Medicare & You 2001

This handbook has important information about:

- **Your Medicare benefits.**
- **Your Medicare plan choices.**
- **Medicare health plans in your area.**
- **Where to call for help.**

How do you find what you need? See page 3.

Please keep this handbook for future reference.

HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

Welcome to *Medicare & You!*

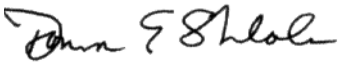
This handbook has important Medicare information. **Please keep it with your important papers so you can find it if you need it**. Page 3 tells you how to find what you need in this handbook. You can get a quick look at Medicare on page 4.

This handbook is good (valid) from January 1, 2001 through December 31, 2001. Use it in place of any older version you have now. You will get a new handbook every fall.

Fall is a good time to think about health coverage for the coming year. Make sure you know what coverage you have now. Find out if you have other options. Get the facts you need to make the best choice for you.

We want you to know:

- ✓ You may have choices in how you get your Medicare health coverage (see page 13).
- ✓ Medicare doesn't pay for all of your health care. You may be able to get help paying the costs that Medicare doesn't pay (see page 11).
- ✓ You can call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) with questions about Medicare (see page 68). Medicare information is also at www.medicare.gov on the Internet.
- ✓ You may need details about Medicare topics that you can't find in this handbook. Medicare has a series of more detailed booklets on some common topics (see page 66).
- ✓ If you get help from family or friends with your health care choices, this handbook might help them. They can call 1-800-MEDICARE (1-800-633-4227) to get their own copy.



Donna E. Shalala
Secretary, Health and
Human Services

Nancy-Ann Min DeParle
Administrator, Health Care
Financing Administration

What's *NEW* in Medicare

This handbook has new information for 2001:

- More help from 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired), see page 68.
- A new Medicare health plan option - Private Fee-for-Service plans, see page 17.
- Comparing Medigap plans on the Internet, see page 60.
- Information about Medicare health plan choices. This includes how to get cost, extra benefits, quality, and disenrollment information for health plans in your area, see page 22.
- More free Medicare booklets you can order, see page 66.

If you have Employer or Union Health Coverage:

Call your employer or union before you make any changes to your health coverage.
See page 12 for important information.

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

Sharing Medicare & You:

Households with up to four people with Medicare will get one handbook to share. This will help save Medicare money. The other people with Medicare in these households will get a postcard. It will tell them how to get an extra handbook if they need it. If your household gets more than one handbook and you want to share one copy in the future, or, if you don't want to get this handbook next year, call and tell a customer service representative at 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). Have your red, white, and blue Medicare card with you when you call.

If your address changes:

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

Turn to page 2 for the Table of Contents.

Medicare & You 2001 explains the Medicare program. It is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

TABLE OF CONTENTS

How to find what you need in this handbook:

Do you:	Look on page(s):
Want to look for a specific topic?	72 – 73. **Index**: See the Index for an alphabetical list of everything in this handbook and the page(s) where you will find the information you need.
Want to sign up for Medicare?	5 and 7
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A Quick Look At Medicare

Medicare is a health insurance program for:

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

Medicare Has Two Parts

Part A (Hospital Insurance, see page 5.)

Most people do not have to pay for Part A.

Part B (Medical Insurance, see page 7.)

Most people pay monthly for Part B.

You may have choices in how you get your health care.

- **The Original Medicare Plan -** For more information, see page 14.
- **Medicare Managed Care Plans (like HMOs) -** For more information, see page 16.
- ***NEW* Medicare Private Fee-for-Service Plans -** For more information, see page 17.

What is Medicare Part A?

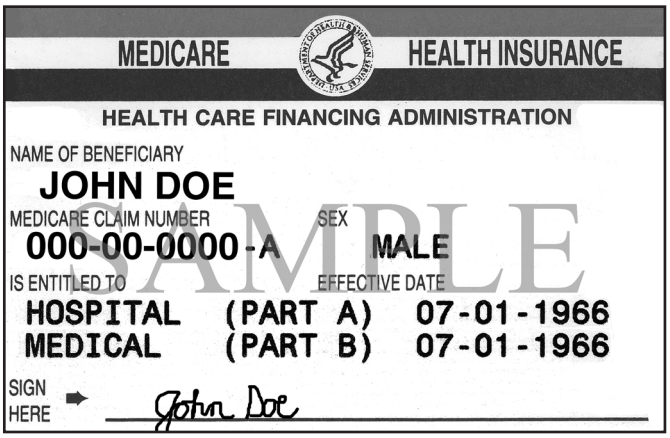
Part A (Hospital Insurance)

Helps Pay For: Care in hospitals as an inpatient, critical access hospitals*, skilled nursing facilities, hospice care, and some home health care. See page 6.

Cost: Most people get Part A automatically when they turn age 65. They do not have to pay a monthly payment called a **premium** for Part A because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. If you are not sure if you have Part A, look on your red, white, and blue Medicare card (see sample card below). It will show "Hospital Part A" on the lower left corner of the card. You can also call the Social Security Administration toll-free at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Do you need a new Medicare card? Call the Social Security Administration toll-free at 1-800-772-1213 or call your local Social Security office.



For More Information:

Call your Fiscal Intermediary about Part A bills and services (see pages 29A-31).

*Critical access hospitals (CAHs) are small facilities that give limited outpatient and inpatient services to people in rural areas. If you have questions about CAHs, call your HCFA Regional Office (see page 44), or your Fiscal Intermediary (see pages 29A-31).

Medicare Part A (Hospital Insurance) Helps Pay For:	What YOU Pay in 2000* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies (this includes care in critical access hospitals). This does not include private duty nursing, or a television or telephone in your room. It also does not include a private room, unless **medically necessary.** Inpatient mental health care coverage in an independent psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period YOU pay:** • A total of $776 for a hospital stay of 1-60 days. • $194 per day for days 61-90 of a hospital stay. • $388 per day for days 91-150 of a hospital stay. (See **Reserve Days** on page 71.) • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care: ** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay). For more information on SNFs, see page 63. To get a booklet about SNF care, see page 66.	**For each benefit period YOU pay:** • Nothing for the first 20 days. • Up to $97 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary (see pages 29A-31).
Home Health Care: ** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services (see page 49). To get a booklet about home health care, see page 66.	**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 pages 32-33).
Hospice Care: ** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered. To get a booklet about hospice care, see page 66.	**YOU pay:** • A **copayment** of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary (see pages 32-33).
Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.	**YOU pay:** For the first 3 pints of blood, unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2001.
** You must meet certain conditions in order for Medicare to cover these services.

If you have general questions about Medicare Part A, call your Fiscal Intermediary (see pages 29A-31).

What is Medicare Part B?

Part B (Medical Insurance)

Helps Pay For: Doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as 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 8-10).

Cost: You pay the Medicare Part B **premium** of $45.50* per month. This is the 2000 amount and may change January 1, 2001. In some cases, this amount may be higher if you did not choose Part B when you first became eligible at age 65. **The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it, except in special cases. You will have to pay this extra 10% for the rest of your life.** For more Part B enrollment information, see page 53.

* The new Part B premium amount will be available by January 1, 2001. You may be able to get help from your state paying this premium (see page 11).

Enrolling in Part B is your choice. You can sign up for Part B anytime during a 7-month period that begins 3 months before you turn 65. Visit your local Social Security office, or call the Social Security Administration at 1-800-772-1213 to sign up. If you choose to have Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. If you do not get any of these above payments, Medicare sends you a bill for your Part B premium every 3 months. You should get your Medicare premium bill by the 10th of the month. If you do not get your bill by the 10th, call the Social Security Administration at 1-800-772-1213 or your local Social Security office. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

For More Information:

Call your Medicare Carrier about Part B bills and services (see pages 25A-F).

Medicare Part B (Medical Insurance) Helps Pay For:	What YOU Pay in 2000* in the Original Medicare Plan (see Note below)
Medical and Other Services: Doctors' services (except for 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. To get a booklet about second surgical opinions, see page 66.	**YOU pay:** • $100 **deductible** (pay once per calendar year). • 20% of **Medicare-approved amount** after the deductible, except in the outpatient setting. (See Q12 on page 56.)
Also covers outpatient physical and occupational therapy including speech-language therapy.	• 20% for all outpatient physical, occupational, and speech-language therapy services.
Outpatient mental health care.	• 50% for outpatient mental health care. (See Q25 on page 63.)
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**YOU pay:** • Nothing for Medicare-approved services.
Home Health Care: ** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services.	**YOU pay:** • Nothing for Medicare-approved services. • 20% of Medicare-approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury. To get a booklet about payment for outpatient hospital services, see page 67.	**YOU pay:** • A coinsurance or fixed copayment amount which may vary according to the service.
Blood: Pints of blood you get as an outpatient, or as part of a Part B covered service.	**YOU pay:** For the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2001.
** You must meet certain conditions in order for Medicare to cover these services or equipment.

Note: Actual amounts you must pay are higher if the doctor or supplier does not accept assignment, and you may have to pay the entire cost. Medicare will then send you its share of the costs (see Q12 on page 56). If you have general questions about Medicare Part B, call your Medicare Carrier (see pages 25A-F). If you have questions about durable medical equipment, including diabetic supplies, call your DMERC (see page 28).

Medicare Part B Covered Preventive Services	Who is covered...	What YOU pay in the Original Medicare Plan...
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare-approved amount (or a set copayment amount) after the yearly Part B **deductible**.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every 12 months. • Flexible Sigmoidoscopy* - Once every 48 months. • Colonoscopy* - Once every 24 months if you are at high risk for cancer of the colon. • Barium Enema - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. (*25% if performed in an ambulatory surgical center or hospital outpatient department.)
Diabetes Services: • Coverage for glucose monitors, test strips, and lancets.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the yearly Part B deductible.
• Diabetes self-management training.	If requested by your doctor or other provider.	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening: Once every 12 months. (You can also get one baseline mammogram between ages 35 and 39.)	All women with Medicare age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every 36 months. Once every 12 months if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding 36 months.	All women with Medicare.	Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set copayment amount) with no Part B deductible.
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.	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 Test.
Shots (vaccinations): • Flu Shot - Once a year in the fall or winter. • Pneumonia Shot - One shot may be all you ever need. Ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis.	All people with Medicare.	Nothing for flu and pneumonia shots if the health care provider accepts assignment (see page 56). For Hepatitis B shots, 20% of the Medicare-approved amount (or set copayment amount) after the yearly Part B deductible.

Part B also helps pay for:

- Ambulance services (when other transportation would endanger your health).
- Artificial limbs and eyes.
- Braces - arm, leg, back, and neck.
- Chiropractic services (limited).
- Emergency care.
- Eyeglasses - one pair after cataract surgery with an intraocular lens.
- Immunosuppressive drug therapy (limited), extended coverage available for transplant patients including some ESRD patients.
- Kidney dialysis and kidney transplants.
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.
- Outpatient prescription drugs (very limited). For example, some oral cancer drugs.
- Preventive services (see page 9).
- Prosthetic devices, including breast prosthesis after mastectomy.
- Services of practitioners such as clinical psychologists, social workers, and nurse practitioners.
- Transplants - heart, lung, kidney, pancreas, and liver (under certain conditions).
- X-rays and some other diagnostic tests.

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

The Original Medicare Plan does not cover everything. Your out-of-pocket costs for health care will include but are not limited to:

- Acupuncture.
- **Deductibles**, **coinsurance**, or **copayments** when you get health care services (see the "What YOU Pay" part of the charts on pages 6, 8, and 9).
- Dental care and dentures (in most cases).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, toileting, 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.
- Orthopedic shoes.
- Outpatient prescription drugs (with only a few exceptions).
- Routine foot care.
- Routine eye care.
- Routine or yearly physical exams.
- Screening tests except those listed on page 9.
- Shots (vaccinations) except those listed on page 9.
- Your monthly Part B **premium** ($45.50 in 2000*).

* New Part A and B amounts will be available by January 1, 2001.

You may be able to get help with the costs Medicare does not cover (see page 11). You may be able to join a Medicare managed care plan or a Private Fee-for-Service plan and get extra benefits (see pages 16-22).

Getting help to pay your health care costs

Most of your health care costs are covered if you have Medicare and you qualify for Medicaid. **Medicaid** is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. People on Medicaid may also get coverage for nursing home care and outpatient prescription drugs which are not covered by Medicare.

States also have programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who have Medicare and a low income.
To qualify, you must have:

- Part A (Hospital Insurance, see page 5 for more information about Part A),
- Assets, such as bank accounts, stocks, and bonds that are not more than $4,000 for a single person, or $6,000 for a couple, and
- A monthly income that is below certain limits (see chart below).

Programs That Help Pay Medical Expenses*

Monthly Income Limits for 2000**	Program Will Pay	Program Name
$716 Individual or $958 Couple	Premiums, deductibles, and coinsurance	Qualified Medicare Beneficiary (QMB)
$855 Individual or $1,145 Couple	Medicare Part B premiums	Specified Low-Income Medicare Beneficiary (SLMB)
$960 Individual or $1,286 Couple	Medicare Part B premiums	Qualifying Individual (QI-1)
$1,238 Individual or $1,661 Couple	A small part of your Medicare Part B premiums	Qualifying Individual (QI-2)

*These programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

**Slightly higher income amounts are allowed in Alaska and Hawaii. Income limits will go up slightly in 2001, and new limits will be available by April 1, 2001.

For more information about these programs, call your state medical assistance office (see pages 42-43). If you need more help, please call 1-800-MEDICARE (1-800-633-4227). The customer service representative will help you find the phone number in your State.

For information about supplement insurance (Medigap), see page 15.

Insure Kids Now

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

Other Kinds of Health Insurance You Might Have

Do you know what health care insurance you have and what it helps pay for? Fall is a good time to review your coverage. Medicare may not be the only health care coverage you can get. You might be able to get more health care coverage, help to lower your out-of-pocket costs, or more benefits than Medicare alone has. Check with your current or past employer or union, or the military if you are a veteran or military retiree. You might be able to get insurance through them. This kind of insurance can help pay the costs Medicare does not pay.

Whether you qualify for employer, union, military, or other health care coverage, you should learn about all of the different kinds of health care coverage. What you choose 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.

If you or your spouse still work or are retired, you may be able to get employer or union health care coverage:

- Call the employer or union to find out if you can get health care coverage based on your or your spouse's past or present employment.
- If you can get this coverage, ask your benefits administrator to help you compare their costs and benefits to Medicare's. In addition, there are rules about who pays first (see page 67 to get a booklet about who pays first).

Caution: If you already have employer or union coverage, talk to your employer or union before you make any changes. If you drop this coverage, you may not be able to get it back.

If you are a veteran or a military retiree, you may be able to get health care benefits:

- If you are a veteran, call the U.S. Department of Veteran Affairs at 1-800-827-1000. If you or your spouse are retired from the military, call the Department of Defense at 1-800-538-9552 for more information.

If you have a low income and limited assets, you may qualify for help paying your health care costs:

- See page 11 to see if you qualify for help from your state to pay your health care costs. You may also call your state medical assistance office (see pages 42-43).

Note: For information about Medicare Supplement Insurance (Medigap), see page 15.

Medicare health plan choices in 2001

In Medicare, you may be able to get your health care coverage from:

- **The Original Medicare Plan (see pages 14-15).**

Or, you can get your coverage through another Medicare health plan under Medicare + Choice. Congress created the Medicare + Choice program to let more private insurance companies offer coverage to people in Medicare. Some of your choices may include:

- **A Medicare managed care plan, like an HMO (see pages 16-22), or**
- **A Medicare Private Fee-for-Service plan (see pages 17-22)**.

These are the only types of Medicare health plans currently available.

No matter how you get your Medicare benefits, you are still in the Medicare program.

In every Medicare health plan:

- You pay the monthly Medicare Part B premium of $45.50 in 2000. It is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment.
- You get all the Medicare Part A and Part B covered services.

When choosing a Medicare health plan, think about:

Cost	What will my out-of-pocket costs be?
Doctor Choice	Can I see the doctor(s) I want to see?
Benefits	Do I need extra benefits and services, like prescription drugs, eye exams, hearing aids, or routine physical exams?
Convenience	Where are the doctors' offices and what are their hours?
Quality	How well does the plan keep its members healthy or treat them when they are sick? Call 1-800-MEDICARE (1-800-633-4227) or look at www.medicare.gov on the Internet for information on Medicare health plan quality. **Quality** information is not available yet for Medicare Private Fee-for-Service plans because they are new.

The Original Medicare Plan

The Original Medicare Plan is also known as "fee-for-service." This plan, offered by the federal government, is available nationwide. You are usually charged a fee for each health care service or supply you get. If you are happy getting your health care this way, you do not have to change. You will stay in the Original Medicare Plan unless you choose to join a **Medicare managed care plan** or a **Private Fee-for-Service plan**.

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 5).

How does the Original Medicare Plan work?

- You may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service.
- You pay the monthly Part B premium of $45.50 in 2000.
- You pay an amount for your health care each year (**deductible**) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (**coinsurance**). After you get a health care service, you get an Explanation of Medicare Benefits or a Medicare Summary Notice in the mail. These are sent by a company that handles bills for Medicare. The notice lists the amount you may be billed.

Your costs in the Original Medicare Plan

What you pay out-of-pocket depends on:

- Whether your doctor or supplier agrees to accept assignment (see Q12 on page 56).
- How often you need health care.
- What type of health care you need.
- Whether you get health care while traveling outside of the United States, since in most cases, you would pay for this care.
- Whether you get services or supplies not covered by Medicare.

Your costs in the Original Medicare Plan (continued)

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

- Keep or get employer or union health coverage (see page 12), or
- Buy a **Medigap** Policy (Medicare Supplement Insurance)* (see below), or
- Check if you qualify for help from your State (see page 11).

You may be able to save money by joining one of the other Medicare health plans (see pages 16-22).

For more information on the Original Medicare Plan, see Q11 and Q12 on page 56.

* For the rest of this book, Medicare Supplement Insurance policies will be called Medigap policies.

Filling the gaps in Original Medicare Plan coverage

What is a Medigap policy?

A "Medigap" policy fills gaps in Original Medicare Plan coverage. Medigap insurance must follow federal and state laws. These laws protect you. All Medigap policies are clearly marked "Medicare Supplement Insurance."

In all states, except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of ten standardized policies to help you 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 certain hospitals and doctors. In an emergency, you may use any doctor or hospital.

For more information about Medigap policies:

- Read Q13-Q16 on pages 57-60.
- Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *2000 Guide to Health Insurance for People with Medicare*. You can also look on the Internet at www.medicare.gov to read or print this booklet.

Medicare managed care plans and Private Fee-for-Service Plans

Medicare managed care plans and Private Fee-for-Service plans are not available in all areas. If you are in either of these types of plans, you must continue to pay the monthly Medicare Part B premium of $45.50 in 2000. You may also have to pay any additional monthly premium.

What is a Medicare managed care plan?

A Medicare managed care plan, sometimes called an HMO, is a health plan offered by private insurance companies. Many people with Medicare choose a managed care plan.

How does managed care work?

- Medicare pays a set amount of money every month to the private insurance company.
- You can often get extra benefits, like prescription drugs.
- In most managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan. Call the plan you are interested in to see which doctors are in the plan.
- Doctors can join or leave managed care plans at any time. If your doctor leaves your plan, ask your plan for the names of plan doctors in your area. If you want to keep getting care from your doctor, ask if he or she belongs to another Medicare managed care plan. You may want to join that plan.
- Generally, you can only see a specialist (like a cardiologist) when you get a **referral**, which means your **primary care doctor** says it is OK to go.
- Some managed care plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who are not a part of the plan. Most of the time this option costs you more, and gives you more choices.

What is a Private Fee-for-Service plan?

This is a new type of health care plan in some areas of the country. A Private Fee-for-Service plan is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan, which is offered by the federal government.

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

- Medicare pays a set amount of money every month to the private insurance company.
- The private insurance company provides health care coverage to people with Medicare who join this plan. You pay and the insurance company pays a fee for each doctor visit or service you get.
- The insurance company, rather than the Medicare program, decides how much it pays, and how much you pay, for the services you get.
- You can go to any doctor or hospital that accepts the plan's payment.
- You may be able to get extra benefits, like coverage for additional days in the hospital.

Caution: Ask the plan if it has any "pre-notification" requirements (for example, a requirement that you notify the plan of any planned inpatient admissions).

Who can join a Medicare managed care plan or Private Fee-for-Service plan?

If you have Medicare, you can join either of these types of plans if:

- You have both Part A (Hospital Insurance) and Part B (Medical Insurance).
- You live in the service area of the plan. The service area is where the plan accepts members. In the case of a managed care plan, it's also where you get services from the plan.
- You do not have **End-Stage Renal Disease** (permanent kidney failure requiring dialysis or a kidney transplant). ESRD patients can stay in the plan they are in or join another plan offered by the same company. 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.

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

If you join one of these plans:

- You are still in the Medicare program.
- You must continue to pay the monthly Medicare Part B premium of $45.50 in 2000.
- You still get all your regular Medicare-covered services (see pages 6, 8, and 9).
- You have Medicare rights and protections (see pages 45-51).

Your costs in a Medicare managed care plan or Private Fee-for-Service plan

What you pay out-of-pocket depends on:

- Whether the plan charges a monthly **premium** in addition to your monthly Part B premium of $45.50 in 2000.

  Note: If you don't pay the additional premium charged by your plan, you may be returned to the Original Medicare Plan.

- How much the plan decides you must pay for each visit.
- The type of health care you need and how often you get it.
- How much the plan charges for extra benefits.

Also:

- In a Medicare managed care plan, you may pay more if you get health care outside the service area of the plan. See exceptions for emergency and urgently needed care on page 62 (Q23 and Q24).
- In a Private Fee-for-Service plan, you may pay more if the plan lets doctors, hospitals, and other providers bill you more than the plan pays for services. If this is allowed, there may be a limit to what they can charge, and you must pay the difference.

How can I tell if I am in a Medicare managed care plan or Private Fee-for-Service plan?

If you joined a Medicare managed care plan or Private Fee-for-Service plan, you should have a membership card with the name of the plan on it. If you are not sure if you are in one of these plans, you can call the number listed on your membership card, or call the Social Security Administration at 1-800-772-1213, or call your local Social Security Office to find out. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

When can I join one of these plans?

During the month of November, Medicare health plans must accept new members. In most cases, if you join a Medicare health plan in November 2000, your coverage begins on January 1, 2001.

Most Medicare health plans may also accept new members at other times of the year. Some Medicare health plans limit the number of members in their plans. These plans may not accept new members all of the time. A plan can tell you if it is signing up new members.

How do I join a Medicare managed care plan or Private Fee-for-Service plan?

To join a 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 give it to the plan representative.

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

Can I join more than one plan?

No. You can't join more than one Medicare health plan at the same time. If you try to join more than one Medicare health plan with the same starting dates, you may end up enrolled in the plan you did not want to be in.

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

You will need to call the health plan to see if you can stay in the plan if you move out of the plan's service area. If you must leave the plan, you must disenroll. You will be covered under the Original Medicare Plan. Or, you can choose to join another Medicare health plan, if one is available in your area.

What if I want to leave the plan?

In the year 2001, you may leave a plan at any time for any reason. Write to the plan or to the Social Security Administration. Tell them you want to leave the plan. The plan should send you a letter with the date your plan coverage ends. If you don't get a letter, call the plan and ask for the date. When you leave a plan, you are automatically returned to the Original Medicare Plan, unless you join another Medicare managed care plan or Private Fee-for-Service plan. If you join another one of these plans, you should get a letter telling you when your coverage starts.

Starting in 2002, you may be able to leave a plan only at certain times. Call 1-800-MEDICARE (1-800-633-4227) for more information.

If you join a new Medicare managed care plan or Private Fee-for-Service plan and change your mind, you must write to the new plan. Tell them you want to cancel.

If you change your mind and your new plan has:

- not processed your enrollment, you can stay in your old plan (including the Original Medicare Plan), or you can join a new Medicare health plan.
- already processed your enrollment, you will be disenrolled from your old plan and enrolled in the new plan. If you want to return to your old plan, you have to re-enroll in it. If your old plan was the Original Medicare Plan, you will be returned to it when you disenroll from the new plan.

Can I keep my Medigap policy if I join one of these plans?

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 managed care plan or Private Fee-for-Service plan. If you drop your Medigap policy, you may not be able to get it back unless you are in a situation listed in Q15 on pages 58-59.

Who decides where Medicare managed care plans and Private Fee-for-Service plans will be available?

Medicare managed care plans and Private Fee-for-Service plans are offered by private companies.

A company can decide that a plan will be available to everyone with Medicare in a state, or be open only in certain counties. The company may also choose to offer more than one plan in an area, with different benefits and costs. Each year, the companies offering Medicare managed care plans and Private Fee-for-Service plans can decide to join or leave Medicare.

How long are Medicare managed care plans and Private Fee-for-Service plans required to stay in Medicare? When can they leave Medicare?

When Medicare health plans sign a contract with Medicare, they agree to stay in Medicare for at least one year (January 1 through December 31). Private companies offer managed care plans and Private Fee-for-Service plans. Each year, they make a business decision to stay in or leave the Medicare program. Costs and extra benefits can also change.

Your plan must let you know if they intend to leave Medicare at the end of the year. You will be notified before your plan coverage ends. The notice the plan must send you will tell you if other Medicare health plans are offered in your area, and what protections you have.

If the plan's quality is poor or they commit fraud, a plan can be asked to leave the Medicare program at any time during the year. You will get a notice before this happens. The notice will tell you how to find a new plan, and what protections you have.

What if I have employer or union coverage?

If you join a Medicare managed care plan or Private Fee-for-Service plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your Medicare health plan coverage. Talk to your benefits administrator about the rules that apply.

Medicare Medical Savings Account Plans

You may have heard about **Medicare Medical Savings Accounts**. At the time this handbook was printed, no private insurance companies were offering these types of plans to people with Medicare. To find out if any of these plans have become available in your area, or to learn more about them, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Your Guide to Medicare Medical Savings Accounts*.

For more information about your Medicare health plan choices:

1. See Q17-Q24 on pages 60-62.
2. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for:
   - A free copy of detailed plan information on costs, extra benefits, **quality**, and disenrollment information for plans in your area.
   - A free copy of *The Worksheet for Comparing Medicare Health Plans* to help you compare plans.
   - A free copy of *Your Guide to Private Fee-for-Service Plans.*
3. Look on the Internet at www.medicare.gov to find plan information for your area, including their costs, extra benefits, quality, and disenrollment information, and booklets that you can read or print out.

Moving?
Call 1-800-MEDICARE (1-800-633-4227), or look on the Internet at www.medicare.gov. Click on Medicare Health Plan Compare to get more information on plans in your new area. Remember to call the Social Security Administration at 1-800-772-1213 to change your address.

Where to call for help with your Medicare questions

The next 29 pages have phone numbers you may call for help. If there is a special number for your state, it will be listed.

If you have questions about...	Call...
Changing your address, Medicare Part A or Part B, lost Medicare card, and Social Security benefits (see page 24).	Social Security Administration (SSA)
Medigap policies, long-term care insurance, Medicare health plan choices, Medicare rights and protections, and help with filing an appeal (see pages 26-27).	State Health Insurance Assistance Program
Part B bills, services, and fraud and abuse (see pages 25 A-F).	Medicare Carrier
Part A bills and services, hospital care, skilled nursing care, and fraud and abuse (see pages 29A-31).	Fiscal Intermediary (FI)
General Medicare information, ordering Medicare booklets, and information about health plans (see page 24).	1-800-MEDICARE Helpline
Discrimination (see page 44).	Office for Civil Rights
Reporting fraud and abuse (see page 24).	Office of the Inspector General
Complaints about quality of care, and filing an appeal or complaint (see pages 34-39).	Peer Review Organization (PRO)
Medigap policies available in your area, and insurance questions (see pages 40-41).	State Insurance Department
Low-income programs to help pay medical bills (see pages 42-43).	State Medical Assistance Office
Medicare bills and coverage, RRB benefits, lost Medicare card, Medicare premium amounts, and enrolling in Medicare (see page 24).	Railroad Retirement Board (RRB) (Railroad Retirement beneficiaries only)

If you are enrolled in a Medicare managed care plan or Private Fee-for-Service plan, you should call your plan with questions about bills, health services, and appeals.

Note: At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or go to the Internet at www.medicare.gov and click on Helpful Contacts.

Pages 23-44 of this publication have been intentionally left blank and will not print out. They contain state specific phone numbers. For the most recent contact information in this section, please visit the Helpful Contacts section of this web site.

Your Medicare Patient Rights

If you have Medicare, you have certain guaranteed rights. You have them whether you are in the Original Medicare Plan, a **Medicare managed care plan**, or a **Private Fee-for-Service plan**.

Information: You have the right to receive easy-to-understand information about Medicare, what costs it pays, and how much you have to pay. And you have a right to know what to do if you have to file a complaint.

Emergency Care: You have the right to get emergency care when and where you need it. You don't need an OK from your health plan. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.

Appeals: You have the right to file an **appeal** if Medicare does not pay for a covered service you have been given, or if your health plan does not give you a service that you believe should be provided (see pages 46-47).

Treatment Choices: You have the right to know all your treatment options from your health care provider in language that is clear to you, and in a language that you understand.

Privacy: You have the right to have any personal information that Medicare collects kept private. Medicare may collect information about you as part of its regular business, such as paying your bills. When Medicare asks for this kind of information, we must tell you that the law lets us collect it, why it is being collected, whether it is required or optional, what happens if you don't give the information, and how it will be used. If you want this information call 1-800-MEDICARE (1-800-633-4227) and ask for more information about how Medicare uses personal information.

Your rights in a Medicare Managed Care Plan

- You have a right to choose a women's health specialist from your plan's list of doctors for routine and preventive health care services.
- If you have a complex or serious medical condition, you have a right to a treatment plan from your doctor which gives you enough visits to a specialist to deal with your needs.
- Medicare managed care plans cannot have rules that stop a doctor from telling you everything you need to know about your health care, including treatment options.
- You have a right to know how your plan pays its doctors. If you want to know how your plan pays its doctors, the plan must tell you in writing. You also have the right to know whether your doctor owns all or part of a health care facility. For example, if you are referred for a blood test to a lab that he or she owns.
- If you have concerns or problems with your plan which are not about payment or service requests, you have a right to file a complaint. This type of complaint is called a **grievance**. For example, if you believe your plan's hours of operation should be different, you can file a grievance. If you believe you are not getting a high quality of care, you may file a **grievance** with either your plan or with the **Peer Review Organization** (PRO) in your State (see pages 34-39).

Your Medicare Appeal Rights

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan or another Medicare health plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

Your Appeal Rights In The Original Medicare Plan ▸

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal.

Appeal Rights In a Medicare Managed Care Plan or Private Fee-for-Service Plan ▸

If you are in a Medicare managed care plan or Private Fee-for-Service plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must reach a decision within 72 hours.

The plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, an independent organization that works for Medicare, not for the plan, reviews the appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. You may also call 1-800-MEDICARE (1-800-633-4227) to ask for more information about your rights during an appeal.

You are Protected from Unexpected Bills ▸

A doctor or supplier might give you a notice that says Medicare probably (or certainly) will not 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 does not pay for it. This is called an Advance Beneficiary Notice. Advance Beneficiary Notices are used in the Original Medicare Plan, but not in Medicare managed care 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 your doctor, hospital, or any

other health supplier. You should get it within 30 days. Also, you can check your Explanation of Medicare Benefits or Medicare Summary Notice to see if the service was billed to Medicare.

If you are in a **Private Fee-for-Service plan**, call your plan to find out if a service or supply will be covered. The plan must tell you if you ask.

You are Protected from Discrimination ▸

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, or sex under certain conditions. If you think that you have not been treated fairly for any of these reasons, call the Office for Civil Rights in your State (see page 44).

You are Protected When You are in the Hospital ▸

If you are admitted to a Medicare participating hospital, you should be given a copy of *An Important Message About Medicare Rights: Admission, Discharge, and Appeals*. It explains your rights as a hospital patient. If you are not given one, ask for it. If you are in a Private Fee-for-Service plan, call your plan to find out what your protections are. They may be different.

The Message tells you:

- You have the right to get all of the hospital care that you need, and any follow-up care after you leave the hospital.
- What to do if you think the hospital is making you leave too soon.

If you have questions about this, call your **Peer Review Organization** (PRO). Their number is on the copy of *An Important Message About Medicare Rights: Admission, Discharge, and Appeals* brochure that you got when you were admitted to the hospital. You may be able to stay in the hospital at no charge while they review your case. The hospital cannot force you to leave before the PRO makes a decision.

You are Protected in a Skilled Nursing Facility ▸

A skilled nursing facility (SNF) is a Medicare-certified facility that has the staff and equipment to give **skilled nursing care** or skilled rehabilitation services and other related health services. You must meet certain conditions for skilled nursing facility care coverage, such as a 3-day hospital stay, before you are admitted. Some nursing homes give this type of skilled care.

For your protection:

- The SNF cannot make you pay anything to be admitted unless it is clear that Medicare does not cover the cost of services;
- You must be told right away if the SNF decides that you do not need the level of skilled care covered by Medicare. If you disagree with this decision, you may ask that the SNF submit a "demand bill" to Medicare for an official decision.

The SNF must submit the demand bill and cannot make you pay a deposit for services that Medicare may not cover until Medicare gives its decision.

You must pay any **coinsurance** due while the demand bill is being processed, and for the services not covered by Medicare. If you are in a Medicare managed care plan or Private Fee-for-Service plan, call your plan for information about Skilled Nursing Facility coverage.

If you have questions about SNF care, call your Fiscal Intermediary (see pages 29A-31). You may also call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of *Medicare Coverage of Skilled Nursing Facility Care*.

You are Protected When Your Home Health Care Ends ▸

Home health care agencies must give you a notice that explains why and when they think Medicare will stop paying for your home health care. If you think you still need home health care, and you think Medicare should keep paying, you can ask Medicare for an official decision.

To get an official decision, you should:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this.
- Pay the home health agency for these services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay.

If Medicare decides to pay, you will get back all of your payments, except for any **coinsurance** for durable medical equipment. If Medicare decides not to pay, you will get a letter that tells you how to appeal. You can always get home health care if you want to pay for it yourself. If you have questions about home health care in the Original Medicare Plan, call your Regional Home Health Intermediary (see pages 32-33). If you have questions about home health care in a Medicare managed care plan or Private Fee-for-Service plan, call your plan. You may also call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Medicare Home Health Services*.

Medigap Policy Protections

You may have the right to buy a **Medigap** policy, even if you are in poor health. For more information, see page 57.

You Can Help Watch Over Spending in Medicare

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

What you can do to watch over spending in Medicare ▸

With help from the honest health care providers, law enforcement, and you, Medicare is solving this problem. Medicare has sent some dishonest providers to jail. Some providers have left the Medicare program. These actions are saving money for taxpayers and protecting Medicare for the future.

You can help protect Medicare by:

- Reviewing all payment notices from Medicare for errors.
- Making sure Medicare was not billed for health care services or medical supplies and equipment you did not get.
- Not giving your Medicare claim number (on your Medicare card) to anyone, except your doctor or other Medicare health professionals. You should not send these numbers over the Internet.
- Not letting anyone, except appropriate medical health professionals, review your medical records.

How to report errors and concerns ▸

If you see a charge on your payment notice that may be wrong, call the health care provider and ask about it. If you think that a provider may be cheating or abusing Medicare, call the Medicare Carrier or Fiscal Intermediary that sent you the notice. Their phone number is printed on the front of the notice.

You can also call the Inspector General's hotline to report Medicare fraud. The hotline number is 1-800-HHS-TIPS (1-800-447-8477). Or, send a note to htips@os.dhhs.gov by e-mail. Medicare will not use your name if you ask that it not be used.

What else can I do to fight fraud?

Call your regional U. S. Administration on Aging Office and ask about programs in your community that train volunteers to detect and report fraud. Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *Medicare Fraud and Abuse Fact Sheet*. You can also look on the Internet at www.medicare.gov to read or print this fact sheet.

Medicare Questions and Answers

On pages 52-65 are frequently asked Medicare questions and answers. They are grouped as follows:

Q1 - Q10 General Medicare questions, like a new Medicare card, address changes, Part B enrollment, travel, prescription drugs, Medicaid, and Private Contracts (pages 52-55).

Q11 - Q12 Other general questions about the Original Medicare Plan (page 56).

Q13 - Q16 Questions about Medigap (supplement insurance that helps fill "gaps" in Original Medicare Plan coverage) (pages 57-60).

Q17 - Q24 Other general questions about Medicare managed care plans (like an HMO) or Private Fee-for-Service plans (pages 60-62).

Q25 - Q30 Questions about mental health, nursing home, and long-term care (pages 63-65).

General Medicare Questions and Answers

Q1: How do I get a new red, white, and blue Medicare card?

A: To get a new Medicare card, call the Social Security Administration at 1-800-772-1213. They will send you a new card. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Q2: My copy of *Medicare & You* was sent to the wrong address. How do I change my address?

A: If you need to change your address, call the Social Security Administration at 1-800-772-1213, or call your local Social Security office. They will make the change for you. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Q3: Why aren't the Medicare premium and coinsurance rates for 2001 in this handbook?

A: The law says Medicare must send you this handbook by October each year, in time for the November period when most plans are required to accept new members. New Medicare premium and coinsurance rates were not available at the time this handbook was printed. If you get Social Security or Railroad Retirement benefits, new rates will be sent to you with your cost of living adjustment notice. You can also get the new rates after December 1, 2000 by calling 1-800-MEDICARE (1-800-633-4227), or look at www.medicare.gov on the Internet.

Q4: What if I didn't sign up for Part B when I first became eligible?

A: If you did not take Part B when you were first eligible for Medicare at age 65, you may sign up during a **General Enrollment Period**. This period runs from January 1 through March 31 of each year. **Remember, the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see below). You will have to pay this extra 10% for the rest of your life.**

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

Q5: How do I sign up for Part B if I or my spouse continued to work and had group health plan coverage through my or my spouse's employer or union after I first became eligible?

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

The Special Enrollment Periods when you can sign up are:

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

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

Most people who sign up for Part B during a Special Enrollment Period do not pay higher **premiums**. However, if you are eligible, but do not sign up during the Special Enrollment Period, the cost of Part B may go up.

Q5: Special Enrollment Period (continued)

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

Q6: Does Medicare cover me when I travel outside of the United States?

A: The Original Medicare Plan generally does not cover care outside the United States, but some Medicare managed care plans, Private Fee-for-Service plans, and Medigap policies do. Check your insurance coverage before you travel outside the country.

Q7: Does Medicare pay for prescription drugs?

A: The Original Medicare Plan does not cover prescription drugs except in a few cases, like certain cancer drugs. Many Medicare managed care plans cover prescription drugs, up to certain dollar limits (sometimes for an extra cost). Some Medigap policies also cover prescription drugs.

Q8: If I have Medicare and Medicaid, who will pay my health care bills first?

A: For services that Medicare covers, your bill should always be sent to Medicare first. The part of the bill that Medicare does not pay will then be sent to your state Medicaid program for further payment.

Q9: Are there any times when Medicare would pay second?

A: Sometimes your other insurance pays your health care bills first and Medicare pays second. This is called Medicare Secondary Payer. Other insurance that may have to pay first includes: employer group health plan insurance under certain conditions, no-fault insurance, any liability insurance, black lung benefits, and workers' compensation. It is important that you tell your doctor or 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 (see page 24). For more information, call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First*.

Q10: What is a "Private Contract," and how does it work?

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

- No Medicare payment will be made for the services you get from this doctor.
- You will have to pay whatever this doctor or provider charges you (the **limiting charge** will not apply).
- Medicare health plans (like managed care plans and Private Fee-for-Service plans) will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is submitted.
- Your Medigap policy, if you have one, will not pay anything for this service. Call your Medigap insurance company if you have any questions before you get the service.
- Many other insurance plans will not pay for the service either.

The private contract only applies to the services you get from the doctor who asked you to sign it. You cannot be asked to sign a private contract in an emergency or urgent health situation. You may want to talk with someone in your **State Health Insurance Assistance Program** before signing a private contract (see pages 26-27). You can also call 1-800-MEDICARE (1-800-633-4227) and ask for information on private contracts.

You are always free to get non-covered services on your own if you choose to pay for these services yourself. In this case, you do not have to sign a private contract and your doctor does not have to stop giving services through Medicare.

Original Medicare Plan Questions and Answers:

Q11: How are my bills paid in the Original Medicare Plan?

A: When you get services covered by the Original Medicare Plan, your provider sends the bill to a private company that handles bills for Medicare. The Fiscal Intermediary pays bills for Part A services (see pages 29A-31) and the Medicare Carrier pays bills for Part B services (see pages 25A-F). After they process the bill, you will get an Explanation of Medicare Benefits or a Medicare Summary Notice. Please check this payment notice to be sure you got all the services, medical supplies, or equipment that Medicare was billed for. If you have any questions about bills or services listed on the payment notice, call the provider and ask about it. If you disagree with what is covered or paid, you have the right to file an appeal (see page 46). If you think the provider is being dishonest, see page 50.

Q12: What is "assignment" in the Original Medicare Plan and why is it important?

A: Assignment is an agreement between Medicare and doctors and suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies). Doctors and suppliers who agree to accept assignment accept the Medicare-approved amount as payment in full. You pay the coinsurance and deductible amounts. If assignment is not accepted, charges are often higher. This means you may pay more. There is a limit on the amount your doctor can bill you. Ambulance suppliers and durable medical equipment suppliers that do not take assignment can charge you any amount. You are responsible to pay their full charges. Medicare will reimburse you later for its share of the bill. For more information about assignment, call 1-800-MEDICARE (1-800-633-4227) to get a free copy of *Does Your Doctor or Supplier Accept Assignment*?

Medigap Questions and Answers:

Q13: Do I need to buy a Medigap policy?

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

You do not need to buy a Medigap policy if you are in a:

- Medicare managed care plan
- Private Fee-for-Service plan

In fact, it may be illegal for anyone to sell you a Medigap policy if they know you are in one of these health plans. If you have Medicaid, it is generally illegal for an insurance company to sell you a Medigap policy. For more information, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *Guide to Health Insurance for People with Medicare*.

Q14: When is the best time to buy a Medigap policy?

A: The best time to buy a **Medigap** policy is during your Medigap open enrollment period. Your Medigap open enrollment period lasts for 6 months. It begins on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

During this period, an insurance company cannot deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or change the price of a policy because of past or present health problems.

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

Note: If you are under age 65 and disabled or have End-Stage Renal Disease (ESRD), you may not have an open enrollment period until you turn 65. However, in some states you may have other options, such as the right to buy the same Medigap policies that are sold to people under age 65.

Medigap (Q14 continued)

For more information:

- Call your State Health Insurance Assistance Program (see pages 26-27).
- Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *2000 Guide to Health Insurance for People with Medicare*.

Note: If you are age 65 or older and have health coverage through an employer or union based on your or your spouse's current or active employment, you may want to wait to enroll in Medicare Part B and delay your Medigap open enrollment period (see page 53).

Q15: What situations give me the right to buy a Medigap policy after my Medigap open enrollment period ends?

A: There are certain situations involving health coverage changes when you may have the right to buy a Medigap policy after your Medigap open enrollment period ends. These are called Medigap protections because insurance companies are required by law to issue you a policy. For example:

- Your Medicare managed care plan or Private Fee-for-Service plan is leaving the Medicare program or stops giving care in your area.
- You move outside your Medicare managed care plan or Private Fee-for-Service plan's service area.
- You leave your Medicare managed care plan or Private Fee-for-Service plan because it failed to meet its contract obligations to you (for example, the marketing material was misleading or quality standards were not met).
- You are in an employer group health plan that supplements or pays some of the costs not paid by Medicare, and the plan ends your coverage.
- Your health coverage (like a Medicare managed care plan, Private Fee-for-Service plan, employer group

Medigap (Q15 continued)

health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy, Program of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends through no fault of your own. For example, the company goes bankrupt.

- You dropped your Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy for the first time, and then leave that plan or policy within one year after joining.

- You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and within one year of joining, you decided to leave the Medicare health plan.

In these situations, the Medigap insurance company can't deny you insurance, place conditions on a policy, or charge you more for a policy because of past or present health problems. If you think any of these situations apply to you, call your State Health Insurance Assistance Program (see pages 26-27) to make sure that you qualify and to find out which of the Medigap policies you can buy. If you are denied Medigap coverage, you should call your State Insurance Department (see pages 40-41).

For more information about Medigap protections, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of *Medigap Policies and Protections*. You can also look on the Internet at www.medicare.gov to read or print this booklet.

Q16: How do I get more information about Medigap policies?

A: Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *2000 Guide to Health Insurance for People with Medicare*. Look at www.medicare.gov on the Internet to get information on Medigap policies in your state. Click on Medigap Compare. If you don't have a computer, your local library or senior center may be able to help you look at this information.

Medicare managed care plan and Private Fee-for-Service plan Questions and Answers:

Q17: How do I find out which plans are offered where I live, what they cost, and what extra benefits are covered?

A: Call 1-800-MEDICARE (1-800-633-4227) and ask for a free, up-to-date list of all the plans offered where you live, with more detailed information comparing extra benefits and costs.

OR

Look at www.medicare.gov on the Internet. Click on Medicare Health Plan Compare. If you do not have a personal computer, your local library or senior center may be able to help you.

Then call any plan you may be interested in. They can tell you if the plan is offered where you live and can send you up-to-date, detailed information about their extra benefits and costs.

Q18: How do I find out if my doctor or hospital belongs to a plan?

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

Q19: How can I find out how the plan rates in quality (keeps its members healthy or treats them when they are sick), or how many people disenrolled (chose to leave their plan) and how many stayed?

A: Call 1-800-MEDICARE (1-800-633-4227) and ask for quality and other information for the plans in your area.

OR

Look at www.medicare.gov on the Internet. Click on Medicare Health Plan Compare. If you do not have a personal computer, your local library or senior center may be able to help you.

Q20: Who can help me compare plans?

A: Call your State Health Insurance Assistance Program (see pages 26-27). Volunteer counselors can help you compare the Medicare health plans available to you.

Q21: What can I do if my Medicare health plan does not stay in the Medicare program?

A: If your Medicare health plan (like a Medicare managed care plan or Private Fee-for-Service plan) leaves the Medicare program, you will be sent a notice. The notice will tell you if there are other Medicare managed care plans or Private Fee-for-Service plans in your area that you can join. Or, you can always return to the Original Medicare Plan. You may be able to get a Medigap policy (see page 58). 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.

Q22: Why aren't Medicare managed care plans or Private Fee-for-Service plans available where I live?

A: These Medicare health plans are offered by private companies. The companies decide which areas they will serve. Companies may decide to offer plans in your area in the future. For the most up-to-date information about Medicare health plans in your area, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or look at www.medicare.gov on the Internet.

Q23: What is a “medical emergency”? How do I get emergency care?

A: A medical emergency is when you believe that your health is in serious danger -- when every second counts. You may have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse. All Medicare managed care plans must allow you to get emergency care whenever you need it from any provider in the United States. You do not need permission from your primary care doctor first. Your plan must pay for emergency care. If you get a bill, give it to the plan to pay. If your plan does not pay for your emergency care, you have the right to **appeal** (see page 47).

Q24: What is "urgently needed care"? How do I get urgently needed care?

A: Urgently needed care is care you need for a sudden illness or injury that is not a medical emergency. In a Medicare managed care plan, you get urgently needed care from your primary care doctor. However, if you are out of the plan's service area and cannot wait until you return home, your plan must pay for urgently needed care. If it does not, you have the right to **appeal** (see page 47).

Special Care Questions and Answers:

Q25: Does Medicare cover mental health care?

A: If you are in the Original Medicare Plan, Part A covers inpatient mental health care, including room, meals, nursing, and other related services and supplies. Part B covers mental health services generally given outside a hospital, including visits with a doctor, clinical psychologist, clinical social worker, and lab tests (see page 8). For more information about Medicare coverage for mental health care, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Medicare and your Mental Health Benefits*, or look at www.medicare.gov on the Internet.

If you are in a Medicare managed care plan or a Private Fee-for-Service plan, read your plan materials or call the plan to learn about their coverage of mental health care. You must get at least the same coverage as provided by Part A and Part B of the Original Medicare Plan.

Q26: Does Medicare pay for care in a nursing home?

A: Usually, no. Most nursing home care is custodial care. This is different than what Medicare covers. Medicare Part A only covers **skilled care** given in a certified skilled nursing facility. You must meet certain conditions and coverage is limited (see page 6).

Skilled care includes nursing or rehabilitation therapies given by skilled health care personnel such as registered nurses, licensed practical and vocational nurses, physical and occupational therapists, speech pathologists, and audiologists.

For more information about Medicare's coverage of skilled care, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Medicare Coverage of Skilled Nursing Facility Care*, or look at www.medicare.gov on the Internet.

Q27: What is long-term care?

A: Long-term care is different from traditional medical care. Someone with a physical illness, a disability, or a memory or thought problem (such as Alzheimer's disease) often needs long-term care. Long-term care is made up of many different services to help people with chronic conditions overcome limitations that keep them from being independent. Long-term care may include custodial care, which is help with activities of daily living (such as shopping, bathing, and dressing). Long-term care can also include home health care, respite care, adult day care, care in a nursing home, and care in an assisted living facility. Long-term care may also include special services that help coordinate and monitor your long-term care services.

Q28: Does Medicare pay for long-term care?

A: No. Generally, Medicare only covers care that is both **medically necessary** and covered under Part A (hospital insurance) and Part B (medical insurance). You must meet certain conditions for Medicare to cover skilled nursing facility, home health, and hospice care. Medicare does not cover custodial care.

Q29: What is long-term care insurance?

A: Long-term care insurance is one way you may pay for long-term care. This type of insurance will pay for some or all of your long-term care. Long-term care insurance is relatively new. It was introduced in the 1980s as nursing home insurance, but it has changed a lot and now covers much more than nursing home care.

For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from your State Insurance Department, or write to the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105-1925.

Q30: How can I find out about the nursing homes in my area?

A: You can get important information on the Internet at www.medicare.gov about the nursing homes in your area. Click on Nursing Home Compare for information and nursing home inspection reports for all the Medicare and Medicaid-certified nursing homes in the country. If you don't have a computer, your local library or senior center may be able to help you look at this information. You can also call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of *Your Guide to Choosing a Nursing Home.*

Free Medicare and Related Booklets

Medicare has many booklets to help you learn about the program. This handbook contains basic information that everyone with Medicare needs to know. Other booklets can give you more details about topics that are of interest to you. Medicare will continue to add new booklets to get you the information you need.

How do I get these booklets?

You can:

1. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the booklet you want.

2. Look on the Internet at www.medicare.gov and click on Publications. You can read or print out these booklets.

What booklets are available?

About Basic Medicare Information:

• Medicare & You 2001

You can get free copies of this handbook in:
- English print (like this one)
- Spanish print
- English large print
- Spanish large print
- English audiotape
- Spanish audiotape
- Braille

About Services Medicare Covers:

- Medicare and Your Mental Health Benefits **New!**
- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services **New!**
- Medicare Coverage of Skilled Nursing Facility Care **New!**
- Medicare Coverage For Second Surgical Opinion
- Medicare Home Health Care Services
- Medicare Hospice Benefits
- Medicare Preventive Services

What booklets are available? (continued)

About Health Care Choices:
- Choosing a Doctor **New!**
- Choosing a Hospital **New!**
- Choosing Treatments **New!**
- Your Guide to Choosing a Nursing Home
- Private Contracts Fact Sheet
- Nursing Homes Fact Sheet

About Medicare Health Plan Choices and Supplemental Coverage:
- Health Plan Comparison Information (with quality data)
- Learning about Medicare Health Plans
- 2000 Guide to Health Insurance for People with Medicare
- Your Guide to Private Fee-for-Service Plans
- Your Guide to Medicare Medical Savings Accounts
- Worksheet for Comparing Medicare Health Plans

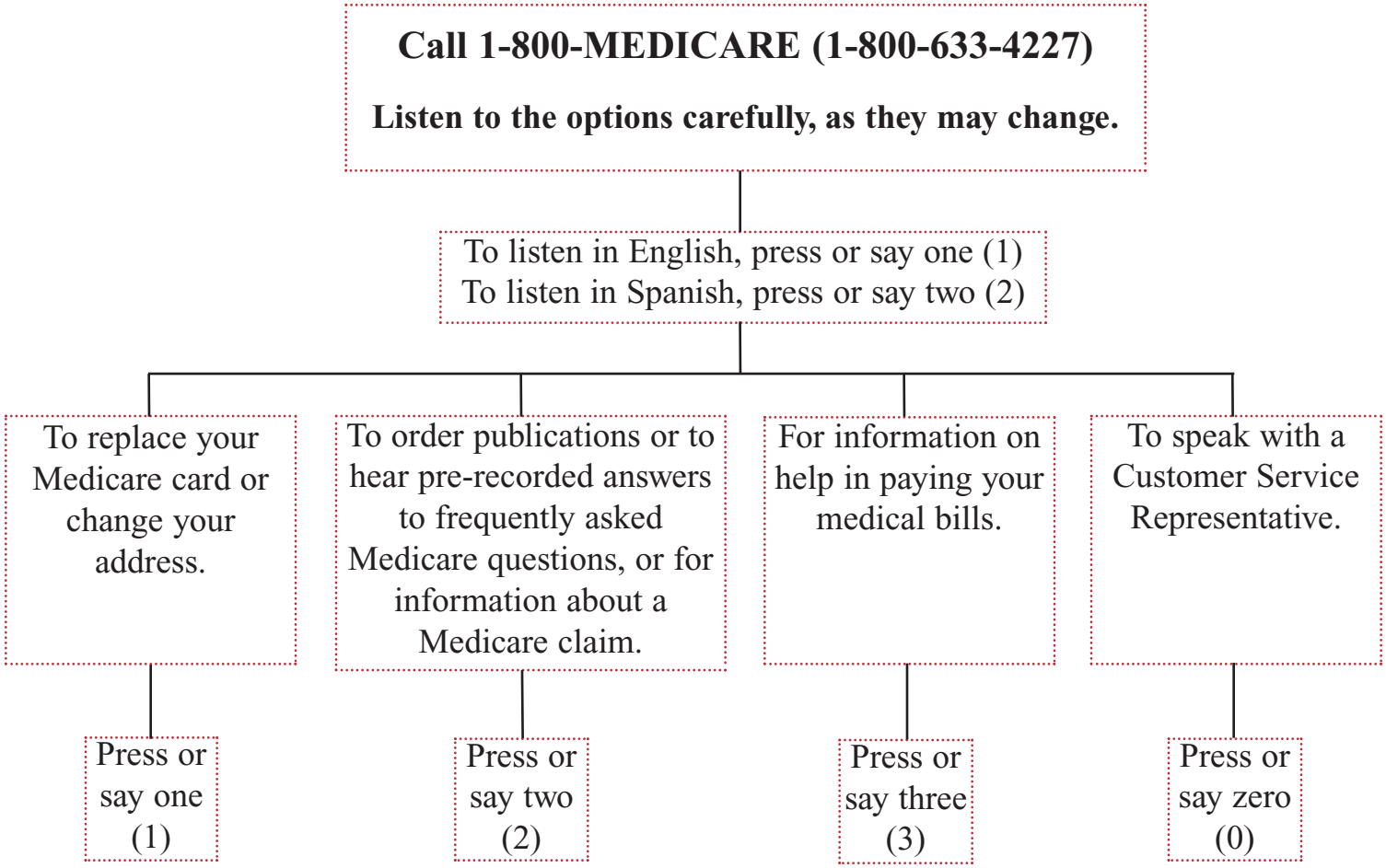
About Your Rights and Protections:
- Medicare Appeals and Grievances (Complaints)
- Medicare Fraud and Abuse
- Medicare Patient Rights
- Medigap Policies and Protections

About Costs and Payment:
- Do You Need Help to Pay Health Care Costs?
- Does Your Doctor or Supplier Accept Assignment?
- Medicare and Other Health Benefits: Your Guide to Who Pays First **New!**
- Your Guide to the Outpatient Prospective Payment System **New!**

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

Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048) to:

- Get more help with your Medicare questions.
- Order quality and other information about the Medicare health plans in your area.
- Listen to recorded questions and answers on topics such as Medicare health plan choices.
- Order Medicare publications. (Some are available in Audiotape, Braille, Large print, and Spanish.)



Important Notes About 1-800-MEDICARE

- If you are hearing or speech impaired, call the TTY/ TDD line toll-free at 1-877-486-2048 for these options.
- Once you have called 1-800-MEDICARE, you can either press the numbers listed or just say the numbers to request what you want.
- You can hear a recording with answers to frequently asked questions, and can order publications 24 hours a day, 7 days a week.
- You can talk with a Customer Service Representative between 8:00 a.m. and 4:30 p.m. in your time zone, Monday through Friday.

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

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care 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 cost of the service (like 20%).

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

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.

End-Stage Renal Disease - Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

General Enrollment Period (GEP) - The GEP is January 1 through March 31 of each year. If you enroll in Part B or Part A (if you don't get it automatically without paying a premium) during the GEP, your coverage starts on July 1.

Grievance - A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have problems with the cleanliness of the health care facility, calling the plan, staff behavior, or operating hours. A grievance is not the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that is not covered (see **Appeal**).

Inpatient Care - Health care that you get when you stay overnight in a hospital.

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

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

Medically Necessary - Services or supplies that:

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

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

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

Medicare Medical Savings Account (MSA) - A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

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

Peer Review Organization (PRO) - Groups of practicing doctors and other health care experts paid by the Federal Government to monitor and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers.

Premium - What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Primary Care Doctor - A doctor who is trained to give you basic care. This includes being the first one to check on health problems and coordinating your preventive health care with other doctors, specialists, and therapists. In many Medicare managed care plans, you must see your primary care doctor before you can see any other health care provider. (See Medicare Managed Care Plan.)

Private Fee-for-Service Plan - A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

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

Reserve Days - Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance amount ($388 in 2000).

Skilled Nursing Facility Care* - A level of care that must be given or managed by licensed health care professionals and is under the general direction of a doctor. All of your needs are taken care of with this type of service, including getting direct services. As long as you need skilled care, it makes no difference whether your illness is acute, chronic, or terminal. Medicare does not cover unskilled (custodial) care, except when it is given in addition to Medicare-covered skilled care.

Special Enrollment Period (SEP) - A set time when you can sign up for Medicare Part B if you did not take Part B during the Initial Enrollment Period, because you or your spouse currently work and have group health plan coverage through the employer or union. You can sign up at any time you are covered under the group plan. If the employment or group health coverage ends, you have 8 months to sign up. The 8-month SEP starts the month after the employment ends or the group health coverage ends, whichever comes first.

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

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

Page(s)

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September 2000

National Medicare Handbook; with a listing of important phone numbers for your area.

To get this handbook on Audiotape, Braille, Large Print, or Spanish, call 1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired.

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¿Necesita usted una copia en Español? Por favor llame gratis al 1-800-633-4227, TTY/TDD: 1-877-486-2048 para personas con impedimento auditivo o de lenguaje oral.