YOUR MEDICARE BENEFITS

Your Health Care Coverage in the Original Medicare Plan

A guide to what Medicare covers, and what you pay for your covered health care services and supplies.

▶ Coverage charts begin on page 10.
How do you find what you need? See index on page 51 and 52.

CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

INTRODUCTION

Welcome!

This booklet explains your Medicare benefits in the Original Medicare Plan (sometimes called fee-for-service).

A benefit is a health care service or supply that is paid for in part or in full by Medicare.

It is important to know that Medicare does not cover everything. And it doesn't pay the total cost for most services or supplies that are covered. Talk to your doctor to be sure you are getting the service or supply that best meets your health care needs.

This booklet explains:

- Medicare basics.
- Which health care services and supplies are covered in the Original Medicare Plan, when they are covered, and how much you pay.
- Where to get help with your questions.

Medicare + Choice Plans

You can get your coverage through the Original Medicare Plan or Medicare + Choice Plans. Congress created the Medicare + Choice program to give you more choices, and sometimes, extra benefits, by letting private companies offer you your Medicare benefits. Your choices may include:

- Medicare Managed Care Plans (like HMOs), and
- Medicare Private Fee-for-Service Plans.

If Medicare Managed Care Plans or Medicare Private Fee-for-Service Plans are available in your area, you can join one and get your Medicare + Choice benefits through the plan. By joining one of these Medicare health plans, you can often get extra benefits, like coverage for prescription drugs or additional days in the hospital. The plan may have special rules that you need to follow. You may also have to pay a monthly premium for the extra benefits.

These plans are available in many areas of the country. For information about the Medicare + Choice Plans available in your area, look at www.medicare.gov on the

"*Your Medicare Benefits*" is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Table of contents

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

MEDICARE BASICS

Medicare is a health insurance program for:

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

Medicare has two parts:

Part A (Hospital Insurance), see page 4.
Most people do not have to pay for Part A.

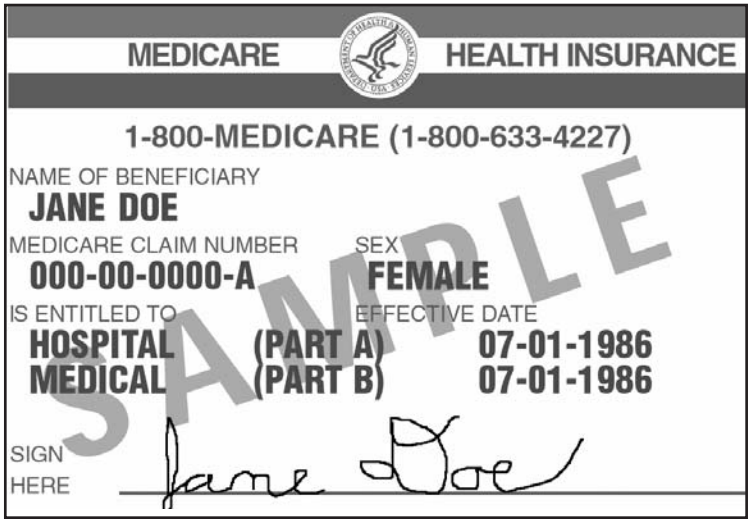
Part B (Medical Insurance), see page 4.
Most people pay monthly for Part B.

Do you need a new Medicare card?

You can order a new Medicare card at www.ssa.gov on the web, or call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your Medicare Card

The parts of Medicare you have are printed on the lower left corner of your card.



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

MEDICARE BASICS

What is Medicare Part A?

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care. You must meet certain conditions.

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

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. If you are not sure if you have Part A, look on your red, white, and blue Medicare card (see sample card on page 3). If you have Part A, "Hospital (Part A)" is printed on the lower left corner of your card. You can also call the Social Security Administration at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

Words in blue are defined on pages 49 - 50.

What is Medicare Part B?

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

Cost: You pay the Medicare Part B premium of $58.70 per month in 2003. This amount may change January 1, 2004. In some cases, this amount may be higher if you did not sign up for Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it. You will have to pay this extra amount as long as you have Part B, except in special cases.

For more information about enrolling in (joining) Medicare, look in your copy of the "*Medicare & You*" handbook, or call the Social Security Administration at 1-800-772-1213 or your local Social Security office. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

INTRODUCTION TO MEDICARE HEALTH PLANS

How do you get your Medicare health care?

Medicare offers you different ways to get your Medicare benefits. These include the Original Medicare Plan and Medicare + Choice Plans. How you get your health care in the Medicare program depends on which plan you choose. Depending on where you live, you may have more than one plan to choose from.

Medicare offers the following types of Medicare health plans:

- **The Original Medicare Plan** (sometimes called fee-for-service) - Everyone with Medicare can join the Original Medicare Plan. This plan is available nationwide. Many people in the Original Medicare Plan also have a Medigap (Medicare Supplement Insurance) policy to help pay health care costs that this plan does not cover, see page 7.

- **Medicare + Choice Plans -** You can get your coverage through the Original Medicare Plan or Medicare + Choice Plans. Congress created the Medicare + Choice program to provide you with more choices, and, sometimes, extra benefits, by letting private companies offer you your Medicare benefits. Your choices may include:

  - **Medicare Managed Care Plans (like HMOs), and**
  - **Medicare Private Fee-for-Service Plans.**

NOTE: Medicare Managed Care Plans and Medicare Private Fee-for-Service Plans must cover at least the same benefits covered by Medicare Part A and Part B. However, your costs may be different, and you may have extra benefits, like coverage for prescription drugs or additional days in the hospital.

For more information about Medicare health plans, see the "*Medicare & You*" handbook. This handbook is mailed to all people with Medicare each fall. To order a free copy, see page 43. To find out which Medicare health plans are located in your area, look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder," or call 1-800-MEDICARE (1-800-633-4227). Select option "0." The Medicare Personal Plan Finder can help you make your best health plan choice.

This booklet explains your coverage in the Original Medicare Plan.

THE ORIGINAL MEDICARE PLAN

What is the Original Medicare Plan?

The Original Medicare Plan is a "fee-for-service" plan. This means you are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care (see the sample card on page 2). If you are happy getting your health care this way, you do not have to change. You will stay in the Original Medicare Plan unless you choose to join a Medicare Managed Care Plan or Medicare Private Fee-for-Service Plan.

How does the Original Medicare Plan work?

- You may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service. If you go to a doctor, specialist, or hospital that does not accept Medicare, Medicare will not pay for the service.

How does the Original Medicare Plan work? (continued)

- If you have Part A, you get all the Medicare Part A covered services listed in the charts on pages 10-42.
- If you pay the monthly Part B premium ($58.70* in 2003), you get all the Medicare Part B covered services listed in the charts on pages 10-42.
- You pay a set amount for your health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment).

*New Medicare premium and coinsurance rates come out each fall and become effective in January. If you get Social Security or Railroad Retirement benefits, new rates are sent to you each year with your cost of living adjustment notice in December. You can also get the new Medicare rates for 2004 after December 1, 2003 by looking at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in blue are defined on pages 49 - 50.

THE ORIGINAL MEDICARE PLAN

What is "Assignment" in the Original Medicare Plan?

Assignment is an agreement between Medicare, and doctors, other health care providers, and suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies). Doctors, providers, and suppliers who agree to accept assignment accept the Medicare-approved amount (the fee Medicare sets as reasonable) as payment in full for Part B services and supplies. You pay the coinsurance and deductible amounts.

In some cases (such as for Medicare-covered ambulance services), your health care providers and suppliers must accept assignment.

If assignment is not accepted, charges are often higher. This means you may pay more. In addition, you may have to pay the entire charge at the time of service. Doctors and suppliers must submit your claim to Medicare. Medicare will then send you its share of the charge.

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

Important: If you get Medicare-covered prescription drugs or supplies, ask if the pharmacy or supplier is enrolled in the Medicare program. If not, Medicare will not pay. All enrolled pharmacies must accept assignment for Medicare-covered prescription drugs or biologicals. All enrolled pharmacies and suppliers for glucose test strips must submit the claim. You cannot send in the claim yourself.

To order a free booklet about assignment, see page 43.
To find out which doctors and suppliers accept assignment in your area, look at www.medicare.gov on the web. Select the "Participating Physician Directory" or the "Supplier Directory."

Will I be told if a health care service or supply I need is not covered?

If the service or supply you need is not covered, you should get an Advance Beneficiary Notice. An Advance Beneficiary Notice is a written notice that tells you why Medicare probably (or certainly) will not pay for a service or supply. A doctor or supplier might give you this notice before you are given the service or supply. Read it carefully. If you still want to get the service or supply, you will be asked to sign an agreement that you will pay for it yourself if Medicare does not pay for it. For more information about what services and supplies Medicare covers, see pages 10-42.

THE ORIGINAL MEDICARE PLAN

What is a Medigap (Medicare Supplement Insurance) policy?

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

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

Do I need to buy a Medigap policy?

Medigap policies help pay health care costs only if you have the Original Medicare Plan. Whether you need a Medigap policy is a decision that only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree coverage, or join a Medicare + Choice Plan.

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

For more information about Medigap policies, costs, and choices, get a copy of "*Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy*" [CMS Pub. No. 02110] (see page 43).

Can I get help from my State to help pay my health care costs?

If you qualify for Medicare Savings Programs or Medicaid, you may be able to get help from your State (see below).

Medicare Savings Programs (Help From Your State)

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

You can apply for these programs if:

- You have Medicare Part A. (If you pay for Medicare Part A but don't have it because you can't afford it, there is a program that may pay the Medicare Part A premium for you.), and
- You are an individual with resources of $4,000 or less, or are a couple with resources of $6,000 or less. Resources include things like money in a checking or savings account, stocks, or bonds, and
- You are an individual with a monthly income of less than $1,031,* or are a couple with a monthly income of less than $1,384.*

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

Call your State Medical Assistance Office and ask for information on Medicare Savings Programs. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). It's very important to call if you think you qualify for any of these Medicare Savings Programs, even if you aren't sure.

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

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

Medicaid

If your income and resources are even more limited than those described under the Medicare Savings Programs section, you may qualify for Medicaid. Most of your health care costs are covered if you have Medicare and you qualify for Medicaid. Medicaid is a joint federal and state program that helps pay medical costs for some people with limited incomes and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for things like nursing home care and outpatient prescription drugs that are not covered by Medicare. For more information about Medicaid, call your State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).

PACE (Programs of All-inclusive Care for the Elderly)

PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid. For more information about PACE, call your State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).

THE ORIGINAL MEDICARE PLAN

For Medicare to cover a service* or supply, you must:

■ Have the part of Medicare (Part A or Part B) that covers the particular supply or service;

■ Need the service or supply for a health condition (it must be medically necessary, see below):

Medically necessary services or supplies:

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

and

■ Meet certain conditions that apply. In some cases, there may be a limit on how often it's covered.

Original Medicare Plan Coverage Charts

On the following pages are charts that list:

■ Some of the services and supplies the Original Medicare Plan covers,

■ The conditions that must be met for some services or supplies to be covered,

■ How often it is covered (limits),

■ How much you pay, and

■ Some of the services and supplies the Original Medicare Plan does not cover.

Page 10 explains how to read the charts.

If a service or supply is not listed on the charts, call for information about the type of service or supply you need. Telephone numbers are listed on pages 44-47. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also find out what services or supplies are covered by Medicare by looking at www.medicare.gov on the web. Select "Your Medicare Coverage."

* There may be a Local Medicare Review Policy written for a service you need that explains how it is covered, and when it is considered medically necessary. Call the organization listed on pages 44-47 for the type of service you need for more information.

THE ORIGINAL MEDICARE PLAN

How to Read the Charts: This is a sample of the charts on pages 11-42 that explain your coverage in the Original Medicare Plan.

Name of service or supply listed alphabetically.

Explains whether Medicare covers the service or supply, any conditions that must be met before Medicare will cover it, and limits to the coverage.

	Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
A	**Acupuncture**	Not covered by Medicare.	100% of the costs.	
	Chiropractic Services	Medicare covers manipulation of the spine to correct a subluxation, when provided by chiropractors or other qualified providers.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B

Services and supplies are listed alphabetically. Letter tabs help you find the service or supply you need.

The part of the charge you pay. It can't be shown as a dollar amount since costs vary. If you have a Medigap policy (see page 7), or other health coverage in addition to Medicare, this amount may be paid in full or in part by the policy.

Words in blue are defined on pages 49-50.

If the service or supply is covered, this column shows which part of Medicare pays for the service or supply. If you have both Medicare Part A and Part B, you don't need to pay attention to this column. However, if you only have one part, you need to look carefully to see if you are covered.

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Acupuncture	Not covered by Medicare.	You pay 100%.	
Ambulance Services	Medicare covers limited ambulance services. If you need to go to a hospital or skilled nursing facility (SNF), ambulance services are covered **only if transportation in any other vehicle could endanger your health**. Generally, transportation from a hospital or SNF is not covered. If the care you need is not available locally, Medicare helps pay for necessary ambulance transportation to the closest facility outside your local area that can provide the care you need. If you choose to go to another facility farther away, Medicare payment is based on how much it would cost to go to the closest facility. All ambulance suppliers must accept assignment. **Medicare does not pay for ambulance transportation to a doctor's office.** Air ambulance is paid only in emergency situations. If you could have gone by land ambulance without serious danger to your life or health, Medicare pays only the land ambulance rate and you are responsible for the difference.	You pay 20% of Medicare-approved amounts. (1)*	B
Ambulatory Surgical Centers	Medicare covers services given in an Ambulatory Surgical Center for a covered surgical procedure.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
Anesthesia	Anesthesia services (outside of doctors changes) are covered along with medical and surgical benefits. Medicare Part A covers anesthesia you get while in an inpatient hospital. Medicare Part B covers anesthesia you get as an outpatient.	You pay 20% of Medicare-approved amounts. (1)*(2)**	A & B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

	Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
A	**Artificial Limbs and Eyes**	Medicare helps pay for artificial limbs and eyes. For more information, see Prosthetic Devices on page 36.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
B	**Blood**	Medicare will cover all but the first 3 pints of blood. Part A covers blood you get as an inpatient, and Part B covers blood you get as an outpatient and in a freestanding Ambulatory Surgical Center.	You pay for the first 3 pints of blood, unless you or someone else donates blood to replace what you use.	A & B
	Bone Mass Measurement	Medicare covers bone mass measurements if you meet certain conditions: 1. This test must be ordered by a doctor or qualified practitioner who is treating you. 2. Every two years or more frequently if medically necessary. 3. You must meet one or more of the conditions below: • Women who are being treated for low estrogen levels and are at clinical risk for osteoporosis, based on their medical history and other findings. • Men and women whose x-rays show previous fractures. • Men and women on prednisone or steroid-type drugs or who are planning to begin such treatment. • Men and women diagnosed with primary hyperparathyroidism. • Men and women being treated with a drug for osteoporosis, to see if the therapy is working.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
	Braces (arm, leg, back, and neck)	Medicare covers arm, leg, back, and neck braces. For more information, see Prosthetic Devices on page 36.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

The original medicare plan

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Breast Prostheses	Medicare covers breast prostheses (including a surgical brassiere) after a mastectomy. For more information, see Prosthetic Devices on page 36.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
Cane/Crutches	Medicare covers canes and crutches. Medicare does not cover white canes for the blind. For more information, see Durable Medical Equipment on pages 20-21.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
Cardiac Rehabilitation Programs	Exercise programs are covered for patients referred by a doctor who have: 1) had a heart attack in the last 12 months, 2) have had coronary bypass surgery, and/or 3) have stable angina pectoris. These programs may be given by the outpatient department of a hospital or in doctor-directed clinics.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
Chemotherapy	Chemotherapy is covered for patients who are hospital inpatients or outpatients, and in freestanding clinics. In the hospital setting, Part A covers chemotherapy. In a freestanding facility, chemotherapy is covered by Part B.	You pay 20% of Medicare-approved amounts. (1)*(2)**	A or B A B
Chiropractic Services	Medicare covers manipulation of the spine to correct a subluxation, when provided by chiropractors or other qualified providers.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
Clinical Trials	Medicare covers routine costs, like doctor visits and tests if you take part in a qualifying clinical trial. Medicare does not pay for the experimental item being investigated in most cases. Clinical trials test new types of medical care, like how well a new cancer drug works. Clinical trials help doctors and researchers see if the new care works and if it is safe. To order a free booklet about Medicare's coverage of clinical trials, see page 43.	You pay the part of the charge that you would normally pay for covered services.	A & B

B

C

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

C

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Colorectal Cancer Screening	Medicare covers several colorectal cancer screening tests. Talk with your doctor about the screening options that are right for you. All people with Medicare age 50 and older are covered. However, there is no minimum age for having a colonoscopy.		
	Colonoscopy: Medicare covers this test once every 24 months if you are at high risk for colon cancer. If you are not at high risk for colon cancer, once every 10 years, but not within 48 months of a screening sigmoidoscopy.	You pay 20% of the Medicare-approved amount. You pay 25% of the Medicare-approved amount if the test is done in a hospital outpatient department. (1)* (2)**	B
	Fecal Occult Blood Test: Medicare covers this test once every 12 months.	You pay nothing for a fecal occult blood test.	B
	Flexible Sigmoidoscopy: Medicare covers this test once every 48 months, but not within 10 years of a screening colonoscopy.	You pay 20% of the Medicare-approved amount. You pay 25% of the Medicare-approved amount if the test is done in a hospital outpatient department.	B
	Barium Enema: Doctor can use this instead of a flexible sigmoidoscopy or colonoscopy.	You pay 20% of the Medicare-approved amount.	B
Commode Chairs	Medicare covers durable medical equipment (DME) like commode chairs that your doctor orders for use in your home. For more information, see Durable Medical Equipment on pages 20-21.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
Cosmetic Surgery	Cosmetic surgery is generally not covered unless it is needed because of accidental injury or to improve the function of a malformed part of the body.	Generally, you pay 100% for cosmetic surgery.	

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Custodial Care (help with activities of daily living, like bathing, dressing, using the bathroom, and eating)	Medicare does not cover custodial care when that is the only kind of care you need. Care is considered custodial when it is for the purpose of helping you with activities of daily living or meeting personal needs and could be done safely and reasonably by people without professional skills or training. For example, custodial care includes help getting in and out of bed, bathing, dressing, eating, and taking medicine. Medicare does cover limited skilled nursing facility care under certain conditions. For more information, see Skilled Nursing Facility Care on pages 38-39.	In general, you pay 100%.	C
Dental Service	Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures. Medicare does not pay for dental plates or other dental devices. Medicare Part A will pay for certain dental services that you get when you are in the hospital. Medicare Part A can pay for hospital stays if you need to have emergency or complicated dental procedures, even when the dental care itself is not covered. Call your Fiscal Intermediary for more information. See pages 44-47 for the telephone number, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.	In general, you pay 100% for dental services.	D
Diabetic Supplies and Services	**Diabetic Supplies:** Medicare covers some diabetic supplies for people with Medicare with diabetes (insulin users and non-insulin users). These include limited quantities of: • blood glucose test strips, • blood glucose meter • lancet devices and lancets	You pay 20% of Medicare-approved amounts. (1)*(2)** **(continued)**	B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

	Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
D	**Diabetic Supplies and Services (continued)**	• glucose control solutions for checking the accuracy of test strips and monitors. (See Durable Medicare Equipment on pages 20-21 for information on blood glucose monitor coverage.) To make sure your Medicare diabetes medical supplies are covered: • Only accept supplies you have ordered. Medicare will not pay for supplies you did not request. • Make sure you request your supply refills. Medicare will not pay for supplies sent from the supplier to you automatically. • All Medicare enrolled pharmacies and suppliers must submit claims for glucose test strips. You cannot send in the claim yourself.	Continued from page 15.	B
		Insulin (unless used with insulin pump), insulin pens, syringes, needles, alcohol swabs, gauze, eye exams for glasses, and routine or yearly physical exams are not covered. If you use an insulin pump, insulin and the pump could be covered as durable medical equipment. There may be some limits on covered supplies or how often you get them.	You pay 100% for insulin (unless used in a pump), syringes, and needles.	B
		Therapeutic Shoes: Medicare covers therapeutic shoes for people with diabetes who have severe diabetic foot disease. The doctor who treats your diabetes must certify your need for therapeutic shoes. The shoes and inserts must be prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, or pedorthist. Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year. Shoe modifications may be substituted for inserts. The fitting of the shoes or inserts is covered in the Medicare payment for the shoes. For more information about diabetic supplies, call your Durable Medical Equipment Regional Carrier. See pages 44-47 for the telephone number.	You pay 20% of Medicare-approved amounts. (1)*(2)**	
		(continued)		

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Diabetic Supplies and Services (continued)	**Diabetic Services:**		
	• **Diabetes Self-Management Training:** Diabetes outpatient self-management training is a covered program to teach you to manage your diabetes. It includes education about self-monitoring of blood glucose, diet, exercise, and insulin. Training is covered if you are newly diagnosed with diabetes, or are newly eligible for Medicare, or are at significant risk for complications from the disease, and your doctor gives you a referral for this service. Medicare Part A covers training in an outpatient facility. Medicare Part B covers training from your doctor or other provider.	You pay 20% of Medicare-approved amounts for outpatient facility charges or doctors services. (1)*(2)**	A & B
	• **Foot Exam:** A foot exam is covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations, as long as you haven't seen a foot care professional for another reason between visits.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
	• **Glaucoma Screening:** Medicare covers glaucoma screening for people with diabetes or a family history of glaucoma.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
	• **Medical Nutrition Therapy Services:** Medical nutrition therapy services are also covered for people with diabetes (or kidney disease) when referred by a doctor. These services can be given by a registered dietician or Medicare-approved nutrition professional and include a nutritional assessment and counseling to help you manage your diabetes. **(continued)**	You pay 20% of Medicare-approved amounts for services. (1)*(2)**	B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

D

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Diabetic Supplies and Services (continued)	For more information about Diabetes Outpatient Self-Management Training from a doctor or other provider, Routine Foot Care, Glaucoma Screening, or Medical Nutrition Therapy Services, call your Medicare Carrier. For more information about Diabetes Outpatient Self-Management Training in an outpatient facility, call your Fiscal Intermediary. See pages 44-47 for the telephone numbers. To order a free booklet about Medicare's coverage of diabetic services and supplies, see page 43.	Continued from page 17.	
Diagnostic Tests, X-rays, and Lab Services	Medicare covers diagnostic tests like CT Scans, MRIs, EKGs, and X-rays. Medicare also covers clinical diagnostic tests and lab services provided by certified laboratories that are participating in Medicare. Diagnostic tests and lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol. Some preventive tests and screenings are covered by Medicare. See Preventive Services on page 35. (Preventive tests and screenings are done to help prevent an illness or condition, or to diagnose it early, before you have symptoms.)	You pay 20% of Medicare-approved amounts for covered diagnostic tests and x-rays. (1)*(2)** You pay $0 for Medicare-covered lab services.	B
Dialysis (Kidney)	Medicare covers some kidney dialysis services and supplies, including: • Inpatient dialysis treatments (if you are admitted to a hospital for special care). **(continued)**	See Hospital Care (Inpatient) on page 27.	A

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Dialysis (Kidney) (continued)	• Outpatient maintenance dialysis treatments (when you get treatments in any Medicare-approved dialysis facility).	You pay 20% of the per treatment rate. (1)*	B
	• Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments).	You pay 20% of the training costs. (1)*(2)**	B
	• Home dialysis equipment and supplies (like alcohol, wipes, sterile drapes, rubber gloves and scissors).	Generally, you pay 20% of the cost to buy or rent equipment and supplies. If you deal with a supplier (not the dialysis facility), the $100 deductible applies and your supplier must accept assignment.	B
	• Certain home support services (may include visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply).	You pay 20% of the cost. If you deal with a supplier (not the dialysis facility), the $100 deductible applies.	B
	• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and Erythropoietin (Epogen®) or Epoetin alfa. To order a free booklet about Medicare's coverage of kidney dialysis, see page 43.	If you deal with the dialysis facility, these drugs may be included in the cost of dialysis. If you deal with a supplier, you pay 20% of the Medicare-approved amount. (1)*(2)**	B
Doctor Office Visits	Medicare covers medically necessary services you get from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location. **Routine annual physicals and gynecological (GYN) exams** are not covered. Some preventive tests and screenings are covered by Medicare. See preventive services on page 35, and Pap Test/Pelvic Exam on page 32.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
D **Drugs**	See Prescription Drugs (Outpatient) on pages 33-34.		
Durable Medical Equipment (DME)	Medicare covers durable medical equipment (DME) that your doctor prescribes for use in your home. Only your own doctor should prescribe medical equipment for you. Durable Medical Equipment: • Durable. • Is used for a medical reason. • Is not usually useful to someone who is not sick or injured. • Is used in your home. **(continued)**	The amount you pay varies. Call your Durable Medical Equipment Regional Carrier (DMERC) for more information. See pages 44-47 for the telephone number. Medicare pays for different kinds of DME in different ways; some equipment must be rented, other equipment must be purchased, and for some equipment you may choose rental or purchase. If a supplier of DME does not accept assignment (see page 6), there is no limit to what can be charged. You also may have to pay the entire bill (your share and Medicare's share) at the time you get the DME. Always ask the supplier if they are enrolled in Medicare. If so, they must accept assignment. If the supplier is not enrolled in Medicare, Medicare will not pay your claim.	B

Note: There may be Medicare + Choice Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Durable Medical Equipment (DME) (continued)	Covered Durable Medical Equipment includes, but is not limited to: • Air fluidized beds • Blood glucose monitors • Canes (white canes for the blind are not covered) • Commode chairs • Crutches • Home oxygen equipment and supplies • Hospital beds • Infusion pumps (and some medicines used in infusion pumps if considered reasonable and necessary) • Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary) • Patient lifts (to lift patient from bed or wheelchair by manual or power operation) • Suction pumps • Traction equipment • Walkers • Wheelchairs Make sure your supplier is enrolled by Medicare and has a Medicare supplier number. Suppliers have to meet strict standards to qualify for a Medicare supplier number. Medicare will not pay your claim if your supplier does not have one even if your supplier is a large chain or department store that sells more than just durable medical equipment.	Continued from page 20.	

Note: There may be Medicare + Choice Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

THE ORIGINAL MEDICARE PLAN

E

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Emergency Room Services	A medical emergency is when you believe that your health is in serious danger. You may have a bad injury, sudden illness, or an illness quickly getting much worse. Medicare covers emergency room services. Emergency services are not covered in foreign countries, except in some instances in Canada and Mexico. For more information, see Travel on page 41. Emergency room visits usually include both facility charges and doctor's charges. Note: If you are admitted to the hospital within 1-3 days of the emergency room visit for the same condition, the emergency room visit is included in the inpatient hospital care charges, not charged separately.	You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 1-3 days of the emergency room visit. (1)*(2)** You pay 20% of doctor charges. (1)*(2)**	B B
Equipment	See Durable Medical Equipment on pages 20-21.	See Durable Medical Equipment.	B
Eye Exams	Medicare does not cover routine eye exams. Some preventive tests and screenings are covered by Medicare. See Glaucoma Screening on page 24. See Macular Degeneration on page 28.	You pay 100% for routine eye exams.	

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Eyeglasses/ Contact Lenses	Generally, Medicare does not cover eyeglasses or contact lenses. However, **following cataract surgery with an intraocular lens**, Medicare can help pay for cataract glasses, contact lenses, or intraocular lenses provided by an optometrist, if the optometrist is authorized to provide such services in your state. Important: • Only standard frames are covered. • Lenses are covered even if you had the surgery before you had Medicare. • Payment may be made for lenses for both eyes even though cataract surgery involved only one eye.	You pay 100%. You are covered for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. (1)*(2)** You pay any additional cost for the upgraded frames	B
Flu Shot	Medicare covers one flu shot a year, usually given in the fall or winter. All people with Medicare are covered.	You pay $0 for a flu shot if the doctor or health care provider accepts assignment.	B
Foot Care	Medicare generally does not cover routine foot care. Medicare Part B covers the services of a podiatrist (foot doctor) for medically necessary treatment of injuries or diseases of the foot (such as hammer toe or bunion deformities and heel spurs). See Therapeutic Shoes and Foot Exam under Diabetic Supplies and Services on pages 16-17.	You pay 100%. You pay 20% of Medicare-approved amounts. (1)*(2)**	B

E

F

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

	Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
G	**Glaucoma Screening**	Medicare covers glaucoma screening once every 12 months for people at high risk for glaucoma. This includes people with diabetes, a family history of glaucoma, or African-Americans who are age 50 and older. The screening must be done or supervised by an eye doctor who is legally allowed to do this service in your state.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
H	**Health/Wellness Education**	Medicare generally does not cover health and wellness education.	Generally, you pay 100%.	
	Hearing Exams/Hearing Aids	Medicare does not cover routine hearing exams or hearing aids. In some cases, diagnostic hearing exams are covered by Part B.	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amount for diagnostic hearing exams. (1)*(2)**	 B
	Home Health Care	Home Health Care is skilled nursing care and certain other health care services you get in your home for the treatment of an illness or injury. Medicare covers some home health care if: 1. Your doctor decides you need medical care in your home, and makes a plan for your care at home, and 2. You need at least one of the following: intermittent (and not full time) skilled nursing care, or physical therapy or speech language pathology services, or a continued need for occupational therapy, and	You pay $0 for all covered home health visits. **(continued)**	A B if you only have B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Home Health Care (continued)	3. You are homebound. This means you are normally unable to leave home and that leaving home is a major effort. When you leave home, it must be infrequent, for a short time. You may attend religious services. You may leave the house to get medical treatment, including therapeutic or psychosocial care. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state, and 4. The home health agency caring for you must be approved by the Medicare program.	Continued from page 24.	
	Note for Women with Osteoporosis: Under Medicare's home health coverage, Medicare helps pay for an injectable drug for osteoporosis in women who are eligible for Medicare Part B, who meet the criteria for the Medicare home health benefit, and who have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. You must be certified by a doctor as unable to learn, or as physically or mentally incapable to give yourself the drug by injection, and that family and/or caregivers are unable or unwilling to give the drug by injection.	You pay 20% of the Medicare-approved cost of the drug.	B
	Medicare also covers the visit by a home health nurse to administer the drug. To order a free booklet about Medicare's coverage of home health care, see page 43.	You pay $0 for the visit by a home health nurse to administer the drug.	A or B

Note: There may be Medicare + Choice Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

THE ORIGINAL MEDICARE PLAN

	Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
H	**Hospice Care**	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. The goal of hospice is to care for you and your family, not to cure your illness. Medicare covers hospice care if: • You are eligible for Medicare Part A; and • Your doctor and the hospice medical director certify that you are terminally ill and probably have less than six months to live; and • You sign a statement choosing hospice care instead of routine Medicare covered benefits for your terminal illness; and • You get care from a Medicare-approved hospice program. **Respite Care:** Medicare also covers respite care if you are getting covered hospice care. Respite care is inpatient care given to a hospice patient so that the usual caregiver can rest. You can stay in a Medicare-approved facility, such as a hospice facility, hospital or nursing home, up to 5 days each time you get respite care. There is no limit to the number of times you can get respite care. The amount you pay for respite care can change each year. Medicare will still pay for covered services for any health problems that are not related to your terminal illness. To order a free booklet about Medicare's coverage of hospice care, see page 43.	You pay $0 for hospice care. You pay a copayment of up to $5 for outpatient prescription drugs. Room and board is generally not payable by Medicare, except in certain cases. For example, if you get general hospice services while you are a resident of a nursing home or a hospice's residential facility. However, room and board are covered for inpatient respite care and during short-term hospital stays. You pay 5% of the Medicare-approved amount for inpatient respite care. The amount you pay for respite care can change each year.	A A A

Note: There may be Medicare + Choice Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Hospital Bed	See Durable Medical Equipment on pages 20-21.		
Hospital Care (Inpatient) **(For Outpatient Services, see pages 30-31)**	Medicare Part A covers inpatient hospital care if all of the following is true: • A doctor says you need inpatient hospital care for treatment of your illness or injury. • You need the kind of care that can be given only in a hospital. • The hospital has agreed to participate in the Medicare program. • The Utilization Review Committee of the hospital does not disapprove your stay while you are in the hospital. • A Quality Improvement Organization or an intermediary does not disapprove your stay after the bill is submitted. Medicare covered hospital services include: a semiprivate room, meals, general nursing, and other hospital services and supplies. This includes care you get in critical access hospitals and inpatient mental health care. This does not include private duty nursing or a television or telephone in your room. It also does not include a private room, unless medically necessary.	You pay for each benefit period in 2003: Days 1 - 60: an initial deductible of $840 Days 61 - 90: $210 each day Days 91 - 150: $420 each day A benefit period begins the day you go to a hospital (or under special circumstances, a skilled nursing facility). The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Lifetime reserve days give you an extra 60 days of inpatient coverage when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime.	A

Note: There may be Medicare + Choice Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
L			
Lab Services	Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. For more information, see Diagnostic Tests on page 18.	You pay $0 for Medicare-approved services.	B
M			
Mammogram Screening	Medicare covers a mammogram screening once every 12 months for all women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39. Medicare covers new digital technologies for mammogram screenings.	You pay 20% of Medicare-approved amounts with no Part B deductible. (2)** You pay 20% of Medicare-approved amounts with no Part B deductible. (2)**	B B
Macular Degeneration	Medicare covers a treatment for some patients with age-related macular degeneration. This treatment is called ocular photodynamic therapy with verteporfin.	You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)*(2)**	B
Mental Health Care	Medicare covers mental health care furnished by a doctor or health care professional who can be paid by Medicare. Ask your doctor, psychologist, social worker, or other health professional if they accept Medicare payment before you get treatment. **Inpatient Mental Health Care:** Medicare covers inpatient mental health care services given in a hospital that requires a hospital stay. These services can be given in a general hospital, or in a specialty psychiatric hospital that only cares for people with mental health problems. Regardless of which type of hospital you choose, Medicare Part A helps pay for mental health services in the same way as it does for any other Medicare inpatient hospital care. If you are in a specialty psychiatric hospital, Medicare Part A helps pay up to 190 days of inpatient care in a Medicare-certified psychiatric facility during your lifetime. You may get care, other than psychiatric services, in general hospitals after you reach the 190-day lifetime limit in specialty psychiatric hospitals.	You pay the same initial deductible and copayments as inpatient hospital care (as listed on page 27). **(continued)**	A

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Mental Health Care (continued)	**Outpatient Mental Health Care:** Medicare covers mental health services on an outpatient basis by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist or physician assistant in an office setting, clinic, or hospital outpatient department.	You usually pay 50% of Medicare-approved amounts. (1)*(2)**	B
	Partial Hospitalization: Partial hospitalization for mental health care is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office. For Medicare to cover a partial hospitalization program, a doctor must say that you would otherwise need inpatient treatment. To order a free booklet about Medicare's coverage of mental health care, see page 43.	You pay a set copayment amount for each day of service. (1)*(2)**	B
Non-Physician Health Care Provider Services	Medicare covers the services of specially qualified non-physician practitioners such as clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, speech-language pathologists, and certified nurse midwives, as allowed by state and local law for medically necessary services.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
Nursing Home Care	Most nursing home care is custodial care. Generally, Medicare does not cover custodial care. Medicare Part A only covers skilled care given in a certified skilled nursing facility (SNF). You must meet certain conditions and coverage is limited. See Skilled Nursing Care on pages 38-39.	You pay 100%.	

M

N

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

	Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
N	**Nutrition Therapy Services (Medical)**	Medicare covers medical nutrition therapy services for people with diabetes, kidney disease (but not on dialysis), and after a kidney transplant when referred by a doctor. These services can be given by a registered dietician or Medicare-approved nutrition professional and include nutritional assessment and counseling. See Diabetic Services and Supplies on pages 15-17.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
O	**Occupational Therapy**	See Physical/Occupational/Speech Therapy on page 32.		
	Ostomy Supplies	Medicare covers ostomy supplies for people who have had a colostomy, ileostomy, or urinary ostomy. Medicare covers the amount of supplies your doctor says you need based on your condition. Call your Durable Medical Equipment Regional Carrier for more information. See pages 44-47 for the telephone number.	You pay 20% of Medicare-approved amounts for the doctor. (1)*(2)**	B
	Outpatient Hospital Services	Medicare Part B covers medically necessary services you get as an outpatient from a Medicare-participating hospital for diagnosis or treatment of an illness or injury. **(continued)**	You pay 20% of Medicare-approved amounts for the doctor. (1)*(2)** **(continued)**	B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Outpatient Hospital Services (continued)	Covered outpatient hospital services include: • Services in an emergency room or outpatient clinic, including same-day surgery; • Laboratory tests billed by the hospital; • Mental health care in a partial hospitalization program, if a physician certifies that inpatient treatment would be required without it; • X-rays and other radiology services billed by the hospitals; • Medical supplies such as splints and casts; and • Drugs and biologicals that you cannot give yourself.	Continued from page 30. You pay a set copayment amount based on each service received. To order a free booklet about Medicare's payment of outpatient services, see page 43.	B
Oxygen Therapy	Medicare covers rental of oxygen equipment, or if you own your own equipment, Medicare will help pay for oxygen contents and supplies for the delivery of oxygen under these conditions: • Your doctor says you have a severe lung disease or you're not getting enough oxygen and your condition might improve with oxygen therapy. • Your arterial blood gas level falls within a certain range. • Other alternative measures have been tried and failed, or were not helpful for you. Medicare helps pay for: • Systems for furnishing oxygen • Containers that store oxygen • Tubing and related supplies for the delivery of oxygen • Oxygen contents If oxygen is provided only for use during sleep, portable oxygen would not be covered. Portable oxygen is not covered when provided only as a backup to a stationary oxygen system. Call your Durable Medical Equipment Regional Carrier for more information. See pages 44-47 for the telephone number.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

The original medicare plan

P

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Pap Test/Pelvic Exam	Medicare covers Pap Tests and Pelvic Exams (and a clinical breast exam) for all women once every 24 months. If you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap Test, Medicare covers this test and exam once every 12 months. If you have your Pap Test, Pelvic Exam, and Clinical Breast Exam on the same visit as a routine physical exam, you pay for the physical exam. Routine physical exams are not covered by Medicare. To order a free booklet about Medicare's coverage for women, see page 43.	You pay $0 for the lab Pap Test. (2)** You pay 20% of Medicare-approved amounts (or a copayment) for the part of the exam when the doctor or health care provider collects the specimen and for the pelvic exam. (2)** If the pelvic exam was provided in a hospital outpatient department, you pay a set copayment amount.	B
Physical Exams (routine)	Routine physical exams are not covered by Medicare.	You pay 100% for routine physical exams.	
Physical/Occupational/ Speech Therapy	Medicare helps pay for medically necessary outpatient physical and occupational therapy and speech pathology services when: • Your doctor or therapist sets up the plan of treatment, and • Your doctor periodically reviews the plan to see how long you will get therapy. You can get these 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. Also, you can get services from a privately practicing, Medicare-approved physical or occupational therapist in his or her office or in your home. (Medicare may not pay for services given by privately practicing speech pathologists.)	You pay 20% of Medicare-approved amounts. (1)*(2)**	B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Prescription Drugs (Outpatient) Very Limited Coverage	Medicare does **not** cover most prescription drugs. Medicare covers a limited number of outpatient prescription drugs. Your pharmacy or doctor must accept assignment on Medicare-covered prescription drugs.	You pay 100% for most prescription drugs.	
	The following outpatient prescription drugs are covered: • **Some Antigens:** Medicare will help pay for antigens if they are prepared by a doctor and given by a properly instructed person (who could be the patient) under doctor supervision. • **Osteoporosis Drugs:** Medicare helps pay for an injectable drug for osteoporosis for certain women with Medicare. See Home Health Care, pages 24-25. • **Erythropoietin (Epogen®) or Epoetin alfa:** Medicare will help pay for erythropoietin by injection if you have end-stage renal disease (permanent kidney failure) and need this drug to treat anemia. • **Hemophilia Clotting Factors:** If you have hemophilia, Medicare will help pay for your clotting factors you give yourself by injection. • **Injectable Drugs:** Medicare covers most injectable drugs given by a licensed medical practitioner. • **Immunosuppressive Drugs:** Medicare covers immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility. **(continued)**	You pay 20% of the Medicare-approved amount for covered prescription drugs. (1)* Coverage is very limited.	B

P

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
P **Prescription Drugs (Outpatient) Very Limited Coverage (continued)**	• **Oral Cancer Drugs:** Medicare will help pay for some oral cancer drugs if the same drug is available in injectable form. Currently, Medicare covers the following oral cancer drugs: • Capecitabine (brand name Xeloda®) • Cyclophosphamide (brand name Cytoxan®) • Methotrexate • Temozolomide (brand name Temodar®) • Busulfan (brand name Myleran®) • Etoposide (brand name VePesid®) • Melphalan (brand name Alkeran®) As new cancer drugs and brand names become available, additional oral cancer drugs may be added to the list of covered drugs. • **Oral Anti-Nausea Drugs:** Medicare will help pay for oral anti-nausea drugs if you are getting Medicare-covered oral cancer drugs. Medicare also covers some drugs used in infusion pumps and nebulizers if considered reasonable and necessary. You should check with your Durable Medical Equipment Regional Carrier (DMERC) for specific coverage information about prescription drugs. See pages 44-47 for the telephone number. **Note:** "Prescription Drug Assistance Programs" on www.medicare.gov on the web has information on programs that offer discounts or free medication to persons in need, including State prescription drug assistance programs, programs sponsored by pharmaceutical companies, and disease-specific programs. "Prescription Drug Assistance Programs" also has information on prescription drug benefits from Medicare Managed Care Plans and Medigap policies.	Continued from page 33.	B

Note: There may be Medicare + Choice Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Preventive Services Covered by Medicare	See: • Bone Mass Measurement on page 12. • Colorectal Cancer Screening on page 14. • Diabetes Services on page 17. • Flu Shot on page 23. • Glaucoma Screening on page 24. • Mammogram Screening on page 28. • Medical Nutrition Therapy on page 17. • Pap Test and Pelvic Examination on page 32. • Prostate Cancer Screening (below). • Shots (vaccinations on page 37) including: - flu shots - pneumococcal pneumonia shots - Hepatitis B shots		B
Prostate Cancer Screening	Medicare covers screening tests for all men with Medicare age 50 and older (coverage begins the day after the 50th birthday) once every 12 months. Covered tests include:		
	• Digital Rectal Examination	Generally, 20% of the Medicare-approved amount for the digital rectal exam. (1)* (2)**	B
	• Prostate Specific Antigen (PSA) Test	You pay $0 for the PSA test and 20% of the Medicare-approved amounts for other related services. (1)*(2)**	B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

The original medicare plan

	Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
P	**Prosthetic Devices**	Medicare covers prosthetic devices needed to replace a body part or function. These include Medicare-approved corrective lenses needed after a cataract operation (see Eyeglasses/Contact Lenses on page 23), ostomy bags and certain related supplies (see Ostomy Supplies on page 30), and breast prostheses (including a surgical brassiere) after a mastectomy (see Breast Prostheses on page 13). Medicare also covers artificial limbs and eyes, and arm, leg, back, and neck braces. Medicare does not pay for orthopedic shoes unless they are a necessary part of the leg brace and the cost is included in the charge for the brace. Medicare does not pay for dental plates or other dental devices. For more information about Durable Medical Equipment, call your Durable Medical Equipment Regional Carriers. See pages 44-47 for the telephone number.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
R	**Radiation Therapy**	Radiation therapy is covered for patients who are hospital inpatients or outpatients, and in freestanding clinics. In the hospital setting, Part A covers radiation therapy. In a freestanding facility, radiation therapy is covered by Part B.	You pay 20% of Medicare-approved amounts. (1)*(2)**	A or B A B
	Respite Care	Medicare covers respite care for hospice patients. For more information, see Hospice Care on page 26.		

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Second Surgical Opinions	Medicare covers a second opinion before surgery. A second opinion is when another doctor gives his or her view about your health problem and how it should be treated. Medicare will also help pay for a third opinion if the first and second opinions are different.	You pay 20% of Medicare-approved amounts. (1)*(2)** You pay nothing for a second opinion for Ambulatory Surgical Center procedure done in a hospital outpatient department.	B
Shots (vaccinations)	Medicare covers all people with Medicare for:		
	• Flu Shot - Once a year in the fall or winter. The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 50 and older. You need a flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect you from the flu for about one year.	You pay $0 for pneumococcal pneumonia and flu shots if the doctor or health care provider accepts assignment.	B
	• Pneumococcal Pneumonia Shot (vaccine) - One shot may be all you ever need. Ask your doctor.		
	• Hepatitis B Shot (vaccine) - If you are at medium to high risk for Hepatitis B.	You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine given in a doctor's office. (1)*(2)** For Hepatitis B Shot given in a hospital outpatient department, you pay a set copayment amount.	B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

	Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
S	**Skilled Nursing Facility (SNF) Care**	Medicare covers skilled care in a skilled nursing facility (SNF) under certain conditions for a limited time. Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Examples of skilled care include changing sterile dressings and physical therapy. It is given in a Medicare-certified SNF. Care that can be given by non-professional staff is not considered skilled care. Medicare covers certain skilled care services that are needed daily on a short-term basis (up to 100 days). Medicare will cover skilled care only if **all** these conditions are met: 1. You have Medicare Part A (Hospital Insurance) and have days left in your benefit period to use. 2. You have a qualifying hospital stay. This means an inpatient hospital stay of 3 consecutive days or more, not including the day you leave the hospital. You must enter the SNF within a short time (generally 30 days) of leaving the hospital. After you leave the SNF, if you reenter the same or another SNF within 30 days, you don't need another 3-day qualifying hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days. 3. Your doctor has decided that you need daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If you are in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just 5 or 6 days a week. **(continued)**	You pay for each benefit period in 2003 following at least a related 3-day covered hospital stay: Days 1 - 20: $0 for each day. Days 21 - 100: $105 for each day. Days over 101: You pay 100%. There is a limit of 100 days of Medicare Part A SNF coverage in each benefit period. A benefit period begins the day you go to a hospital (or under special circumstances, a skilled nursing facility). The benefit period ends when you have not received any hospital (or skilled care in a SNF) for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	A

Note: There may be Medicare + Choice Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Skilled Nursing Facility Care (continued)	4. You get these skilled services in a SNF that has been certified by Medicare. 5. You need these skilled services for a medical condition that: • Was treated during a qualifying 3-day hospital stay, or • Started while you were getting Medicare-covered SNF care. For example, if you are in the SNF because you had a stroke, and you fall and sprain your wrist.	Continued from page 38.	A
Speech Therapy	See Physical/Occupational/Speech Therapy on page 32.		
Substance Abuse Treatment (Outpatient)	Medicare covers substance abuse treatment in an outpatient treatment center if they have agreed to participate in the Medicare program. See Mental Health Care (Outpatient) on page 29.	See Mental Health Care (Outpatient).	B
Supplies	Common medical supplies like bandages and gauze are generally not covered by Medicare. Medicare covers some diabetic and dialysis supplies. See Diabetic Supplies and Services on pages 15-18 and Dialysis (Kidney) on pages 18-19. For items such as walkers, oxygen, and wheelchairs, see Durable Medical Equipment on pages 20-21.	You pay 100% for most common medical supplies.	 B B

Note: There may be Medicare + Choice Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

T

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Therapeutic Shoes	See Diabetic Supplies and Services (Therapeutic shoes) on page 16.		B
Transplants (Facility Charges)	Medicare covers transplants of the heart, lung, kidney, pancreas, intestine/multivisceral, bone marrow, cornea, and liver under certain conditions and, for some types of transplants, only at Medicare-approved facilities. Medicare only approves facilities for kidney, heart, liver, lung, and intestine/multivisceral transplants. Bone marrow, pancreas, and cornea transplants are not limited to approved facilities. Transplant coverage includes necessary tests, labs, and exams before surgery for you and the organ donor, follow-up care for you and a live donor, and procurement of organs and tissues. To get a free booklet about Medicare's coverage of kidney transplants, see page 43.	Call your Medicare Carrier for information about cornea and bone marrow transplants. Call your Fiscal Intermediary for information about all other transplants. See pages 44-47 for their telephone numbers. For Inpatient Transplants, see Hospital Care (Inpatient) on page 27.	A for inpatient trans-plants B for cornea and bone marrow trans-plants
Transplants (Doctor Services)	Medicare covers doctor services for transplants as listed above.	You pay 20% of Medicare-approved payment amount for doctor services. (1)*(2)**	B
Transportation (routine)	Medicare generally does not cover transportation to get routine health care. For more information, see Ambulance Services on page 11.	You pay 100% for transportation to get routine health care.	

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
Travel Outside of the United States (Health Care Coverage During Travel)	The Original Medicare Plan generally does not cover health care while you are traveling outside the United States. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States. There are some exceptions. In rare cases, Medicare can pay for inpatient hospital services that you get in Canada or Mexico. Medicare can pay only if: 1. You are in the United States when a medical emergency occurs and the Canadian or Mexican hospital is closer than the nearest U.S. hospital that can treat the emergency. 2. You are traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest United States hospital that can treat the emergency. 3. You live in the United States and the Canadian or Mexican hospital is closer to your home than the nearest United States hospital that can treat you medical condition, regardless of whether an emergency exists. Medicare also pays for doctor and ambulance services furnished in Canada or Mexico as part of a covered inpatient hospital stay.	Health care services and supplies are NOT covered outside the United States except under limited circumstances. You pay the part of the charge that you would normally pay for covered services.	A for inpatient services B for outpatient services

Note: There may be Medicare + Choice Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

THE ORIGINAL MEDICARE PLAN

	Service or Supply	Who is covered, and when?	What do YOU pay in 2003?	Part A or B
W	**Walker/Wheelchair**	Medicare covers walkers and wheelchairs as durable medical equipment (DME) that your doctor prescribes for use in your home. For more information, see Durable Medical Equipment on pages 20-21.	You pay 20% of Medicare-approved amounts. (1)*(2)**	B
X	**X-rays**	Medicare covers medically necessary diagnostic x-rays that are ordered by your treating doctor. For more information, see Diagnostic Tests on page 18.	You pay 20% of Medicare-approved amounts. (1)*(2)** For x-rays in a hospital outpatient setting, you pay a set copayment amount.	B B

* (1) You must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers do not accept assignment.

FOR MORE INFORMATION

Free Booklets About Medicare and Related Topics

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

To get these booklets:

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

2. Call 1-800-MEDICARE (1-800-633-4227) and select option "4" to order a free copy of the booklet you want. TTY users should call 1-877-486-2048. You will get your copy within three weeks.

3. Put your name on the web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select "Subscribe to Our Mailing List" at the bottom of the page. Then, select the topic "Publications," type your e-mail address in the box at the bottom, and select "Subscribe."

Note: Some booklets may not be available in print, but all will be available at www.medicare.gov on the web.

Name of Publication	CMS Pub. No.
Does Your Doctor or Supplier Accept Assignment?	10134
Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy	02110
Medicare & Clinical Trials	02226
Medicare & You	10050
Medicare Coverage of Diabetes Supplies and Services	11022
Medicare Coverage of Kidney Dialysis and Transplant Services	10128
Medicare Coverage of Skilled Nursing Facility Care	10153
Medicare Home Health Care	10969
Medicare Hospice Benefits	02154
Medicare Preventive Services	10110
Medicare Savings Programs	10126
Medicare and Other Health Benefits: Your Guide to Who Pays First	02179
Medicare and Your Mental Health Care	10184
Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam, And Clinical Breast Exam	02248
Your Guide to the Outpatient Prospective Payment System	02118
Your Medicare Rights and Protections	10112

FOR MORE INFORMATION

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

FOR MORE INFORMATION

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

FOR MORE INFORMATION

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

FOR MORE INFORMATION

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

WORDS TO KNOW

Assignment - In the Original Medicare Plan, this means a doctor, other health care provider, and supplier of health care equipment and supplies agrees to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor, provider, and supplier accepts assignment. You still pay your share of the cost of the doctor visit. See page 6 for more assignment information.

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

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

Copayment - Copayments are set payments for some hospital outpatient services in the Original Medicare Plan.

Critical Access Hospital - A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Deductible - The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. In 2003, the Part A deductible is $840 for each benefit period. The Part B deductible is $100. You must pay the first $100 of your Part B services or supplies each year before Medicare begins to pay its share. These amounts can change every year.

Lifetime Reserve Days - Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($420 in 2003).

WORDS TO KNOW

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

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

Medically Necessary - Services or supplies that:

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

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

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

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

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

Index

Index

NOTES:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Publication No. CMS - 10116
Revised April, 2003

For additional information, call 1-800-MEDICARE (1-800-633-4227). This 24-hour Helpline is available to help you with your Medicare questions. TTY users should call 1-877-486-2048.

¿Necessita usted una copia en español? Llame gratis al 1-800-MEDICARE (1-800-633-4227).