicare Part B during the special enrollment period, you will only be able to sign up during the general enrollment period and the cost of Medicare Part B may go up.

WHAT MEDICARE COVERS

Hospital Insurance (Part A)

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

Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

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

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

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

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

Medical Insurance (Part B)

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

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

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

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

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

Preventive Services. Bone mass measurements, colorectal cancer screening, diabetes services, glaucoma testing, screening mammograms, Pap test and pelvic examination (includes a clinical breast exam), prostate cancer screening, and shots (Flu, Pneumococcal Pneumonia, and Hepatitis B). (In 2005, preventive benefits coverage will expand as described on page 3.)

What is not paid for by the Original Medicare Plan?

The Original Medicare Plan doesn't cover everything. Items and services that aren't covered by Part A or Part B include, but aren't limited to:

- acupuncture;
- deductibles, coinsurance, or copayments when you get health care services;
- dental care and dentures (with only a few exceptions);
- cosmetic surgery;
- custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home;

- health care you get while traveling outside of the United States (except in limited cases);
- hearing aids and hearing exams not ordered by your doctor, or for the purpose of fitting a hearing aid;
- long-term care, such as custodial care in a nursing home;
- orthopedic shoes (with only a few exceptions);
- outpatient prescription drugs (with only a few exceptions);
- routine foot care (with only a few exceptions);
- routine eye care and most eye glasses;
- routine or yearly physical exams;
- screening tests (except those listed on pages 14-15);
- shots (except those listed on page 15);
- some diabetic supplies (like syringes or insulin unless used with an insulin pump);
- virtual colonoscopies.

Medical Insurance Claims

Palmetto GBA, a subsidiary of Blue Cross and Blue Shield of South Carolina, processes medical insurance (Part B) claims for railroad retirement beneficiaries in the Original Medicare Plan. If you are in the Original Medicare Plan, your hospital, doctor, or other health care provider should submit Part B claims directly to:

Palmetto GBA
Railroad Medicare Part B Office
P.O. Box 10066
Augusta, GA 30999-0001

If you have questions about Part B claims under the Original Medicare Plan, write to Palmetto GBA at the above address; telephone them toll-free at 1-800-833-4455, (TTY/TDD: 1-877-566-3572); or go to www.palmettogba.com on the Internet, click on "Railroad Medicare" under "Beneficiaries," and select "Contact Us."

OPTIONS FOR RECEIVING HEALTH CARE SERVICES

Medicare beneficiaries may have choices for receiving health care services. What you choose is a personal decision based on your particular health needs. However, you should consider all of the options carefully and decide what is best for you. A well-

informed and well-thought-out decision could save you a lot of money and inconvenience.

Original Medicare Plan

Under the Original Medicare Plan, which is managed by the Federal government and available nationwide, you can visit the hospital, doctor, or health care provider of your choice who accepts Medicare patients. Medicare pays a set percentage of the expenses, and you are responsible for certain deductibles and coinsurance payments--the portion of the bill Medicare does not pay. Because the Original Medicare Plan doesn't pay for all of your health care, you may want to buy a Medicare supplemental insurance or "Medigap" policy.

A Medigap policy is a health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. In all states, except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of 10 standardized policies so you can compare them easily. Each policy has a different set of benefits.

In addition, any standardized policy may be sold as a "Medicare SELECT" policy. Medicare SELECT policies usually cost less because you must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from

the policy. In an emergency, you may use any doctor or hospital.

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

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

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

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

You can get more detailed information about Medigap policies from the publica-

tions *Medigap Policies, The Basics* or *Guide to Health Insurance for People with Medicare*. To get copies, call the Medicare toll-free number 1-800-633-4227 or go to www.medicare.gov on the Internet and click on "Publications."

Medicare Savings Programs can also help people with limited income and resources save money each year. The State-run programs pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance.

To be able to apply, you must have Medicare Part A (hospital insurance), a limited income, and your assets, such as bank accounts, stocks, and bonds, must not be more than $4,000 for a single person or $6,000 for a couple.

To find out if you qualify, contact your State medical assistance office, as described on page 5 of this leaflet.

Medicare Advantage Plans

You can get your coverage through the Original Medicare Plan or Medicare Advantage Plans (formerly known as "Medicare + Choice"). Congress created the Medicare Advantage program to provide you with more choices and, sometimes, extra benefits by letting private companies offer you your Medicare benefits. Medicare pays a set amount of money for your care every month to these private health plans. In turn, the

Medicare Advantage Plan manages the Medicare coverage for its members. If you are in a Medicare Advantage plan, you don't need to buy a Medicare supplemental insurance or "Medigap" policy. If you join a Medicare Advantage Plan, you may have the following choices:

Medicare Managed Care Plans

One available option, which may save you money and provide additional benefits, is joining a managed care plan. The most common plans are health maintenance organizations (HMOs).

Medicare Managed Care Plans that have contracts with the Medicare program must provide all hospital and medical benefits covered by Medicare. However, usually you must obtain services from your Managed Care Plan's network of health care providers (doctors, hospitals, skilled nursing facilities, for example). In most cases, neither the Managed Care Plan nor Medicare will pay for services not authorized by your Managed Care Plan (except emergency services or services urgently required while you are out of the Managed Care Plan's service area).

Each Managed Care Plan that has a contract with Medicare gets paid every month for services it provides to you. As a Medicare Managed Care Plan member, you will have to enroll in Medicare Part B. You may also have to continue to pay

some or all of your Part B monthly premium.

Many Managed Care Plans that have contracts with Medicare also provide benefits beyond those Medicare pays for. The benefits may vary by Managed Care Plan and you'll need to read the individual descriptions to determine which benefits are offered by each.

Preferred Provider Plan

A Medicare Preferred Provider Organization Plan (PPO) works with many of the same rules as Medicare Managed Care Plans; however, in a PPO you don't need referrals to see a specialist although you may have to get plan approval before getting certain services. In a PPO you can see any doctor or provider that accepts Medicare (in most cases). However, if you go to doctors, hospitals, or other providers who aren't part of the plan ("out of network" or "nonpreferred"), it may cost extra.

Private Fee-for-Service Plan

This is a health care choice in some areas of the country. A Private Fee-for-Service Plan is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan, which is offered by the Federal government. In a Private Fee-for-Service Plan, Medicare pays a set amount of money every month to the private company. The private company pro-

vides health care coverage to people with Medicare on a pay-per-visit arrangement. The insurance company, rather than the Medicare program, decides how much you pay for the services you get.

Medicare Specialty Plans

Medicare is working to create specialty plans, which are new ways to provide more focused health care for some people. These Medicare specialty plans are designed to give you all your Medicare health care, as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or end-stage renal disease. The goal is to provide your health care in an efficient, effective, high quality manner.

More Information About Other Plans

You can get more information about your health care options from the following publications:

- *Medicare & You*.--This general guide describes the benefits, costs, and health care service options available.

- *Guide to Health Insurance for People with Medicare*.--A guide to how other health insurance plans supplement Medicare and some shopping hints for people looking at those plans.

To get a copy of these, or any other, publications, call the Medicare toll-free number 1-800-633-4227 or go to

www.medicare.gov on the Internet and click on "Publications."

Some publications may instruct you to call or visit an office of the Social Security Administration for assistance. Railroad retirement beneficiaries should contact the nearest Railroad Retirement Board office.

For information on other health care plan options in your area, call the Medicare toll-free number 1-800-633-4227 and ask for a free, up-to-date list of all the plans offered where you live. Or you can go to www.medicare.gov on the Internet and click on "Medicare Personal Plan Finder," where you can also get a summary of your health care options and what each plan in your area offers.

If you need to talk to someone about deciding which plan is right for you, you can call your State Health Insurance Assistance Program and a volunteer counselor will help you. You can get the telephone number of the program in your State by calling the Medicare toll-free number. Or you can go to www.medicare.gov, click on "Helpful Contacts" and then "General Medicare Information."

Need More Information?

Railroad retirement beneficiaries should contact the nearest Railroad Retirement Board office for general information on their Medicare coverage. They can also use the Board's automated toll-free number and Web site or Medicare's information sources as described on the back cover of this leaflet.

NONDISCRIMINATION ON THE BASIS OF DISABILITY

Under Section 504 of the Rehabilitation Act of 1973 and Railroad Retirement Board regulations, no qualified person may be discriminated against on the basis of disability. The Board's programs and activities must be accessible to all qualified applicants and beneficiaries, including those with impaired vision and/or hearing. Individuals with disabilities needing assistance (including auxiliary aids or program information in accessible formats) should contact the nearest Board office. Complaints of alleged discrimination by the Board on the basis of disability must be filed within 90 days in writing with the Director of Administration, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-2092. Questions about individual rights under this regulation may be directed to the Board's Director of Equal Opportunity at the above address.

FRAUD AND ABUSE HOT LINE

Call the toll-free Hot Line if you have reason to believe that someone is receiving railroad retirement or unemployment-sickness benefits to which he or she is not entitled; that a person responsible for the financial affairs of a minor or other benefit recipients who are unable to manage their own affairs is misappropriating benefits; or that a doctor, hospital or other provider of health care services is performing unnecessary or inappropriate services or billing Medicare for services not provided.

You may also use the Hot Line to report any suspected misconduct by a Railroad Retirement Board employee. The Hot Line has been installed by the Railroad Retirement Board's Inspector General to receive any evidence of such fraud or abuse of the Board's benefit programs. The toll-free Hot Line number nationwide is 1-800-772-4258. You may send your complaints in writing to RRB, OIG, Hot Line Officer, 844 North Rush Street, Chicago, Illinois 60611-2092 or via e-mail at hotline@oig.rrb.gov. Please do not call or write the Inspector General's Hot Line with questions about eligibility requirements, delayed payments, or similar problems. Such matters should be directed to the nearest Railroad Retirement Board office.

Railroad Retirement Board Help Line and Web Site

1-800-808-0772
www.rrb.gov

The Railroad Retirement Board's toll-free automated Help Line is available at 1-800-808-0772. Callers can find the address and telephone number for the field office serving their area and listen to special announcements about the benefit programs administered by the agency. Railroad Medicare beneficiaries can request a replacement Medicare card. Retirees can call the Help Line to request a letter showing their current monthly benefit rate. Active railroad employees can use the Help Line to request a statement of their creditable railroad service and compensation and information on unemployment-sickness claims is available. *The Help Line is available 24 hours a day, 7 days a week.*

Most of these services and others, including online railroad retirement annuity estimates, are also available on the Board's Web site at www.rrb.gov. In addition, the Web site has information about benefit requirements, customer service standards and other topics of interest. Many Board publications are available for viewing and downloading.

Medicare Toll-Free Number and Web Site

1-800-MEDICARE (1-800-633-4227)
TTY/TDD 1-877-486-2048
www.medicare.gov

Call the Medicare toll-free number or look on the Web site to get help with your Medicare questions.

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