

CENTERS FOR MEDICARE & MEDICAID SERVICES



Your Medicare Benefits

This is the official government booklet with important information about the following:

- ★ The services and supplies Original Medicare covers
- ★ How much you pay
- ★ Where to get more information



ABOUT THIS BOOK

Deciding how you get your health care is important.

One way to get Medicare coverage is through Original Medicare. You can get Part A (Hospital Insurance) and Part B (Medical Insurance) coverage in Original Medicare and add prescription drug coverage (sometimes called “Part D”) for an additional monthly **premium**.

Another way to get Medicare coverage is through a Medicare health plan, like an HMO or PPO. These plans are offered by private companies. The most common type of Medicare health plan is a **Medicare Advantage Plan**, which is sometimes called “Part C.” Medicare Advantage Plans provide all of your Part A and Part B coverage and must cover at least all of the **medically-necessary** services that Original Medicare provides. However, Medicare Advantage Plans can charge different **copayments**, **coinsurances**, and **deductibles**. Most of these plans cover extra benefits like vision, hearing, dental coverage, and Medicare prescription drug coverage.

This booklet explains which health care services and supplies are covered under Medicare, and how to get those benefits through Original Medicare. It includes the rules for what specific benefits you can get, and when. It also explains how much Medicare pays for each service, and how much you pay. Finally, it gives you information on how to get help with any questions you may have.

If you have questions that aren't answered in this book, look in your copy of the “Medicare & You” handbook mailed to you each year, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Blue words in the text are defined on pages 59-61.

“Your Medicare Benefits” isn’t a legal document. The official Medicare Program legal guidance is contained in the relevant laws, regulations, and rulings.

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Note: The information in this booklet was correct when it was written. Changes may occur. To find out if the information has been updated, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Medicare Basics

1

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has the following parts:

Part A (Hospital Insurance)

Medicare Part A helps cover your inpatient care in hospitals ([critical access hospitals](#) and inpatient rehabilitation facilities), skilled nursing facilities after a hospital stay, and [Religious Nonmedical Health Care Institutions](#). Part A also helps cover hospice services and home health care services. Medicare doesn't cover custodial or long-term care. You must meet certain conditions to get these benefits.

Cost: Most people are automatically enrolled in Part A and don't have to pay a monthly [premium](#) if 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 still be able to apply for Part A, but you will have to pay a premium. You pay up to \$423 each month in 2008 if you don't get premium-free Part A. This amount changes each year.

Part B (Medical Insurance)

Medicare Part B helps cover [medically-necessary](#) services like doctors' services, outpatient care, and other medical services that Part A doesn't cover. Part B is optional. Part B helps pay for covered medical services and items when they are medically necessary.

Cost: Most people will pay the standard monthly Part B premium of \$96.40 for 2008, but some people will pay a higher premium based on their income. If you are single (file an individual tax return) and your yearly modified adjusted gross income is more than \$82,000 or if you are married (file a joint tax return) and it is more than \$164,000, your monthly Medicare Part B premium may be higher than the standard premium. These amounts change each year.

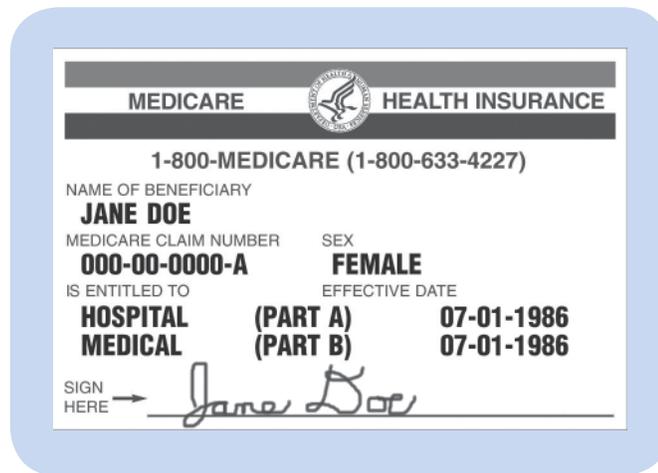
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Section 1: Medicare Basics

Part B (Medical Insurance) (continued)

Also, in some cases, your monthly **premium** 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. You will have to pay this extra amount as long as you have Part B, except in special cases.

You can find out if you have Part A and/or Part B by looking at your Medicare card. Your card may look slightly different than the card below. It's still valid. Keep this card safe. You will use this card to get your Medicare-covered services in Original Medicare.



For more information about getting Medicare Part A or Part B, or if you need to replace your card, visit www.socialsecurity.gov on the web, or call Social Security 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, or visit www.rrb.gov on the web. Select “Benefit Online Services.”

Blue words in the text are defined on pages 59-61.

What is Assignment in Original Medicare?

2

Assignment is an agreement between you, Medicare, and doctors, other health care providers, or suppliers. When you “assign” a claim to your doctor, Medicare will pay your doctor, provider, or supplier directly for the services you get.

If your doctor, provider, or supplier accepts assignment

Getting services and supplies from a doctor, provider, or supplier who accepts assignment can reduce your out-of-pocket costs.

- Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. In some cases they must accept assignment, like when they have a participation agreement with Medicare and give you Medicare-covered services.
- If a doctor, provider, or supplier accepts assignment, they agree to only charge you the Medicare **deductible** or **coinsurance** amount and will wait for Medicare to pay its share.
- All doctors, providers, and suppliers that give you Medicare-covered services have to submit your claim to Medicare directly. They can't charge you for submitting the claim.

Section 2: What is Assignment in Original Medicare?

If your doctor, provider, or supplier doesn't accept assignment

- They still must submit a claim to Medicare when they give you Medicare-covered services. If they don't submit the claim for these services, you should contact the company that handles Medicare claims for your State to file a complaint. You can call 1-800-MEDICARE (1-800-663-4227) for their telephone number. TTY users should call 1-877-486-2048. In the meantime, you might have to pay the entire charge at the time of service, and then submit your claim to Medicare to get paid back.
- They may charge you more than the Medicare-approved amount, but there is a limit called "the limiting charge." They can only charge you 15% over the Medicare-approved amount (but may be lower in your state). The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment.

To find doctors and suppliers who accept assignment, visit www.medicare.gov on the web. Select "Find a Doctor" or "Find Suppliers of Medical Equipment in Your Area." You can also call 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Blue words in the text are defined on pages 59-61.

How are Bills Paid in Original Medicare?

3

If you get a Medicare-covered service, like a lab test or doctor's visit, you will get a **Medicare Summary Notice (MSN)** in the mail. The MSN shows all the services or supplies that were billed to Medicare during each 3-month period, what Medicare paid, and what you may owe the provider. **The MSN isn't a bill.** When you get your MSN, you should do the following:

- If you have other insurance, check to see if your other insurance covers anything that Medicare didn't.
- Keep your receipts and bills and compare them to your MSN to be sure you got all the services, supplies, or equipment listed.
- If you pay a bill before you get your MSN, compare your MSN with the bill to make sure you paid the right amount for your services.

MSNs are mailed out every 3 months. If you are due a refund check from Medicare, the MSN will be mailed out as soon as the claim is processed. If you need to change your address on your MSN, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get RRB benefits, call your local RRB office, or 1-800-808-0722. After January 1, 2009, call 1-877-772-5772.

You can also track your Medicare claims by visiting www.MyMedicare.gov on the web.

What if I have other health insurance?

Tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you have Original Medicare and you have questions about how it works with your other insurance, or you need to update your other health insurance information, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

Section 3: How are Bills Paid in Original Medicare?

What if I need a health care service or supply that Medicare doesn't cover?

If you have Original Medicare and your health care supplier or provider thinks that Medicare probably (or certainly) won't pay for certain services for you, the supplier or provider must tell you in writing. This is called an Advance Beneficiary Notice, or ABN, and it explains what items and services Medicare won't pay for and why. You will be asked to choose an option on the ABN indicating whether you still want to get the service and to sign the ABN. If you choose to get the service listed on the ABN, you must agree to pay if Medicare doesn't pay.

An ABN isn't an official denial of coverage by Medicare. You can still ask your health care provider or supplier to submit the bill to Medicare. If payment is denied, you can file an [appeal](#). If you aren't sure if Medicare was billed for the services you got, call or 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 health care provider.

What happens if Medicare doesn't pay for a health care service or supply?

After you get a service or supply, your provider should bill Medicare. Later, Medicare will send you a Medicare Summary Notice (MSN) that describes the bills it got from your providers. The MSN will also tell you whether Medicare paid the bills. Read it carefully. If Medicare didn't pay for a service or supply, and you think it should have, you have 120 days from the date you get the notice to file an appeal. The back of your MSN will have information on how to file an appeal.

If you are getting Medicare-covered services from a hospital (as an inpatient), skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your services are ending too soon, you may have the right to a "fast appeal." This fast appeal is also called an "expedited determination." An independent reviewer will decide if your services should continue.

Blue words in the text are defined on pages 59-61.

Section 3: How are Bills Paid in Original Medicare?

Protect Yourself and Medicare from Billing Fraud

Most doctors, pharmacists, plans, and other health care providers who work with Medicare are honest. Unfortunately, there may be some who are dishonest.

Medicare is working with other government agencies to protect you and the Medicare Program from such dishonesty. Medicare fraud happens when Medicare is billed for services or supplies 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.

The following are examples of possible Medicare fraud:

- A health care provider bills Medicare for services you never got.
- A supplier bills Medicare for equipment different than what they provided to you.
- Someone uses another person's Medicare card to get medical care, supplies, or equipment.
- Someone bills Medicare for home medical equipment after it has been returned.
- A company offers a Medicare drug plan that hasn't been approved by Medicare.
- A company uses false information to mislead you into joining a Medicare plan.

If you suspect billing fraud, here's what you can do:

1. Contact your health care provider to be sure the bill is correct.
2. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
3. Call the Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950.

Protect Yourself from Identity Theft

It's also important to keep your personal information safe. You have control over when you provide and who you allow to have your personal information.

Generally, no one should call you or come to your home uninvited selling Medicare-covered products. Don't give your personal information to someone who does this. **Only give personal information to doctors, other providers, and plans approved by Medicare, and to people in the community who work with Medicare, like your State Health Insurance Assistance Program (SHIP) or Social Security.** Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a provider is approved by Medicare. TTY users should call 1-877-486-2048.

If you think someone is using your personal information, you can call any of these numbers:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The Fraud Hotline of the HHS Office of the Inspector General at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950.
- The Federal Trade Commission's ID Theft Hotline at 1-877-438-4338 to make a report. TTY users should call 1-866-653-4261. For more information about identity theft, visit www.consumer.gov/idtheft on the web.

The Senior Medicare Patrol Program Can Help You

The Senior Medicare Patrol (SMP) Program educates and empowers people with Medicare to take an active role in detecting and preventing health care fraud and abuse. There is a SMP Program in every state, the District of Columbia, Guam, U.S. Virgin Islands, and Puerto Rico. To find your state's SMP Program, visit www.smpresource.org on the web, or call 1-877-808-2468.

Blue words in the text are defined on pages 59-61.

Other Ways to Pay Medicare Costs

4

Medigap

Original Medicare pays for many health care services and supplies, but there are many costs it doesn't cover. To help cover health care costs, you might want to buy a [Medigap](#) (Medicare Supplement Insurance) [policy](#). Medicare doesn't pay any of the costs for a Medigap policy.

A Medigap policy is health insurance sold by private insurance companies to fill “gaps” in Original Medicare coverage. Medigap policies help pay your share ([coinsurance](#), [copayments](#), or [deductibles](#)) of the costs of Medicare-covered services, and some policies cover certain costs not covered by Original Medicare.

For more information about Medigap policies, visit www.medicare.gov on the web to view a copy of “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare” by selecting “Find a Medicare Publication.” You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Help from Your State

States have programs for people with limited income and resources that pay Medicare Part A and/or Part B [premiums](#), and in some cases, may also pay Medicare deductibles and coinsurance.

Section 4: Other Ways to Pay Medicare Costs

How do I qualify for these programs?

- You must have Medicare Part A. (If you are paying a premium for Medicare Part A, these programs may pay the Medicare Part A premium for you.)
- You must be an individual with resources of \$4,000* or less, or a married couple with resources of \$6,000* or less. Resources include things like money in a checking or savings account, stocks, and bonds, but doesn't include things like your home or car.
- You must be an individual with a monthly income of less than \$1,190*, or a married couple with a monthly income of less than \$1,595*.

Many states figure your income and resources differently, so you may be eligible in your state even if your income is higher.

*These amounts may change each year. If you live in Alaska or Hawaii, income limits are slightly higher. Individual states may have higher income and/or resource limits.

For more information, call your State Medical Assistance ([Medicaid](#)) office. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state. 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, even if you aren't sure.

Medicaid

If your income and resources are limited, you may qualify for full coverage under Medicaid. Most of your health care costs are covered if you have both Medicare and full coverage from Medicaid. Medicaid is a joint Federal and state program that helps pay medical costs for some people with limited income and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for services like nursing home care and home health care that aren't fully covered by Medicare. For more information about Medicaid, call your State Medical Assistance (Medicaid) office. To get the telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Blue words in the text are defined on pages 59-61.

Section 4: Other Ways to Pay Medicare Costs

How do I qualify for these programs? (continued)

Extra Help Paying for Medicare Prescription Drug Coverage

If you have limited income and resources, you may qualify for extra help paying your prescription drug costs. If you qualify, you will get help paying for your drug plan's monthly premium, yearly **deductible**, and prescription **copayments**. See page 17 for more information about Medicare Prescription Drug Coverage.

The amount of extra help you get will be based on your income and resources (including your savings and stocks, but not counting your home or car). In 2008, you may qualify if your monthly income is less than \$1,300 (\$1,750 for a married couple living together), and your resources are less than \$11,990 (\$23,970 for a married couple living together).

Social Security sends people with certain incomes an application for this extra help. If you get this application, fill it out and send it back to Social Security as soon as possible. If you don't get an application, but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (**Medicaid**) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify, how much extra help you will get, and what you need to do next.

You automatically qualify for extra help and don't need to apply if you meet any of the following conditions:

- You have Medicare and full Medicaid coverage.
- You get Supplemental Security Income (SSI) benefits.
- You get help from your state Medicaid program paying your Medicare Part B premiums (belong to a Medicare Savings Program).

Medicare Prescription Drug Coverage

5

Medicare offers prescription drug coverage (Part D) for everyone with Medicare. To get Medicare drug coverage, you must join a Medicare drug plan. Medicare drug plans are run by insurance companies and other private companies approved by Medicare. Each plan can vary in cost and drugs covered. Even if you don't take a lot of prescription drugs now, you should still consider joining a Medicare drug plan.

If you join a Medicare drug plan, you usually pay a separate monthly **premium** in addition to your Part B premium. There are two ways to get Medicare prescription drug coverage:

- 1) Join a Medicare Prescription Drug Plan. These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
- 2) Join a **Medicare Advantage Plan** (like an HMO or PPO) or another Medicare health plan that includes prescription drug coverage. You get all of your Medicare coverage (Part A and Part B) and prescription drugs (Part D) through these plans. These plans are sometimes called "MA-PDs."

Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get information about the Medicare drug plans available in your area. TTY users should call 1-877-486-2048.

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Section 5: Medicare Prescription Drug Coverage

Even if you wait to sign up for Medicare drug coverage, you won't have to pay a late-enrollment penalty if you have been covered under certain other types of prescription drug coverage, called “[creditable prescription drug coverage](#).” You may not have to pay a late-enrollment penalty if you join later and you have creditable coverage through another source. This could include drug coverage from a former employer or union, TRICARE, the Department of Veterans Affairs, or certain [Medigap policies](#). Your current prescription drug coverage is required to tell you each year whether the drug coverage you have is creditable. **Keep this annual notice, as you may need it if you decide to enroll in a Medicare drug plan later.**

Important:

If you have, or are eligible for, other types of prescription coverage, read all the materials you get from your insurer or plan provider to find out if enrolling in a Medicare drug plan will affect your current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veteran's Affairs, or a Medigap policy. If you still have questions, talk to your benefits administrator, insurer, or plan provider before you make any changes to your current coverage.

Blue words in the text are defined on pages 59-61.

List of What Original Medicare Covers

6

The charts starting on the next page include the following information:

- Many of the services and supplies covered by Original Medicare
- Conditions and limits for coverage
- How much you pay

As you read the charts below, keep these two points in mind:

1. Unless otherwise noted, in 2008, you pay an annual \$135 **deductible** for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.
2. Actual amounts you pay may be higher if doctors, other health care providers, or suppliers don't accept assignment, depending on the service or supply.

The information about services and supplies listed in these charts apply to all people with Original Medicare. If you are enrolled in a Medicare Advantage Plan or other Medicare health plan, you have the same basic benefits, but the rules vary by plan. Some services and supplies may not be listed in this chart because the coverage depends on where you live. To find out more, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Preventive Services

There is a picture of an apple next to each **preventive service** that Medicare covers. These services can keep you from getting certain illnesses, or can find health problems early, when treatment works best. Talk with your doctor about which preventive services Medicare will cover for you.



Section 6: List of What Original Medicare Covers

A

Abdominal Aortic Aneurysm Screening

Medicare Part B covers a one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.

In 2008 YOU pay 20% of the Medicare-approved amount. The Part B deductible doesn’t apply.

Acupuncture

Medicare doesn’t cover acupuncture.

Ambulance Services

Medicare Part B covers emergency ground transportation when you need to be transported to a hospital or skilled nursing facility for **medically-necessary** services, and transportation in any other vehicle could endanger your health.

Medicare will pay for transportation in an airplane or helicopter if you require immediate and rapid ambulance transportation that ground transportation can’t provide. In some cases, Medicare may pay for limited non-emergency transportation if you have orders from your doctor. Medicare will only cover services to the nearest appropriate medical facility that is able to give you the care you need.

In 2008 YOU pay 20% of the Medicare-approved amount. All ambulance suppliers must accept assignment.

Ambulatory Surgical Centers

Medicare Part B covers approved surgical procedures provided in an Ambulatory Surgical Center.

In 2008 YOU pay 20% of the Medicare-approved amount.

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Artificial Limbs and Eyes

Medicare Part B covers artificial limbs and eyes when ordered by a doctor.

In 2008 YOU pay 20% of the Medicare-approved amount.

Anesthesia

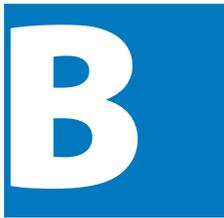
Medicare Part A covers anesthesia services provided by a hospital for an inpatient. Medicare Part B covers anesthesia services provided by a hospital for an outpatient or by a freestanding ambulatory surgical center for a patient.

In 2008 YOU pay 20% of the Medicare-approved amount for the anesthesia service provided by a doctor or certified registered nurse anesthetist. The anesthesia service must be associated with the underlying medical or surgical service.

Blood

Medicare Part A covers blood you get as an inpatient. Medicare Part B covers blood you get as an outpatient or at a freestanding ambulatory surgical center. Medicare doesn't cover the first three pints of blood you get under Part A and Part B combined in a calendar year.

In 2008 YOU pay either the provider costs for the first three pints of blood you get in a calendar year, or you must have the blood replaced if the provider has to buy blood for you. In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. You pay 20% of the Medicare-approved amount for additional pints of blood you get as an outpatient, and the Part B deductible applies.



Section 6: List of What Original Medicare Covers

Bone Mass Measurement

Medicare Part B covers bone mass measurements ordered by a doctor or qualified practitioner if you meet one or more of the following conditions:

Women

- You are at clinical risk for osteoporosis, based on your medical history and other findings.

Men and Women

- Your X-rays show possible osteoporosis, osteopenia, or vertebrae fractures.
- You are on prednisone or steroid-type drugs or are planning to begin such treatment.
- You have been diagnosed with primary hyperparathyroidism.
- You are being monitored to see if your osteoporosis drug therapy is working.

The test is covered once every 24 months for qualified individuals and more often if [medically necessary](#).

In 2008 YOU pay 20% of the [Medicare-approved amount](#).

In a hospital outpatient setting, you pay a [copayment](#).

Braces (arm, leg, back, and neck)

Medicare Part B covers arm, leg, back, and neck braces.

In 2008 YOU pay 20% of the Medicare-approved amount.

Breast Prostheses

Medicare Part B covers breast prostheses (including a post-surgical brassiere) after a mastectomy.

In 2008 YOU pay 20% of the Medicare-approved amount.

Canes/Crutches

Medicare Part B covers canes and crutches. Medicare doesn't cover white canes for the blind. For more information, see Durable Medical Equipment on page 32.

In 2008 YOU pay 20% of the Medicare-approved amount.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Cardiac Rehabilitation Program

Medicare Part B covers comprehensive programs that include exercise, education, and counseling for patients whose doctor referred them and who had any of the following:

- A heart attack in the last 12 months
- Coronary bypass surgery
- Stable angina pectoris
- Heart valve repair/replacement
- Angioplasty or coronary stenting
- A heart or heart-lung transplant

These programs may be given by the outpatient department of a hospital or in doctor-directed clinics.

In 2008 YOU pay 20% of the [Medicare-approved amount](#).

Cardiovascular Screening

Medicare Part B covers screening tests for cholesterol, lipid, and triglyceride levels every five years to help you prevent a heart attack or stroke.

In 2008 YOU pay \$0 for this test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.

Chemotherapy

Medicare Part A covers chemotherapy for cancer patients who are hospital inpatients. Medicare Part B covers chemotherapy for outpatients, or patients in a doctor's office or freestanding clinic.

In 2008 YOU pay 20% of the Medicare-approved amount for chemotherapy in a hospital outpatient setting, doctor's office, or freestanding clinic. For chemotherapy in the hospital, see Hospital Care (Inpatient) on page 39.

Blue words in the text are defined on pages 59-61.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Chiropractic Services

Medicare Part B covers manipulation of the spine if **medically necessary** to correct a subluxation (when one or more of the bones of your spine move out of position) when provided by chiropractors or other qualified providers.

In 2008 YOU pay 20% of the **Medicare-approved amount**.

Clinical Research Studies

Clinical research studies test new types of medical care, like how well a cancer drug works. These studies help doctors and researchers see if the new care works and if it's safe. Medicare Part A and/or Part B covers some costs, like doctor visits and tests, in a qualifying clinical research study.

In 2008 YOU pay the part of the charge that you would normally pay for covered services.

Colorectal Cancer Screening

Medicare Part B covers several colorectal cancer screening tests. All people age 50 and older with Medicare are covered. However, there is no minimum age for having a colonoscopy.

Colonoscopy: Medicare covers this test once every 24 months if you are at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, the test is covered once every 120 months or 48 months after a screening flexible sigmoidoscopy.

In 2008 YOU pay only a **copayment** or **coinsurance**. The Part B **deductible** doesn't apply

Fecal Occult Blood Test: Medicare covers this lab test once every 12 months if age 50 or older.

In 2008 YOU pay \$0 for this test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Colorectal Cancer Screening (continued)

Flexible Sigmoidoscopy: Medicare covers this test once every 48 months for most people age 50 or older, or for those not at high risk, 120 months after a previous screening colonoscopy.

In 2008 YOU pay 20% of the Medicare-approved amount. The Part B deductible doesn't apply.

Barium Enema: Once every 48 months (high risk every 24 months) when used instead of a flexible sigmoidoscopy or colonoscopy.

In 2008 YOU pay 20% of the Medicare-approved amount. The Part B deductible doesn't apply.

Commode Chairs

Medicare Part B covers commode chairs that your doctor orders for use in your home if you are confined to your bedroom. For more information, see Durable Medical Equipment on page 32.

In 2008 YOU pay 20% of the Medicare-approved amount.

Cosmetic Surgery

Medicare generally doesn't cover cosmetic surgery unless it's needed because of accidental injury or to improve the function of a malformed part of the body. Medicare covers breast reconstruction if you had a mastectomy because of breast cancer.

Custodial Care (help with activities of daily living, like bathing, dressing, using the bathroom, and eating)

Medicare doesn't cover custodial care when it's the only kind of care you need. Care is considered custodial when it helps you with activities of daily living or personal needs and could be done safely and reasonably by people without professional skills or training.

Defibrillator (Implantable Automatic)

Medicare Part A and Part B cover defibrillators for certain people diagnosed with heart failure.

In 2008 YOU pay inpatient or outpatient coinsurance and/or deductibles may apply.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.



Section 6: List of What Original Medicare Covers



Dental Services

Medicare doesn't cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices.

Medicare Part A will pay for certain dental services that you get when you are in the hospital.

Medicare Part A can pay for hospital stays if you need to have emergency or complicated dental procedures, even when the dental care isn't covered.

Diabetes Screenings

Medicare Part B covers tests to check for diabetes. These tests are available if you have any of the following risk factors: high blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar.

Medicare also covers these tests if you have two or more of the following:

- Age 65 or older
- Overweight
- Family history of diabetes (parents, brothers, sisters)
- A history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds

Based on the results of these tests, you may be eligible for up to two diabetes screenings every year.

In 2008 YOU pay \$0 for this test, but you generally have to pay 20% of the [Medicare-approved amount](#) for the doctor's visit.

Diabetes Supplies and Services

Medicare Part B covers some diabetes supplies, including the following:

- Blood sugar (glucose) test strips
- Blood sugar monitor
- Lancet devices and lancets
- Glucose control solutions for checking test strip and monitor accuracy

There may be limits on how much or how often you get these supplies.

For more information, see Durable Medical Equipment on page 32.

In 2008 YOU pay 20% of the Medicare-approved amount.

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Diabetes Supplies and Services (continued)

Insulin: Medicare doesn't cover insulin (unless used with an insulin pump), insulin pens, syringes, needles, alcohol swabs, or gauze. Insulin and certain medical supplies used to inject insulin, such as syringes, gauze, and alcohol swabs are covered under Part D.

If you use an external insulin pump, insulin and the pump could be covered as durable medical equipment. See Durable Medical Equipment (DME) on page 32.

In 2008 YOU pay 100% for insulin unless used with an insulin pump (then you pay 20% of the [Medicare-approved amount](#)) and 100% for syringes and needles, unless you have Part D.

Therapeutic Shoes or Inserts: Medicare Part B covers therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. The shoes and inserts must be prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, or pedorthist. Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year. Shoe modifications may be substituted for inserts. The fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

In 2008 YOU pay 20% of the Medicare-approved amount.

Section 6: List of What Original Medicare Covers

Diabetes Supplies and Services (continued)

Medicare covers these diabetes services:



Diabetes Self-Management Training: Medicare Part A and Part B cover diabetes outpatient self-management training to teach you to manage your diabetes. It includes education about how you monitor your blood sugar, diet, exercise, and insulin. If you've been diagnosed with diabetes, Medicare may cover up to 10 hours of initial diabetes self-management training. You may also qualify for up to 2 hours of follow-up training each year if the following conditions are met:

- It's provided in a group of 2 to 20 people.*
- It lasts for at least 30 minutes.
- It takes place in a calendar year following the year you got your initial training.
- Your doctor or a qualified non-physician practitioner ordered it as part of your plan of care.

* Some exceptions apply if no group session is available or if your doctor or qualified non-physician practitioner says you have special needs that prevent you from participating in group training.

In 2008 YOU pay 20% of the [Medicare-approved amount](#).

Yearly Eye Exam: Medicare Part B covers yearly eye exams for diabetic retinopathy.

In 2008 YOU pay 20% of the Medicare-approved amount.

Foot Exam: Medicare Part B covers a foot exam every 6 months for people with diabetic peripheral neuropathy and loss of protective sensations, as long as you haven't seen a foot care professional for another reason between visits.

In 2008 YOU pay 20% of the Medicare-approved amount for outpatient facility charges or doctors' services.



Glaucoma Tests: Medicare Part B covers glaucoma tests every 12 months for people with diabetes or a family history of glaucoma, African Americans age 50 and older, or Hispanics age 65 and older.

In 2008 YOU pay 20% of the Medicare-approved amount.

Blue words in the text are defined on pages 59-61.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Diabetes Supplies and Services (continued)



Medical Nutrition Therapy Services: Medicare Part B covers medical nutrition therapy services for people with diabetes or kidney disease when referred by a doctor. These services can be given by a registered dietitian or Medicare-approved nutrition professional. They can include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.

In 2008 YOU pay 20% of the [Medicare-approved amount](#).

Diagnostic Tests, X-rays, and Clinical Laboratory Services

Medicare Part B covers diagnostic tests like CT scans, MRIs, EKGs, and X-rays when your doctor or health care provider orders them as part of treating a medical problem. Medicare also covers clinical diagnostic laboratory services provided by certified laboratories enrolled in Medicare. Diagnostic tests and lab services are done to help your doctor diagnose or rule out a suspected illness or condition.

Medicare doesn't cover most routine screening tests, like checking your hearing. Medicare covers some preventive tests and screenings to help prevent, find, or manage a medical problem. For more information, see [Preventive Services](#) on page 48.

In 2008 YOU pay 20% of the Medicare-approved amount for covered diagnostic tests and X-rays done in a doctor's office or independent testing facility. You pay a [copayment](#) for diagnostic tests and X-rays in the hospital outpatient setting. You pay \$0 for Medicare-covered lab services.

Section 6: List of What Original Medicare Covers

Dialysis (Kidney) Services and Supplies

Medicare covers some kidney dialysis services and supplies.

Inpatient dialysis treatments: Medicare Part A covers dialysis if you're admitted to the hospital for special care. See Hospital Care (Inpatient) on page 39.

Outpatient maintenance dialysis treatments: Medicare Part B covers dialysis if you need regular treatments, and you get treatments in any Medicare-approved dialysis facility.

In 2008 YOU pay 20% of the Medicare-approved amount.

Certain home dialysis support services: Medicare Part B covers visits by trained dialysis workers to check on your home dialysis, to help in dialysis emergencies when needed, and to check your dialysis equipment and hemodialysis water supply.

In 2008 YOU pay 20% of the Medicare-approved amount. Only dialysis facilities can furnish home dialysis support services.

Certain drugs for home dialysis: Medicare Part B covers heparin, the antidote for heparin when medically necessary, and topical anesthetics.

In 2008 YOU pay 20% of the Medicare-approved amount, if you deal with a supplier. If you deal with the dialysis facility, these drugs are included in the cost of dialysis.

Erythropoiesis–stimulating Agents: Medicare covers agents like Epogen®, Procrit®, Epoetin alfa, Arnesp®, or Darbepoetin alfa to treat anemia if you have End-Stage Renal Disease.

In 2008 YOU pay 20% of the Medicare-approved amount.

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Dialysis (Kidney) Services and Supplies (continued)

Self-dialysis training: Medicare Part B covers training for you and the person helping you with your home dialysis treatments.

In 2008 YOU pay 20% of the [Medicare-approved amount](#). If you deal with a dialysis facility, the cost of home dialysis equipment and supplies is included in the cost of dialysis. If you deal with a medical supply company, it (not the dialysis facility) must accept assignment.

Home dialysis equipment and supplies: Medicare Part B covers equipment and supplies like alcohol, wipes, sterile drapes, rubber gloves, and scissors.

In 2008 YOU pay 20% of the Medicare-approved amount.

Doctor's Services

Medicare Part B covers [medically-necessary](#) services you get from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location.

Medicare doesn't cover routine annual physicals, except the one-time "Welcome to Medicare" physical exam. See page 45. Medicare covers some preventive tests and screenings. See [Preventive Services](#) on page 48.

In 2008 YOU pay 20% of the Medicare-approved amount.

Drugs

See Prescription Drugs (Outpatient) on page 46.

Section 6: List of What Original Medicare Covers

Durable Medical Equipment (DME)

Medicare Part B covers Durable Medical Equipment (DME) that your doctor prescribes for use in your home. Only your doctor can prescribe medical equipment for you.

Durable Medical Equipment meets the following criteria:

- Durable (Long lasting)
- Used for a medical reason
- Not usually useful to someone who isn't sick or injured
- Used in your home

The DME that Medicare covers includes, but isn't limited to, the following:

- Air-fluidized beds
- Blood sugar monitors
- Canes (canes for the blind aren't covered)
- Commode chairs
- Crutches
- Dialysis machines
- Home oxygen equipment and supplies
- Hospital beds
- Infusion pumps (and some medicines used in infusion pumps if considered reasonable and necessary)
- Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary)
- Patient lifts (to lift patient from bed or wheelchair by hydraulic operation)
- Suction pumps
- Traction equipment
- Walkers
- Wheelchairs

Make sure your doctor or supplier is enrolled in Medicare. In some cases, you may have to use a contract supplier. See page 33. Doctors and other suppliers have to meet strict standards to enroll and stay enrolled in the Medicare Program.

If your doctor or supplier isn't enrolled, Medicare won't pay the claim submitted by your doctor or supplier, even if your supplier is a large chain or department store that sells more than just durable medical equipment.

Blue words in the text are defined on pages 59-61.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Durable Medical Equipment (DME) (continued)

In 2008 YOU pay 20% of the Medicare-approved amount. Medicare pays for different kinds of DME in different ways; some equipment must be rented, other equipment may be purchased, and you may choose to rent or buy some equipment. If a DME supplier doesn't accept assignment, Medicare doesn't limit how much the supplier can charge you. You also may have to pay the entire bill (your share and Medicare's share) at the time you get the DME.

Note: Ask if the supplier is a participating supplier in the Medicare Program before you get Durable Medical Equipment. If the supplier is a participating supplier, it **must** accept assignment. If the supplier is enrolled in Medicare but isn't "participating," it may choose not to accept assignment.

Emergency Room Services

Medicare Part B covers emergency room services. Emergency services may be covered in foreign countries only in rare circumstances. For more information, see Travel on page 55. A medical emergency is when you believe that you have an injury or illness that requires immediate medical attention to prevent a disability or death.

In 2008 YOU pay a copayment for each emergency room visit unless you are admitted to the same hospital for the same condition within 3 days of your emergency room visit.

When you go to an emergency room, you pay a specified copayment for each hospital service. You also pay a coinsurance of 20% of the Medicare-approved amount for each doctor who treats you.

Equipment

See Durable Medical Equipment on page 32.



Section 6: List of What Original Medicare Covers

Eye Exams

Medicare doesn't cover routine eye exams (refractions) for eye glasses/contacts. Medicare covers some preventive and diagnostic eye exams:

- See yearly eye exams under Diabetes Supplies and Services on page 26.
- See Glaucoma Tests on page 35.
- See Macular Degeneration on page 40.

Eyeglasses/Contact Lenses

Generally, Medicare doesn't cover eyeglasses or contact lenses.

However, **following cataract surgery with an implanted intraocular lens**, Medicare Part B helps pay for corrective lenses (eyeglasses or contact lenses).

In 2008 YOU pay 100%, in general. You pay 20% of the **Medicare-approved amount** for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. You pay any additional cost for upgraded frames.

Eye Refractions

Medicare doesn't cover routine eye refractions for eye glasses/contacts. See Eye Exams.

Flu Shots



Medicare Part B normally covers one flu shot per flu season in the fall or winter.

In 2008 YOU pay \$0 for a flu shot if the doctor or supplier accepts assignment for administering the shot. If the doctors or supplier doesn't accept assignment, you pay 20% of the Medicare-approved amount.

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Foot Care

Medicare Part B covers the services of a podiatrist (foot doctor) for [medically-necessary](#) treatment of injuries or diseases of the foot (such as hammer toe, bunion deformities, and heel spurs), but it doesn't cover routine foot care. See Therapeutic Shoes and Foot Exam under Diabetes Supplies and Services starting on page 27.

In 2008 YOU pay 100% for routine foot care, in most cases.

You pay 20% of the Medicare-approved amount for medically-necessary treatment.

Glaucoma Tests

Medicare Part B covers a glaucoma test once every 12 months for people at high risk for glaucoma. This includes people with diabetes, a family history of glaucoma, African Americans age 50 and older, or Hispanic Americans age 65 and older. The screening must be done or supervised by an eye doctor who is legally allowed to do this in your state.

In 2008 YOU pay 20% of the Medicare-approved amount.

Health Education/Wellness Programs

Medicare generally doesn't cover health education and wellness programs. However, Medicare does cover medical nutrition therapy for people with diabetes or kidney disease and diabetes education for people with diabetes (see page 20), counseling to stop smoking (see page 52), and a one-time "Welcome to Medicare" physical exam (see page 45).



Section 6: List of What Original Medicare Covers

Hearing and Balance Exams/Hearing Aids

In some cases, Medicare Part B covers diagnostic hearing and balance exams. Medicare doesn't cover routine hearing exams, hearing aids, or exams for fitting hearing aids.

In 2008 YOU pay 100% for routine exams and hearing aids.

You pay 20% of the [Medicare-approved amount](#) for covered exams.

Hepatitis B Shots



Medicare Part B covers this shot for people at high or medium risk for Hepatitis B. Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), or a condition that lowers your resistance to infection. Other factors may also increase your risk for Hepatitis B. Check with your doctor to see if you are at high or medium risk for Hepatitis B.

In 2008 YOU pay 20% of the Medicare-approved amount for the Hepatitis B shots given in a doctor's office.

You pay a [copayment](#) for a Hepatitis B shot given in a hospital outpatient department.

Home Health Services

If you have Medicare, you can use your home health benefits under Medicare Part A and/or B if you meet all the following conditions:

- Your doctor must decide that you need medical care at home, and make a plan for this care.
- You must need at least one of the following, qualifying skilled services:
 - Intermittent skilled nursing care (other than just drawing blood)
 - Physical therapy
 - Speech-language pathology services
 - Continued occupational therapy
- The home health agency caring for you must be approved by Medicare (Medicare-certified).

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Home Health Services (continued)

- You must be homebound, meaning that you are normally unable to leave home unassisted. When you do leave the home, it's a considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to attend religious services. You can still get home health care if you attend adult day care.

Note: Home health services may also include part-time or intermittent home health aide services, medical social services, medical supplies, durable medical equipment (see page 32), and an injectable osteoporosis drug.

In 2008 YOU pay \$0 for all covered home health visits.

Osteoporosis Drugs for Women: Medicare Part A and B help pay for an injectable drug for osteoporosis in women who are eligible for Medicare Part B, meet the criteria for the Medicare home health benefit, and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. You must also be certified by a doctor as unable to learn or unable to give yourself the drug by injection, and that family and/or caregivers are unable or unwilling to give the drug by injection. Medicare covers the visit by a home health nurse to give the drug.

In 2008 YOU pay 20% of the [Medicare-approved amount](#) of the drug. You pay \$0 for the home health nurse visit to give the drug.

Section 6: List of What Original Medicare Covers

Hospice Care

Medicare Part A covers hospice care if you meet all of the following conditions:

- You are eligible for Medicare Part A.
- Your doctor certifies that you are terminally ill and probably have less than 6 months to live.
- You accept palliative care (for comfort) instead of care to cure your illness.
- You sign a statement choosing hospice care instead of routine Medicare-covered benefits for your terminal illness.
- In a Medicare-approved hospice, nurse practitioners aren't permitted to certify the patient's terminal diagnosis, but after a doctor certifies the diagnosis, the nurse practitioner can serve in place of an attending doctor.

You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you are terminally ill.

Inpatient Respite Care: Respite care is inpatient care given to a hospice patient so that the usual caregiver can rest. You can stay in a Medicare-approved facility, such as a hospice facility, hospital, or nursing home, up to 5 days each time you get respite care.

Medicare will still pay for covered benefits for any health problems that aren't related to your terminal illness.

In 2008 YOU pay \$0 for hospice care. You may need to pay a **copayment** of up to \$5 for outpatient prescription drugs for symptom control or pain relief. Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).

In certain cases, if the hospice staff determines that you need inpatient care in a hospice facility or your caregiver needs a short period of respite, the costs for room and board are included in Medicare's payment. You pay 5% of the **Medicare-approved amount** for inpatient respite care.

Blue words in the text are defined on pages 59-61.

Hospital Bed

See Durable Medical Equipment on page 33.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Hospital Care (Inpatient) (For Outpatient Services, see page 43.)

Medicare Part A covers inpatient hospital care when **all** of the following are true:

- A doctor says you need inpatient hospital care to treat your illness or injury.
- You need the kind of care that can be given only in a hospital.
- The hospital accepts Medicare.
- The Utilization Review Committee of the hospital approves your stay while you are in the hospital.

Medicare-covered hospital services include the following: a semiprivate room, meals, general nursing, and other hospital services and supplies. This includes care you get in [critical access hospitals](#) and inpatient mental health care. See page 41. This doesn't include private-duty nursing, a television, or a telephone in your room. It also doesn't include a private room, unless [medically necessary](#).

In 2008 YOU pay for each [benefit period](#):

Days 1 - 60: \$1,024 [deductible](#)

Days 61 - 90: \$256 coinsurance each day

Days 91 - 150: \$512 coinsurance each day

Beyond 150 days: all costs

You pay for private-duty nursing, a television, or a telephone in your room. You pay for a private room unless it's medically necessary.

For information about benefit periods and [lifetime reserve days](#), see page 59.

Kidney (Dialysis)

See Dialysis on page 30.



Section 6: List of What Original Medicare Covers

Laboratory Services (Clinical)



Medicare Part B covers **medically-necessary** diagnostic lab services that are ordered by your treating doctor. They must be provided by a laboratory that meets Medicare requirements. For more information, see Diagnostic Tests on page 29.

In 2008 YOU pay \$0 for Medicare-approved lab services.

Macular Degeneration



Medicare Part B covers certain diagnoses and treatment of diseases and conditions of the eye for some patients with age-related macular degeneration (AMD) like ocular photodynamic therapy with verteporfin (Visudyne®).

In 2008 YOU pay 20% of the **Medicare-approved amount**.

Mammograms



Medicare Part B covers a screening mammogram once every 12 months (11 full months must have gone by from the last screening) for all women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.

In 2008 YOU pay 20% of the Medicare-approved amount. The Part B deductible doesn't apply.

Medicare Part B covers diagnostic mammograms when medically necessary.

In 2008 YOU pay 20% of the Medicare-approved amount.



Medical Nutrition Therapy Services

See Diabetes Supplies and Services on page 26.

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Mental Health Care

Medicare Part A and Part B cover mental health services in a variety of settings.

Inpatient Mental Health Care: Medicare Part A covers inpatient mental health care services. These services can be given in hospitals, including specialized psychiatric units, or specialized psychiatric hospitals. Medicare helps pay for inpatient mental health services in the same way that it pays for all other inpatient hospital care.

Note: If you are in a specialty psychiatric hospital, Medicare only helps pay for a total of 190 days of inpatient care during your lifetime.

In 2008 YOU pay the same deductible and copayments as inpatient hospital care. See Hospital Care (Inpatient) on page 39.

Outpatient Mental Health Care: Medicare Part B covers mental health services on an outpatient basis when provided by a doctor, clinical psychologist, clinical social worker, nurse practitioner, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department.

In 2008 YOU pay usually 50% of the [Medicare-approved amount](#) for some professional mental health treatment services such as individual or group psychotherapy. You also pay a [copayment](#) or [coinsurance](#) for the facility service when provided in a hospital outpatient department or clinic.

Partial Hospitalization: Medicare Part B covers partial hospitalization in some cases. It's a structured program of outpatient active psychiatric treatment that is more intense than the care you get in your doctor's or therapist's office. To be eligible for a partial hospitalization program, a doctor must certify that you would otherwise need inpatient treatment. Medicare covers the services of qualified non-physician practitioners such as clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants, as allowed by state and local law for [medically-necessary](#) services.

In 2008 YOU pay a set copayment amount for each day of service.

You also pay a copayment or coinsurance for the facility service when provided in a hospital outpatient department or community mental health center.

Section 6: List of What Original Medicare Covers

Nursing Home Care

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Most nursing home care is custodial care (such as help with bathing or dressing). Medicare doesn't cover custodial care if that's the only care you need. However, if it's **medically necessary** for you to have skilled care (like changing sterile dressings), Medicare Part A will pay for care given in a certified skilled nursing facility (SNF). See Skilled Nursing Facility (SNF) Care on page 51.

Nutrition Therapy Services (Medical)

Medicare Part B covers medical nutrition therapy services, when ordered by a doctor, for people with kidney disease (but who aren't on dialysis) or who have a kidney transplant, or people with diabetes. If you get dialysis in a dialysis facility, Medicare covers medical nutrition therapy as part of your overall dialysis care. These services can be given by a registered dietitian or Medicare-approved nutrition professional. Services may include nutritional assessment, one-on-one counseling, and therapy through an interactive telecommunications system. See Diabetes Supplies and Services on page 26.

In 2008 YOU pay 20% of the Medicare-approved amount.

Occupational Therapy

O

See Physical Therapy/Occupational Therapy/Speech-Language Pathology on page 45.

Orthotics

Medicare Part B covers artificial limbs and eyes, and arm, leg, back and neck braces. Medicare doesn't pay for orthopedic shoes unless they are a necessary part of the leg brace. Medicare doesn't pay for dental plates or other dental devices. See Diabetes Supplies and Services (Therapeutic Shoes) on page 26.

In 2008 YOU pay 20% of the Medicare-approved amount.

Blue words in the text are defined on pages 59-61.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Ostomy Supplies

Medicare Part B covers ostomy supplies for people who have had a colostomy, ileostomy, or urinary ostomy. Medicare covers the amount of supplies your doctor says you need, based on your condition.

In 2008 YOU pay 20% of the Medicare-approved amount for the doctor's services and supplies.

Outpatient Hospital Services

Medicare Part B covers **medically-necessary** services you get as an outpatient from a Medicare-participating hospital for diagnosis or treatment of an illness or injury. Covered outpatient hospital services include the following:

- Services in an emergency room or outpatient clinic, including same-day surgery
- Laboratory tests billed by the hospital
- Mental health care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Screenings and **preventive services**
- Certain drugs and biologicals that you can't give yourself

In 2008 YOU pay 20% of the Medicare-approved amount for the doctor. For other than doctors' services, you pay a **copayment** for each service you get in an outpatient hospital setting.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Oxygen Therapy

Medicare Part B covers the rental of oxygen equipment. Or, if you own your own equipment, Medicare will help pay for oxygen contents and supplies for the delivery of oxygen when all of the conditions below are met.

Your doctor says you have a severe lung disease, or you're not getting enough oxygen and your condition might do the following:

- Improve with oxygen therapy
- Your arterial blood gas level falls within a certain range
- Other alternative measures have failed

Under the above conditions Medicare helps pay for the following:

- Systems for furnishing oxygen
- Containers that store oxygen
- Tubing and related supplies for the delivery of oxygen, and oxygen contents

In 2008 YOU pay 20% of the Medicare-approved amount.

Pap Test/Pelvic Exam (Screening)

Medicare Part B covers Pap tests and pelvic exams (and a clinical breast exam) for all women once every 24 months. Medicare covers this test and exam 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. Routine physical exams aren't covered by Medicare, except for the one-time "Welcome to Medicare" physical exam. See page 45.

In 2008 YOU pay \$0 for the lab Pap test. You pay 20% of the Medicare-approved amount for the part of the exam when the doctor or other health care provider collects the specimen. If the pelvic exam was provided in a hospital outpatient department, you pay a copayment.

If you have your Pap test, pelvic exam, and clinical breast exam in the same visit as a routine physical exam, you must pay for the physical exam.

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Blue words in the text are defined on pages 59-61.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Physical Exams (routine) (one-time “Welcome to Medicare” physical exam)



Medicare Part B covers a one-time “Welcome to Medicare” physical exam, which includes a review of your health, as well as education and counseling about the [preventive services](#) you need, including certain screenings and shots. Referrals for other care, if you need it, may also be included. Medicare doesn’t cover routine physical exams.

Important: You must have the physical exam within the first 12 months you have Medicare Part B. The Part B deductible doesn’t apply.

In 2008 YOU pay 100% for most routine physical exams, in general.

You pay 20% of the [Medicare-approved amount](#) for the “Welcome to Medicare” physical exam.

Physical Therapy/Occupational Therapy/Speech-Language Pathology Service

Medicare Part B helps pay for [medically-necessary](#) outpatient physical and occupational therapy and speech-language pathology services when both of these conditions are met:

- Your doctor or therapist sets up the plan of treatment.
- Your doctor periodically reviews the plan to see how long you will need therapy.

You can get outpatient services from a Medicare-approved outpatient provider such as a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or a comprehensive outpatient rehabilitation facility. Also, you can get services from a Medicare-approved physical or occupational therapist, in private practice, in his or her office, or in your home. (Medicare doesn’t pay for services given by a speech-language pathologist in private practice.)

In 2008, there may be limits on physical therapy, occupational therapy, and speech-language pathology services. If so, there may be exceptions to these limits.

In 2008 YOU pay 20% of the Medicare-approved amount.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Pneumococcal Shot

Medicare Part B covers a pneumococcal shot to help prevent pneumococcal infections (like certain types of pneumonia). Most people only need this preventive shot once in their lifetime. Talk with your doctor to see if you need this shot.

In 2008 YOU pay \$0 for a pneumococcal shot if the doctor or supplier accepts assignment for administering the shot.

Practitioner Services (Non-physician)

Medicare Part B covers certain services provided by clinical social workers, physician assistants, and nurse practitioners.

In 2008 YOU pay 20% of the [Medicare-approved amount](#).

Prescription Drugs (Outpatient) Limited Coverage

Part B covers a limited number of outpatient prescription drugs. Your pharmacy or doctor must accept assignment on prescription drugs covered under Part B.

Part B covers drugs that aren't usually self-administered when you are given them in a hospital outpatient department or doctor's office.

Generally, Medicare doesn't cover self-administered drugs you get in an outpatient setting like an emergency room or observation unit.

You can get comprehensive drug coverage by joining a Medicare drug plan (also called "Part D"). For more information, see page 17.

For example, the following outpatient prescription drugs are covered:

- Drugs infused through an item of durable medical equipment, such as an infusion pump or nebulizer if considered reasonable and necessary.
- **Some Antigens:** Medicare will help pay for antigens if they are prepared by a doctor and given by a properly-instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Medicare helps pay for an injectable drug for osteoporosis for certain women with Medicare. See note for women with osteoporosis under Home Health Services on page 37.
- **Erythropoiesis-stimulating Agents (such as Epogen[®], Procrit[®], Epoetin alfa, or Aranesp[®], Darbepoetin alfa):** Medicare will help pay for erythropoietin by injection if you have End-Stage Renal Disease (permanent kidney failure) or need this drug to treat anemia related to certain other conditions.

Blue words in the text are defined on pages 59-61.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Prescription Drugs (Outpatient) Limited Coverage (continued)

For example, the following outpatient prescription drugs are covered (continued):

- **Blood Clotting Factors:** If you have hemophilia, Medicare will help pay for clotting factors you give yourself by injection.
- **Injectable Drugs:** Medicare covers most injectable drugs given by a licensed medical practitioner, if the drug is considered reasonable and necessary for treatment.
- **Immunosuppressive Drugs:** Medicare covers 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.

Note: Medicare drug plans may cover immunosuppressive drugs, even if Medicare or an employer or union group health plan didn't pay for the transplant.

- **Oral Cancer Drugs:** Medicare will help pay for some cancer drugs you take by mouth if the same drug is available in injectable form. Currently, Medicare covers the following cancer drugs you take by mouth:
 - Capecitabine (Xeloda®)
 - Cyclophosphamide (Cytoxan®)
 - Methotrexate (Rheumatrex®)
 - Temozolomide (Temodar®)
 - Busulfan (Myleran®)
 - Etoposide (VePesid®)
 - Melphalan (Alkeran®)

As new cancer drugs become available, Medicare may cover them.

- **Oral Anti-Nausea Drugs:** Medicare will help pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered within 48 hours and must be used as a full therapeutic replacement for the intravenous anti-nausea drugs that would otherwise be given.

In 2008 YOU pay 100% for most prescription drugs you take at home, unless you have Part D. You pay **coinsurance** or a **copayment** for prescription drugs that you are given when you are in a doctor's office or hospital outpatient department. You pay 20% of the **Medicare-approved amount** for covered prescription drugs. Coverage under Part B is limited.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Preventive Services

Medicare Part B covers the following preventive and screening services that may help prevent illness or detect illness at an early stage, when treatment is likely to work best:

- Abdominal Aortic Aneurysm Screening on page 20
- Bone Mass Measurement on page 22
- Cardiovascular Screening Blood Tests on page 23
- Colorectal Cancer Screening on page 24
- Diabetes Screening on page 26
- Diabetes Self-Management Training on page 28
- Glaucoma Tests on page 35
- Mammogram (screening) on page 40
- Medical Nutrition Therapy Services on page 40
- One-time “Welcome to Medicare” physical exam on page 45
- Pap Test/Pelvic Exam (screening) on page 44
- Prostate Cancer Screening on page 48
- Shots 50 including the following:
 - Flu Shot on page 34
 - Pneumococcal Shot on page 46
 - Hepatitis B Shot on page 36
- Smoking Cessation Counseling on page 52

In 2008 YOU pay the cost listed on the page for that specific service.

Prostate Cancer Screenings

Medicare Part B covers prostate cancer screening tests once every 12 months for men with Medicare age 50 and older. Coverage begins the day after your 50th birthday. Covered tests include the following:

Digital Rectal Examination

In 2008 YOU pay generally, 20% of the [Medicare-approved amount](#) for the digital rectal exam.

Prostate Specific Antigen (PSA) Test

In 2008 YOU pay \$0 for the PSA test.

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Prosthetic Devices

Medicare Part B covers prosthetic devices needed to replace an internal body part or function. These include Medicare-approved corrective lenses needed after a cataract operation (see Eyeglasses/Contact Lenses on page 34), ostomy bags and certain related supplies (see Ostomy Supplies on page 43), and breast prostheses (including a surgical brassiere) after a mastectomy (see Breast Prosthesis on page 22).

In 2008 YOU pay 20% of the Medicare-approved amount.

Radiation Therapy

Medicare Part A covers radiation therapy for patients who are hospital inpatients. Medicare Part B covers it for outpatients or patients in freestanding clinics.

In 2008 YOU pay the inpatient deductible and coinsurance (if applicable).

In 2008 YOU pay a set copayment (for outpatient radiation therapy).

In 2008 YOU pay 20% of the Medicare-approved amount for radiation therapy at a freestanding facility.



Religious Nonmedical Health Care Institution (RNHCI)

Medicare doesn't cover the religious portion of RNHCI care. Medicare Part A covers inpatient nonmedical care when the following conditions are met:

- The RNHCI has agreed and is currently certified to participate in Medicare, and the Utilization Review Committee agrees that you'd require hospital or skilled nursing facility care if it weren't for your religious beliefs.
- You have a written agreement with Medicare indicating that your need for this form of care is based on your religious beliefs. The agreement must also indicate that if you decide to accept standard medical care, you may have to wait longer to get RNHCI services in the future. You're always able to access medically-necessary Medicare Part A services.
- The care provided is reasonable and necessary.

In 2008 YOU pay for each benefit period you pay:

Days 1 - 60: \$1,024 deductible

Days 61 - 90 \$256 coinsurance each day

Days 91 - 150: \$512 coinsurance each day

Beyond 150 days: all costs

For information about benefit periods and lifetime reserve days, see pages 59–60.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Respite Care (Inpatient)

Medicare Part A covers respite care (inpatient care given to a hospice patient so that the usual caregiver can rest) for hospice patients. See Hospice Care on page 38.

In 2008 YOU pay 5% of the Medicare-approved amount.

Rural Health Clinic and Federally-Qualified Health Center Services

Medicare Part B covers a broad range of primary care services usually provided on an outpatient basis.

In 2008 YOU pay 20% of the Medicare-approved amount.

Second Surgical Opinions

Medicare Part B covers a second opinion before surgery that isn't an emergency. A second opinion is when another doctor gives his or her view about your health problem and how it should be treated. Medicare will also help pay for a third opinion if the first and second opinions are different.

In 2008 YOU pay 20% of the Medicare-approved amount.

Shots (Vaccinations)

Medicare covers the following shots:

- **Flu Shot** on page 34
- **Pneumococcal Shot** on page 46
- **Hepatitis B Shot** on page 36

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Skilled Nursing Facility (SNF) Care

Medicare Part A covers skilled care in a skilled nursing facility (SNF) under certain conditions for a limited time. Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Medicare covers certain skilled care services that are needed daily on a short-term basis (up to 100 days).

In 2008 YOU pay for each **benefit period** (following at least a related 3-day covered hospital stay):

Days 1 - 20: \$0 each day

Days 21 - 100: up to \$128 each day

Beyond 100 days: You pay 100%.

There is a limit of 100 days of Medicare Part A SNF coverage in each benefit period. For information about benefit periods and **lifetime reserve days**, see pages 59–60.

Medicare will cover skilled care if all these conditions are met:

1. You have Medicare Part A (Hospital Insurance) and have days left in your benefit period to use.
2. You have a qualifying hospital stay. This means an inpatient hospital stay of 3 consecutive days or more, including the day you're admitted to the hospital, but not including the day you leave the hospital. You must enter the SNF within a short time (generally 30 days) of leaving the hospital and require skilled services related to your hospital stay. See item 5. After you leave the SNF, if you re-enter the same or another SNF within 30 days, you don't need another 3-day qualifying hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days.
3. Your doctor has decided that you need daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If you are in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just 5 or 6 days a week, as long as you need and get the therapy services each day they are offered.
4. You get these skilled services in a SNF that is certified by Medicare.

Unless otherwise noted, in 2008, you pay an annual \$135 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

Section 6: List of What Original Medicare Covers

Skilled Nursing Facility (SNF) Care (continued)

5. You need these skilled services for a medical condition that was either of the following:
 - Treated during a qualifying 3-day hospital stay.
 - Started while you were getting care in the SNF for a hospital-related medical condition. For example, Medicare will cover skilled care if you are in the SNF because you had a stroke, and you develop an infection that requires IV antibiotics, and you meet the conditions listed in items 1–4 on page 51.

While you are in a non-covered stay in the Medicare-certified part of the facility, your Part B therapy services (physical therapy, occupational therapy, and speech-language pathology) must be billed by the facility. No other therapy service may be billed by another setting, such as an outpatient hospital department. If you leave the Medicare-certified part of the facility, your therapy services in the non-Medicare-certified part of the facility are limited by a specific dollar amount each year unless you get the services from an outpatient hospital setting.

Smoking Cessation (counseling to stop smoking)



Medicare Part B covers up to 8 face-to-face visits in a 12-month period if you are diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco.

In 2008 YOU pay 20% of the Medicare-approved amount.

Speech-Language Pathology

See Physical Therapy/Occupational Therapy/Speech-Language Pathology on page 45.

Blue words in the text are defined on pages 59–61.

Section 6: List of What Original Medicare Covers

Substance-Related Disorders

Medicare covers treatment for substance-related disorders in inpatient or outpatient settings. Certain limits apply. See Mental Health Care (Inpatient or Outpatient) on page 41.

Supplies (you use at home)

Medicare Part B generally doesn't cover common medical supplies like bandages and gauze. Medicare covers some diabetes and dialysis supplies. See Diabetes Supplies and Services on page 26 and Dialysis (Kidney) on page 30. For items such as walkers, oxygen, and wheelchairs, see Durable Medical Equipment on page 32.

In 2008 YOU pay 100% for most common medical supplies you use at home, in general.

Surgical Dressing Services

Medicare Part B covers **medically-necessary** treatment of a surgical or surgically-treated wound.

In 2008 YOU pay 20% of the **Medicare-approved amount** for doctor services.

Telemedicine

Telemedicine is medical or other health services given to a patient using a communications system (like a computer, telephone, or television) by a practitioner in a location different than the patient's.

Medicare Part B covers telemedicine in some rural areas, under certain conditions and only in a provider's office, a hospital, or a Federally-qualified health center.

In 2008 YOU pay 20% of the Medicare-approved amount for doctor services.



Section 6: List of What Original Medicare Covers

Therapeutic Shoes

See Diabetes Supplies and Services (Therapeutic Shoes) on page 27.

Transplants (Doctor Services)

Medicare Part B covers doctor services for transplants, see Transplants (Facility Charges).

In 2008 YOU pay 20% of the **Medicare-approved amount** for doctor services.

Transplants (Facility Charges)

Medicare Part A covers transplants of the heart, lung, kidney, pancreas, intestine, and liver under certain conditions and only at Medicare-approved facilities. Medicare only approves facilities for kidney, heart, liver, lung, intestine, and some pancreas transplants. Medicare Part B covers cornea and bone marrow transplants. Bone marrow and cornea transplants aren't limited to approved facilities.

Transplant coverage includes necessary tests, labs, and exams before surgery. It also includes immunosuppressive drugs (under certain conditions), follow-up care for you, and procurement of organs and tissues. Medicare pays for the costs for a living donor for a kidney transplant.

In 2008 YOU pay various amounts. For Inpatient Transplants, see Hospital Care (Inpatient) on page 39.

Transportation (Routine)

Medicare doesn't cover transportation to get routine health care. For more information, see Ambulance Services on page 20.

Blue words in the text are defined on pages 59-61.

Section 6: List of What Original Medicare Covers

Travel (health care needed when traveling outside the United States)

Medicare generally doesn't cover health care while you are traveling outside the United States. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States. There are some exceptions. In some cases, Medicare Part B may pay for services that you get while on board a ship within the territorial waters adjoining the land areas of the United States. In rare cases, Medicare Part A may pay for inpatient hospital services that you get in a foreign country under the following circumstances:

- You are in the United States when a medical emergency occurs and the foreign hospital is closer than the nearest United States hospital that can treat the emergency.
- You are traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest United States hospital that can treat the emergency.
- You live in the United States and the foreign hospital is closer to your home than the nearest United States hospital that can treat your medical condition, regardless of whether an emergency exists.

Medicare also pays for doctor and ambulance services you get in a foreign country as part of a covered inpatient hospital stay.

In 2008 YOU pay 100% of charges, in most cases.

In the situations described above, you pay the part of the charge that you would normally pay for covered services.

Section 6: List of What Original Medicare Covers

Walker/ Wheelchair



Medicare Part B covers power-operated vehicles (scooters), walkers, and wheelchairs as durable medical equipment that your doctor prescribes for use in your home. For more information, see Durable Medical Equipment on page 32.

Power Wheelchair: You must have a face-to-face examination and a written prescription from a doctor or other treating provider before Medicare helps pay for a power wheelchair.

In 2008 YOU pay 20% of the [Medicare-approved amount](#).

X-rays



Medicare Part B covers [medically-necessary](#) diagnostic X-rays that are ordered by your treating doctor. For more information, see Diagnostic Tests on page 29.

In 2008 YOU pay 20% of the Medicare-approved amount.

For X-rays in a hospital outpatient setting, you pay a [copayment](#).

Blue words in the text are defined on pages 59-61.

For More Information

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Visit MyMedicare.gov on the web for Personalized Information

Register at www.MyMedicare.gov on the web (Medicare’s secure online service for accessing your personal Medicare information). Use it to see your health care claims, track which [preventive services](#) you need, and get the most current details about how to get the most out of your Medicare benefits. If you don’t have access to the web, the same information is available by calling 1-800-MEDICARE (1-800-633-4227) and through Medicare’s many partners in the community. TTY users should call 1-877-486-2048.

Visit www.medicare.gov on the web for General Information about Medicare

You can do the following:

- See what Medicare plans are available in your area.
- Find doctors who accept Medicare.
- See what Medicare covers, including preventive services.
- Get Medicare [appeals](#) information and forms.
- Get information on the quality of care provided by nursing homes, hospitals, home health agencies, plans, and dialysis facilities.
- Look up helpful telephone numbers for your area.
- View Medicare publications.

Call the 1-800-MEDICARE Helpline for Answers to Your Medicare Questions

The 1-800-MEDICARE (1-800-633-4227) helpline has a speech-automated system to make it easier for you to get the information you need 24 hours a day, including weekends. The system will ask you questions to direct your call automatically. Speak clearly, call from a quiet area, and have your Medicare card in front of you. See sample card on page 6. If you need help, you can say “Agent” at any time to talk to a customer service representative. TTY users should call 1-877-486-2048.

Note: If you want Medicare to give your personal health information to someone other than you, you need to let Medicare know in writing. You can fill out a “Medicare Authorization to Disclose Personal Health Information” form. You can do this online by visiting www.medicare.gov on the web or calling 1-800-MEDICARE (1-800-633-4227) to get a copy of the form. TTY users should call 1-877-486-2048.

Section 7: For More Information

Free Booklets About Medicare and Related Topics

Health care decisions are important. Medicare provides information to help you make informed decisions. Detailed booklets are available on Medicare topics such as [preventive services](#), hospice care, home health care, mental health care, Medicare prescription drug coverage, choosing a nursing home, skilled nursing care, and rights and protections. **To get these booklets** visit www.medicare.gov on the web. Select “Find a Medicare Publication.”

Other Important Contacts

Below are telephone numbers for organizations that provide nationwide services. These numbers were correct at the time of printing. Sometimes these numbers change.

State Health Insurance Assistance Program (SHIP)

Call for free personalized health insurance counseling, including help making health care decisions, information on programs for people with limited income and resources, and help with claims, billing, and appeals. Call 1-800-MEDICARE for telephone number.

Social Security

Call for a replacement Medicare card, address or name changes, for information about Medicare Part A and/or Part B eligibility, entitlement and enrollment, to apply for extra help with Medicare prescription drug costs, and to report a death. 1-800-772-1213
TTY 1-800-325-0778

Coordination of Benefits Contractor

Call for information on whether Medicare or your other insurance pays first.
1-800-999-1118 TTY 1-800-318-8782

Department of Defense

Call for questions about TRICARE or TRICARE for Life. **TRICARE** 1-888-363-5433
TRICARE for Life 1-866-773-0404

Department of Health and Human Services Office of Inspector General

Call if you suspect fraud. 1-800-447-8477 TTY 1-800-377-4950

Office for Civil Rights

Call if you think you've been treated unfairly. 1-800-368-1019 TTY 1-800-537-7697

Department of Veterans Affairs

Call if you are a veteran or have served in the U.S. military. 1-800-827-1000
TTY 1-800-829-4833

Railroad Retirement Board (RRB)

Call if you get RRB benefits and have questions about benefits, address or name changes, death notification, to enroll in Medicare, or to replace your Medicare card. Call your Local RRB office, 1-800-808-0772, or 1-877-772-5772 (after January 1, 2009).

Words to Know

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Appeal— A special kind of complaint you make if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if you request a health care service, supply, or prescription that you think you should be able to get, or if you request payment for health care you already got, and Medicare or your plan denies the request. You can also appeal if you are already getting coverage and Medicare or the plan stops paying.

Benefit Period— The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins.

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

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

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

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

Section 8: Words to Know

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

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

Limiting Charge— In Original Medicare, 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.

Medicaid— A joint Federal and state program that helps with medical costs for some people with limited income and 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 needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare Advantage Plan (Part C)— A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-Approved Amount— In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Section 8: Words to Know

Medicare Prescription Drug Plan (Part D)— A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medigap Policy— Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare coverage.

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

Preventive Services— Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Religious Nonmedical Health Care Institution— A facility that provides nonmedical health care items and services to people who need hospital or skilled nursing facility care, but for whom that care would be inconsistent with their religious beliefs.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850

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- 1-800-MEDICARE (1-800-633-4227)
- TTY 1-877-486-2048

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*My Health.
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