Physician Edition

Medicare & You

2004

This is the official government handbook with important information about:

- Your Medicare benefits.
- Choosing a health plan that's right for you.
- Your Medicare privacy rights.

Medicare is here for you 24 hours a day, every day.

- Visit www.medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227)

Welcome to Medicare & You!

The Medicare program is working directly with physicians towards a common goal, high quality medical care for over 40 million Medicare beneficiaries. Every year the Centers for Medicare & Medicaid Services (CMS) develops new policies that affect physicians. By establishing ways to gather considerable input from practicing physicians from around the country, CMS can continually review agency policies and procedures affecting physicians with a view toward streamlining, simplifying and clarifying them. We are increasing physician education and outreach and this special supplement is just one example. We are committed to working more closely and collegially with you to facilitate your relationship with Medicare, including addressing billing questions or errors.

The Administration has placed increased emphasis on a culture of responsiveness, fiscal responsibility and ensuring that Medicare consumers are properly educated. The ever-increasing complexity of the Medicare program necessitates an increase in the informational and educational resources for physicians. CMS is actively working to give Medicare's 1.2 million providers, physicians, and suppliers the information they need to understand the Medicare program and to keep current of changes, and to bill correctly. We strive to accomplish this goal by using a variety of information delivery systems, partnerships, and educational products and services.

Our goal is to make the Medicare program truly supportive of you as you provide care to people with Medicare. We hope you find your Physician Edition of the Medicare & You Handbook to be a useful resource.

"Medlearn Matters…Information for Medicare Providers"

http://www.cms.hhs.gov/medlearn/matters

The Centers for Medicare & Medicaid Services (CMS) has added a new web page called "Medlearn Matters…Information for Medicare Providers". This web page is where CMS has centralized all change request-related outreach materials and "Special Edition" articles, unrelated to change requests. The "Medlearn Matters…Information for Medicare Providers" articles are designed to help providers understand new or changed Medicare policy. The table located on this web page, contains links to each article and its corresponding Program instructions, if applicable.

Physicians Information Resource for Medicare

http://www.cms.hhs.gov/physicians

The Centers for Medicare & Medicaid Services (CMS) has expanded and improved CMS' Website for physicians to make it quicker and simpler to access valuable information that will help you better service Medicare beneficiaries. The information found on the website is focused on the information needs and interests of Medicare physicians and other practitioners. The website contains links to many sites of interest to physicians including the Physicians Regulatory Issues Team (PRIT) page which supports exchange of ideas and issues of special interest to physicians and links to information on federal regulations and notices, training and educational activities, enrollment and coverage issues.

Provider Audience Pages

CMS provides customized provider audience pages to assist unique provider types in obtaining relevant 'specialty' information more quickly and to obtain general Medicare information of interest to all providers: *http://www.cms.hhs.gov/providers*

Practice Administration Information Resource for Medicare

http://www.cms.hhs.gov/providers/pair

This web resource page was designed with recommendations from the Medicare Group Management Association (MGMA). This resource contains information for private practice providers and their administrative staff.

Therapy Resources

http://www.cms.hhs.gov/medlearn/therapy

This web resource page includes information about physical therapy, occupational therapy, speech-language pathology, and audiology.

Medicare Ambulance Services

http://www.cms.hhs.gov/suppliers/ambulance

Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS)
http://www.cms.hhs.gov/suppliers/dmepos

Hospitals
http://www.cms.hhs.gov/providers/hopital.asp

Medicare Health Plans
http://www.cms.hhs.gov/healthplans

Medicare Home Health
http://www.cms.hhs.gov/providers/hha

Medicare Hospice
http://www.cms.hhs.gov/providers/hospiceps

Medicare News

For Immediate Release:	Contact:
Thursday, October 30, 2003	CMS Office of Public Affairs 202-690-6145
For questions about Medicare please call 1-800-MEDICARE or visit *http://www.medicare.gov*	

MEDICARE ANNOUNCES 2004 PHYSICIAN FEE SCHEDULE AND PAYMENT POLICY CHANGES

The Centers for Medicare & Medicaid Services (CMS) announced today a final rule that will update payment rates under the Medicare physician fee schedule for 2004 and revise a number of other policies affecting Medicare Part B payments under the fee schedule.

The fee schedule contains payment rates for physicians and other providers for more than 7,000 health care services and procedures, ranging from simple office visits to complex surgery. In calendar year 2004, Medicare is expected to pay approximately $48.8 billion to 900,000 physicians and medical professionals for services paid under the fee schedule, up from a projected $48.0 billion in 2003.

The physician fee schedule is updated on an annual basis according to a formula specified by statute that is intended to control the rate of growth in spending for physician services. The formula requires CMS to adjust the update up or down depending on how actual expenditures compare to a target rate, called the sustainable growth rate or "SGR." The SGR, in turn, is calculated based on medical inflation, the projected growth in the domestic economy, increases in the number of beneficiaries in fee-for-service Medicare, and changes in law or regulation.

In 2002, the number of services provided by physicians grew dramatically. The result is an update for 2004 of negative 4.5 percent, though actual spending will rise 1.7 percent.

"The Medicare reform package now pending before Congress contains a provision that would adjust these payments for 2004," said CMS Administrator Tom Scully. "However, CMS has no option other than to base this final rule on the current law. If Congress does pass legislation improving payments to physicians, CMS will implement the new payment rates as quickly as possible."

CMS is adopting several changes to the Medicare payment methodology in 2004. These include rebasing and revising the Medicare Economic Index (MEI), which measures inflation in physician practice costs

and general wage levels. The MEI is one of the key components used to update physician payment rates. First, CMS is changing the base year used to determine the structure of costs for physician practices from 1996 to 2000. CMS is also changing the data sources, cost categories and price proxies used in the MEI.

To address concerns about rising premiums for professional liability (or medical malpractice) coverage, the MEI revisions will increase the weight given to the costs of the coverage. In addition, CMS will adjust the proportion of Medicare payments attributable to physician work, practice expense and professional liability insurance to match their weights in the MEI. The change will generally benefit surgical and other physician specialties that have high professional liability rates. CMS is also revising the geographic factors that adjust payments to reflect the cost of malpractice insurance to better reimburse physicians affected by local market changes in insurance premiums.

CMS also is creating a number of new codes to improve the way Medicare reimburses physician care for dialysis patients. Medicare currently pays a monthly composite rate to physicians for medical oversight without regard to the patient's condition or the number of times the physician sees the patient. The new codes will base payment to physicians for care of patients with end-stage renal disease (ESRD) on the level of their involvement in patient's treatment. In response to public comments on the proposed rule, CMS substantially revised the payment amounts in this final rule to recognize the greater amount of physician work that nephrologists perform in addition to the face-to-face visits with their patients.

Also in response to public comments, CMS is creating several new codes for the management of home dialysis patients, and separate codes for home dialysis patients who may be hospitalized during the month. These codes will allow physicians to be paid for daily management of a home dialysis patient for the days the patient is not in the hospital.

While CMS is committed to reforming the way Medicare pays physicians for the administration of drugs, as well as for the drugs themselves, this rule does not address these issues. Congress is currently considering legislation that would reform the Medicare Part B drug payment system.

"CMS is engaged in that legislative activity, which we expect to produce significant reform that we will swiftly implement. If Congress does not act in the coming weeks, CMS is prepared to quickly implement a final rule to address both AWP reform and appropriate physician practice expense adjustments," said CMS Administrator Scully.

The final rule will be published in the November 7, 2003 Federal Register, and will become effective January 1, 2004.

Medicare Learning Network

http://www.cms.hhs.gov/medlearn

The Medicare Learning Network is the brand-name for official CMS educational products. These products are available on our Medlearn Website which gives easy access to web-based training courses, written educational materials, CD-ROMs, videos, satellite broadcasts and other training activities for Medicare providers. These educational products cover a variety of topics including the basics of the Medicare program, coding and payment guidelines. Products are available to you free of charge and can be ordered on-line via the Medlearn Website.

Current Medicare Learning Network products include 10 web-based training courses including Medicare Fraud and Abuse, Women's Health, Adult Immunization, and Medicare Home Health Benefit to name a few.

Another useful publication entitled Resident & New Physician Guide: Helping Health Care Professionals Navigate Medicare includes:

- Mandatory claims submission
- Mandatory assignment
- Advanced beneficiary notice
- Claims filing procedures
- Appeals
- Preventive services
- Medicare limiting charge
- E and M
- How to obtain a UPIN

Other Medicare Learning Network educational resources available on the Medlearn Web site are educational quick reference guides, electronic listservs, and links to other important Medicare program information.

Medicare Billing and Coding Information

Medicare Physician Fee Schedule

http://www.cms.hhs.gov/physicians/mpfsapp.asp

This website is designed to provide information on services covered by the Medicare Physician Fee Schedule (MPFS). It provides more than 10,000 physician services, the associated relative value units, a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc).

National Correct Coding Initiative (NCCI)

CMS has made it easier for physicians and other providers to bill properly and be paid promptly for their services to people with Medicare coverage. CMS has posted on its website the automated edits used to identify questionable claims and adjust payments to reflect what would have been paid if the claim had been filed correctly. The edits, known as the National Correct Coding Initiative (NCCI) can be found at *http://www.cms.hhs.gov/physicians/cciedits*, will be updated quarterly and can be used to identify pairs of services that normally should not be billed by the same physician for the same patient on the same day. The NCCI also promotes uniformity among the contractors that process Medicare claims in interpreting Medicare payment policies. Until recently, the NCCI edits have been available to physicians and other providers on a paid subscription basis, but now they are available to anyone with a personal computer.

If you need help with determining the proper way to code and bill for specific services, or with problem solving, here are some resources.

- Check your Medicare Carrier's Web site *http://www.cms.hhs.gov/contacts/incardir.asp*
  Announcements about educational activities, answers to frequently asked questions, an on-line version of your Carrier Bulletin, information clearing up some areas of concern/confusion and more.

- Contact your Medicare Carrier through a toll-free number
  http://www.cms.hhs.gov/medlearn/tollnums.asp
  The customer service representatives have been trained to provide clear answers to many of your billing questions and may recommend a variety of technical educational products that will provide you with more detailed information. Customer service representatives can also refer you to the carrier's medical director.

- Contact your Regional Office for the Centers for Medicare & Medicaid Services
  http://www.cms.hhs.gov/about/regions/professionals.asp
  In ten regional offices located across the country, we work with physicians, their professional associations, beneficiaries and others to assure that the program runs smoothly. These offices work closely with the Carriers. Many of these offices have physicians serving as Chief Medical Officers.

- Contact Your Professional Association. Ask that they work with us.
  We value the input we receive from your associations, because they can aggregate your individual concerns and communicate these to CMS. This can lead to the identification of systemic problems or policy flaws, allowing us to correct them in a timely way.

Medicare National and Local Coverage Information

Medicare Coverage Database

Information on National and local coverage can be accessed through our Medicare Coverage Database
http://www.cms.hhs.gov/coverage/default.asp

This database allows you to search for the following four types of policies:

- National Coverage Determinations: Set forth Medicare coverage of specific services, procedures and technologies on a national basis.
- National Coverage Analyses: Contains the documents that support the national coverage determination process.
- Local Medical Review Policies: Assist providers, physicians and suppliers in submitting correct payment claims.
- LMRP Articles: Address local coverage, coding, and medical review related billing issues.

Additional information can be found at the following websites:

Contacts

Contact Us Resource – Submit questions related to Medicare coverage.
http://www.cms.hhs.gov/coverage/8c2.asp

E-Mail Subscriptions – Receive regular updates about what's new in Medicare Coverage.
http://www.cms.hhs.gov/coverage/listserv.asp

Contractors

Fiscal Intermediary Contacts: Alphabetical listing of Fiscal Intermediaries who process both Part A and some Part B claims.
http://www.cms.hhs.gov/mcd/index_contacts.asp?

Carrier Contacts – Alphabetical Listing of Carriers who process most Part B claims.
http://www.cms.hhs.gov/mcd/index_contacts.asp?orgtype=A

Contractor Web sites – Alphabetical listing of Part A and B contractor websites.

Quarterly Provider Update

http://www.cms.hhs.gov/providerupdate

This update lists all non-regulatory changes to Medicare including Program Memoranda, Manual changes, and other instructions affecting providers on a quarterly basis. The Quarterly Provider Update also lists the regulations and instructions from the previous quarter. A listserv is also available so you can receive notification when regulations and program instructions are added throughout the quarter.

Medicare Medicaid Program Instructions

http://www.cms.hhs.gov/manuals/cmsindex.asp

Program instructions are day-to-day operating instructions, policies and procedures based on statutes and regulations, guidelines, models, and directives. They are used by CMS program components, contractors, and State survey agencies to administer CMS programs. For many others, they are a good source of technical and professional information about the Medicare and Medicaid programs.

Instructions found on this site are included in manuals, transmittals, and program memoranda. CMS manuals are currently undergoing a transformation. As we update manual instructions, we move the updated material into the new CMS Manual System and eliminate the corresponding material from the outgoing paper-based manuals. We will continue this phase-out/phase-in process until all manual instructions are included in the CMS Manual System. In the meantime, you should check both sets of manuals for current policy and procedures.

Open Door Initiative

http://www.cms.hhs.gov/opendoor

The open door forums open the doors of the agency to better hear and interact with those beneficiaries, providers, and other stakeholders interested in the delivery of quality healthcare for our nation's seniors.

The current open door forums are listed below.

- Ambulance
- Beneficiary disabilities
- Beneficiary Diversity
- ESRD/Clinical Laboratories
- Health Plans
- Home Health/Hospice/Durable Medical Equipment
- Hospitals
- Low-Income Health Access
- New Freedom Initiative
- Nurses & Allied Health Professionals
- Nursing Homes/Long Term Care
- Pharmaceutical, Pharmacy and Device Manufactures
- Physicians
- Rural Health

Practicing Physicians Advisory Council (PPAC)

http://www.cms.hhs.gov/faca/ppac

The Practicing Physicians Advisory Council (PPAC) is a Congressionally mandated council that meets quarterly to advise the HHS Secretary and CMS Administrator on Medicare issues that affect physicians.

Medicare Summary Notice (MSN)

A Medicare Summary Notice (MSN) is a notice sent to Medicare beneficiaries that explains how much they could be billed for services provided to them. A detailed explanation of how to read an MSN is available in the Medicare & You 2004 handbook on page 36.

Medicare Preventive Services

Information on Medicare preventive services is available in the Medicare Resident and New Physician Guide (*http://www.cms.hhs.gov/medlearn*) and the Medicare & You 2004 handbook.

Beneficiary Notices Initiative

http://www.cms.hhs.gov/medicare/bni

The purpose of the CMS Beneficiary Notices Initiative [BNI] is to wed consumer rights and protections with effective beneficiary communication so that beneficiaries are given the opportunity to timely exercise their rights and protections in a well-informed manner. These rights and protections are both statutorily & regulatorily mandated, as well as by Executive Order, and are enunciated in various venues and formats, such as providers' Conditions of Participation, the President's Consumer Bill of Rights & Responsibilities, Privacy Act Statements, and statements of non-discrimination (the Civil Rights Act).

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
http://www.cms.hhs.gov/hipaa

This website will provide you with information regarding HIPAA and its implementation. Also check your Carrier or Fiscal Intermediary websites for important HIPAA information.

HIPAA Administrative Simplification Information Series for Providers
http://www.cms.hhs.gov/hipaa/hipaa2/education/default.asp

CMS Electronic Listservs
http://www.cms.hhs.gov/medlearn/listserv.asp

Available listservs include:

- Ambulance Fee Schedule
- Ambulatory Surgical Centers
- Community Mental Health Centers
- Clinical Trials
- Coverage Policies
- End Stage Renal Disease
- Federally Qualified Health Centers
- Home Health
- HIPAA
- Hospital Outpatient PPS
- Inpatient Rehabilitation Facility
- Long Term Care Hospitals
- Medlearn Educational Products
- Physicians
- Medicare Prospective Payment System
- Pricer
- Rural Health
- Hospice/Comprehensive Outpatient Rehabilitation Facilities PPS
- Resident Training

Interactive Databases

CMS hosts a website dedicated to beneficiary information at *http://www.medicare.gov* . Interactive Databases that may be of interest to physicians are listed below:

Participating Physician Directory

Identifies U.S. physicians accepting Medicare payment rates. If a physician identifies his/her information contained in this directory is incorrect, the physician can send an email through the feedback tool found under the Participating Physician Directory "note" tab.
http://63.240.208.221/Physician/Search/PhysicianSearch.asp

Supplier Directory

Contact information on Medicare Participating Suppliers.
http://www.medicare.gov/Supplier/Home.asp

Prescription Drug and Other Assistance Programs

Programs offering discounts or free medication to patients in need. May require a physician to apply of behalf of the patient.
http://www.medicare.gov/AssistancePrograms/home.asp?version=default&browser=IE%7C6%7CWin2000&language=English&defaultstatus=0&pagelist=Home

Nursing Home Compare

Inspection reports on every Medicare and Medicaid certified nursing home in the country. Based on State Survey data.
http://www.medicare.gov/NHCompare/home.asp

Medicare Personal Plan Finder

Helps a patient narrow down their Medicare health plan choices and choose the plan that's best for them.
http://63.240.208.220/MPPF/DefaultVersion/home.asp?version=default&browser=IE%7C6%7CWin2000&language=English&year=2004&defaultstatus=1&pagelist=Home

Helpful Contacts

Local contact information to allow patients to find additional help (and/or counseling).
http://www.medicare.gov/Contacts/Home.asp

Dialysis Compare

Facility characteristics (location, number of stations, hours of operation) and quality measures.
http://www.medicare.gov/Dialysis/Home.asp

Medicare Eligibility Tool

Medicare patients can determine their Medicare eligibility and enrollment status.
http://www.medicare.gov/MedicareEligibility/home.asp?version=default&browser=IE%7C6%7CWin2000&language=English

Help your patients get Medicare Information

Always feel free to refer you Medicare patient to the Medicare Beneficiary Toll Free Line 1-800-MEDICARE.

Customer service representatives are available 24 hours a day, 7 days a week at *1-800-MEDICARE (1-800-633-4227)* in English and Spanish. TTY/TTD: *1-877-486-2048* for the hearing and speech impaired.

Medicare Information to Distribute from your Office

When people with Medicare and their caregivers are asked where they would like to get Medicare information, they say their physician's office. Physicians have a unique relationship with their patients. We appreciate the role physicians often play in helping their Medicare patients get information. You can order booklets, free of charge, about many issues including Medicare's benefits, skilled nursing facility care, hospice care, home health care, dialysis, preventive services, and woman's health. Give them to you Medicare patients and their families when they need specialized care. The Guide to Choosing a Nursing Home is also available and can help people through this difficult decision making process.

To order copies of these and other publications visit
http://www.medicare.gov/Publications/Ordering.asp

or view the publication online or to download a copy of the publication visit
http://www.medicare.gov/Publications/Search/View/ChoosePubCriteria.asp.

Dear Physician:

The Physician Regulatory Issues Team (PRIT) is a team of CMS subject matter experts who work with me to reduce the regulatory burden on physicians (and other practitioners) who participate with the Medicare Program.

As the PRIT Director and a board-certified emergency medicine physician, I am in a unique position to hear and facilitate resolution of your concerns. Responses to recent physician requests have included CMS issued new instructions giving physician offices easy telephone access to information on whether their patient is in Medicare managed care or fee-for-service. CMS has also clarified circumstances in which physicians may co-sign for verbal orders of a colleague. PRIT brought to CMS' attention providers' concerns about the phrase "not medically necessary" in the Advance Beneficiary Notice, which was removed in the revised version. To see the issues that the Physician Regulatory Issues Team (PRIT) is currently working on, visit the PRIT tracking report at *http://www.cms.hhs.gov/physicians/prit/issues.asp* . If you have a Medicare Program issue that you would like PRIT to address, please contact me at *prit@cms.hhs.gov. or call me at 202-236-3338*.

It is my goal to simplify the lives of physicians by the elimination of unnecessary regulation, and help make Medicare participation a pleasure rather than a burden.

Sincerely,

William Rogers, M.D., FACEP
Senior Medical Advisor
Centers for Medicare & Medicaid Services (CMS)

PRIT FOR THE MEDICARE & YOU 2004

The Physicians Regulatory Issues Team, led by Dr. William Rogers, exists solely to advocate for physicians! We are very interested in hearing from providers when they have questions about a Medicare Policy or Regulation. You can learn more about the PRIT by visiting our website at *http://www.cms.hhs.gov/physicians/prit.*

PRIT has addressed a number of issues for physicians, CMS has:

1) Clarified the proper way to code for repeat procedures.

2) Removed the requirement that the postanesthesia visit be performed by the anesthesiologist who administered the anesthetic.

3) Made sure physicians would be paid for administering a medication to a patient even if the physician did not dispense the medication.

4) Permitted any member of a physician's group to sign verbal orders if it is impossible for the ordering physician to do so.

5) Reduced as much as possible the administrative hassles involved in completing the CMN

6) Made it clear that family physicians could be paid for rounding on their patients even though another physician had admitted them.

7) Written new simplified guidelines for documentation of resident supervision.

The PRIT earnestly solicits physician issues. You can reach Dr. Rogers by e-mail at *wrogers@cms.hhs.gov* or by calling *202-236-3338*.

Quality Initiatives

Quality health care for people with Medicare is a high priority for President Bush, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services (CMS). We are committed to assure quality health care for all Americans. Under Secretary Thompson's leadership, CMS has developed various quality improvement efforts.

Home Health Quality Initiative

The Home Health Quality Initiative (HHQI) Phase I began with the publication of home health quality measures for eight states in the Spring of 2003. On May 1, 2003 Secretary Tommy Thompson announced the new Home Health Compare Web site on *www.medicare.gov* . For the first time, home health quality measures are available to consumers to help them choose a home health agency. Home Health Quality Measures are available for home health agencies in Florida, Massachusetts, Missouri, New Mexico, Oregon, South Carolina, West Virginia and Wisconsin on Home Health Compare.

Hospital Quality Initiative (HQI)

http://www.cms.hhs.gov/quality/hospital

CMS has several efforts in progress to provide hospital quality information to consumers and others and improve the care provided by the nation's hospitals. These initiatives build upon previous CMS and QIO strategies to identify illnesses and/or clinical conditions that affect Medicare beneficiaries in order to promote the best medical practices associated with the targeted clinical disorders; prevent or reduce further instances of these selected clinical disorders; and prevent or reduce further instances of these selected clinical disorders; and prevent related complications.

Nursing Home Quality Initiative

http://www.cms.hhs.gov/quality/nhqi/

This page contains links to reports and other documents that describe in more detail the national release and the quality measures for all Medicare and Medicaid certified nursing homes for the national release.

The Department of Health and Human Services' Focus on Diabetes Detection

For a variety of reasons physicians are seeing epidemic numbers of people with diabetes as they care for both young and old patients. It is estimated that there are one million people with undiagnosed diabetes among the 40 million Medicare beneficiaries. In response to the increasing prevalence of diabetes in the United States the Secretary of the Department of Health and Human Services has developed a program, the Diabetes Detection Initiative: Finding the Undiagnosed, which encourages Americans to complete a simple but scientifically validated risk assessment instrument which will identify those adults who require further testing to determine if they have diabetes. This program is being rolled out in November in ten locations in the country. Patients may present to your office with completed surveys and request that you test them for diabetes. Even if the Diabetes Detection Initiative is not yet being conducted in your area, it is important that you assess your patients' risk for diabetes. The Secretary hopes that you will not only perform the appropriate tests but also take this opportunity to educate your patients about healthy lifestyles and weight control. Regular exercise and good diet will contribute to good health even if the tests do not confirm that the patient has diabetes.

Both the patient and your office manager will be concerned about Medicare payments for this testing. As you may know the original law creating the Medicare program states in Section 1862(a)(1)(A) of Title XVIII that "Medicare coverage and payment are only allowed for those services that are considered to be medically reasonable and necessary for the diagnosis and treatment of an illness or injury or to improve the functioning of a malformed body member". This is the law that forbids payment for "screening" i.e. the performance of tests for a disease in the absence of signs or symptoms of that disease.

Laboratory testing of Medicare Beneficiaries is a covered benefit as long as the beneficiary has a sign or symptom that would lead the practitioner to believe that the beneficiary might be suffering from the disease for which the test is ordered. Because of practitioner concerns about the uniform application of this standard the Medicare program, through a process called negotiated rulemaking, came up with a list of signs and symptoms that justify laboratory testing. This list can be found in CFR Vol. 66 No 226 page 58846. The website *www.gpoaccess.gov* allows you to retrieve Volume 66 of the Federal Register page 58846. You will find that the criteria for coverage of blood glucose testing are very generous. There is a long list of ICD 9 codes that will justify testing and it is certain that any Medicare Beneficiary who has a need for diabetes testing will qualify for payment. Even abnormal weight gain ICD-9 783.1 will fulfill the Medicare requirement for payment. Your Medicare Part B carrier is a good source for clarification of coverage issues.

Important Information Before You Read This Handbook

If there are words in this handbook you don't understand:

Throughout this handbook, you will see blue words in the text. You can find definitions of those words in the "Words to Know" section on pages 73-76. Look there to get a brief explanation of what a word in blue means.

If you have Employer or Union Health Coverage:

Call your employer or union before you make any changes to your health coverage. Your employer or union may offer different plans (which may work with your Medicare benefits) from those described in this handbook.
See pages 15-16, 52, and 63 for important information.

If you are a Railroad Retirement Beneficiary:

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

If you need help paying health care costs:

See pages 66-67 for information about state programs that may help pay your Medicare premiums, coinsurance, or deductibles.

If your address changes:

Call the Social Security Administration (SSA) at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

If you got more than one copy of *Medicare & You 2004*:

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

Medicare & You 2004 explains the Medicare program. It is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Important Information Before You Read This Handbook

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

This handbook has valuable information about Medicare and is a good resource. It is good (valid) starting January 1, 2004. Use it in place of any older version you have. Keep it where you can find it if you need it.

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

There are two ways to find the information you need:

1. Look at the **"Table of Contents"** on pages 2-3. This lists topic areas by section, with page numbers.
2. Look at the **"List of Topics"** section on pages 4-6. This is an alphabetical list of specific topics discussed in this handbook, with page numbers. This is the easiest way to find information.

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

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

- Look at www.medicare.gov on the web. This is Medicare's official website. You can find the most up-to-date Medicare information and answers to your questions any time.
- Call 1-800-MEDICARE (1-800-633-4227). This toll-free helpline is available 24 hours a day, seven days a week to answer your questions. You can speak to a Customer Service Representative in English or Spanish. TTY users should call 1-877-486-2048.

We want you to have all the information you need to make the most of the Medicare services you know and trust.

Table of Contents

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If you want a more detailed listing of topics in this handbook, look at pages 4-6.

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

Section 1: List of Topics

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Section 2: What's NEW in Medicare

21st Century Medicare -More Choices, Better Benefits

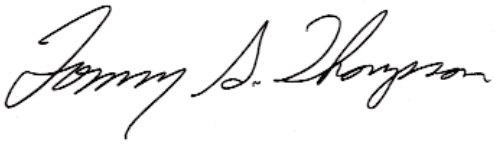
On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003. This new law preserves and strengthens the current Medicare program, adds important new prescription drug and preventive benefits, and provides extra help to people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

Medicare-Approved Drug Discount Cards will be available in 2004 to help you save on prescription drugs. Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare's seal of approval can help you save 10-25% on prescription drugs. You can enroll beginning as early as May 2004 and continuing through December 31, 2005. Enrolling is your choice. Medicare will send you information soon with details about how to enroll.

People in the greatest need will have the greatest help available to them. If your income in 2003 is less than $12,124 for a single person or less than $16,363 for a married couple, you might 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.)

Also new in 2004, Medicare Advantage is the new name for Medicare + Choice plans. Medicare Advantage rules and payments are improved to give you more health plan choices and better benefits. Plan choices might have improved already in your area. If you are happy with the Medicare coverage you have, you can keep it exactly the same. Or, you can choose to enroll in these new options. No matter what you decide, you are still in the Medicare program.

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



Tommy G. Thompson
Secretary
Department of Health and Human Services

Dennis G. Smith
Acting Administrator
Centers for Medicare & Medicaid Services

Section 2: What's NEW in Medicare

New Information for 2004:

Each year, Medicare & You provides important information about your Medicare benefits, your rights, and your health plan choices. The following information is new for *Medicare & You 2004*:

- **A New Way to Get Your Medicare Summary Notices (MSNs)**

  Medicare is testing electronic (on the web) MSNs (see page 35).

- **National Coverage Determinations and Local Medicare Review Policies**

  Information about how Medicare payment decisions are made (see page 40).

- **New Billing Requirements**

  Doctors, suppliers, and providers must send Medicare claims electronically (see page 40).

- **Medicare Specialty Plans**

  New types of focused care, like Disease Management Plans (see page 47).

- **New Rights for Patients in Nursing Homes and Home Health Agencies**

  There is a new "fast-track" appeals process if you think services are ending too soon (see page 56).

- **Generic Drug Message**

  A note about the safety and efficiency of generic drugs (see page 67).

- **A New Way to Get Information**

  1-800-MEDICARE has a new Speech-Automated System for easy access to the information you need (see page 70).

- **The State Health Insurance Assistance Program Telephone Number for Your Local Area**

  Call for free health insurance counseling (see pages 80-82).

The Medicare Program

Medicare is a health insurance program for:

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

Medicare Has Two Parts

Part A Hospital Insurance, see pages 10-11.
Most people pay for Part A through their payroll taxes when they are working.

Part B Medical Insurance, see pages 12-19.
Most people pay monthly for Part B.

Medicare Health Plans

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

- The Original Medicare Plan - Available nationwide.
  For more information, see page 29.
- Medicare + Choice Plans (pronounced "Medicare plus Choice," see page 43), including:
  - Medicare Managed Care Plans (see page 45).
  - Medicare Private Fee-for-Service Plans (see page 46).
  - Medicare Preferred Provider Organization Plans (see page 47).

Medicare + Choice Plans are available in many areas.

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

For help comparing your health plan choices, use the "Medicare Personal Plan Finder" at www.medicare.gov on the web. See page 28 for details. If you don't have a computer, your local senior center or library may be able to help you get this information. You can also call 1-800-MEDICARE (1-800-633-4227) to get this information.

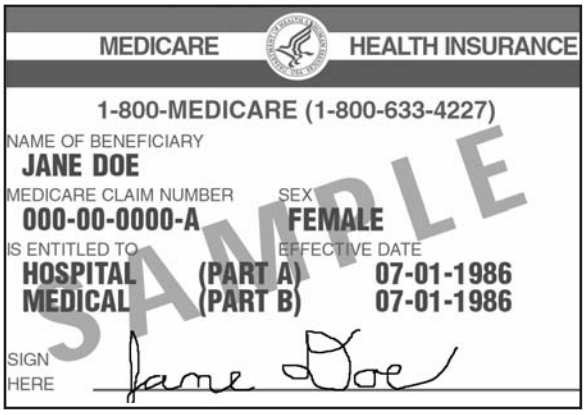
What is Medicare Part A?

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

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

If you (or your spouse) didn't pay Medicare taxes while you worked and you are age 65 or older, you may be able to buy Part A*. If you aren't sure if you have Part A, look on your red, white, and blue Medicare card (see sample card below). If you have Part A, "Hospital (Part A)" is printed on the lower left corner of your card. You can also call the Social Security Administration at 1-800-772-1213 or visit your local Social Security office for more information about buying Part A.

* You may be able to get help from your state to pay this premium (see pages 66-67).



Note: There are earlier versions of this card that are slightly different. They are still valid.

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

Enrolling in (Joining) Part A

If you are already getting benefits from Social Security or the Railroad Retirement Board, you will automatically get Medicare Part A starting the first day of the month you turn age 65. If you are under age 65 and disabled, you will automatically get Medicare Part A after you get Social Security disability or Railroad Retirement benefits for 24 months. If you are close to age 65 and aren't yet getting Social Security or Railroad Retirement benefits, you must apply for Medicare Part A. Call the Social Security Administration at 1-800-772-1213 or visit your local Social Security office for more information.

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

Medicare Part A Helps Cover Your Medically Necessary:

Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care you get in critical access hospitals and mental health care. This doesn't include private duty nursing, or a television or telephone in your room. It also doesn't include a private room, unless medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

Skilled Nursing Facility Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related 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.

Note: Your share of the costs for the services in the Original Medicare Plan is on page 31.

What is Medicare Part B?

Medicare Part B (Medical Insurance) helps cover your doctors' services and outpatient hospital care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary (see pages 17-20).

* You may be able to get help from your state to pay this premium (see pages 66-67).

Cost: You pay the Medicare Part B premium each month* ($66.60 in 2004). In some cases, this amount may be higher if you didn't sign up for Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but didn't sign up for it, except in special cases (see Special Enrollment Period on page 15). You will have to pay this extra amount as long as you have Part B.

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

Enrolling in (Joining) Part B

** You have to be disabled for five full calendar months in a row to qualify for Social Security disability benefits.

Enrolling in Part B is your choice. If you already get Social Security or Railroad Retirement benefits, you are automatically enrolled in Part B starting the first day of the month you turn age 65. If you are under age 65 and disabled, you are automatically enrolled in Part B after you get Social Security or Railroad Retirement benefits for 24 months**. Your Medicare card (see sample card on page 10) will be mailed to you about three months before your 65th birthday or your 25th month of disability benefits. **If you don't want Medicare Part B, follow the instructions that come with your Medicare card.**

Enrolling in (Joining) Part B (continued)

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

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

1. Initial Enrollment Period (see below)
2. General Enrollment Period (see page 14)
3. Special Enrollment Period (see page 15)

1. Initial Enrollment Period

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

- Begins three months before the month you turn age 65.
- Ends three months after the month you turn age 65.

Note: Start date for Medicare Part B may be delayed if you wait until you are 65 or sign up during the last three months of your Initial Enrollment Period.

To apply, you can visit your local Social Security office or call Social Security at 1-800-772-1213. You may be able to apply at www.socialsecurity.gov on the web if you meet certain conditions. If you are a railroad employee or railroad retirement beneficiary, call your local RRB office or 1-800-808-0772 to apply.

Note: Information is available at www.medicare.gov on the web to help you make decisions about joining Medicare Part B.

Enrolling in (Joining) Part B (continued)

2. General Enrollment Period

If you didn't sign up for Medicare Part B when you first became eligible, you may sign up during the General Enrollment Period. Below is specific information about the General Enrollment Period:

- The General Enrollment Period runs from January 1 through March 31 of each year.
- Your Medicare Part B coverage will start on July 1 of the year you sign up.
- The cost of Medicare Part B will go up 10% for each 12-month period that you could have had Medicare Part B but didn't take it, except in special cases (see page 15). You will have to pay this extra amount as long as you have Medicare Part B.
- During this time, you can sign up for Medicare Part B at your local Social Security office. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Enrolling in (Joining) Part B (continued)

3. Special Enrollment Period

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

- 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).

Note: If you are still working and plan to keep your employer's group health plan coverage, you should talk to your benefits administrator or your State Health Insurance Assistance Program (see pages 80-82 for their telephone number) to help you decide the best time to enroll in Medicare Part B. When you sign up for Medicare Part B, you automatically begin your Medigap (Medicare Supplement Insurance) open enrollment period. Once your Medigap open enrollment period begins, it can't be changed or restarted. For more details about Medigap policies, see pages 64-65.

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.

Remember, most people who sign up for Medicare Part B during a Special Enrollment Period don't pay higher premiums. However, if you are eligible but don't sign up for Medicare Part B during the Special Enrollment Period, you will only be able to sign up during the General Enrollment Period (see page 14), and the cost of Medicare Part B may go up. For more information about signing up for Medicare Part A and Part B, call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Part B and COBRA Coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a law that lets some people keep their employer group health plan coverage when their employment ends. If you are eligible for COBRA because you have stopped working or because you qualify for other reasons, you should consider enrolling in Part B even if you choose to get COBRA coverage. You **won't** get another Special Enrollment Period when your COBRA coverage ends.

If you are age 65 or older and you choose COBRA coverage, you must sign up for Part B during the first eight months that you have COBRA coverage. If you don't sign up during the eight-month period, you must wait until the next General Enrollment Period (see page 14). You should talk with your State Health Insurance Assistance Program to help decide whether enrolling in COBRA or choosing a Medigap policy is the best choice for you (see pages 80-82 for their telephone number).

If you are under age 65 and receiving disability benefits from Social Security or the Railroad Retirement Board, and you choose COBRA coverage, you should enroll in Part B when you are first eligible.

Part B and Group Health Plan Coverage

If you have Part B and then drop it because you, your spouse, or a family member is working and have group health plan coverage through the employer or union, you can sign up for Part B again during a Special Enrollment Period. It is important to make sure that your group health plan coverage is in effect before you drop Part B. In this case, the cost of Part B won't go up when you get it again. Remember, when you drop Part B, your coverage ends the last day of the next month. Also, if you drop Part B after age 65, you won't get another Medigap open enrollment period when you restart Part B (see pages 64-65).

Part B and TRICARE

If you are a military retiree and you have Medicare Part A but do not have Medicare Part B, you may enroll in Part B without a premium surcharge during a special enrollment period that will continue through December 31, 2004. The special enrollment period will be announced on www.tricare.osd.mil, the TRICARE Web site.

Part B and TRICARE (continued)

If you are a military retiree who enrolled in Medicare Part B in 2001, 2002 or 2003 and you are paying more than $66.60 each month for Part B, you can have the premium surcharge removed by providing evidence that you are covered under TRICARE. The premium surcharge will be removed effective January 1, 2004. Procedures for having the surcharge removed will be announced on www.tricare.osd.mil, the TRICARE Web site.

Medicare Part B Helps Cover Your Medically Necessary:

Medical and Other Services: Doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). 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.

Note: Your share for the costs of the services in the Original Medicare Plan is on page 31.

Preventive Services to Help You Stay Healthy

Medicare Part B Covered Preventive Services	Who is Covered
Bone Mass Measurements: Once every 24 months for qualified individuals and more frequently if medically necessary.	Discuss with your doctor to see if you qualify.
Colorectal Cancer Screening: Fecal Occult Blood Test (FOBT) - Once every 12 months. Flexible Sigmoidoscopy - Once every 48 months. Colonoscopy - Once every 24 months if you are at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy. Barium Enema - Doctor can use this instead of a flexible sigmoidoscopy or colonoscopy. It is covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.	All people with Medicare age 50 and older, except there is no minimum age for having a colonoscopy.
Diabetes Services: Diabetes self-management training.	Certain people with Medicare who are at risk for complications from diabetes. Your doctor or other health care provider must request these services.
Glaucoma Testing: Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.	People with Medicare who are at high risk for glaucoma, including people with diabetes, a family history of glaucoma, or African-Americans age 50 and older.

Preventive Services to Help You Stay Healthy (continued)

Medicare Part B Covered Preventive Services	Who is Covered
Screening Mammograms: Once every 12 months (11 full months must have elapsed from the last screening). Medicare also covers new digital technologies for mammogram screening.	All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.
Pap Test and Pelvic Examination (Includes a clinical breast exam): Once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months.	All women with Medicare.
Prostate Cancer Screening: Digital Rectal Examination - Once every 12 months. Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older (coverage begins the day after your 50th birthday).
Shots (vaccinations):	
Flu Shot* - Once a flu season in the fall or winter.	All people with Medicare.
Pneumococcal Pneumonia Shot - One shot may be all you ever need. Ask your doctor.	All people with Medicare.
Hepatitis B Shot	Certain people with Medicare at medium to high risk for Hepatitis B.

*** Why should I get a flu shot every year?** The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 50 and older. You need a flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect you from the flu for about one year. There is a chance that you may still get the flu, but your symptoms will be less severe.

Medicare Also Helps Cover:

- Ambulance services when other transportation would endanger your health (see page 21).
- Artificial eyes.
- Artificial limbs that are prosthetic devices, and their replacement parts.
- Braces - arm, leg, back, and neck.
- Chiropractic services (limited), for manipulation of the spine to correct a subluxation.
- Emergency care (see page 22).
- Eyeglasses - one pair of standard frames after cataract surgery with an intraocular lens.
- Foot exams if you have diabetes-related nerve damage and meet certain conditions.
- Hearing and balance exams if ordered by your doctor to see if medical treatment is needed.
- Oral immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Kidney dialysis.
- Medical nutrition therapy services for people who have diabetes or kidney disease (unless you are on dialysis) with a doctor's referral. The medical nutrition therapy services will be covered for three years after the kidney transplant.
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.
- Outpatient prescription drugs (very limited). For example, some oral drugs for cancer.
- Preventive services (see pages 18-19).
- Prosthetic/orthotic devices, including breast prosthesis after mastectomy.
- Second surgical opinion by a doctor (in some cases).
- Services of practitioners such as clinical social workers, physician assistants, and nurse practitioners.
- Telemedicine services in some rural areas.
- Therapeutic shoes for people with diabetes (in some cases).
- Transplants - heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions and in Medicare-certified facilities only).
- X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests.

Medicare Coverage for Common Services and Items

Below and pages 22-23 list specific services and supplies that people with Medicare often need. On the right side is a description of what Medicare does and doesn't cover for each item. If a service or supply isn't listed, call 1-800-MEDICARE (1-800-633-4227) for information about the type of service or supply you need. TTY users should call 1-877-486-2048. You can also find out what Medicare covers by looking at www.medicare.gov on the web. Select "Your Medicare Coverage."

Ambulance Services

Look on page 72 for details about how to get a free copy of *Medicare Coverage of Ambulance Services* (CMS Pub. No. 11021).

Medicare covers ambulance services when you must be taken to a hospital or skilled nursing facility and transportation in any other vehicle would endanger your health. Medicare pays for the ambulance mileage to the nearest hospital or skilled nursing facility that provides the services you need.

Clinical Trials

Look on page 72 for details about how to get a free copy of *Medicare & Clinical Trials* (CMS Pub. No. 02226).

Medicare pays for routine costs if you take part in a qualifying clinical trial. Medicare doesn't cover the cost of the experimental care. Clinical trials test new types of medical care, like how well a new cancer drug works. Clinical trials help doctors and researchers see if the new care works and if it is safe. It is important for you to ask what costs you will have to pay before signing up for a clinical trial.

Dental Services

Medicare doesn't cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures. Medicare Part A will pay for certain dental services that you get when you are in the hospital. Call your local Fiscal Intermediary for more information (see page 78). Some Medicare + Choice Plans may offer additional dental coverage.

Diabetic Supplies

Look on page 72 for details about how to get a free copy of *Medicare Coverage of Diabetic Supplies & Services* (CMS Pub. No. 11022).

Medicare covers glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes. There may be limits on supplies or how often you get them. You should ask if the pharmacy or supplier is enrolled in the Medicare program (see page 42).

Note: Syringes or insulin (unless used with an insulin pump) **aren't** covered.

Medicare Coverage for Common Services and Items (continued)

Emergency Care

A medical emergency is when you believe that your health is in serious danger - when every second counts. You may have a bad injury, sudden illness, or an illness quickly getting much worse. (Also see urgently needed care on page 23.)

If you are in the Original Medicare Plan, Part B covers emergency care.

Some Medicare + Choice Plans may have rules that you see only doctors in the plan, but they must allow you to get emergency care whenever you need it from any provider in the United States. Your plan must pay for emergency care and you may have to pay a portion of the cost. If you get a bill, give it to the plan to pay. If your plan doesn't pay for your emergency care, you have the right to appeal (see page 55). Before you get emergency care, you don't need to get permission from your Medicare + Choice Plan or primary care doctor.

Long-term Care

Look on page 72 for details about how to get a free copy of *Medicare Coverage of Skilled Nursing Facility Care* (CMS Pub. No. 10153).

Most long-term care, in a nursing home or at home, is custodial care (help with activities of daily living like bathing, dressing, using the bathroom, and eating). **Medicare doesn't cover this kind of care if this is the only kind of care you need.** Medicare Part A only covers skilled care given in a certified skilled nursing facility or in your home. You must meet certain conditions for Medicare to pay for skilled care when you get out of the hospital.

If you are in a Medicare + Choice Plan, ask your plan about what nursing home services are covered and their costs.

Mental Health Care

Look on page 72 for details about how to get a free copy of *Medicare and Your Mental Health Benefits* (CMS Pub. No. 10184).

Medicare Part A covers inpatient mental health care, including room, meals, nursing, and other related services and supplies. Medicare Part B covers mental health services generally given outside a hospital, including visits with a doctor, clinical psychologist, or clinical social worker, and lab tests. With the exception of lab tests, Medicare pays 50 percent of the costs for outpatient mental health treatment. You pay the other 50 percent.

If you are in a Medicare + Choice Plan, read your plan materials or call the plan to learn about its coverage of mental health care. Medicare + Choice Plans must cover at least the services described above.

Medicare Coverage for Common Services and Items (continued)

Prescription Drugs

The Original Medicare Plan doesn't cover prescription drugs except in a few cases, like certain cancer drugs. If you are eligible to get drugs that are covered, you should ask if the pharmacy is enrolled in the Medicare program (see page 42). If the pharmacy isn't enrolled, Medicare won't pay. Many Medicare + Choice Plans cover prescription drugs, up to certain dollar limits. This may cost extra. Some Medigap policies and state programs like Medicaid also cover prescription drugs. For information about "Prescription Drug and Other Assistance Programs," look at www.medicare.gov on the web (see page 67). You can use this to learn about different ways to get prescription drug coverage, including Medicare + Choice Plans and Medigap policies. You can also call 1-800-MEDICARE (1-800-633-4227) or your State Health Insurance Assistance Program (see pages 80-82 for their telephone number) to get this information.

Travel outside the United States

Look on page 72 for details about how to get a free copy of *Medicare Coverage Outside the U.S.* (CMS Pub. No. 11037).

The Original Medicare Plan doesn't cover health care when you travel outside the United States, except for some emergency situations in Mexico and Canada. Some Medicare + Choice Plans, Medigap policies (see pages 64-65), and the Railroad Retirement Board have different rules. Check your insurance coverage before you travel outside the United States.

Urgently Needed Care

Urgently needed care is care you need for a sudden illness or injury that isn't a medical emergency. (Also see emergency care on page 22.)

The Original Medicare Plan Medicare Part B covers urgently needed care.

In a Medicare Managed Care Plan, you get urgently needed care from your primary care doctor. However, if you are in the United States but out of the plan's service area and can't wait until you return home, your plan must pay for urgently needed care (you may have to pay a portion of the cost). If it doesn't pay, you have the right to appeal (see page 55). In a Medicare Private Fee-for-Service Plan, you can get urgently needed care from any doctor who accepts the terms of the plan's payment. In a Medicare Preferred Provider Organization Plan, you can get urgently needed care from any doctor who accepts Medicare. However, if you go to a doctor who isn't part of the plan, it may cost extra.

An Important Note about Private Contracts

A private contract is a written agreement between you and a doctor who has decided not to give services through the Medicare program. The private contract only applies to the services you get from the doctor (such as a physician, dentist, podiatrist, or optometrist) who asked you to sign it. You can't be asked to sign a private contract in an emergency situation or when you get urgently needed care. If you sign a private contract with your doctor:

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

It's important that you talk with someone in your State Health Insurance Assistance Program before signing a private contract (see pages 80-82 for their telephone number).

Introduction to Medicare Health Plans

Introduction to Health Plan Choices

Today's Medicare is about choice. Medicare is committed to offering you different ways to get your Medicare benefits and giving you the tools you need to make the choice that is best for you. This section will give you some general information about options for getting your Medicare benefits.

The Health Plan Choice You Make Can Mean Additional Coverage

The Original Medicare Plan (explained in detail on pages 29-42) covers most health care services and supplies, but it doesn't cover everything. Most people choose to get some type of additional coverage to pay some of the costs not covered by the Original Medicare Plan. Some people with the Original Medicare Plan (Part A and Part B) buy a Medigap (Medicare Supplement Insurance) policy from a private company to cover some of the "gaps" in the Original Medicare Plan's coverage (see pages 64-65).

Many people with Medicare (Part A and Part B) choose a Medicare + Choice Plan (pronounced "Medicare plus Choice"). Private companies contract with the Medicare program to offer Medicare + Choice Plans (explained in more detail on pages 43-54). If you choose to get your health care from a Medicare + Choice Plan, you are still in Medicare.

How you get your health care in the Medicare program depends on which health plan you choose. Depending on where you live, you may have more than one plan to choose from.

Remember, words in blue are defined on pages 73-76.

Making the Best Choice for You

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

Your choice will affect:

Cost — What will your out-of-pocket costs be? More information about out-of-pocket costs starts on page 30.

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

Doctor Choice — Can you see the doctor(s) you want to see? Do you need a referral to see a specialist?

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

Quality Data to Help You Choose

The Medicare program measures the quality of care that people like you get in Medicare health plans. This information is available to everyone. To compare the quality of care given by the Medicare health plans in your area, go to www.medicare.gov on the web. Select "Medicare Personal Plan Finder." Or, call 1-800-MEDICARE (1-800-633-4227) and ask for information about health plan quality. TTY users should call 1-877-486-2048.

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

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

- Medicare pays for most health care services and supplies, but it doesn't pay for all health care costs.
- You get at least all the Medicare Part A covered services listed on page 11.
- You get at least all the Medicare Part B covered services listed on pages 17-20 if you pay the monthly Part B premium ($66.60 in 2004).

Remember, you must have Medicare Part A and Part B to join a Medicare + Choice Plan.

For more information to help you make your health care choice:

- Learn how each type of health plan works (see pages 45-47).
- Get information on the quality of the health plans in your area (see page 26).
- Learn about other types of coverage like Medigap (Medicare Supplement Insurance) policies, coverage from employers and unions, states, special programs, and for veterans (see pages 63-68).

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

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

Step-by-Step Help for Choosing the Right Plan for You

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

You can get personalized information two ways:

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

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

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

You will need to answer some simple questions, including:

- What parts of Medicare do you have (Part A and/or Part B)?
- What is your age?
- What is your ZIP code?

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

If you want more help choosing a Medicare health plan, call your State Health Insurance Assistance Program (see pages 80-82 for their telephone number). You can get help over the telephone or in person.

Original Medicare Plan

Se

What is the Original Medicare Plan?

The Original Medicare Plan is a "fee-for-service" plan. This means you are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care (see the sample card on page 10). If you are happy getting your health care this way, you don't have to change. You will stay in the Original Medicare Plan unless you choose to join a Medicare + Choice Plan.

How does the Original Medicare Plan work?

- You may go to any doctor or specialist that accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility. Generally, a fee is charged each time you get a health care service.
- If you have Medicare Part A, you get all the Part A covered services listed on page 11.
- If you pay the monthly Medicare Part B premium ($66.60 in 2004), you get all the Part B covered services listed on pages 17-20.
- You pay a set amount for your health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment).
- After you get a health care service, you get a Medicare Summary Notice in the mail (see pages 36-39). This notice is sent by companies that handle bills for Medicare. The notice lists the amount you may be billed.

Remember, words in blue are defined on pages 73-76.

Your costs in the Original Medicare Plan

What you pay out-of-pocket depends on:

- Whether you have Part A and Part B.
- Whether your doctor or supplier agrees to accept "assignment" (see page 42).
- How often you need health care.
- What type of health care you need.
- Whether you choose to get services or supplies not covered by Medicare. In this case, you would pay for these services yourself.
- Whether you have other insurance.

Note: In most cases, Medicare doesn't pay for health care you get while traveling outside of the United States (see page 23).

The charts on the next few pages show what you pay in the Original Medicare Plan. For details about these covered services, see page 11 for Part A and pages 17-20 for Part B.

See pages 63-68 for information about help to cover the costs that the Original Medicare Plan doesn't cover.

Section 5: Original Medicare Plan

Medicare Part A (Hospital Insurance) Helps Pay For:

What YOU Pay in the Original Medicare Plan

(The amounts shown are for 2004. These amounts might change January 1, 2005. For more information on coverage, see page 11.)

Hospital Stays

For each benefit period YOU pay:

- A total of $876 for a hospital stay of 1-60 days.
- $219 per day for days 61-90 of a hospital stay.
- $438 per day for days 91-150 of a hospital stay. (See Lifetime Reserve Days on page 74.)
- All costs for each day beyond 150 days.

Skilled Nursing Facility Care

Look on page 72 for details about how to get a free booklet for more information.

For each benefit period YOU pay:

- Nothing for the first 20 days.
- Up to $109.50 per day for days 21-100.
- All costs beyond the 100th day in the benefit period.

If you have questions about skilled nursing facility care and conditions of coverage, call your Fiscal Intermediary (see page 78).

Home Health Care

Look on page 72 for details about how to get a free booklet for more information.

YOU pay:

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

If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see page 79).

Hospice Care

Look on page 72 for details about how to get a free booklet for more information.

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

If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary (see page 79).

Blood

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

Section 5: Original Medicare Plan

Medicare Part B (Medical Insurance) Helps Pay For:	What YOU Pay in the Original Medicare Plan **(The amounts shown are for 2004. These amounts might change January 1, 2005. For more information on coverage, see pages 17-20.)**
Medical and Other Services	**Each year YOU pay:** ■ $100 deductible (once per calendar year). ■ 20% of Medicare-approved amount after the deductible (if the doctor, provider, or supplier accepts "assignment," see page 42). ■ 20% for all outpatient physical, occupational, and speech-language therapy services. ■ 50% for outpatient mental health care.
Clinical Laboratory Services	**YOU pay** nothing for Medicare-approved services.
Home Health Care Look on page 72 for details about how to get a free booklet for more information.	**YOU pay:** ■ Nothing for Medicare-approved services. ■ 20% of the Medicare-approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see page 79).
Outpatient Hospital Services	**YOU pay** a coinsurance or copayment amount, which may vary according to the service. Look on page 72 for details about how to get a free booklet for more information.
Blood	**YOU pay** for the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

Note: After December 1, 2004 you can find out about new Medicare amounts for 2005. Actual amounts you must pay may be higher if the doctor or supplier doesn't accept assignment, **and you may have to pay the entire charge at the time of service**. Medicare will then send you its share of the charge (see page 42).

If you have general questions about Medicare Part B, call your Medicare Carrier. If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier. To get these telephone numbers, call 1-800-MEDICARE (1-800-633-4227).

Medicare Part B Covered Preventive Services	What YOU pay in the Original Medicare Plan **(For more information on coverage, see pages 18-19.)**
Bone Mass Measurements	20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.
Colorectal Cancer Screening	Nothing for the fecal occult blood test (FOBT). For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount after the yearly Part B deductible if the test is done in a hospital outpatient department. **Note:** Medicare doesn't cover virtual colonoscopies. If you get a virtual colonoscopy, you will have to pay the entire cost for this service.
Diabetes Services	20% of the Medicare-approved amount after the yearly Part B deductible.
Glaucoma Testing	20% of the Medicare-approved amount after the yearly Part B deductible.
Screening Mammograms	20% of the Medicare-approved amount with no Part B deductible.
Pap Test and Pelvic Examination (includes a clinical breast exam)	Nothing for the Pap lab test. For Pap test collection, and pelvic and breast exams, 20% of the Medicare-approved amount (or a copayment amount) with no Part B deductible.
Prostate Cancer Screening	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA (Prostate Specific Antigen) test.
Shots (vaccinations)	Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment (see page 42). For Hepatitis B shots, 20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.

Note: See pages 18-19 for how often you can get these services.

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

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

- Acupuncture.
- Deductibles, coinsurance, or copayments when you get health care services (see the "What YOU Pay" part of the charts on pages 31-33).
- Dental care and dentures (with only a few exceptions).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- Health care you get while traveling outside of the United States (except in limited cases).
- Hearing aids and hearing exams for the purpose of fitting a hearing aid.
- Hearing exams not ordered by your doctor.
- Long-term care, such as custodial care in a nursing home.
- Orthopedic shoes (with only a few exceptions).
- Outpatient prescription drugs (with only a few exceptions).
- Routine foot care (with only a few exceptions).
- Routine eye care and most eyeglasses (see page 20).
- Routine or yearly physical exams.
- Screening tests except those listed on pages 18-19.
- Shots (vaccinations) except those listed on page 19.
- Some diabetic supplies (like syringes or insulin unless it is used with an insulin pump).
- Virtual colonoscopies.

See pages 63-68 for information about help to cover the costs that the Original Medicare Plan doesn't cover.

How are my bills paid in the Original Medicare Plan?

For Part A Services and Some Part B Services:
The provider of the covered service such as a hospital or home health agency sends a claim to your Fiscal Intermediary or your Regional Home Health Intermediary.

For Part B Services and Supplies:
The provider of the covered service or supply sends a claim to your Medicare Carrier or your Durable Medical Equipment Regional Carrier.

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

- Questions about the charges? Call the provider of the service or supply.
- Think a service you got should be covered? You can appeal (see page 55).
- Think the provider is being dishonest? Call the company that sent you the MSN. Their telephone number is on the front of the MSN.

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

NEW SERVICE

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

This service is being tested in some areas to evaluate the benefit of this service before Medicare makes it available for all people with Medicare. To see if e-MSNs are available in your area, look at www.medicare.gov on the web.

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

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice

SAMPLE

1 June 16, 2004

Name 4
Street Address
City, State ZIP Code

CUSTOMER SERVICE INFORMATION 2

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

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

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

5

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

6 This is a summary of claims processed from 5/15/04 through 6/15/04.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

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

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

See page 38 for the rest of the Medicare Summary Notice.
See next page for an explanation of the numbered items 1-15.

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

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

Medicare Summary Notice (continued)

Notes Section: 16

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

Deductible Information: 17

You have now met $44.35 of your $100 Part B deductible for 2004.

General Information: 18

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

Appeals Information - Part B 19

If you disagree with any claims decision on this notice, you can request an appeal by October 2004.

Follow the instructions below:

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

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

3) Sign here_____Phone Number (___)_____

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

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

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

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

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

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

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

New Billing Requirements

New: Doctors, suppliers, and providers must send Medicare claims electronically.

Starting October 16, 2003, in most cases, doctors, suppliers, and providers must send claims electronically to the Medicare Carrier or Fiscal Intermediary for Medicare-covered services or supplies. If Medicare denies any claim because it wasn't sent electronically, the doctor, supplier, or provider can't bill you for these services or supplies. If they bill you, you should:

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

2. Call your Medicare Carrier if your doctor or supplier still doesn't file a Medicare claim electronically after you have called and asked. Your Medicare Carrier will contact the doctor or supplier for you to make the doctor or supplier aware of their responsibility for filing a Medicare claim.

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

How Medicare Decides What's Covered

At times, Medicare makes a national coverage decision about whether a medical service or medical equipment is covered or not after reviewing information about how a service or equipment improves health or helps manage a health problem. If Medicare makes a decision that applies to people with Medicare, it is called a "National Coverage Determination."

The Medical Director at a Fiscal Intermediary or Medicare Carrier sets rules for the way Medicare claims in your local area are reviewed. These rules are also followed to decide whether a claim will be paid or not. These local rules must be consistent, scientific, and meet Medicare's guidelines. In addition, the local rules can't disagree with any existing national coverage determinations. However, they can be different from one area to another. These rules are called "Local Medical Review Policies (LMRP)." You can find out if there is an LMRP for a specific service or supply. Look at www.medicare.gov on the web. Select "Your Medicare Coverage" and the supply or service you need. If you disagree with a local medical review policy, you can appeal (see page 55).

How Medicare Decides What Is Covered (continued)

You can get a list of all the national coverage determinations Medicare made in the previous year. Medicare will also tell you how to get more information on each determination. To see all the national coverage determinations and local medical review policies/local coverage determinations, go to www.cms.hhs.gov/mcd on the web.

How Your Bills Get Paid If You Have Other Health Insurance

Sometimes your other insurance pays your health care bills first and the Original Medicare Plan pays second. Other insurance that may have to pay first includes: employer group health plan coverage under certain conditions, no-fault insurance, liability insurance, black lung benefits, and workers' compensation.

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

It's important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you have questions about who pays first, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. For more information, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). Look on page 72 for details about how to get this booklet.

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

Assignment is an agreement between Medicare and doctors, other health care providers, suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies), and pharmacies. Doctors, providers, suppliers, and pharmacies that agree to accept assignment accept the Medicare-approved amount as payment. You still pay the coinsurance (usually 20% of the approved amount) and deductible amounts. Using doctors and suppliers that accept Medicare assignment can save you money.

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

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

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

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

For more information about assignment, get a free copy of *Does your Doctor or Supplier Accept Assignment?* (CMS Pub. No. 10134). Look on page 72 for details about how to get this booklet. To find physicians and suppliers who participate in Medicare, look at www.medicare.gov on the web. Select "Participating Physician Directory" or "Supplier Directory." You can also call your Medicare Carrier for this information.

Medicare + Choice Plans

What are Medicare + Choice Plans?

You can get your coverage through the Original Medicare Plan or Medicare + Choice Plans (pronounced "Medicare plus Choice"). Congress created the Medicare + Choice program to provide you with more choices and, sometimes, extra benefits by letting private companies offer you your Medicare benefits. If you join a Medicare + Choice Plan, you may have the following choices:

- Medicare Managed Care Plans (see page 45).
  In most of these plans, you can only go to doctors, specialists, or hospitals on the plan's list. This is called the plan's "network." You may also have to choose a primary care doctor and get referrals to see a specialist. You may get extra benefits, like coverage for prescription drugs.

- Medicare Private Fee-for-Service Plans (see page 46).
  If you join one of these plans, you can go to any doctor or hospital that accepts the terms of the plan's payment. The private company, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may get extra benefits, like coverage for prescription drugs or extra days in the hospital.

- Medicare Preferred Provider Organization Plans (PPOs) (see page 47).
  In most of these plans, you use doctors, specialists, and hospitals on the plan's list (network). You can go to doctors, specialists, or hospitals not on the plan's list, but it may cost extra. You don't need referrals to see specialists. You may get extra benefits, like coverage for prescription drugs.

- Medicare Specialty Plans (see page 47).
  These plans provide more focused health care for some people. If you join one of these plans, you get all your Medicare health care as well as more focused care to manage a specific disease or condition.

Remember, words in blue are defined on pages 73-76.

What are Medicare + Choice Plans? (continued)

Medicare + Choice Plans are available in many areas of the country. A company can decide, with Medicare's approval, that a plan will be available to everyone with Medicare in a state, or be open only in certain counties or parts of counties. A company may also choose to offer more than one plan in an area, with different benefits and costs.

Medicare pays a set amount of money for your care every month to these private health plans. In turn, the Medicare + Choice Plan manages the Medicare coverage for its members. If Medicare + Choice Plans are available in your area, and you have Medicare Part A and Part B, you can join one and get your Medicare-covered benefits through the plan (see page 50). The plan may have special rules that you need to follow. You may also have to pay a monthly premium for the extra benefits.

If you join a Medicare + Choice Plan:

- You are still in the Medicare program.
- You still have Medicare rights and protections (see pages 55-56).
- You still get all your regular Medicare-covered services (see pages 11 and 17-20).
- You may be able to get extra benefits like coverage for prescription drugs or extra days in the hospital.

Remember, you must have Medicare Part A and Part B to join a Medicare + Choice Plan. If you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan. If you have End-Stage Renal Disease, see page 51.

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

How does a Medicare Managed Care Plan work?

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

- In most Medicare Managed Care Plans, there are doctors and hospitals that join the plan (called the plan's "network"). You may need to get most of your care and services from the plan's network. Call or get a list from the plan to see which doctors and hospitals are in the plan.
- When you join a plan, you may be asked to choose a primary care doctor. If you want to keep seeing your current doctor, call and ask if he or she is in the Medicare Managed Care Plan and can continue to see you if you join the plan.
- If you want to change your primary care doctor, you can ask your plan for the names of other plan doctors in your area.
- Doctors can join or leave Medicare Managed Care Plans at any time. If your primary care doctor should leave your plan, your plan will notify you in advance and give you a chance to pick a new doctor.
- Special rules might apply in emergencies or for urgently needed care (see pages 22-23).
- If you get health care outside the service area of the plan, you may pay more or it may not be covered. The service area is where the plan accepts members and where plan services are provided.
- You usually need a referral to see a specialist (like a cardiologist). A referral is a written OK from your primary care doctor for you to see a specialist or get certain services.
- There are special rules for certain services. For example, if you are a woman, you can go once a year, without a referral, to a specialist in the network for Medicare-covered routine and preventive women's care services. If the specialist you need isn't available, the plan will arrange for care outside the network.
- At the end of each year, Medicare Managed Care Plans may leave the Medicare program or change their benefits. However, new plans may also become available.

Some Medicare Managed Care Plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who aren't a part of the plan ("out-of-network"), but may cost extra.

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

Medicare Private Fee-for-Service Plans work like the Original Medicare Plan, but are offered by private companies. The private companies provide health care coverage to people with Medicare who join a Medicare Private Fee-for-Service Plan. The general rules for how Medicare Private Fee-for-Service Plans work are below.

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

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

A Medicare Preferred Provider Organization Plan (PPO) works with many of the same rules as Medicare Managed Care Plans listed on page 45. However, in a PPO you:

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

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

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

Medicare is working to create specialty plans, which are new ways to provide more focused health care for 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.

To find out if any Medicare specialty plans are available in your area, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your costs in a Medicare + Choice Plan

What you pay out-of-pocket depends on:

- Whether the plan charges a monthly premium in addition to your monthly Part B premium ($66.60 in 2004).
- How much you pay for each visit or service (like a copayment or coinsurance).
- The type of health care you need and how often you get it.
- The types of extra benefits you need, and whether the plan covers them.
- Whether you follow plan rules. If you don't, you may have to pay the full cost for your care.

Note: To get information about your out-of-pocket costs in various plans, look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."

Saving on Your Medicare Part B Premium

Medicare + Choice Plans may offer an additional benefit by reducing the amount you pay for your Medicare Part B premium. If you join a plan that offers this benefit, it may save you money. You would still get all Medicare Part A and Part B covered services.

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

How Your Bills Get Paid If You Have Other Health Insurance

Sometimes your other insurance pays your health care bills first and your Medicare + Choice Plan pays second. Other insurance that may have to pay first includes: employer group health plan coverage under certain conditions, no-fault insurance, liability insurance, black lung benefits, and workers' compensation. It's important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you have questions about who pays first, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. For more information about who pays first, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). Look on page 72 for details about how to get this booklet.

Can I appeal my Medicare + Choice Plan's payment decisions?

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

For more information about your appeal rights, get a free copy of *Your Medicare Rights and Protections* (CMS Pub. No. 10112). Look on page 72 for details about how to get this booklet.

Joining a Medicare + Choice Plan

Who can join a Medicare + Choice Plan?

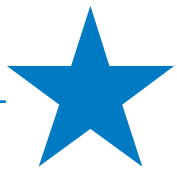
You can join a Medicare + Choice Plan if:

- You have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) and continue to pay the monthly Medicare Part B premium ($66.60 in 2004). If you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan.
- You live in the service area of the plan. The service area is where you must live for the plan to accept you as its member. In the case of a Medicare Managed Care Plan, it's also usually where you get services from the plan. The plan can give you more information about its service areas.
- You don't have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), except as explained on page 51.

When can I join one of these plans?

Generally, you can join a Medicare + Choice Plan at any time. However, Medicare + Choice Plans must accept new members from November 15 through December 31 of each year. If you join a Medicare + Choice Plan during this time, your coverage begins on January 1 of the next year. If you join a Medicare + Choice Plan at any other time, generally, your coverage will begin the first day of the month after the plan gets your enrollment form.

Note: Some Medicare + Choice Plans limit the number of members in their plans. These plans can't accept new members when they reach their limit. A plan can tell you if it is signing up new members.



Joining a Medicare + Choice Plan (continued)

How do I join a Medicare + Choice Plan?

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

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

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

Caution: You can't join more than one Medicare + Choice Plan at the same time. If you try to join more than one Medicare + Choice Plan with the same starting dates, you may be returned to the Original Medicare Plan.

Special Rules for People with End-Stage Renal Disease:

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

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

If you have ESRD and are in a Medicare + Choice Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare + Choice Plan. You don't have to use your one-time right to join a new Medicare + Choice Plan immediately. If you change directly to the Original Medicare Plan after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare + Choice Plan at a later date as long as you are in a managed care election period (described on page 50).

A new specialty plan for people with ESRD may be available in your area (see page 47).

Joining a Medicare + Choice Plan (continued)

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

Yes, you can keep it. However, it may cost you a lot and you may get little benefit from it while you are in a Medicare + Choice Plan. You can call the State Health Insurance Assistance Program if you need help deciding (see pages 80-82 for their telephone number).

If you drop your Medigap policy, you may not be able to get it back, except in certain situations. If you join a Medicare + Choice Plan when you first become eligible for Medicare at age 65, or if this is the first time you've enrolled in a Medicare + Choice Plan, you may have special Medigap protections that give you a right to buy a Medigap policy later if you choose. For more information on Medigap policies and protections, get a free copy of the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110). Look on page 72 for details about how to get this booklet.

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

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

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

When you join a Medicare + Choice Plan, you should get a membership card with the name of the plan on it. If you aren't sure if you are in a Medicare + Choice Plan, you can call the telephone number listed on your membership card. You can also call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772. Ask the Customer Service Representative to check if you are in a Medicare + Choice Plan.

Leaving a Medicare + Choice Plan

When can I leave a Medicare + Choice Plan?

You may leave a Medicare + Choice Plan at any time for any reason. Your plan will let you know, in writing, the date your coverage ends. Generally, this date will be the first day of the month after you ask the plan to disenroll you.

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

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

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

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

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

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

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

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

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

Generally, you will have to leave the plan. However, you can call the health plan to see if you can stay in the plan if you move out of the plan's service area. If you must leave the plan, follow the instructions on page 53 for leaving a Medicare + Choice Plan. You can choose to join another Medicare + Choice Plan, if one is available in your new area and they are accepting new members, or, you can choose the Original Medicare Plan. You may also have the right to buy a Medigap policy (see pages 64-65).

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

If your Medicare + Choice Plan leaves the Medicare program, you will be sent a notification letter. The letter will tell you if there are other Medicare + Choice Plans in your area that you can join. You can always choose the Original Medicare Plan. You will be automatically returned to the Original Medicare Plan if you don't choose to join another Medicare + Choice Plan. You may have the right to buy a Medigap policy (see pages 64-65). In this case, you should learn as much as you can about your choices before making a decision. No matter what you choose, you are still in the Medicare program and will get all Medicare-covered services.

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

Your Medicare + Choice Plan may decide not to provide services in all counties or ZIP codes in an area. If your Medicare + Choice Plan reduces its service area and there are no other Medicare + Choice Plans in your area, you may be able to keep your coverage. Ask your plan. In this case, you must agree to get all your services (except for emergency and urgently needed care) in the plan's reduced service area. If your plan doesn't offer this option, you will automatically return to the Original Medicare Plan on January 1. In this case, you may have the right to buy a Medigap policy (see pages 64-65).

Your Medicare Rights

Your Medicare Rights

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

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

Information on how to file an appeal is on the Medicare Summary Notice (if you have the Original Medicare Plan) or in your health plan materials (if you have a Medicare + Choice Plan). If you decide to file an appeal, ask your doctor or provider for any information that may help your case. You can also call your State Health Insurance Assistance Program for help filing an appeal (see pages 80-82 for their telephone number).

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

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

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

Remember, words in blue are defined on pages 73-76.

Your Medicare Rights (continued)

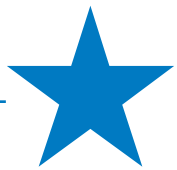
In addition, you have certain rights to:

- Information
- Get emergency services
- See doctors; specialists, including women's health specialists; and go to Medicare-certified hospitals
- Participate in treatment decisions
- Know your treatment choices
- Get culturally competent services (for example, under certain circumstances, getting information in languages other than English from Medicare, and its providers and contractors)
- File complaints
- Nondiscrimination
- Privacy of personal information
- Privacy of health information

NEW RIGHTS

If you are enrolled in a Medicare + Choice Plan, you will have the right to a new fast-track appeals process beginning January 1, 2004. You will receive a notice from your provider that will tell you how to ask for an appeal if you believe that your health plan is ending services too soon. You will be able to obtain a quick review of this decision, with independent doctors looking at your case and deciding if your services need to continue. This option will be available whenever you are receiving services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility. You may have additional rights if you are in the hospital or a skilled nursing facility, or if your home health care ends.

For more information about your rights and protections, call 1-800-MEDICARE (1-800-633-4227) to get a free copy of *Your Medicare Rights and Protections* (CMS Pub. No. 10112). Look on page 72 for details about how to get this booklet.



Notice of Privacy Practices for the Original Medicare Plan

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

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

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

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

Medicare **has the right** to use and give out your personal medical information to pay for your health care and to operate the Medicare program. For example:

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

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

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

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

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

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

By law, you have the right to:

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

Look at www.medicare.gov on the web for more information on:

- Exercising your rights set out in this notice.
- Filing a complaint, if you believe the Original Medicare Plan has violated these privacy rights. Filing a complaint won't affect your benefits under Medicare.

You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. Ask to speak to a Customer Service Representative about Medicare's privacy notice. TTY users should call 1-877-486-2048.

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

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

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

The Notice of Privacy Practices for the Original Medicare Plan listed above and on pages 57-59 became effective April 14, 2003.

How We Share Information for Research Studies and Clinical Trials

Research studies and clinical trials help doctors and researchers find better ways to operate the Medicare program or to prevent, diagnose, or treat diseases. Medicare may contact you about taking part in a study. Medicare may also share personal medical information with some organizations that conduct these studies to help them find people who qualify to take part in these studies. These organizations must meet all privacy law requirements. They might use the information Medicare gives them to contact you directly about their studies. It is your choice to take part or not. You may want to talk to your doctor about clinical trials (see page 21 for more information about clinical trials).

You Are Protected From Discrimination

Every company or agency that works with Medicare must obey the law. You can't be treated differently because of your race, color, national origin, disability, age, religion, or sex under certain conditions. Also your rights to health information privacy are protected. If you think that you haven't been treated fairly for any of these reasons, call the Office for Civil Rights in your state (see page 83) or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also look at www.hhs.gov/ocr or www.hhs.gov/ocr/hipaa(privacy) on the web for more information.

Let People Know Your Wishes About The Health Care You Want If You Cannot Tell Them Yourself

As people live longer, the chance that they may not be able to make their own health care decisions increases. To let people know what kind of treatment you want if you can't make your own health care decisions in the future, you need to fill out a "health care advance directive" (also called a "living will"). This is a written document in which you give directions about who you want to speak for you and what kind of health care you want or don't want if you can't speak for yourself. You might be able to get more information by calling your State Health Insurance Assistance Program (see pages 80-82 for their telephone number).

You Can Help Protect Yourself and Medicare from Fraud

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

Medicare fraud happens when Medicare is billed for services you never got. Medicare fraud takes a lot of money every year from the Medicare program. You pay for it with higher premiums. A fraud scheme can be carried out by individuals, companies, or groups of individuals.

Use this three step approach if you suspect fraud:

1. Call your health care provider.
2. Call your Medicare Carrier or Fiscal Intermediary.
3. Call the Inspector General's hotline 1-800-HHS-TIPS (1-800-447-8477).

When you get health care in the Original Medicare Plan, you get a Medicare Summary Notice (MSN) from a company that handles bills for Medicare. It shows what services or supplies were charged and how much Medicare paid. You should check the notice for mistakes. Make sure that Medicare wasn't charged for any services or supplies that you didn't get. If you see a charge on your bill that may be wrong, call the health care provider and ask about it. The bill may be correct, and the person you speak to may help you to better understand the services or supplies you got. Or, you may have discovered an error in billing which needs to be corrected. If you aren't satisfied after speaking with your provider, call the Medicare Carrier or Fiscal Intermediary for help. Their telephone number is printed on the front of the MSN.

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

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

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

- You report Medicare fraud,

AND

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

AND

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

If you want to know more about this program, call your Medicare Carrier or Fiscal Intermediary (see page 78).

Other Insurance and Ways to Pay Health Care Costs

Now is a good time to review your health care coverage. Medicare may not be the only health care coverage you have or can get. You might be able to get help to lower your out-of-pocket costs by having or buying more health care coverage. The coverage you have will affect how much you pay, what benefits you may have, which doctors you can see, and other things that may be important to you.

For more information about how these kinds of insurance work with Medicare, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). Look on page 72 for details about how to get this booklet.

1. Employer or Union Health Coverage

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

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

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

A Note about COBRA: If you are eligible for COBRA because you have stopped working or because you qualify for other reasons, you should still consider enrolling in Part B (see page 13). You won't get another Special Enrollment Period (see pages 15-16) when your COBRA coverage ends, and you may have to pay more for Part B.

2. Medigap (Medicare Supplement Insurance) Policies

If you live in Massachusetts, Minnesota, or Wisconsin, different standardized plans are sold in your state. See page 77 for important contact information.

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

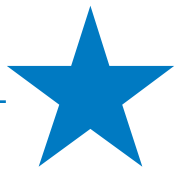
In all states, except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of ten standardized policies so you can compare them easily. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy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

For more information about Medigap policies, costs, and choices, call 1-800-MEDICARE (1-800-633-4227) and speak with a Customer Service Representative. Or, call your State Health Insurance Assistance Program (see pages 80-82 for their telephone number).

Do I need to buy a Medigap policy?

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

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



When is the best time to buy a Medigap policy?

The best time to buy a Medigap policy is during your Medigap open enrollment period. 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.

Important: If you don't buy a Medigap policy during your open enrollment period, you may not be able to buy the one you want later, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back. (However, special rules may apply if you have been in a Medicare + Choice Plan, see page 52).

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

For information about buying a Medigap policy, get a free copy of the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110). Look on page 72 for details about how to get this booklet.

3. Veterans' Benefits

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

4. Military Retiree Benefits

TRICARE is a program for active duty and retired uniformed services members and their families. It includes TRICARE Prime, TRICARE Extra, TRICARE Standard, and TRICARE for Life. Medicare-eligible uniformed services retirees age 65 or older and certain family members have access to expanded medical coverage known as TRICARE for Life (TFL). You must have Medicare Part A and Part B to get TFL benefits.

In general, Medicare pays first for Medicare-covered services. If Medicare doesn't pay all of the bill, TRICARE might pay some of the costs as the second payer. TRICARE will also pay the Medicare deductible, coinsurance, and copayment amounts, and for any services not covered by Medicare that TRICARE covers.

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

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

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

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

You can apply for these programs if:

- You have Medicare Part A. (If you are paying a premium for Medicare Part A, but can't afford it, the Medicare Savings Program may pay the Medicare Part A premium for you.)

and

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

and

Medicare Savings Programs (continued)

- You are an individual with a monthly income of less than $1,031*, or are a couple with a monthly income of less than $1,384*.

  *Income limits will change slightly in 2004. If you live in Alaska or Hawaii, income limits are slightly higher.

Call your State Medical Assistance Office (see page 79). Since the names of these programs may vary by state, ask for information on Medicare Savings Programs. It's very important to call if you think you qualify for any of these Medicare Savings Programs, even if you aren't sure.

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

6. Medicaid

If your income and resources are limited, you may qualify for Medicaid. Most of your health care costs are covered if you have Medicare and Medicaid. Medicaid is a joint Federal and State program that helps pay medical costs for some people with limited incomes and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for things like nursing home care, home care, and outpatient prescription drugs that aren't covered by Medicare. For more information about Medicaid, call your State Medical Assistance Office (see page 79).

7. Assistance Programs

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

Note about Generic Drugs

The Food and Drug Administration (FDA) ensures that your generic drug is safe and effective. All generic drugs are put through a rigorous, multi-step approval process. From quality and performance to manufacturing and labeling, everything must meet FDA's high standards. The FDA makes it tough to become a generic drug in America, so it's easy for you to rest assured.

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

PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid.

To find out if you are eligible and if there is a PACE site near you, or for more information, call your State Medical Assistance Office (see page 79). You can also look at www.medicare.gov/Nursing/Alternatives/PACE.asp on the web for PACE locations and telephone numbers.

9. Long-Term Care Insurance

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

It's very important to think about long-term care before you may need care or before a crisis occurs. You will have more control over your decisions. For more information about the types of long-term care, get a free copy of *Choosing Long-Term Care: A Guide for People with Medicare* (CMS Pub. No. 02223). Look on page 72 for details about how to get this booklet.

For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State Insurance Department (see page 79) or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600.

State Children's Health Insurance Program (SCHIP)

Free or low-cost health insurance is available now in your State for uninsured children under age 19. State Children's Health Insurance Programs help reach low-income, uninsured children whose families don't qualify for Medicaid. Information on your State's program is available through Insure Kids Now at 1-877-KIDS-NOW (1-877-543-7669). You can also look at www.insurekidsnow.gov on the web for more information.

For More Information

Sec

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

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

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

★ Compare Home Health Agencies

Select "Home Health Compare" to find general information about home health agencies in your area. Learn how well home health agencies provide care to their patients.

★ Compare Medicare Health Plans and Medigap Policies

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

★ Compare Nursing Homes

Trying to find a nursing home? Check out "Nursing Home Compare" for details on nursing homes in your area, including state inspection results and nursing staff information, and information about nursing home quality.

★ Find Publications

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

★ Learn about your Benefits

Select "Your Medicare Coverage" to see what is covered, when it's covered, and how much you pay in the Original Medicare Plan.

★ Get Answers to Your Questions

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

★ Look for a Physician or Supplier

Select the "Participating Physician Directory" or "Supplier Directory" for a list of physicians or suppliers who participate in Medicare. These directories include names, addresses, and more.

★ Find Help Paying Health Care Costs

Select "Prescription Drug and Other Assistance Programs" to learn about a wide range of health care coverage choices and prescription drug programs that may help pay for some of your health care costs.

★ And more...

Medicare's website helps you find the answers you need. You can search for what Medicare covers, health information, telephone numbers for helpful contacts, and more. Some information is available in Spanish.

Coming Soon - Medicare's New Speech-Automated System

Call 1-800-MEDICARE (1-800-633-4227) to get answers and information, 24 hours a day, including weekends.

Medicare is always working to improve its service to you. The 1-800-MEDICARE helpline is changing to a new speech-automated system. This new system has replaced the touch-tone system in some areas, and will be introduced nationwide in 2004.

The system will ask you questions that you answer with your voice. Your call is automatically directed to where you can get the information you need.

Remember to:

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

You can direct your call faster if you say what you need, at any time during the call.

If you are calling about...	Just say...
Doctor's bills, x-rays or outpatient doctor's care	"Doctor's Service"
Inpatient or outpatient hospital visit or emergency room care	"Hospital Stay"
Oxygen, wheelchairs, walkers, eyeglasses, diabetic supplies or Medicare-covered prescription drugs	"Medical Supplies"
Medicare Health Plans or Medicare + Choice	"Managed Care"
Frequently asked questions - like "What does Medicare cover?" or "Who is eligible for Medicare?" and other important questions	"Answers"
Ordering Medicare publications	"Publications"
If you want to talk to a Customer Service Representative at any time	**"Help"**

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

The Current Telephone System is Being Replaced

The touch-tone system at 1-800-MEDICARE is being replaced with the new speech-automated system to better serve you. However, it won't be available in all areas right away. Until the new speech-automated system is available in your area, these are your calling options:

> **Thank you for calling 1-800-MEDICARE**
> We offer service in English and Spanish.
> For **English,** press (1). Para **Español**, oprima dos (2).

You can choose from these options:

Press 1 - To sign up for Medicare, change your address, or replace your Medicare card. (You will be directed to call the Social Security Administration at 1-800-772-1213.)

Press 2 - For information on Medicaid programs and the phone number of your local Medicaid office.

Press 3 - To find out how your doctor, supplier, or hospital bill is paid.

Press 4 - To order Medicare publications.

Press 5 - For answers to frequently asked questions, including information about the status of your Medicare coverage.

Press 0 - To speak to a Customer Service Representative.

The options may change so listen carefully when you call.

Tip: If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

You can also visit www.medicare.gov on the web for quick answers to your questions.

Section 9: For More Information

Free Booklets About Medicare and Related Topics

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

How do I get these booklets?

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

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

3. Put your name on the web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select "Mailing List" at the bottom of the page. Then, select the topic "Publications" and choose "Join or leave the list, or update options."

Many booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish).

Look at www.medicare.gov on the web for a list of available Medicare publications.

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

Section 10

Words To Know

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

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

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

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

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

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

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

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

Section 10: Words To Know

Fiscal Intermediary - A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

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

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

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

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

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

Medically Necessary - Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition,
- are provided for the diagnosis, direct care, and treatment of your medical condition,
- meet the standards of good medical practice in the local area, and
- aren't mainly for the convenience of you or your doctor.

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

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

Medicare Managed Care Plan - A Medicare + Choice Plan option that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Section 10: Words To Know

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

Medicare Preferred Provider Organization (PPO) Plan - A Medicare + Choice Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-for-Service Plan - A Medicare + Choice Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

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

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

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

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

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

Preventive Services - Health care to keep you healthy or to prevent illness. For example, Pap tests, pelvic exams, yearly mammograms, and flu shots.

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

Section 10: Words To Know

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

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

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

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

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

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

Important Contacts

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In this section, you will find important telephone numbers to help you with your questions.

- Below and on page 83 - Find answers to Medicare-related questions.
- Pages 78 and 79 - Find out how to get telephone numbers for organizations in your local area that can answer your questions.
- Pages 80 through 82 - Find the telephone number of the State Health Insurance Assistance program in your state.

Call:	With your questions about:
1-800-MEDICARE (1-800-633-4227) 24 hours a day TTY users should call 1-877-486-2048.	■ Medicare (in general) ■ Medicare health plans ■ Ordering Medicare booklets ■ Medigap policies ■ Assistance Programs (including help paying health care costs, such as prescription drugs) ■ Telephone numbers for local organizations who work with Medicare, including TTY numbers
Social Security Administration 1-800-772-1213 TTY users should call 1-800-325-0778.	■ Address/name changes ■ Death notification ■ Enrolling in Medicare ■ Medicare card (replacement) ■ Social Security benefits

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

Tip: These telephone numbers are busiest early in the week. To cut down on the time you have to wait, it is best to call on Wednesday, Thursday, or Friday.

Section 11: Important Contacts

There are many partners who work with Medicare in your local area. The list below explains each organization and the questions they can help answer. To get their telephone number, visit www.medicare.gov on the web and select "Helpful Contacts." You can also call 1-800-MEDICARE (1-800-633-4227) and talk to a Customer Service Representative to get the local telephone number. Listen carefully to the available options at the main menu. TTY users should call 1-877-486-2048.

Organization:	They can answer questions about:
Centers for Medicare & Medicaid Services Regional Offices - Local offices for the Federal agency that oversees the Medicare program.	Reporting a complaint directly to the Federal Medicare Agency.
Durable Medical Equipment Regional Carrier - A private company that contracts with Medicare to pay durable medical equipment bills.	Bills and approved suppliers for durable medical equipment, prosthetics, orthotics, and other supplies.
Fiscal Intermediary - A private company that contracts with Medicare to pay Part A bills and Part B bills for outpatient hospital services.	Part A bills and services, hospital care, skilled nursing care, hospital outpatient services, and fraud and abuse. Calls may be referred to another company that covers your claims.
Medicare Carrier - A private company that contracts with Medicare to pay Part B bills.	Part B bills and services, medical services, and fraud and abuse. Calls may be referred to another company that covers your claims.

Section 11: Important Contacts

Organization:	They can answer questions about:
Quality Improvement Organization - Groups of practicing doctors and other health care experts that are paid by the Federal Government to check and improve the care given to Medicare patients.	Complaints you have about your Medicare-covered services and questions about your rights as a hospital patient.
Regional Home Health Intermediary - A private company that contracts with Medicare to pay home health and hospice bills and check on the quality of home health care.	Home health care, hospice care, and fraud and abuse.
State Health Insurance Assistance Program (SHIP) - A State program that gives free local health insurance counseling to people with Medicare. The names of SHIPs vary from State to State. The Federal Government gives money to states to support this counseling.	Buying a Medigap policy, long-term care insurance options, dealing with payment denials or appeals, Medicare rights and protections, help choosing a Medicare health plan, and Medicare bills. **Note: The telephone number of the SHIP for your area is listed on pages 80-82.**
State Insurance Department - A State agency that regulates insurance.	Medigap policies available in your area, and insurance-related questions and problems.
State Medical Assistance Office - A State agency that is in charge of the State's Medicaid program.	Programs to help people with limited incomes and resources pay medical bills and help with prescription drug coverage.

Section 11: Important Contacts

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

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Section 11: Important Contacts

Call:	With your questions about:
Coordination of Benefits Contractor 1-800-999-1118 TTY users should call 1-800-318-8782.	■ Which insurance pays first ■ Initial enrollment questionnaire (Medicare)
Department of Health and Human Services, Office of the Inspector General 1-800-447-8477 TTY users should call 1-800-377-4950.	■ Fraud and abuse
Railroad Retirement Board (RRB) 1-800-808-0772	■ Railroad Retirement benefits ■ All other services listed for the Social Security Administration for people who get RRB benefits
Department of Veterans Affairs 1-800-827-1000 TTY users should call 1-800-829-4833.	■ Veteran's benefits
Department of Defense 1-888-DOD-LIFE (1-888-363-5433) 1-800-538-9552	■ TRICARE for Life ■ Eligibility for military retiree health benefits
Office for Civil Rights 1-800-368-1019 TTY users should call 1-800-537-7697.	■ Discrimination ■ File a privacy complaint

5 Steps to Safer Health Care

1. Speak up if you have questions or concerns.

It's important to ask questions and make sure you understand the answers. Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers.

2. Keep a list of all the medicines you take.

Tell your doctor and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbs. Tell them about any drug allergies you have.

Ask your doctor and pharmacist about side effects and what to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.

3. Make sure you get the results of any test or procedure.

Ask your doctor or nurse when and how you will get the results of tests or procedures. If you don't get them when expected in person, on the phone, or in the mail, don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

Hospitals treat a variety of conditions. Some hospitals have more experience or better results treating certain conditions or performing certain procedures. If you have more than one hospital to choose from to get the health care you need, ask your doctor which hospital has the best care and results for your condition. When you leave the hospital, be sure you understand the instructions you get about follow-up care.

5. Make sure you understand what will happen if you need surgery.

Ask your doctor, "Who will take charge of my care while I'm in the hospital?" Ask your surgeon:

- Exactly what will you be doing?
- How long will it take?
- What will happen after the surgery?
- How can I expect to feel during recovery?

Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation. Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia.

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

¿Necesita usted una copia en español? También está disponible en audiocasete y letra grande. Llame gratis al 1-800-MEDICARE (1-800-633-4227).