THE MEDICARE HANDBOOK

INCLUDING INFORMATION FOR BENEFICIARIES ON:

MEDICARE BENEFITS

PARTICIPATING PHYSICIANS AND SUPPLIERS

HEALTH INSURANCE TO SUPPLEMENT MEDICARE

LIMITS TO MEDICARE COVERAGE

ABOUT THIS HANDBOOK

Medicare pays for many of your health care expenses, but it does not cover all of them. It is important for you to know what Medicare does and does not pay for. This Handbook will help you understand how the Medicare program works and what your benefits are. You can use the alphabetical index at the back of the book to find information on specific subjects. This Handbook is also available in Spanish. (See inside back cover for how to order.)

Don't Miss

The Assignment Method of Payment

Many doctors and suppliers have agreed to be part of Medicare's participating physician and supplier program. They accept assignment on all Medicare claims. If you get your medical services from one of these participating doctors or suppliers, you can often save money. See page 28 for more information about the assignment method of payment, and what you can do to find a participating doctor or supplier.

Your Appeal Rights

Pages 35 and 36 explain how to appeal when Medicare does not pay your Part A or Part B claims.

If You Need Financial Assistance to Pay for Health Care

Sometimes you can get help paying for Medicare. Look on pages 2 and 3 for more information.

New primary and preventive services

Medicare now has a Federally Qualified Health Center benefit. Look on page 24.

New Information About Insurance to Supplement Medicare

Some people want to have insurance to pay medical bills Medicare doesn't cover. See pages 8 and 9 to find out about Medicare supplement "Medigap" insurance, including a new open enrollment period.

New Benefits

Recently added Medicare Part B benefits for cancer screening--mammograms and Pap smears--are described on page 25.

Who Pays First?

Medicare is not always the insurer that pays first on claims. For example, some people are employed, or their spouse is employed, and the employer health insurance pays first. For more about who pays first, see pages 10 and 11.

Where to Call or Write

Look on the inside front cover to find where to call or write to ask questions about Medicare.

This handbook is meant to explain the Medicare program, but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and Rulings.

Save this handbook for reference. It is revised each year and is available from Social Security, but you will not automatically get a handbook in the mail unless there are major changes in the Medicare program.

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What is Medicare?

The Medicare program is a federal health insurance program for people 65 or older and certain disabled people. It is run by the Health Care Financing Administration of the U.S. Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program.

The Two Parts of Medicare

There are two parts to the Medicare program. Hospital Insurance (Part A) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care. Medical Insurance (Part B) helps pay for doctors' services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by the Hospital Insurance part of Medicare. Throughout this handbook, Medicare Hospital Insurance is called Part A and Medicare Medical Insurance is called Part B.

Part A has deductibles and coinsurance, but most people do not have to pay premiums for Part A (see page 33). Part B has premiums, deductibles, and coinsurance amounts that you must pay yourself or through coverage by another insurance plan. Premium, deductible and coinsurance amounts are set each year based on formulas established by law. New payment amounts begin each January 1. When amounts increase, you will be notified. For 1993 deductible, premium and coinsurance amounts, see the charts on pages 37 and 38.

Who Can Get Medicare Hospital Insurance (Part A)?

Generally, people age 65 and older can get premium-free Medicare Part A benefits, based on their own or their spouses' employment. (Premium-free means there are no premium payments. Most people do not pay premiums for Medicare Part A.) You can get premium-free Medicare Part A if you are 65 or older and any of these three statements is true:

- You receive benefits under the Social Security or Railroad Retirement system.
- You could receive benefits under Social Security or the Railroad Retirement system but have not filed for them.
- You or your spouse had Medicare-covered government employment.

If you are under 65, you can get premium-free Medicare Part A benefits if you have been a disabled beneficiary under Social Security or the Railroad Retirement Board for more than 24 months.

Certain government employees and certain members of their families can also get Medicare when they are disabled for more than 29 months. They should apply at the Social Security Administration office as soon as they become disabled.

Or, you may be able to get premium-free Medicare Part A benefits if you receive continuing dialysis for permanent kidney failure or if you have had a kidney transplant. (People who can get Medicare because of kidney disease may get a copy of Medicare Coverage of Kidney Dialysis and Kidney Transplant Services from the Consumer Information Center. See inside back cover for how to

order.)

Check with Social Security to see if you have worked long enough under Social Security, Railroad Retirement, as a government employee, or a combination of these systems to be able to get Medicare Part A benefits. Generally, if either you or your spouse worked for 10 years, you will be able to get premium-free Medicare Part A benefits.

Who Can Get Medicare Medical Insurance (Part B)?

Any person who can get premium-free Medicare Part A benefits based on work as described above can enroll for Part B, pay the monthly Part B premiums (in 1993, $36.60 for most beneficiaries), and get Part B benefits. In addition, most United States residents age 65 or over can enroll in Part B.

Buying Medicare Part A and Part B

If you or your spouse do not have enough work credits to be able to get Medicare Part A benefits and you are 65 or over, you may be able to buy Medicare Parts A and B--or just Medicare Part B--by paying monthly premiums. Also, you may be able to buy Medicare Parts A and B if you are disabled and lost your premium-free

Part A solely because you are working. (See page 34 for more information.)

Enrollment in Medicare

If you are already getting Social Security or Railroad Retirement benefit payments when you turn 65, you will automatically get a Medicare card in the mail. The card will show that you can get both Medicare Hospital Insurance (Part A) and Medical Insurance (Part B) benefits. If you do not want Part B, follow the instructions that come with the card.

The above process also applies when you have been a disability beneficiary under Social Security or Railroad Retirement for 24 months. A Medicare card will come in the mail.

Some people do not automatically get a Medicare card. They must file an application to get Medicare benefits. If you have not applied for Social Security or Railroad Retirement benefits, or if government employment is involved, or if you have kidney disease, you must file an application for Medicare. Check with Social Security if you are able to get Medicare under the Social Security system or based on Medicare-covered government employment; check with the Railroad Retirement office if you are able to get Medicare under the Railroad Retirement system.

If you must file an application for Medicare, you should apply during your initial enrollment period, to avoid late enrollment penalties under Medicare Part B (unless you qualify for a special enrollment period as described on page 33). Your initial enrollment period is a seven-month period that starts three months before the month you first meet the requirements for Medicare. If you do not sign up for Medicare during the first three months of your initial enrollment period, there will be a delay in starting your Part B coverage. Your coverage will be delayed from one to three months after enrollment.

If you do not enroll for Medicare Part B at any time during your initial enrollment period, you will not have another chance to enroll until the next general enrollment period. A general enrollment period is held each year from January 1 through March 31 and if you enroll during this period you will not be able to get Medicare until July of that year. You may also be charged a premium penalty for late

enrollment (unless you qualify for a special enrollment period as described on page 33).

The enrollment period requirements and penalties for late enrollment described above for Part B also apply to people who buy Part A. (See page 33 for more information about buying Medicare Part A.)

Your Medicare Card

The Medicare card shows the Medicare coverage you have--Hospital Insurance (Part A), Medical Insurance (Part B), or both--and the date your protection started. If you do not have both parts of Medicare, see page 33 for information on how you can get the part you don't have.

Your Medicare card also shows your health insurance claim number. Sometimes this claim number is referred to as your Medicare number. The claim number usually has nine digits and one or two letters. There may also be another number after the letter. Your full claim number must always be included on all Medicare claims and correspondence. When a husband and wife both have Medicare, each receives a separate card and claim number. Each spouse must use the exact name and claim number shown on his or her card.

It is important that you remember to:

Use your Medicare card only after the effective date shown on it.

Keep your card handy. And be sure to carry your card with you whenever you are away from home.

Always show your Medicare card when you receive services that Medicare helps pay for.

Always write your complete health insurance claim number (including any letters) on all checks for Medicare premium payments or any correspondence about Medicare. Also, you should have your Medicare card available when you make a telephone inquiry.

Immediately ask Social Security to get you a new card if you lose yours.

Never let anyone else use your Medicare card.

Assistance for Low-Income Beneficiaries

Federal law requires that state Medicaid programs pay Medicare costs for certain elderly and disabled people with low incomes and very limited resources, described below. The following is a general description only; rules may vary from state to state.

Qualified Medicare Beneficiaries (QMB)

In general, you must meet these requirements:

You must be entitled to Medic are Hospital Insurance (Part A).

Your annual income for 1992 must be at or below $7,050 for one person and $9,430 for a family of two (amounts are somewhat higher in Alaska and Hawaii).* Amounts for 1993 will be slightly higher than those for 1992.

You cannot have resources such as bank accounts or stocks and bonds worth more than $4,000 for an individual or $6,000 for a couple. Your personal home, automobile, burial plot, furniture, jewelry, or life insurance are not counted, unless those items are of extraordinary value.

If you qualify as a QMB, your Medicare premiums, deductibles and coinsurance will be covered.

This amount is based on a percentage of the national poverty guidelines plus an income disregard of $240.

Specified Low-income Medicare Beneficiaries (SLMB)

Beginning January 1, 1993, there is a new program for certain low-income Medicare beneficiaries whose income is above the level to qualify as a QMB, but whose income is below 110 percent of the national poverty guidelines. If you qualify as a SLMB, Medicaid will pay your Medicare Part B premium only ($36.60 per month in 1993).

Where to Apply

If you think you may qualify for any of these benefits, you should file an application at the state or local welfare, social service or public health agency that serves people on Medicaid. All of these agencies are state--not federal--agencies.

If you need the telephone number for Medicaid, call 1-800-638-6833. Give the operator the name of your state and explain that you want the Medicaid telephone number so you can get information about these benefits.

Intermediaries and Carriers

The federal government contracts with private insurance organizations called intermediaries and carriers to process claims and make Medicare payments. Intermediaries handle inpatient and outpatient claims submitted on your behalf by hospitals, skilled nursing facilities, home health agencies, hospices and certain other providers of services.

You will not usually need to get in touch with intermediaries because Medicare pays most hospitals, skilled nursing facilities, home health agencies, hospices and other providers of services directly. But, if you have a question about your Part A bill, ask someone who works at the facility for help. If you cannot get an answer there, ask someone in the billing office at the facility to help you get in touch with the Medicare intermediary.

Carriers handle claims for services by doctors and suppliers covered under Medicare's Part B program. If you have questions about Medicare Part B claims, contact your Medicare carrier. The addresses and phone numbers of carriers are on pages 39 to 44.

If you want someone to contact Medicare for you, see "Your Rights Under the Privacy Act," (page 5) for more information.

Peer Review Organizations

Peer Review Organizations (PROs) are groups of practicing doctors and other health care

professionals who are paid by the federal government to review the care given to Medicare patients. Each state has a PRO that decides, for Medicare payment purposes, whether care is reasonable, necessary, and provided in the most appropriate setting. PROs also decide whether care meets the standards of quality generally accepted by the medical profession. PROs have the authority to deny payments if care is not medically necessary or not delivered in the most appropriate setting.

PROs investigate individual patient complaints about the quality of care and respond to:

Requests for review of notices of noncoverage issued by hospitals to beneficiaries; and

Requests for reconsideration of PRO decisions by beneficiaries, physicians, and hospitals.

The PRO will tell you in writing if the service you got was not covered by Medicare. See page 12 for a discussion of what is not covered by Medicare.

If you are admitted to a Medicare participating hospital, you will receive An Important Message From Medicare which explains your rights as a hospital patient and provides the name, address and phone number of the PRO for your state. If you are not given a copy of the message, be sure to ask for one.

If you feel that you are improperly refused admission to a hospital or that you are forced to leave the hospital too soon, ask for a written explanation of the decision. Such a written notice must fully explain how you can appeal the decision and it must give you the name, address and phone number of the PRO where your appeal or request for review can be submitted. (See page 35 for further discussion of your appeal fights under Medicare.)

Beneficiary Complaints

PROs are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; ambulatory surgical centers; and certain health maintenance organizations.

If you believe that you have received poor quality care from one of these facilities, you may complain to the PRO. The PRO will investigate written complaints from beneficiaries, or their representatives, about the quality of Medicare services received.

Your complaint must be in writing. If you wish, the PRO will help you put your complaint in writing by taking the information from you over the telephone and writing the complaint. If someone other than the PRO makes a complaint for you or on your behalf, you must give written permission for that person to represent you in the complaint.

Medicare PROs for each state are listed on pages 45 to 49.

Your Right to Decide About Your Medical Care

Under a new Medicare law, when you are admitted to a Medicare hospital or skilled nursing facility, get Medicare home health care, or enroll in a Medicare-approved hospice or health maintenance organization, you must be given written information about your rights to make decisions about your medical care.

Generally, you will be told about your fight to accept or refuse medical or surgical treatment. You will also be told about your fight to make--if you choose--an "advance directive." An advance directive contains written instructions about your choices for health care or naming someone to make those choices for you. The instructions are to be used if you are too sick or otherwise unable to talk. (The paper giving your health care choices may be called a "living will" or "a durable power of attorney for health care.")

You do not have to have an advance directive. But, if you have one you can say "yes" in advance to treatment you want if you get too sick to talk to your health care provider. You can also say "no" in advance to treatment you don't want.

Laws governing advance directives vary from state to state. Your treatment choices will depend on what is legal in your state. You can ask health care professionals in your state about the state's rules for living wills or durable powers of attorney. You can also contact your local state's attorney's office for this information.

Fraud and Abuse

Suspected Fraud Should be Reported

If you have reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services you did not receive, you should immediately report to the Medicare carrier or intermediary that handles your claims (see page 3).

The routine waiver of deductibles and coinsurance by doctors or suppliers of durable medical equipment is unlawful. Coinsurance and deductible payments may be waived only after careful consideration of a particular patient's financial hardship. Therefore, if a doctor or supplier offers to waive coinsurance or deductible payments, without having considered your individual circumstances or when you have not asked to have the payments waived, you should immediately report the. offer to the Medicare carrier or intermediary.

Report to the Medicare Carrier or Intermediary First

Call the carrier or intermediary first when you suspect fraud. Medicare carriers and intermediaries routinely look into cases of possible fraud and will appreciate your alerting them to your case. The carrier or intermediary will need to know the exact nature of the wrongdoing you suspect, the date it occurred, and the name and address of the party involved. Have this information ready when you call. (The telephone number of the Medicare intermediary or carrier is listed on the notice explaining Medicare's decision on your Medicare claim. Medicare carriers are also listed on pages 39 to 44.)

Calling For Further Help

If the Medicare carrier or intermediary does not respond to your report of Medicare fraud or abuse, you may call the Health Care Financing Administration (HCFA) hotline at 1-800-638-6833. There is no charge to you when you call this number. The hotline operator will refer you to the appropriate staff person at a HCFA regional office.

Be prepared to tell the HCFA regional office staff person:

- The exact nature of the wrongdoing you suspect, the date it occurred, and the name and

address of the party involved.

The name and location of the Medicare intermediary or carrier you reported it to, and when you reported it.

The name of any intermediary or carrier employee to whom you spoke and what advice that person gave you.

Your Rights Under the Privacy Act

Under the Privacy Act all federal agencies must safeguard information they collect about the people they serve.

When the Health Care Financing Administration (the agency that administers the Medicare program) asks you to fill out forms giving information about yourself to Medicare, we must:

Explain why we are collecting the information.

Tell you whom we plan to give it to.

Tell you whether you must, by law, give us the information.

When you give Medicare information, the Privacy Act allows you to:

Review your records for accuracy.

Make corrections, if you believe there are errors.

Know exactly what we will do with your records.

The Privacy Act also allows the government to verify the information you give us, using computer matches with other federal or state governments. If we do computer matches, we must tell you that they take place and give you a chance to protest our findings.

We include information about matches on all the forms you fill out. We also put a notice in the Federal Register, which is published by the federal government to notify the public of official actions. Copies are available at many libraries. (A computer-data match using Medicare, Internal Revenue Service and Social Security information is discussed on page 11.)

Medicare Carriers and Intermediaries must follow Privacy Act rules: These Medicare contractors may not discuss personal information about you with your family members or others who write or telephone on your behalf unless you give the contractors written permission.

What Are Coordinated Care Plans?

More and more Medicare beneficiaries are joining coordinated care plans. These coordinated care plans are prepaid, managed care plans, most of which are health maintenance organizations (HMOs) or competitive medical plans (CMPs). Both HMOs and CMPs contract with Medicare and follow the same contracting rules. In this handbook, HMOs will be used to illustrate the benefits for both.

Many beneficiaries find that coordinated care plans are a good way to get more health care for their

dollar. HMOs provide or arrange for all Medicare covered services, and generally charge you fixed monthly premiums and only small co-payments. This means that if you join a coordinated care plan and get all of your services through the HMO, your out-of-pocket costs are usually more predictable. Also, depending on your health needs, those costs may be less than you would pay if you had to pay the regular Medicare deductible and coinsurance amounts.

Coordinated care plans may also offer benefits not covered by Medicare for little or no additional cost. Benefits may include preventive care, dental care, heating aids and eyeglasses.

Who Can Enroll in Coordinated Care Plans?

Most Medicare beneficiaries are eligible to enroll in HMOs. HMOs cannot screen applicants to decide if they are healthy, or delay coverage for pre-existing conditions. The only enrollment criteria for Medicare HMOs are:

- You must be enrolled in Medicare Part B and continue to pay the Part B premiums (you do not need to be able to get Part A).
- You must live in the plan's service area.
- You cannot be receiving care in a Medicare-certified hospice.
- You cannot have permanent kidney failure.

If you develop permanent kidney failure after joining a coordinated care plan, the plan will provide, pay for, or arrange for your care. If you choose to receive hospice care after joining a coordinated care plan, the plan must inform you about hospice services available in your area. Staff at the coordinated care plan will explain how the hospice choice affects your plan membership.

Joining a Coordinated Care Plan

To join a coordinated care plan, contact plans in your area that have a contract with Medicare. All HMOs with Medicare contracts have an advertised open enrollment period at least once a year. Once you join, you may stay with the plan as long as it continues to contract with Medicare. And you may return to regular Medicare at any time. You can find out if there are HMOs in your area that contract with Medicare by calling the Health Care Financing Administration (HCFA) regional office nearest you. Medicare Coordinated Care contact numbers are listed in the box on page 7.

If you enroll in a coordinated care plan you will usually be required to get all care from the plan. In most cases, if you get services that are not authorized by the HMO (unless they are emergency services or services you urgently need when you are out of the plan's service area) neither the plan nor Medicare will pay for the services.

When you join an HMO, be sure to read your membership materials carefully to learn your fights and coverage.

Ending Enrollment in a Coordinated Care Plan

To end your enrollment in a coordinated care plan, send a signed request to your plan or to your local Social Security or Railroad Retirement Board office. You return to regular Medicare the first day of the month following the month your request is received by one of these offices. (If you leave a

coordinated care plan to return to regular Medicare and buy a Medigap policy, you may have to wait for up to 6 months for the new Medigap policy to cover any pre-existing condition.)

If You Have Problems

If you belong to a Medicare HMO and you are unhappy with the quality of care, you can:

Follow your HMO's grievance procedure, or

Complain to your Peer Review Organization (PRO). PROs are groups of practicing doctors and other health care professionals under contract to Medicare to review the care provided to Medicare patients (seepage 3).

If you have reason to believe that your Medicare HMO did not give you necessary care, inappropriately ended your enrollment, charged you an excessive premium, or falsified or misrepresented information, you can:

Write to the Office of Prepaid Health Care Operations and Oversight, Room 4406 Cohen Building, 330 Independence Ave., SW, Washington, DC 20201.

Describe your problem. The Office will see that your case is reviewed.

If you believe that your HMO has made an incorrect decision on coverage of benefits or payment of a claim, you can appeal--your appeal fights are similar to those provided under traditional Medicare. (See page 36 for more information about appeals.)

NOTE: A new Medicare supplement (Medigap) option is now available in some states. It is a kind of coordinated care plan called Medicare SELECT (see page 8 for more information).

If you need more information about Medicare and coordinated care plans, you can get a copy of Medicare and Coordinated Care Plans from the Consumer Information Center (see inside back cover).

Regional Office Coordinated Care Contacts

Health Care Financing Administration staff at the offices listed below can tell you if there are HMOs in your area that contract with Medicare.

Boston: (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont)
Beneficiary Services Branch (617) 565-1232

New York: (New Jersey, New York, Puerto Rico and the Virgin Islands) Carrier Operations Branch
(212) 264-8522

Philadelphia: (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia)
Beneficiary Services Branch
(215) 596-1332

Atlanta: (Alabama, North and South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)

Beneficiary Services and HMO Branch
(404) 331-2549

Chicago: (Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin)
Beneficiary Services and HMO Branch
(312) 353-7180

Dallas: (Arkansas, Louisiana, New Mexico, Oklahoma and Texas)
Beneficiary Services Branch
(214) 767-6401

Kansas City: (Iowa, Kansas, Missouri and Nebraska)
Program Services Branch
(816) 426-2866

Denver: (Colorado, Montana, North and South Dakota, Utah and Wyoming)
Beneficiary Services Branch
(303) 844-4024 ext 238

San Francisco: (American Samoa, Arizona, California, Guam, Hawaii and Nevada)
Beneficiary Services Branch
(415) 744-3617

Seattle: (Alaska, Idaho, Oregon and
Washington)
Beneficiary Services Branch
(206) 553-0800

Medicare and Other Insurance

Buying Health Insurance to Supplement Medicare

Medicare provides basic protection against the cost of health care, but it will not pay all of your medical expenses, nor most long-term care expenses. For this reason, many private insurance companies sell supplement (Medigap) insurance as well as separate long-term care insurance. The federal government does not sell or service such insurance.

Shopping for Medigap Insurance

If you are thinking about buying a new private insurance policy or replacing an old policy to supplement your Medicare protection or cover long-term care costs, you should shop carefully. You can get a booklet, Guide to Health Insurance for People with Medicare, to help you make Medicare supplement decisions. (See box below for more information about the guide.)

New Standardized Medigap Policies

Most states have adopted regulations limiting the sale of Medigap insurance to no more than 10 standard policies. One of the 10 is a basic policy offering a "core package" of benefits. These standardized plans are identified by the letters A through J. Plan A is the core package. The other nine plans each have a different combination of benefits, but they all include the core package. The basic policy, offering the core package of benefits, is available in all states.

To find out what standardized policies are available in your state, check with your state insurance department. The telephone number of your state insurance department is probably listed under "state agencies" in your telephone book. If not, you can get a copy of the Guide to Health Insurance for People with Medicare (see box below).

In most cases, if you already have a Medigap policy, you may keep it but there are a few states where you must convert your policy to one of the standard plans. In all cases, if you buy a new policy, you will be required to choose a standardized plan.

Open Enrollment Period for Medigap Policies

An open enrollment period for selecting Medigap policies guarantees that for six months immediately following the effective date of Medicare Part B coverage, people age 65 or older cannot be denied Medigap insurance or charged higher premiums because of health problems.

No matter how you enroll in Part B--whether by automatic notification or through an initial, special or general enrollment period--you are covered by the new guarantees if both of the following are true:

- You are 65 or older and are enrolled in Medicare based on age rather than disability.

- The date you get by adding six months to the effective date for your Part B coverage (printed on your Medicare card) is in the future. The date you get tells you when your Medigap open enrollment ends.

NOTE: Even when you buy your Medigap policy in this open enrollment period, the policy may still exclude coverage for "pre-existing conditions" during the first six months the policy is in effect. Pre-existing conditions are conditions that were either diagnosed or treated during the six-month period before the Medigap policy became effective.

Medicare SELECT

A new kind of Medigap insurance-available through 1994-has been introduced in 15 states. It is called Medicare SELECT. The difference between Medicare SELECT and regular Medigap insurance is that a Medicare SELECT policy may (except in emergencies) limit Medigap benefits to items and services provided by certain selected health care professionals or may pay only partial benefits when you get health care from other health care professionals.

You can order a free copy of the Guide to health Insurance for People With Medicare from the Consumer Information Center. There is ordering information on the inside back cover of this book. The guide:

- Explains how supplemental insurance works.

- Tells how to shop for Medigap insurance.

- Gives information on the new standard plans.

- Gives information on Medicare SELECT.

Lists names, addresses and telephone numbers of state insurance departments and state agencies on aging. Some of these offices may have free counseling services available.

Insurers, including some HMOs, offer Medicare SELECT in the same way standard Medigap insurance is offered. The policies are required to meet certain federal standards and are regulated by the states in which they are approved. The premiums charged for Medicare SELECT policies are expected to be lower than premiums for comparable Medigap policies that do not have this selected-provider feature.

Medicare SELECT policies are permitted to be offered in Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington and Wisconsin. If you live in one of these states, you can ask your state insurance department about the Medicare SELECT policies that have been approved for sale in the state.

Employment-related Retiree Coverage Instead of Medigap

Some retired people can get health coverage through their former employer or union. This health coverage may supplement Medicare but it is not Medigap insurance and does not have to meet federal and state Medigap requirements. (See below for rules about selling Medigap Insurance.)

Retiree coverage is usually provided free or at a greatly reduced price and may be a good bargain. But the benefits may not be adequate to serve as your supplement to Medicare. Does your retiree plan have an "escape clause," so that benefits might be changed? On the other hand, does your retiree plan protect you from the preexisting condition restriction that might be applied during the first six months under a Medigap policy? Check carefully before you decide whether to stay with your retiree coverage or buy a Medigap policy.

Medicaid Recipients

Low-income people who are eligible for Medicaid usually do not need additional insurance. Medicaid pays for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care. If you have Medigap insurance purchased on or after November 5, 1991, and you become eligible for Medicaid, you can ask that the Medigap benefits and premiums be suspended for up to two years while you are covered Medicaid. If you become ineligible for Medicaid benefits during the two years, your Medigap policy is automatically reinstituted if you give proper notice and begin paying premiums again.

Coordinated Care Plans Instead of Medigap

Coordinated care plans that contract with Medicare are not Medigap plans, but they can be an alternative to standard Medigap insurance. (See page 6 for more information about coordinated care plans.)

There are Rules for Selling Medigap Insurance

Both state and federal laws govern sales of Medigap insurance. Companies or agents selling Medigap insurance must avoid certain illegal practices. Federal criminal and civil penalties (fines) may be imposed against any insurance company or agent that knowingly:

Sells you a health insurance policy that duplicates your Medicare or Medicaid coverage, or any private health insurance coverage you may have.

Tells you that they are employees or agents of the Medicare program or of any government agency.

Makes a false statement that a policy meets legal standards for certification when it does not.

Sells you a Medigap policy that is not one of the 10 approved standard policies (after the new standards have been put in place in your state).

Denies you your Medigap open enrollment period by refusing to issue you a policy, placing conditions on the policy, or discriminating in the price of a policy because of your health status, claims experience, receipt of health care, or your medical condition.

Uses the U.S. mail in a state for advertising or delivering health insurance policies to supplement Medicare if the policies have not been approved for sale in that state.

If You Suspect Illegal Sales Practices

If you suspect that you have been the victim of illegal sales practices, you should report these practices to your state insurance department. States are responsible for the regulation of insurance policies issued within their boundaries. Because federal laws also govern Medigap sales practices, you should also report the practices to the appropriate federal officials.

Your state insurance department may be listed in your telephone book. If not, you can get a copy of the booklet, Guide to Health Insurance for People with Medicare (see box on page 8).

To talk to federal officials about the suspected illegal sales practices, you may call this number: 1-800-638-6833.

When Other Insurance Pays Before Medicare

If any of the following insurance situations applies to you, please notify your doctor, hospital, and all other providers of services. For more information about any of these insurance situations, ask Social Security for a copy of Medicare and Other Health Benefits. The publication is also available free from the Consumer Information Center (see inside back cover).

When You or Your Spouse Continue To Work

Medicare has special rules that apply to beneficiaries who have employer group health plan coverage through their current employment or the current employment of a spouse.

Group health plans of employers with 20 or more employees are primary payers and Medicare is secondary payer for workers age 65 or older, and workers' spouses age 65 or older. Group health plans must offer these people the same health insurance benefits under the same conditions offered to younger workers and spouses. You and your spouse have the option to reject the plan offered by the employer. If you reject the employer's health plan, Medicare will remain the primary health insurance payer. In that case, the employer's plan is not permitted to offer you coverage that supplements Medicare covered services. If your employer plan denies you coverage, offers you different coverage, or pays benefits that are secondary to Medicare, notify the carrier that handles your Medicare claims.

If You Are Disabled and Under Age 65

Medicare is the secondary payer for certain disabled people who have premium-free Medicare Part A and are covered under their employer's health plan or the employer health plan of an employed family member. This secondary payer provision applies to group health plans of employers that employ 100 or more people. The secondary payer provision also applies to group health plans of employers with fewer than 100 employees if their employers are part of a multi-employer plan in which at least one employer has 100 or more employees.

Other Situations Where Medicare is the Secondary Payer

If you have a work-related illness or injury, services provided as treatment of that illness or injury should be covered by workers' compensation or federal black lung benefits. It is important that your Medicare claim form note that the treatment is related to a work-related illness or injury, even if the injury or illness occurred in the past.

Medicare is a secondary payer during a period (generally 18 months) for beneficiaries who have Medicare solely on the basis of permanent kidney failure, if they have employer group health plan coverage themselves or through a family member.

Medicare also serves as the secondary payer in cases where no-fault insurance or liability insurance is available as the primary payer.

Although Medicare benefits are secondary to benefits paid by liability insurers, Medicare may make a conditional payment if it receives a claim for services covered by liability insurance. In those cases, Medicare may pay the claim; then, when a liability settlement is reached, Medicare recovers its conditional payment from the settlement amount.

If You Have or Can Get Both Medicare and Veterans Benefits

If you have or can get both Medicare and veterans benefits, you may choose to get treatment under either program. But, Medicare:

> Cannot pay for services you receive from Veterans Affairs (VA) hospitals or other VA facilities, except for certain emergency hospital services; and
>
> Generally cannot pay if the VA pays for VA-authorized services that you get in a non-VA hospital or from a non-VA physician.

Since July 1986, the VA has been charging coinsurance payments to some veterans who have non-service connected conditions for treatment in a VA hospital or medical facility, or for VA-authorized treatment by nonVA sources. The VA charges coinsurance payments when the veteran's income exceeds a particular level. If the VA charges you a coinsurance payment for VA-authorized care by a non-VA physician or hospital, Medicare may be able to reimburse you, in whole or in part, for your VA coinsurance payment obligation. (If you have Medigap insurance, your Medigap policy may pay the VA coinsurance and deductible obligations, even if Medicare cannot.)

NOTE: Medicare cannot reimburse you for VA coinsurance payments for services furnished by VA hospitals and facilities, unless the services are emergency inpatient or outpatient hospital services. Then, the Medicare payment is subject to Medicare deductible and coinsurance amounts.

If you have questions about whether the VA or Medicare should pay for your doctor or other services covered under Medicare Part B, contact your Medicare carrier. If you have questions about whether the VA or Medicare should pay for hospital or other services covered under Medicare Part A, ask the provider of services to check with the Medicare intermediary.

The Data Match

In 1989, Congress passed a; law that will help Medicare get back an estimated $1 billion in taxpayer money. The law enables Medicare to get accurate information about beneficiaries' health insurance.

The law authorizes the Health Care Financing Administration (the agency that administers the Medicare program), the Internal Revenue Service, and the Social Security Administration to share information about whether Medicare beneficiaries or their spouses are working and whether they have employment-related health insurance.

The process for sharing information from other agencies is called the Data Match. The Data Match will help Medicare find cases where another insurer should have paid first on Medicare beneficiaries' health care claims. A designated Medicare contractor will contact employers to confirm health insurance coverage information. (For information about your fights under the Data Match, see "Your Rights Under the Privacy Act," page 5.)

What Medicare Does Not Pay For

Custodial Care

Medicare does not pay for custodial care when that is the only kind of care you need. Care is considered custodial when it is primarily for the purpose of helping you with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. Much of the care provided in nursing homes to people with chronic, long-term illnesses or disabilities is considered custodial care. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility, Medicare does not cover your stay if you need only custodial care.

Care Not Reasonable and Necessary Under Medicare Program Standards

Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. These services include drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA;* and services, including drugs or devices, not considered safe and effective because they are experimental or investigational.

> Some services are not covered by Medicare even when FDA has approved the drug or device used.

If a doctor admits you to a hospital or skilled nursing facility when the kind of care you need could be provided elsewhere (for example, at home or in an outpatient facility), your stay will not be considered reasonable and necessary, and Medicare will not pay for your stay. If you stay in a hospital or skilled nursing facility longer than you need to be there, Medicare payments will end when inpatient care is no longer reasonable and necessary.

If a doctor (or other practitioner) comes to treat you---or you visit him or her for treatment--more

often than is medically necessary, Medicare will not pay for the "extra" visits. Medicare will not pay for more services than are reasonable and necessary for your treatment.

Medicare always bases decisions about what is reasonable and necessary on professional medical advice.

Services Medicare Does Not Pay For

Medicare, by law, cannot pay for certain services. These include services performed by immediate relatives or members of your household, and services paid for by another government program. If you have a question about whether Medicare pays for a particular service, ask your Medicare carrier. (See pages 39 to 44 for the name and telephone number of your carrier.)

Limitation of Liability

Under Medicare law you will not be held responsible for payment of the cost of certain health care services for which you were denied Medicare payment if you did not know or you could not reasonably be expected to know (for example, you had not received a written notice) that the services were not covered by Medicare. This provision is called limitation of liability and is often referred to as a "waiver of liability." This protection from financial liability applies only when the care was denied because it was one of the following: Custodial care.

Not "reasonable and necessary" under Medicare program standards for diagnosis or treatment.

> For home health services, the patient was not homebound or not receiving skilled nursing care on an intermittent basis.
>
> The only reason for the denial is that, in error, you were placed in a skilled nursing facility bed that was not approved by Medicare.

This limitation of liability provision does not apply to Medicare Part B services provided by a non-participating physician or supplier who did not accept assignment of the claim. However, in certain situations Medicare law will protect you from paying for services provided by a non-participating physician on a non-assigned basis that are denied as "not reasonable and necessary." If your physician knows or should know that Medicare will not pay for a particular service as "not reasonable and necessary," he or she must give you written notice--before performing the service--of the reasons why he or she believes Medicare will not pay. The physician must get your written agreement to pay for the services. If you did not receive this notice, you are not required to pay for the service. If you did pay, you may be entitled to a refund. (This written notice is not an official Medicare. determination. If you disagree with it, you may ask your doctor to submit a claim for payment to get an official Medicare determination.)

Medicare Hospital Insurance (Part A)

What Medicare Part A Includes

Medicare Part A helps pay for four kinds of medically necessary care:

1. Inpatient hospital care.

2. Inpatient care in a skilled nursing facility following a hospital stay.

3.Home health care.

4.Hospice care.

There is a limit on how many days of hospital or skilled nursing facility care Medicare helps pay for in each benefit period. But, your Part A protection is renewed every time you start a new benefit period. (Benefit periods are described below.)

Skilled nursing facility care is the only type of nursing home care that Medicare covers. Medicare does not pay for care that is primarily custodial. (See pages 17 and 20 for more about custodial care.)

Benefit Periods

A benefit period is a way of measuring your use of services under Medicare Part A. Your First benefit period starts the first time you receive inpatient hospital care after your Hospital Insurance begins. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). If you remain in a facility (other than a hospital) that primarily provides skilled nursing or-rehabilitation services, a benefit period ends when you have not received any skilled care there for 60 days in a row. After one benefit period has ended, another one will start whenever you again receive inpatient hospital care.

There is no limit to the number of benefit periods you can have for hospital and skilled nursing facility care. However, special limited benefit periods apply to hospice care (see page 19).

Here are two examples of how the benefit period works:

Example 1: Ms. Jones enters the hospital on January 5. She is discharged on January 15. She has used 10 days of her first benefit period. Ms. Jones is not hospitalized again until July 20. Since more than 60 days elapsed between her hospital stays, she begins a new benefit period, her Part A coverage is completely renewed, and she will again pay the hospital deductible. (The hospital deductible is explained on page 15.)

Example 2: Ms. Smith enters the hospital on August 14. She is discharged on August 24. She also has used 10 days of her first benefit period. However, she is then readmitted to the hospital on September 20. Since fewer than 60 days elapsed between hospital stays, Ms. Smith is still in her first benefit period and will not be required to pay another hospital deductible. This means that the first day of her second admission is counted as the eleventh day of hospital care in that benefit period. Ms. Smith will not begin a new benefit period until she has been out of the hospital (and has not received any skilled care in a skilled nursing facility) for 60 consecutive days.

How Medicare Pays for Part A Services

Medicare Part A helps pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency or hospice program. There are covered services and noncovered services under each kind of care. Covered services are services and supplies that Part A pays for.

Hospitals, skilled nursing facilities, home health agencies and hospices are called "providers" under

the Medicare Part A program. Providers submit their claims directly to Medicare--you cannot submit claims for their services. The provider will charge you for any part of the Part A deductible you have not met and any coinsurance payment you owe. Providers cannot require you to make a deposit before being admitted for inpatient care that is or may be covered under Part A of Medicare.

When a hospital, skilled nursing facility, home health agency, or hospice sends Medicare a Part A claim for payment, you get a Notice of Utilization that explains the decision Medicare made on the claim. This notice is not a bill. If you have any questions about the notice, get in touch with the people who sent you the notice.

When You Are a Hospital Inpatient

Medicare Part A helps pay for inpatient hospital care if all of the following four conditions are met:

1. A doctor prescribes inpatient hospital care for treatment of your illness or injury.

2. You require the kind of care that can be provided only in a hospital.

3. The hospital is participating in Medicare.*

4. The Utilization Review Committee of the hospital, a Peer Review Organization or an intermediary does not disapprove your stay.

    Under certain conditions, Medicare helps pay for emergency inpatient care you receive in a non-participating hospital.

If you meet these four conditions, Medicare will help pay for up to 90 days of medically necessary inpatient hospital care in each benefit period.**

> Medicare pays for only limited inpatient care in a psychiatric hospital (see page 16). The hospital can tell you about these limits.

During 1993, from the first day through the 60th day in a hospital during each benefit period, Part A pays for all covered services except the first $676. This is called the inpatient hospital deductible. (A deductible is an amount you owe before Medicare begins paying for services and supplies covered by the program.) The hospital may charge you the deductible only for your first admission in each benefit period. If you are discharged and then readmitted before the benefit period ends, you do not have to pay the deductible again.

From the 61st through the 90th day in a hospital during each benefit period, Part A pays for all covered services except for $169 a day. This daily amount is called coinsurance. The hospital charges you the $169.

Hospital reserve days (explained below) can help with your expenses if you need more than 90 days of inpatient hospital care in a benefit period.

Medicare Part A does not pay for the services of doctors and certain other practitioners, even though you receive these services in a hospital. Instead, those services are covered under Medicare Part B. (A description of Medicare Part B begins on page 21.)

Major services covered under Part A when you are a hospital inpatient:

A semiprivate room (two to four beds in a room).

All your meals, including special diets.

Regular nursing services.

Costs of special care units, such as intensive care or coronary care units.

Drugs furnished by the hospital during your stay.

Blood transfusions furnished by the hospital during your stay. (See page 16 for information about coverage of blood.)

Lab tests included in your hospital bill.

X-rays and other radiology services, including radiation therapy, billed by the hospital.

Medical supplies such as casts, surgical dressings, and splints.

Use of appliances, such as a wheelchair.

Operating and recovery room costs.

Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services.

Some services not covered under Part A when you are a hospital inpatient:

Personal convenience items that you request such as a telephone or television in your room.

Private duty nurses.

Any extra charges for a private room unless it is determined to be medically necessary.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the fight to appeal the decision (see page 35).

Hospital Inpatient Reserve Days

Medicare helps pay for your care in a hospital for up to 90 days in each benefit period. Medicare Part A also includes an extra 60 hospital days you can use if you have a long illness and have to stay in the hospital for more than 90 days. These extra days are called reserve days.

You have only 60 reserve days in your lifetime. For example, if you use 8 reserve days in your first hospital stay this year, the next time you visit a hospital you will have only 52 reserve days left to use, whether or not you have a new benefit period.

You can decide when you want to use your reserve days. After you have been in the hospital 90

days, you can use all or some of your 60 reserve days if you wish.

If you do not want to use your reserve days, you must tell the hospital in writing, either when you are admitted to the hospital, or at any time afterwards up to 90 days after you are discharged. If you use reserve days and then decide that you did not want to use them, you must request approval from the hospital to get them restored.

During 1993, Medicare Part A pays for all covered services except $338 a day for each reserve day you use. You are responsible for paying this $338.

All Medigap plans pay some part of hospital bills after you have used all your reserve days. (See page 8 for more information about Medigap insurance.)

Coverage of Blood Under Part A

Part A helps pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration. If you receive blood as an inpatient of a hospital or skilled nursing facility, Part A will pay for these blood costs, except for any nonreplacement fees charged for the first three pints of whole blood or units of packed red cells per calendar year. (The nonreplacement fee is the amount that some hospitals and skilled nursing facilities charge for blood that is not replaced.)

You are responsible for the nonreplacement fees for the first three pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can either replace the blood personally or arrange to have another person or an organization replace it for you. A hospital or skilled nursing facility cannot charge you for any of the first three pints of blood you replace or arrange to replace. (If you have already paid for or replaced blood under Medicare Part B during the calendar year, you do not have to meet those costs again under Medicare Part A. See page 21 for an explanation of coverage of blood under Medicare Part B.)

Care in a Psychiatric Hospital

Part A helps pay for no more than 190 days of inpatient care in a participating psychiatric hospital in your lifetime. Once you have used these 190 days, Part A does not pay for any more inpatient care in a psychiatric hospital.

Also, a special role applies if you are in a participating psychiatric hospital at the time your Part A starts. Social Security can give you more information.

Care Outside the United States

Medicare generally does not pay for hospital or medical services 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.)

If you are planning to travel outside the United States, you may want to buy special short-term health insurance for foreign travel. If you have other health insurance in addition to Medicare, check to see if health care in a foreign country is covered under your policy.

There are rare emergency cases where Medicare can pay for care in Canada or Mexico. Also,

Medicare can sometimes pay if a Mexican or Canadian hospital is closer to your home than the nearest U.S. hospital that can provide the care you need. If you get emergency treatment in a Canadian or Mexican hospital or if you live near a Canadian or Mexican hospital, ask someone who works at the hospital about Medicare coverage, or have the hospital help you contact the Medicare intermediary.

Care in a Christian Science Sanatorium

Medicare Part A helps pay for inpatient hospital and skilled nursing facility services you receive in a participating Christian Science sanatorium if it is operated or listed and certified by the First Church of Christ, Scientist, in Boston. (However, Medicare Part B will not pay for the practitioner.)

The Prospective Payment System

Medicare pays for most inpatient hospital care under the Prospective Payment System (PPS). Under PPS, hospitals are paid a predetermined rate per discharge for inpatient services furnished to Medicare beneficiaries. The predetermined rates are based on payment categories called Diagnosis Related Groups, or DRGs. In some cases, the Medicare payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high or the length of stay is unusually long, the hospital receives additional payment. But even if Medicare pays the hospital less than the cost of your care, you do not have to make up the difference.

It is important to remember that the PPS system does not change your Medicare Part A protection as described in this handbook. PPS does not determine the length of your stay in the hospital or the extent of care you receive. The law requires participating hospitals to accept Medicare payments as payment in full, and those hospitals are prohibited from billing the Medicare patient for anything other than the applicable deductible and coinsurance amounts, plus any amounts due for noncovered items or services such as television, telephone or private duty nurses.

Skilled Nursing Facility Care

Medicare Part A can help pay for certain inpatient care in a Medicare-participating skilled nursing facility following a hospital stay. Your condition must require daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility, and the skilled care you receive must be based on a doctor's orders.

What is a Skilled Nursing Facility?

A skilled nursing facility is a specially qualified facility that specializes in skilled care. It has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist.

Most nursing homes in the United States are not skilled nursing facilities that participate in Medicare. In some facilities, only certain portions participate in Medicare. If you are not sure whether a facility participates in Medicare as a skilled nursing facility, ask someone in the facility's business office. If staff at the facility cannot tell you, ask Social Security to check with the Health Care Financing Administration.

When Can Medicare Pay?

Medicare Part A can help pay for your care in a Medicare-participating skilled nursing facility if you meet all of these five conditions:

1. Your condition requires daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility.

2. You have been in a hospital at least three days in a row (not counting the day of discharge) before you are admitted to a participating skilled nursing facility.

3. You are admitted to the facility within a short time (generally within 30 days) after you leave the hospital.

4. Your care in the skilled nursing facility is for a condition that was treated in the hospital, or for a condition that arose while you were receiving care in the skilled nursing facility for a condition which was treated in the hospital.

5. A medical professional certifies that you need, and you receive, skilled nursing or skilled rehabilitation services on a daily basis.

All five conditions must be met. Remember, you must need skilled nursing care or skilled rehabilitation services on a daily basis. Part A will not pay for your stay if you need skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if you do not need to be in a skilled nursing facility to get skilled services. Also, Medicare will not pay for your stay if you are in a skilled nursing facility mainly because you need custodial care.

Skilled Care or Custodial Care?

The only type of "nursing home" care Medicare helps pay for is skilled nursing facility care. Medicare does not pay for custodial care when that is the only kind of care you need.

Care is considered custodial when it is primarily for the purpose of helping the patient with daily living or meeting personal needs, and could be provided safely and reasonably by people Without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

When your stay in a skilled nursing facility is covered by Medicare, Part A helps pay for a maximum of 100 days in each benefit period, but only if you need daily skilled nursing care or rehabilitation services for that long.

If you leave a skilled nursing facility and are readmitted within 30 days, you do not have to have a new three day stay in the hospital for your care to be covered. If you have some of your 100 days left and you need skilled nursing or rehabilitation services on a daily basis for further treatment of a condition treated during your previous stay in the facility, Medicare will help pay.

In each benefit period, Part A pays for all covered services for the first 20 days you are in a skilled nursing facility. During 1993, for days 21 through 100, Part A pays for all covered services except for $84.50 a day. You may be charged up to this daily coinsurance amount by the skilled nursing facility.

Medicare Part A does not cover your doctor's services while you are in a skilled nursing facility. Medicare Part B covers doctors' services. (A description of Medicare Part B begins on page 21.)

Major services covered under Part A when you are in a skilled nursing facility:

A semiprivate room (two to four beds in a room).

All your meals, including special diets furnished by the facility.

Regular nursing services.

Physical, occupational, and speech therapy.

Drugs furnished by the facility during your stay.

Blood transfusions furnished during your stay. (See page 16 for information about coverage of blood.)

Medical supplies such as splints and casts furnished by the facility.

Use of appliances such as a wheelchair furnished by the facility.

Some services not covered under Part A when you are in a skilled nursing facility:

Personal convenience items that you request such as a television in your room.

Private duty nurses.

Any extra charges for a private room, unless it is determined to be medically necessary.

Rules That Protect You

Skilled nursing facilities cannot require you to pay a deposit or other payment as a condition of admission to the facility unless it is clear that services are not covered by Medicare.

If you are already an inpatient in a skilled nursing facility and the staff at the facility decides you no longer need the level of skilled care covered by Medicare, they must notify you immediately. If you disagree with this decision, the facility must submit your claim at your request to Medicare for an official Medicare decision on coverage. The facility may not require you to pay a deposit until Medicare issues its decision. You must pay for any coinsurance while your claim is being processed, and for any services which are never covered by Medicare.

Complaints and Appeals

If you want to complain about a skilled nursing facility's treatment of patients or other conditions that concern you, you can contact the state survey agency. Each skilled nursing facility can give you the telephone number and address of the state survey agency if you ask for it. You can also look at a copy of the skilled nursing facility's latest certification survey report. The survey report will tell you the results of the state survey agency's review of how well the agency thinks the facility followed the rules about patient's rights, safety and quality of care.

Also, if you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the fight to appeal the decision (see page 35).

Home Health Care

If you need skilled health care in your home for the treatment of an illness or injury, Medicare pays for covered home health services furnished by a participating home health agency. A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in your home. (A hospital or other facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

Medicare pays for home health visits only if all four of the following conditions are met:

1. The care you need includes intermittent skilled nursing care, physical therapy, or speech therapy.

2. You are confined to your home (homebound).

3. You are under the care of a physician who determines you need home health care and sets up a home health plan for you.

4. The home health agency providing services participates in Medicare.

Once all four of these conditions are met, either Medicare Part A or Medicare Part B will pay for all medically necessary home health services. When you no longer need intermittent skilled nursing care, physical therapy, or speech therapy, Medicare will pay for home health services if you continue to need occupational therapy.

Medicare home health services do not include coverage for general household services such as laundry, meal preparation, shopping, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.

To determine whether you can get services under the Medicare home health benefit, ask your physician to refer you to a Medicare participating home health agency. The home health agency will evaluate your case and tell you whether you meet the requirements for Medicare coverage. Home health agencies should not charge for this evaluation.

Home health services covered by Medicare:

Part-time or intermittent skilled nursing care. (This can include eight hours of reasonable and necessary care per day for up to 21 consecutive days--or longer in certain circumstances.)

Physical therapy.

Speech therapy.

If you need intermittent skilled nursing care, or physical or speech therapy, Medicare also pays for:

Occupational therapy.

Part-time or intermittent services of home health aides.

Medical social services.

Medical supplies.

Durable medical equipment (80 percent of approved amount).

Home health services not covered by Medicare.

24-hour-a-day nursing care at home.

Drugs and Biologicals.

Meals delivered to your home.

Homemaker services.

Blood transfusions.

Medicare pays the full approved cost of all covered home health visits. You may be charged only for any services or costs that Medicare does not cover. However, if you need durable medical equipment, you are responsible for a 20 percent coinsurance payment for the equipment. (See page 26 for more information about durable medical equipment.)

The home health agency will submit the claim for payment. You do not have to send in any bills yourself.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the fight to appeal the decision (see page 35).

Hospice Care

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people.

Hospice care is a special type of care for people who are terminally ill. It includes both home care and inpatient care, when needed, and a variety of services not otherwise covered under Medicare. Under the Medicare hospice benefit, Medicare pays for services every day and also permits a hospice to provide appropriate custodial care, including homemaker services and counseling.

Medicare Part A helps pay for hospice care if all three of these conditions are met:

1. A doctor certifies that the patient is terminally ill.

2. The patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness.

3. Care is provided by a Medicare-participating hospice program.

Special benefit periods apply to hospice care. Part A pays for two 90-day periods, followed by a 30-day period, and--when necessary--an extension period of indefinite duration. If a beneficiary cancels hospice care during one of the first three benefit periods, any days left in that period are lost, but the remaining benefit period(s) are still available, And, a beneficiary may disenroll from the hospice during any benefit period, return to regular Medicare coverage, then later re-elect the hospice benefit if another benefit period is available.

Two Benefit Period Examples:

> Mr. Jones cancelled his hospice care at the end of 59 days during his first 90-day benefit period. He lost the 31 remaining days of the first 90-day period. But if he wants to, he can choose hospice care again. He still has a 90-day period, a 30-day period, and the indefinite extension period.
>
> Ms. Smith cancelled hospice care during her final extension period. She cannot use the Medicare hospice benefit again.

There are no deductibles under the hospice benefit. The beneficiary does not pay for Medicare-covered services for the terminal illness, except for small coinsurance amounts for outpatient drugs and inpatient respite care.

The patient is responsible for five percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less. For inpatient respite care, the patient pays five percent of the Medicare-allowed rate (approximately $4.48 per day in 1993). The rate varies slightly depending on the area of the country.

Respite care under the hospice program is a short-term inpatient stay in a facility. The Medicare beneficiary's inpatient stay gives temporary relief--a respite--to the person who regularly assists with home care. Each inpatient respite care stay is limited to no more than five days in a row.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

Services covered by Part A when provided by a hospice:

> Nursing services.
>
> Doctors' services.
>
> Drugs, including outpatient drugs for pain relief and symptom management.

Physical therapy, occupational therapy and speech language pathology.

> Home health aide and homemaker services.
>
> Medical social services.
>
> Medical supplies and appliances.
>
> Short-term inpatient care, including respite care.

Counseling.

The Medicare Part A hospice benefit does not pay for treatments other than for pain relief and symptom management of a terminal illness. Regular Medicare can usually help pay for treatments not related to the terminal illness.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision (see page 35).

Medicare Medical Insurance (Part B)

What Medicare Part B Includes

Medicare Part B helps pay for:

Doctors' services.

Outpatient hospital care.

Diagnostic tests.

Durable medical equipment.

Ambulance services.

Many other health services and supplies that are not covered by Medicare Part A.

The following sections tell you more about these different kinds of care, the services that are and are not covered by Medicare Part B, and what part of your medical expenses Medicare will pay.

Deductible and Coinsurance Amounts Under Part B

The Annual Deductible

You must pay the first $100 in approved charges for covered medical expenses in 1993. This is called the Medicare Part B annual deductible. You need to meet this $100 deductible only once during the year, and the deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you receive.

The Blood Deductible

You must pay any nonreplacement fees charged for the first three pints or units of blood and blood components you use each year. (The nonreplacement fee is the amount that some practitioners and facilities charge for blood that is not replaced.) This is called the Medicare Part B blood deductible. After you have replaced or paid for the first three pints of blood and you have met the $100 annual deductible, Medicare will pay 80 percent of the approved amount for blood, starting with the fourth pint. (If you have already paid for or replaced some units of blood under Medicare Part A during the calendar year, you do not have to pay for or replace that number of units again under Medicare Part B.)

Coinsurance

After you pay the annual deductible, you will owe a share of the Medicare-approved amount for most services and supplies. This share is called coinsurance. Usually, your coinsurance share is 20 percent of the Medicare-approved amount.

Medicare determines the approved amount for each service you receive. If your services were provided "on assignment," you pay only the coinsurance (see page 28 for an explanation of assignment).

If your services were not provided "on assignment," and the charges for your services were more than the Medicare-approved amount, you usually owe the Medicare coinsurance plus certain charges above the Medicare-approved amount. (See "Medicare Approved Amounts" on page 29.) There are limits on the amount your doctor can charge you.

NOTE: This explanation of your deductible and coinsurance amounts describes Medicare's payment system for most services covered by Medicare Part B. In cases where payment for services is handled in a different way, you will be given an explanation along with the description of services covered. (You will find more information about how Medicare pays Part B claims in the section beginning on page 28.)

Doctors' Services Covered By Medicare Part B

Medicare Part B helps pay for covered services you receive from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location.

Major doctors' services covered by Medicare Part B:

- Medical and surgical services, including anesthesia.
- Diagnostic tests and procedures that are part of your treatment.
- Radiology and pathology services by doctors while you are a hospital inpatient or outpatient.
- Treatment of mental illness. (Medicare payments for treatment are limited; see page 27)
- Other services such as:
  - X-rays.
  - Services of your doctor's office nurse.
  - Drugs and Biologicals that cannot be self-administered.
  - Transfusions of blood and blood components,
  - Medical supplies.
  - Physical/occupational therapy and speech pathology services.

Some doctors' services not covered by Medicare Part B:

Routine physical examinations, and tests directly related to such examinations (except some Pap smears and mammograms, see page 25).

Most routine foot care and dental care.

Examinations for prescribing or fitting eyeglasses or hearing aids.

Immunizations (except pneumococcal pneumonia vaccinations or immunizations required because of an injury or immediate risk of infection, and hepatitis B for certain persons at risk).

Cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body.

Types of Doctors

Most doctors' services are furnished by a doctor of medicine or a doctor of osteopathy. Other "physicians" that can furnish some covered services include chiropractors, doctors of podiatric medicine (podiatrists), doctors of dental surgery or of dental medicine (dentists), and doctors of optometry (optometrists).

Chiropractors' Services

Medicare helps pay for only one kind of treatment furnished by a licensed chiropractor: manual manipulation of the spine to correct a subluxation that is demonstrated by X-ray. Medicare Part B does not pay for any other diagnostic or therapeutic services, including Xrays, furnished by a chiropractor.

Podiatrists' Services

Medicare Part B helps pay for any covered services of a licensed podiatrist to treat injuries and diseases of the foot. Examples of common problems include ingrown toenails, hammer toe deformities, bunion deformities and heel spurs.

Medicare generally does not pay for routine foot care such as cutting or removal of corns and calluses, trimming of nails, and other hygienic care. But, Medicare does help pay for some routine foot care if you are being treated by a medical doctor for a medical condition affecting your legs or feet (such as diabetes or peripheral vascular disease) which requires that the routine care be performed by a podiatrist or by a doctor of medicine or osteopathy.

Dentists' Services

Medicare Part B generally does not pay for care in connection with the treatment, filling, removal, or replacement of teeth; root canal therapy; surgery for impacted teeth; or other surgical procedures involving the teeth or structures directly supporting the teeth. However, Medicare does help pay for services of a dentist in certain cases when the medical problem is more extensive than the teeth or structures directly supporting them. (If you need to be hospitalized because of the severity of a dental procedure, Medicare Part A may pay for your inpatient hospital stay even if the dental care itself is not covered by Medicare.)

Optometrists' Services

Medicare helps pay for Medicare-covered vision care, including the services of an optometrist if the optometrist is legally authorized to perform those services by the state in which he or she performs them. However, Medicare will not pay for routine eye exams and usually will not pay for eyeglasses. (Medicare will pay for cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery. Medicare will also pay for one pair of conventional eyeglasses or conventional contact lenses if necessary after cataract surgery with insertion of an intraocular lens.)

Second Opinion Before Surgery

Sometimes your doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, we recommend that you get an opinion from a second doctor to help you decide about surgery. Medicare will help pay for a second opinion. Medicare will also help pay for a third opinion if the first and second opinions contradict each other.

Your own doctor is the best source for referral to another doctor. But, if you wish, you can call your Medicare Part B carrier for the names and phone numbers of doctors in your area who provide second opinions. (Medicare carriers are listed on pages 39 to 44.)

Services of Special Practitioners

Medicare Part B helps pay for covered services you receive from certain specially qualified practitioners who are not physicians. The practitioners must be approved by Medicare. Medicare-approved practitioners are listed below:

Certified registered nurse anesthetist.

Certified nurse midwife.

Clinical psychologist.

Clinical social worker (other than in a hospital).

Physician assistant. (A physician assistant can furnish certain services in a hospital or certain other facilities, can serve as an assistant-at-surgery, and can furnish services in any location that is designated as a rural health professional shortage area.)

Nurse practitioner and clinical nurse specialist in collaboration with a physician. (A nurse practitioner can furnish services in a skilled nursing facility or a Medicaid nursing facility in any area. In addition, a nurse practitioner or clinical nurse specialist can furnish services in a rural area.)

Outpatient Hospital Services

Medicare Part B helps pay for covered services you receive as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury. Under certain conditions, Medicare helps pay for emergency outpatient care you receive from a non-participating hospital.

When you get outpatient hospital services, you are responsible for the annual Medicare Part B deductible. In addition to the deductible, you are responsible for a coinsurance of 20 percent of the hospital's charge above the deductible.

When you go to a hospital for outpatient services, you are sometimes asked how much of your Part B deductible you have met. One easy way to answer that question is to show your most recent Explanation of Your Medicare Part B Benefits notice. From this form, hospital staff can usually tell how much of the $100 annual deductible you have met.

If the hospital cannot tell how much of the $100 deductible you have met and the charge for the services you received is less than $100, the hospital may ask you to pay the entire bill. The amount you pay the hospital can be credited toward any part of the deductible you have not met. If you pay the hospital for deductible amounts you do not owe, the hospital or the Medicare intermediary will refund the amount you overpaid.

Major outpatient hospital services covered by Part B:

- 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 psychiatric program, if a physician 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.
- Drugs and Biologicals that cannot be selfadministered.
- Blood transfusions furnished to you as an outpatient.

Some outpatient hospital services not covered by Part B:

- Routine physical examinations and tests directly related to such examinations (except some Pap smears and mammograms, see page 25).
- Eye or ear examinations to prescribe or fit eyeglasses or hearing aids.
- Immunizations (except pneumococcal pneumonia and hepatitis B vaccinations, or immunizations required because of an injury or immediate risk of infection).
- Most routine foot care.

Other Services and Supplies Covered by Medicare

Ambulatory Surgical Services

An ambulatory surgical center is a facility that provides surgical services that do not require a hospital stay. Medicare Part B will pay for the use of an ambulatory surgical center for certain approved

surgical procedures. However, by law Medicare can only pay centers that have an agreement with Medicare to participate in the Medicare program. If you do not know whether an ambulatory surgical center participates in Medicare, ask someone in the center's business office. If that person does not know, contact Social Security and ask them to check with the Health Care Financing Administration.

In addition to helping pay for the use of the ambulatory surgical center, Medicare also helps pay for physician and anesthesia services that are provided in connection with the procedure.

Home Health Services

If you have both Medicare Part A and Part B, your Part A pays for home health services. But Part B will pay for home health services if you do not have Part A. Medicare home health services are described on page 18.

Outpatient Physical and Occupational Therapy and Speech Pathology Services

Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy or speech pathology services, if all the following three conditions are met:

1. Your doctor prescribes the service.

2. Your doctor or therapist sets up the plan of treatment.

3. Your doctor periodically reviews that plan.

You can receive physical therapy, occupational therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or public health agency. The provider of services may charge you only for any part of the $100 annual deductible you have not met, 20 percent of the remaining approved amount, and any noncovered services.

Also, you can receive services directly from an independently practicing, Medicare-approved physical or occupational therapist in his or her office or in your home if such treatment is prescribed by a doctor. (Medicare does not pay for services provided by independently practicing speech pathologists.) But, the maximum amount Medicare pays for each of these services provided by an independently practicing physical or occupational therapist in 1993 is $600 a year. (This is 80 percent of the maximum approved amount of up to $750.) The Medicare payment would be less than $600 if charges for these services are used to meet part or all of your $100 annual deductible.

Comprehensive Outpatient Rehabilitation Facility Services

Under certain circumstances, Medicare helps pay for outpatient services you receive from a Medicareparticipating comprehensive outpatient rehabilitation facility (CORF). Covered services include physicians' services; physical, speech, occupational and respiratory therapies; counseling; and other related services. You must be referred by a physician who certifies that you need skilled rehabilitation services. For most CORF services, you are responsible only for the annual deductible and 20 percent of the Medicare approved-charges. Medicare helps pay for mental health treatment in a CORF; the Medicare payment limit for mental health treatment in a CORF is discussed on page 27.

Partial Hospitalization for Mental Health Treatment

Partial hospitalization (sometimes called day treatment) is a program of outpatient mental health care. Under certain conditions, Medicare Part B helps pay for these programs when provided by hospital outpatient departments or by community mental health centers. If you are considering mental health treatment, check with the program you have chosen to see if it meets the conditions for Medicare payment.

Rural Health Clinic Services

Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses (under certain conditions), clinical psychologists, and clinical social workers furnished by a rural health clinic. You are responsible only for the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the clinic.

Federally Qualified Health Center Services

Federally qualified health centers are located in both rural and urban areas and any Medicare beneficiary may seek services at them. As part of the "federally qualified health center benefit," Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses (under certain conditions), clinical psychologists, and clinical social workers. Also, as part of the federally qualified health center benefit, Medicare helps pay for certain preventive health services. The center can tell you what services are part of the federally qualified health center benefit.

You do not have to pay the Medicare Part B annual deductible for services provided under the federally qualified health center benefit. You are responsible for 20 percent of the Medicare-approved charge for the clinic. (There are some cases, under Public Health Service guidelines, when the federally qualified health center may waive all or part of the 20 percent Part B coinsurance which is applicable for center services.)

Federally qualified health centers often provide services in addition to those offered under the Medicare federally qualified health center benefit. Examples of these services are X-rays and equipment like crutches and canes. As long as the center meets Medicare requirements to provide these services, Medicare Part B can help pay for them. You are responsible for any unmet part of the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the service.

Laboratory Services

All laboratories must be certified under the Clinical Laboratory Improvement Amendments to perform laboratory testing. Medicare Part B pays the full approved fee for covered clinical diagnostic tests provided by certified laboratories that are participating in Medicare. The laboratory can be independent, part of a hospital outpatient department or in a doctor's office. The laboratory must accept assignment for the tests. (See page 28 for an explanation of assignment.) It may not bill you for the tests.*

> In the state of Maryland only, you may be charged 20 percent coinsurance for hospital outpatient tests.

Some laboratories are approved only for certain kinds of tests. Your doctor can usually tell you

which laboratories are approved and whether the tests he or she is ordering from an approved laboratory are covered by Medicare. If your doctor can not tell you, call your Part B carrier. (Carriers are listed on pages 39 to 44.)

Portable Diagnostic X-ray Services

Medicare Part B helps pay for portable diagnostic X-ray services you receive in your home or other locations if they are ordered by a doctor and if they are provided by a Medicare-approved supplier. You can ask your Part B carrier whether the supplier is Medicare-approved. (Carriers are listed on pages 39 to 44.)

Other Diagnostic Tests

Medicare Part B also helps pay for other diagnostic tests, including X-rays, that your doctor orders to evaluate your medical problems.

Pap Smear Screening

Medicare Part B helps pay once every three years for Pap smears to screen for cervical cancer. Medicare helps pay more frequently for certain women at high risk.

Medicare also pays for diagnostic Pap smears as needed when symptoms are present.

Breast-Cancer Screening (Mammography)

Medicare Part B helps pay for X-ray screenings for the detection of breast cancer, if they are provided by a Medicare-approved supplier. Women 65 or older can use the benefit every other year. Some younger women covered by Medicare can use the screening benefit more frequently. Your Medicare carrier can tell you how often Medicare will pay for a screening mammogram for you. Medicare also pays for diagnostic mammograms as needed when symptoms are present.

For accurate up-to-date information on cancer prevention, detection, diagnosis, and treatment for patients, their families, and the general public, call the Cancer Information Service at 1-800-4-CANCER.

Radiation Therapy

Medicare Part B helps pay for outpatient radiation therapy given under the supervision of your doctor.

Kidney Dialysis and Transplants

Medicare Part B helps pay for kidney dialysis and transplants. For detailed information on this coverage, you can get a copy of Medicare Coverage of Kidney Dialysis and Kidney Transplant Services from the Consumer Information Center (see inside back cover).

Heart and Liver Transplants

Under certain limited conditions, Medicare Part B helps pay for heart and liver transplants in a Medicare-approved facility. If you are considering a heart or liver transplant, you and your physician can find out about Medicare coverage by contacting your Medicare carrier. If you belong to an

HMO, the HMO will give you the information you need about Medicare coverage.

Ambulance Transportation

Medicare Part B helps pay for medically necessary ambulance transportation, including air ambulance, but only if:

- The ambulance, equipment and personnel meet Medicare requirements.
- Transportation in any other vehicle could endanger your health.

Under these conditions, Medicare helps pay for ambulance transportation but only to a hospital or skilled nursing facility, or from a hospital or skilled nursing facility to your home. Medicare does not pay for ambulance use from your home to a doctor's office or to a dialysis facility that is not in or next to a hospital.

Medicare usually helps pay only if the ambulance transportation is in your local area. But, if there are no local facilities equipped to provide the care you need, Medicare helps pay for necessary ambulance transportation to the closest facility outside your local area that can provide the necessary care. If there is a local facility equipped to provide the care you need but you choose to go to another institution that is farther away, Medicare payment is based on the charge for transportation to the closest facility that can provide the necessary care.

Durable Medical Equipment

Medicare Part B helps pay for durable medical equipment such as oxygen equipment, wheelchairs, and other medically necessary equipment that your doctor prescribes for use in your home. (A hospital or facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

To be considered durable medical equipment, the equipment must be able to be used over again by other patients, must primarily serve a medical purpose, must not be useful to people who are not sick or injured, and must be appropriate for use in your home. Not all types of equipment that you might find useful can meet all four of these requirements.

Only your own doctor should prescribe medical equipment for you. An equipment supplier should not take any of the following actions:

- Contact you first, either by phone or by mail, and offer to get your doctor or Medicare to approve an item. (It is all fight for the supplier to contact you in response to calls from your doctor or other health care workers.)
- Say he or she works for, or represents, Medicare.
- Deliver equipment to your home that neither you nor your doctor ordered.
- Send you used items, while billing Medicare for new ones.

Some of these actions may be against the law. If you believe a supplier has taken any of these actions, you should alert Medicare. First, ask your doctor whether he or she ordered the item. If your doctor did not order the item, you should file a complaint with your Medicare carrier. You can

file a complaint by phone, in person or in writing. Your carrier will investigate.

It is also illegal for a supplier to offer you items at no cost to you or offer to pay the Medicare coinsurance on items. If a supplier makes one of these offers, file a complaint with your Medicare carrier as described above.