CENTERS FOR MEDICARE & MEDICAID SERVICES

Your Medicare Benefits

This is the official government booklet with important information about your health care coverage in the Original Medicare Plan.

- Coverage and payment charts begin on page 17.
- For an alphabetical list of topics, look at the index on pages 2–3.

INTRODUCTION

Welcome!

This booklet explains your Medicare benefits under 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's important to know that Medicare doesn't cover everything. Medicare doesn't pay the total cost for most covered services or supplies. Talk to your doctor to be sure you get the service or supply that meets your health care needs.

This booklet explains

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

The Original Medicare Plan is one of your health coverage choices as part of the Medicare Program. You will be in the Original Medicare Plan unless you join a Medicare Advantage Plan (like an HMO or PPO) or another type of Medicare plan.

Medicare prescription drug coverage is also available to everyone with Medicare.

If you have questions that aren't answered in this book, look in your copy of the "Medicare & You" handbook mailed to you each October, or see page 61 of this booklet for how to get more information.

"Your Medicare Benefits" isn't a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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Note: The information in this booklet was correct when it was posted to www.medicare.gov on the web. Changes may occur after posting. To find out if this booklet is available in print, other formats, or if the information has been updated, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in blue are defined on pages 63–65.

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MEDICARE BASICS

Medicare is health insurance for people

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

Medicare has

Part A (Hospital)—See page 9. Most people automatically get Part A coverage without having to pay a monthly premium because they, or their spouses, paid Medicare taxes while working.

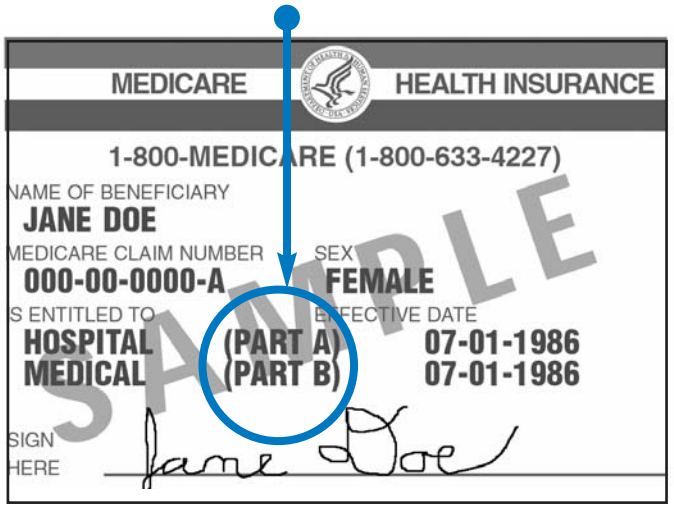
Part B (Medical)—See page 9. Most people pay a monthly premium for Part B.

Part C (Medicare Advantage Plans like HMOs and PPOs)—See page 6. Plans include Part A (Hospital) and Part B (Medical) coverage. Most also include Medicare prescription drug coverage. You pay a monthly premium for your health and prescription drug coverage.

Part D (Prescription Drug Coverage)—See page 7. Most people pay a monthly premium for this coverage. Some plans don't charge a premium.

Your Medicare Card

The parts of Medicare you have are printed on your card.



Note: Your card may be slightly different. It's still valid.

If you need to replace your Medicare card

You can order a replacement Medicare card at www.socialsecurity.gov on the web, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772, or visit www.rrb.gov on the web. Select "Benefit Online Services."

INTRODUCTION TO MEDICARE PLANS

How do you get your Medicare health care?

How you get your health care in the Medicare Program depends on which plan you choose. Medicare covers most of your health care needs, and today's Medicare is working with private companies to bring you ways to get more coverage for both your health care and prescription drug needs. These options let you choose how you get your health care and prescription drug coverage. Your decisions are important because they affect how much you pay and what is covered. Depending on where you live, you may have more than one plan to choose from. For more information about Medicare plans, look in your copy of the "Medicare & You" handbook mailed to you each October, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You can get Medicare coverage in the following ways:

- **Original Medicare Plan**
- **Medicare Advantage Plans (like an HMO or PPO)**
- **Other Medicare Plans**
- **Medicare Prescription Drug Coverage (Part D)**

Original Medicare Plan

The Original Medicare Plan is a fee-for-service plan managed by the Federal Government. This means you are usually charged a fee for each health care service or supply you get. For some services, you will pay an amount called a deductible before Medicare pays its part. Then, when you get a Medicare-covered medical supply or service, Medicare pays its share, and you pay your share, called the coinsurance or a copayment.

The Original Medicare Plan includes Part A and Part B. Part B is optional. Many people in the Original Medicare Plan also have a Medigap (Medicare Supplement Insurance) policy that is offered by private companies to help pay health care costs that the Original Medicare Plan doesn't cover, see page 13.

You are in the Original Medicare Plan until you join another type of Medicare plan. If you are a member of a health plan (like an employer or union plan), contact your plan sponsor for more information about your Medicare options.

INTRODUCTION TO MEDICARE PLANS

Medicare Advantage Plans (like an HMO or PPO)

Medicare Advantage Plans are run by private companies. They give you more choices, and sometimes, extra benefits. These plans are still part of the Medicare Program and are also called "Part C." They provide all your Part A (Hospital) and Part B (Medical) coverage. Some may also provide Part D (prescription drug) coverage. To join a Medicare Advantage Plan, you must have both Medicare Part A and Part B and live in the plan's service area. The plan may have special rules that you need to follow like seeing doctors that belong to the plan or going to certain hospitals to get services. You may also have to pay a monthly premium for the extra benefits. Medicare pays a set amount of money for your care every month to these health plans.

With Medicare Advantage, your plan choices may include

- Medicare Preferred Provider Organizations (PPOs) Plans,
- Medicare Health Maintenance Organizations (HMOs) Plans,
- Medicare Private Fee-for-Service (PFFS) Plans,
- Medicare Special Needs Plans, and
- Medicare Medical Savings Account (MSA) Plans.

Other Medicare Plans

There are some types of Medicare plans that provide health care coverage that aren't Medicare Advantage Plans, but are still part of the Medicare Program. They provide your Medicare Part A and Part B coverage, and some provide Part D (prescription drug coverage) as well. Below are other Medicare plans that may be available to you:

- Medicare Cost Plans
- Demonstrations/Pilot Programs
- PACE (Programs of All-inclusive Care for the Elderly)

INTRODUCTION TO MEDICARE PLANS

Medicare Prescription Drug Coverage (Part D)

You can get prescription drug coverage no matter how you get your Medicare health care. There are two types of Medicare plans that provide insurance coverage for prescription drugs.

1. **Medicare Prescription Drug Plans.** These plans add coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans if you join one.

2. **Prescription drug coverage that is a part of Medicare Advantage Plans and other Medicare plans.** If you join one, you would get all of your Medicare coverage through these plans, including prescription drug coverage.

These plans are offered by insurance companies and other private companies approved by Medicare. Both types of plans are referred to as Medicare drug plans.

Medicare prescription drug coverage is insurance available to everyone with Medicare. Like other insurance, if you join a plan offering Medicare drug coverage, there is a monthly premium. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. You will also pay a share of the cost of your prescriptions. If you have limited income and resources, you may qualify for extra help paying for Medicare prescription drug coverage costs. Medicare drug plans will offer different benefit designs. Some plans might offer more coverage and additional drugs for a higher monthly premium. If you decide not to join a drug plan when you are first eligible, you may pay a penalty if you choose to join later.

Even if you don't take a lot of prescription drugs now, you still should consider joining a drug plan. As we age, most people need prescription drugs to stay healthy. For most people, joining a Medicare drug plan when you are first eligible for Medicare means you will pay your lowest possible monthly premium. If you don't join a plan when you are first eligible, you will likely have to wait until November 15 to December 31 of each year to join. If you don't join a Medicare drug plan when you are first eligible and you have a continuous period of 63 days or more without creditable prescription drug coverage, you may have to pay a late enrollment penalty when you do join. Your premium cost will go up 1% of the current year's national average premium for every full month you were eligible to join and didn't. The 2007 national average premium is $27.35, so you would pay $0.27 extra for each month you were eligible to join and didn't. If you join by December 31, your coverage will begin January 1 of the next year.

Important:

If you have, or are eligible for, other types of prescription coverage, read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veteran's Affairs, or a Medigap policy. If you still have questions, talk to your benefits administrator, insurer, or plan provider before you make any changes to your current coverage. Your choices for prescription drug coverage may be different, or you may have other decisions to consider.

For more information about Medicare prescription drug coverage, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227).

THE ORIGINAL MEDICARE PLAN

What is the Original Medicare Plan?

The Original Medicare Plan is one of your health plan choices as part of the Medicare Program. You will be in the Original Medicare Plan unless you join another Medicare plan.

How does the Original Medicare Plan work?

The Original Medicare Plan is a fee-for-service plan that is managed by the Federal Government. The general rules for how the Original Medicare Plan works are below:

- You use your red, white, and blue Medicare card when you get health care (see the sample card on page 4).
- If you have Medicare Part A, you get all the medically-necessary Part A-covered services listed in the charts beginning on page 17.
- If you have Medicare Part B, you get all the medically-necessary Medicare Part B-covered services listed in the charts beginning on page 17. You usually pay a monthly premium for Part B (see page 9).
- You can go to any doctor, supplier, hospital or other facility that is enrolled in Medicare.
- 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 a copayment) for covered services and supplies.
- To get prescription drug coverage, you can join a Medicare Prescription Drug Plan.
- You will get a Medicare Summary Notice (MSN) in the mail every three months if you got a Medicare-covered health service during that period, and you weren't due a payment check from Medicare. If you are due a payment check from Medicare, your MSN will be mailed out as the claim is processed. Companies that handle bills for Medicare send the MSN. It lists the details of the services you got and the amount you may be billed. If you disagree with the information on the MSN, you can file an appeal. For more information about the MSN or for help with an appeal, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227).

Note: New Medicare premium rates become effective every year in January. If you get Social Security or Railroad Retirement Board benefits, the new premium rates are sent to you each December with your cost of living adjustment notice. After January 1, you can also get the new Medicare rates for the following year 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.

THE ORIGINAL MEDICARE PLAN

What is Medicare Part A?

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

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

If you (or your spouse) didn't pay Medicare taxes while you worked and you are age 65 or older, you may be able to buy Part A. If you aren't sure if you have Part A, look on your red, white, and blue Medicare card (see sample card on page 4). If you have Part A, "Hospital (Part A)" is printed on your card. You can call Social Security at 1-800-772-1213, or visit 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.

What is Medicare Part B?

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

Part B also covers some preventive services like exams, lab tests, and screening shots to help prevent, find, or manage a medical problem.

Cost: Most people will pay the standard monthly Part B premium of $93.50 for 2007. However, starting January 1, 2007, some people will pay a higher premium based on their modified adjusted gross income. If you file an individual tax return and your annual income is more than $80,000 (or if you are married (file a joint tax return) and your annual income is more than $160,000), your monthly Medicare Part B premium may be higher than the standard 2007 monthly premium of $93.50. These amounts change each year.

In some cases, your monthly premium amount may be higher if you didn't sign up for Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but didn't sign up for it. You will have to pay this extra amount as long as you have Part B, except in special cases.

For more information about enrolling in Medicare, look in your copy of the "Medicare & You" handbook, call Social Security at 1-800-772-1213, or visit 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.

Assignment

What is "assignment" in the Original Medicare Plan?

Assignment is an agreement between you (the person with Medicare), doctors, other health care suppliers, or providers, and Medicare. **You** "assign" **Medicare** to pay your **doctor**, **supplier**, or **provider** directly for care. Most doctors, suppliers, and providers accept assignment.

If a doctor, other health care supplier, or provider accepts assignment, it means the following:

- They agree to be paid by Medicare.
- They agree to get only the amount Medicare approves for their services.
- They can only charge you, or other insurance you have, the Medicare deductible or coinsurance amount.

In some cases, doctors, other health care suppliers, and providers must accept assignment. For example, assignment must be accepted if you get Medicare-covered physician assistant's services.

If the doctor, other health care supplier, or provider doesn't agree to accept assignment, they may charge you more than the Medicare-approved amount; however, there is a limit to what they can charge you for most services. The highest amount you can be charged is called the limiting charge.

The limiting charge is 15% over the Medicare-approved amount (it may be lower in your state). The limiting charge applies only to certain services and doesn't apply to supplies and other durable medical equipment. In addition, you might have to pay the entire charge at the time of service. Medicare will send you payment for its share of the charge when the claim is processed.

Also, assignment must be accepted for drugs covered under Part B and home dialysis supplies and equipment. Doctors, other health care suppliers, and providers have to submit your claim to Medicare directly and can't charge you for submitting the claim. You can't submit a claim for glucose monitor test strips yourself.

To find doctors and suppliers enrolled in Medicare, visit www.medicare.gov on the web. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

THE ORIGINAL MEDICARE PLAN

How Bills are Paid

How are my bills paid in the Original Medicare Plan?

The provider of the covered service or supply must send a claim to companies that handle bills for Medicare.

You will get a Medicare Summary Notice (MSN) in the mail every three months if you got a Medicare-covered health service during that period, and you weren't due a payment check from Medicare. If you are due a payment check from Medicare, your MSN will be mailed out as the claim is processed. The MSN lists all the services or supplies that were billed to Medicare during that period. Check this notice to be sure you got all the services, supplies, or equipment listed. **The MSN isn't a bill**. You may get a bill from your provider before you get an MSN. Please compare the MSN with the bill to make sure you pay the appropriate amount for your services.

Can another health plan pay before Medicare?

Sometimes your other insurance pays your health care bills first and the Original Medicare Plan pays second. Other insurance that may pay first includes the following: group health plan coverage when coverage is based on your or a family member's current employment, no-fault insurance (including automobile insurance), liability insurance (including automobile insurance), black lung benefits, and workers' compensation. In most cases, these types of insurance must pay first. It's important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you are in the Original Medicare Plan and you have questions about who pays first or you need to update your other health insurance information, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

In general, for Medicare to cover a service or supply, you must

- have the part of Medicare (Part A or Part B) that covers the particular service or supply,
- need the medically-necessary or Medicare-covered preventive service or supply for a health condition,
- go to a provider or supplier enrolled in Medicare, and
- meet certain conditions that apply. In some cases, there may be a limit on how often the service or supply is covered.

Medically-necessary services or supplies are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

THE ORIGINAL MEDICARE PLAN

Will I be told if a health care service or supply I need isn't covered?

If you are in the Original Medicare Plan, your health care supplier or provider may give you a notice that says Medicare probably (or certainly) won't pay for some Medicare services in certain situations.

If you still want to get the service, you will be asked to sign an agreement that you will pay for the service yourself if Medicare doesn't pay for it. This agreement is called an Advance Beneficiary Notice (ABN). Advance Beneficiary Notices are used in the Original Medicare Plan to explain what items and services Medicare won't pay for and why. Information on the ABN helps you choose whether you want to get the item or service, even if you might have to pay for it yourself.

If you aren't sure if Medicare was billed for the services you got, call or write to the health care provider and ask for an itemized statement. This statement will list each Medicare item or service you got from them. You should get the statement from your health care provider within 30 days. Also, check your MSN to see if the service was billed to Medicare. If the service wasn't billed to Medicare, tell the health care supplier or provider to submit the bill to Medicare.

Medicare plans like HMOs and PPOs, and Medicare Prescription Drug Plans have other ways of providing this information. If you're in one of these Medicare plans, call your plan to find out if a service or item will be covered.

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

Your MSN gives you information about the services or supplies that Medicare won't pay for. A MSN is a written notice that tells you all the services, medical supplies or equipment that providers billed to Medicare for you during the past 90 days. The MSN will also tell you whether Medicare paid for the service or supplies. Read it carefully. If you believe that Medicare should have paid for the service or supply, you have 120 days from the date you get the notice to file an appeal. The back of your MSN will have information on how to ask Medicare to make another decision about whether it will pay for the services or supplies you got.

Whenever you are discharged from an inpatient hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, you have the right to a "fast appeal" if you think you are being discharged too soon. This fast appeal is also called an "expedited determination." An independent reviewer will look at your case to decide if your services need to continue. You will get a notice from your provider telling you how to ask for a fast appeal. You may have other appeal rights if you miss the timeframe for filing a fast appeal.

THE ORIGINAL MEDICARE PLAN

Medigap (Medicare Supplement Insurance)

The Original Medicare Plan pays for many health care services and supplies, but there are many costs it doesn't cover. To help cover extra health care costs, you might want to buy a Medigap policy. **Note:** Medicare doesn't pay any of the costs for a Medigap policy.

What is a Medigap policy?

A Medigap policy is health insurance sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Medigap policies help pay your share (coinsurance, copayments, or deductibles) of the costs of Medicare-covered services, and some policies cover certain costs not covered by the Original Medicare Plan. If you are in the Original Medicare Plan and have a Medigap policy, then Medicare and your Medigap policy will both pay their shares of covered health care costs. Insurance companies can only sell you a "standardized" Medigap policy. These Medigap policies must all have specific benefits.

Generally, when you buy a Medigap policy you must have Medicare Part A and Part B. You or someone on your behalf (like a former employer or union) will have to pay the monthly Medicare Part B premium. You will also have to pay a premium to the Medigap insurance company.

In most states, you may be able to choose from up to 12 different standardized Medigap policies (Medigap Plans A through L). Medigap policies must follow Federal and state laws.

A Medigap policy only works with the Original Medicare Plan. Medigap policies generally provide some of the same kinds of supplemental coverage as Medicare Advantage Plans. If you join a Medicare Advantage Plan (like an HMO or PPO), your Medigap policy won't pay any deductibles, copayments, or other cost-sharing that may apply under your Medicare Advantage Plan. Therefore, you may want to drop your Medigap policy if you join a Medicare Advantage Plan. You have a legal right to keep the Medigap policy, but you will have to continue to pay premiums, and you may get little or no benefit. However, if you aren't sure you will stay in the Medicare Advantage Plan and you cancel your Medigap policy, you might not be able to get the same policy back, or in some cases, any policy, if you leave the Medicare Advantage Plan. Your rights to buy a Medigap policy may vary by state.

Medigap Policies and Medicare Prescription Drug Coverage

Although some Medigap policies sold in the past covered prescription drugs, no new Medigap policies covering prescription drugs are being sold. To cover prescription drug costs, you may want to buy Medicare prescription drug coverage (Part D) offered by private companies approved by Medicare. If you join a Medicare Prescription Drug Plan, and you have a Medigap policy that covers drugs, you must tell your Medigap insurer to remove the prescription drug coverage from your Medigap policy.

Help Paying Health Care Costs

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

States have programs for people with limited income and resources that pay Medicare Part A and/or Part B premiums, and in some cases, may also pay Medicare deductibles and coinsurance. These programs help millions of people with Medicare save money each year.

How do I qualify for these programs?

- You must have Medicare Part A. (If you are paying a premium for Medicare Part A, these programs may pay the Medicare Part A premium for you.)
- You must be an individual with **resources** of $4,000 or less, or a married couple with **resources** of $6,000 or less. Resources include things like money in a checking or savings account, stocks, and bonds, but doesn't include things like your home or car.
- You must be an individual with a monthly **income** of less than $1,123*, or a married couple with a monthly **income** of less than $1,505*.

* Income limits will change slightly in 2007. If you live in Alaska or Hawaii, income limits are slightly higher. Individual states may have higher income and/or resource limits.

Call your State Medical Assistance (Medicaid) office, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state. Since the names of these programs may vary by state, ask for information on Medicare Savings Programs. It's very important to call if you think you qualify, even if you aren't sure.

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

Medicaid

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

Extra Help Paying for Medicare Prescription Drug Coverage

If you have limited income and resources, you may qualify for extra help paying your prescription drug costs. If you qualify, you will get help paying for your drug plan's monthly premium, yearly deductible, and prescription copayments.

The amount of extra help you get will be based on your income and resources (including your savings and stocks, but not counting your home or car). In 2006, you may qualify if your income is less than $14,700 ($19,800 for a married couple living together), and your resources are less than $11,500 ($23,000 for a married couple living together). These amounts will change in early 2007.

Extra Help Paying for Medicare Prescription Drug Coverage (continued)

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

You automatically qualify for extra help and don't need to apply if you

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

Note: Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa have their own rules for providing extra help to their residents. To find out more about their rules call your State Medical Assistance (Medicaid) office, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227).

How does Medicare decide what's covered?

At times, Medicare makes a decision about whether to cover a medical service or equipment after reviewing information about how a service or equipment improves health or helps manage a health problem. If Medicare makes a decision that applies to all people with Medicare, it is called a "National Coverage Determination."

There may be a Local Coverage Determination that explains if a service is covered in your area and when it is considered medically necessary.

For more information, look at www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227).

Original Medicare Plan Coverage Charts

On the following pages are charts that list

- services and supplies covered by the Original Medicare Plan,
- conditions and limits for coverage, and
- how much you pay.

If a service or supply isn't listed on the charts, 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.

Page 17 explains how to read the charts.

NOTES

HOW TO READ THE ORIGINAL MEDICARE PLAN COVERAGE CHARTS

This is a **SAMPLE** of the charts beginning on the next page that explains your coverage in the Original Medicare Plan.

Name of service or supply.

Explains Medicare's coverage, conditions, and limits to the coverage.

	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
A	**Acupuncture**	Medicare doesn't cover acupuncture.	You pay 100%.	
	Ambulatory Surgical Centers	Medicare covers services given in an Ambulatory Surgical Center for a covered surgical procedure.	You pay 20% of the Medicare-approved amount. (1)(2)	B

Letter tabs help you find the service or supply you need in alphabetical order.

The part of the charge you pay in 2007. Amounts may change every year. It can't be shown as a dollar amount since costs vary. If you have a Medigap policy (see page 13) or other health coverage in addition to Medicare, this amount may be paid in full or in part by the Medigap policy.

Words in blue are defined on pages 63–65.

Shows which part of Medicare pays for the service or supply. Look carefully to see if you have the part of Medicare that covers what you need.

THE ORIGINAL MEDICARE PLAN

The following charts talk about what the Original Medicare Plan covers. The Original Medicare Plan doesn't cover everything (like most prescription drugs). However, you can get extra benefits and coverage for prescription drugs from other Medicare plans (like HMOs, PPOs, and Medicare drug plans).

	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
A	**Acupuncture**	Medicare doesn't cover acupuncture.	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 would endanger your health**. Medicare helps pay for necessary ambulance transportation to the closest appropriate facility 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 appropriate facility. All ambulance suppliers must accept assignment. **Medicare generally doesn't pay for ambulance transportation to a doctor's office.** Air ambulance is paid only in the most severe 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 the Medicare-approved amount. (1)	B
	Ambulatory Surgical Centers	Medicare covers services given in an Ambulatory Surgical Center for a covered surgical procedure.	You pay 20% of the Medicare-approved amount. (1)(2)	B

(1) In 2007, you must pay an annual $131 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 don't accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Anesthesia	Medicare covers anesthesia services 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 the Medicare-approved amount. (1)(2)	A&B
Artificial Limbs and Eyes	Medicare helps pay for artificial limbs and eyes. For more information, see Prosthetic Devices on page 50.	You pay 20% of the Medicare-approved amount. (1)(2)	B
Blood	Medicare doesn't cover the first three pints of blood you get under Part A and Part B combined in a calendar year. 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 three pints of blood, unless you or someone else donates blood to replace what you use. After the first three pints of blood, you pay 20% of the Medicare-approved amount. Once the blood deductible is met, it is met for both Part A and Part B. (1)(2)	A&B

A

B

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	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
B	**Bone Mass Measurement**	Medicare covers bone mass measurements ordered by a doctor or qualified practitioner who is treating you if you meet one or more of the following conditions: **Women** • You are being treated for low estrogen levels and are at clinical risk for osteoporosis, based on your medical history and other findings. **Men and Women** • Your X-rays show possible osteoporosis, osteopenia, or vertebrae fractures. • You are on prednisone or steroid-type drugs or are planning to begin such treatment. • You have been diagnosed with primary hyperparathyroidism. • You are being monitored to see if your osteoporosis drug therapy is working. The test is covered once every two years for qualified individuals and more often if medically necessary.	You pay 20% of the Medicare-approved amount. (1)(2) In the hospital setting, you pay a copayment. (1)	B
	Braces (arm, leg, back, and neck)	Medicare covers arm, leg, back, and neck braces. For more information, see Orthotics on page 43.		
	Breast Prostheses	Medicare covers breast prostheses (including a surgical brassiere) after a mastectomy. For more information, see Prosthetic Devices on page 50.	You pay 20% of the Medicare-approved amount. (1)(2)	B

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Canes/Crutches	Medicare covers canes and crutches. Medicare doesn't cover canes for the blind. For more information, see Durable Medical Equipment on page 31.	You pay 20% of the Medicare-approved amount. (1)(2)	B
Cardiac Rehabilitation Programs	Medicare covers comprehensive programs that include exercise, education, and counseling for patients whose doctor referred them and who have 1) had a heart attack in the last 12 months, 2) had coronary bypass surgery, 3) stable angina pectoris, 4) had heart valve repair/replacement, 5) had angioplasty or coronary stenting, and/or 6) had a heart or heart-lung transplant. These programs may be given by the outpatient department of a hospital or in doctor-directed clinics.	You pay 20% of the Medicare-approved amount. (1)(2)	B
Cardiovascular Screening	Medicare covers screening tests for cholesterol, lipid, and triglyceride levels every five years. Ask your doctor to test your cholesterol, lipid, and triglyceride levels so he or she can help you prevent a heart attack or stroke.	You pay $0 if the doctor or health care provider accepts assignment.	B
Chemotherapy	Medicare covers chemotherapy for patients who are hospital inpatients, outpatients, or patients in a doctor's office or freestanding clinics. In the inpatient hospital setting, Part A covers chemotherapy. In a hospital outpatient setting, freestanding facility, or doctor's office, Part B covers chemotherapy.	You pay 20% of the Medicare-approved amount. (1)(2) You pay a copayment in the hospital outpatient setting. (1)	A or B B

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C

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Chiropractic Services	Medicare covers manipulation of the spine if medically necessary to correct a subluxation (when one or more of the bones of your spine moves out of position) when provided by chiropractors or other qualified providers.	You pay 20% of the Medicare-approved amount. (1)(2)	B
Clinical Trials	Medicare covers routine costs, like doctor visits and tests, if you take part in a qualifying clinical trial. 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. Medicare doesn't pay for the experimental item being investigated, in most cases.	You pay the part of the charge that you would normally pay for covered services.	A&B
Colorectal Cancer Screening	Medicare covers several colorectal cancer screening tests. Talk with your doctor about the screening test that is right for you. All people age 50 and older with Medicare are covered. However, there is no minimum age for having a colonoscopy.		
	Colonoscopy: Medicare covers this test once every 24 months if you are at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, the test is covered once every 120 months, but not sooner than 48 months after a screening sigmoidoscopy.	In 2006, you pay a copayment or coinsurance and a deductible. In 2007, you pay only a copayment or coinsurance.	B
	Fecal Occult Blood Test: Medicare covers this lab test once every 12 months.	You pay $0 for this test, but you generally have to pay for the doctor's visit.	B

(continued)

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Colorectal Cancer Screening (continued)	**Flexible Sigmoidoscopy:** Medicare covers this test once every 48 months for people 50 and older.	In 2006, you pay a copayment or coinsurance and a deductible. In 2007, you pay only a copayment or coinsurance.	B
	Barium Enema: Once every 48 months (high risk every 24 months) when used instead of a flexible sigmoidoscopy or colonoscopy.	In 2006, you pay a copayment or coinsurance and a deductible. In 2007, you pay only a copayment or coinsurance. Starting in 2007, Medicare covers its share of costs for these colorectal cancer screening tests even if you haven't met the yearly Part B deductible.	B
Commode Chairs	Medicare covers commode chairs that your doctor orders for use in your home if you are confined to your bedroom. For more information, see Durable Medical Equipment on page 32.	You pay 20% of the Medicare-approved amount. (1)(2)	B
Cosmetic Surgery	Medicare generally doesn't cover cosmetic surgery unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Medicare covers breast reconstruction if you had a mastectomy because of breast cancer.	Generally, you pay 100% for cosmetic surgery.	

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THE ORIGINAL MEDICARE PLAN

	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
C	**Custodial Care** (help with activities of daily living, like bathing, dressing, using the bathroom, and eating)	Medicare doesn't cover custodial care when it's the only kind of care you need. Care is considered custodial when it's for the purpose of helping you with activities of daily living or personal needs that 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.	In general, you pay 100%.	
D	**Dental Services**	Medicare doesn't cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures. Medicare doesn't 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 isn't covered.	In general, you pay 100%.	

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Diabetes Screening	Medicare covers tests to check for diabetes. These tests are available if you have any of the following risk factors: high blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar. Medicare also covers these tests if you have two or more of the following characteristics: • age 65 or older, • overweight, • family history of diabetes (parents, brothers, sisters), • a history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds. Based on the results of these tests, you may be eligible for up to two diabetes screenings every year.	You pay $0 if the doctor or health care provider accepts assignment.	B
Diabetes Supplies and Services	Medicare covers some diabetes supplies, including • blood glucose test strips, • blood glucose monitor, • lancet devices and lancets, and • glucose control solutions for checking the accuracy of test strips and monitors. There may be limits on how much or how often you get these supplies. For more information, see Durable Medical Equipment on page 32.	You pay 20% of the Medicare-approved amount. (1)(2) **(continued)**	B

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	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
D	**Diabetes Supplies and Services** (continued)	Here are some ways you can make sure your Medicare diabetes medical supplies are covered: • Only accept supplies you have ordered. Medicare won't pay for supplies you didn't order. • Make sure you request your supply refills. Medicare won't pay for supplies sent from the supplier to you automatically. • All Medicare-enrolled pharmacies and suppliers must submit claims for glucose test strips. You can't send in the claim yourself.		
		Medicare doesn't cover insulin (unless used with an insulin pump), insulin pens, syringes, needles, alcohol swabs, gauze, eye exams for glasses, and routine or yearly physical exams. If you use an external 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. Insulin and certain medical supplies used to inject insulin are covered under Medicare prescription drug coverage.	You pay 100% for insulin (unless used in a pump), syringes, and needles, unless you have Medicare prescription drug coverage.	B
		Therapeutic Shoes or Inserts: Medicare covers therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. The shoes and inserts must be prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, or pedorthist. Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year. Shoe modifications may be substituted for inserts. The fitting of the shoes or inserts is covered in the Medicare payment for the shoes.	You pay 20% of the Medicare-approved amount. (1)(2)	B
			(continued)	

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Diabetes Supplies and Services (**continued**)	Medicare covers these diabetes 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. If you've been diagnosed with diabetes, Medicare may cover up to ten hours of initial diabetes self-management training. You may also qualify for up to two hours of follow-up training each year if • it is provided in a group of 2 to 20 people*, • it lasts for at least 30 minutes, • it takes place in a calendar year following the year you got your initial training, and • your doctor or a qualified non-physician practitioner ordered it as part of your plan of care. * Some exceptions apply if no group session is available or if your doctors or qualified non-physician practitioner says you have special needs that prevent you from participating in group training.	You pay 20% of the Medicare-approved amount for outpatient facility charges or doctors' services. (1)(2)	A&B
	• **Yearly Eye Exam:** Medicare covers yearly eye exams for diabetic retinopathy.	You pay 20% of the Medicare-approved amount. (1)(2)	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 the Medicare-approved amount. (1)(2)	B
	• **Glaucoma Screening:** Medicare covers glaucoma screening every 12 months for people with diabetes or a family history of glaucoma, African Americans age 50 and older, or Hispanics age 65 and older.	You pay 20% of the Medicare-approved amount. (1)(2) (**continued**)	B

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D

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Diabetes Supplies and Services (continued)	• **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 dietitian or Medicare-approved nutrition professional and include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. For more information, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.	You pay 20% of the Medicare-approved amount for services. (1)(2)	B
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 enrolled in Medicare. Diagnostic tests and lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare doesn't cover most routine screening tests, like checking your hearing.	You pay 20% of the Medicare-approved amount for covered diagnostic tests and X-rays done in a doctor's office or independent testing facility. (1)(2)	B
		You pay a copayment for diagnostic tests and X-rays in the hospital outpatient setting. (1)	B
	Some preventive tests and screenings are covered by Medicare to help prevent, find, or manage a medical problem. For more information, see Preventive Services on page 49.	You pay $0 for Medicare-covered lab services.	B

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Dialysis (Kidney)	Medicare covers some kidney dialysis services and supplies, including the following:		
	• Inpatient dialysis treatments (if you are admitted to a hospital for special care).	See Hospital Care (Inpatient) on page 39.	A
	• Outpatient maintenance dialysis treatments (when you get treatments in any Medicare-approved dialysis facility).	You pay 20% of the per treatment rate. (1)	B
	• Certain home dialysis support services (may include visits by trained dialysis workers to check on your home dialysis, to help in dialysis emergencies when needed, and check your dialysis equipment and hemodialysis water supply).	You pay 20% of the cost. Only dialysis facilities can furnish home dialysis support services. (1)	B
	• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics.	If you deal with the dialysis facility, these drugs are included in the cost of dialysis. If you deal with a supplier, you pay 20% of the Medicare-approved amount. (1)	B
	• Erythropoiesis–stimulating Agents (such as Epogen®, Epoetin alfa), or Darbepoetin alfa (Aranesp®) are drugs used to treat anemia if you have End-Stage Renal Disease. For more information, see Prescription Drugs on page 47.	You pay 20% of the Medicare-approved amount. (1)	B
	• Self-dialysis training (includes training for you and the person helping you with your home dialysis treatments).	You pay 20% of the training costs. (1)	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 medical supply company (MSC) (not the dialysis facility), your MSC must accept assignment. (1)	B

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THE ORIGINAL MEDICARE PLAN

D

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Doctor's 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 aren't covered, except the one-time "Welcome to Medicare" physical exam (see page 46). Some preventive tests and screenings are covered** by Medicare. See Preventive Services on page 49, and Pap Test/Pelvic Exam on page 45.	You pay 20% of the Medicare-approved amount. (1)(2)	B
Drugs	See Prescription Drugs (Outpatient) on page 47.		

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Durable Medical Equipment (DME)	Medicare covers Durable Medical Equipment (DME) that your doctor prescribes for use in your home. Only your own doctor can prescribe medical equipment for you. Durable Medical Equipment is • (long lasting) durable, • used for a medical reason, • not usually useful to someone who isn't sick or injured, and • used in your home. **(continued)**	The amount you pay varies. Medicare pays for different kinds of DME in different ways; some equipment must be rented, other equipment may be purchased, and you may choose rental or purchase some equipment. If a supplier of DME doesn't accept assignment, 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. **Note:** Ask if the supplier is a participating supplier in the Medicare Program before you get Durable Medical Equipment. If the supplier is a participating supplier, they **must** accept assignment. If the supplier is enrolled in Medicare but isn't "participating," they have the option to accept assignment. If the supplier isn't enrolled in Medicare, Medicare **won't** pay your claim. (1)	B

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	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
D	**Durable Medical Equipment (DME)** (**continued**)	The Durable Medical Equipment that Medicare covers includes, but isn't limited to the following: • Air-fluidized beds • Blood glucose monitors • Canes (canes for the blind aren't covered) • Commode chairs • Crutches • Dialysis machines • Home oxygen equipment and supplies • Hospital beds • Infusion pumps (and some medicines used in infusion pumps if considered reasonable and necessary) • Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary) • Patient lifts (to lift patient from bed or wheelchair by hydraulic operation) • Suction pumps • Traction equipment • Walkers • Wheelchairs Make sure your supplier is enrolled in Medicare and has a Medicare supplier number. Suppliers have to meet strict standards to qualify for a Medicare supplier number. Medicare won't pay your claim if your supplier doesn't have one, even if your supplier is a large chain or department store that sells more than just durable medical equipment.		

THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Emergency Room Services	Medicare covers emergency room services. Emergency services aren't covered in foreign countries, except in some instances in Canada and Mexico. For more information, see Travel on page 57. A medical emergency is when you believe that your health is in serious danger. You may have an injury or illness that requires immediate medical attention to prevent a severe disability or death. When you go to an emergency room, you will pay a copayment for each hospital service, and you will also pay coinsurance for each doctor who treats you. **Note:** If you are admitted to the hospital within three 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 a copayment for each emergency room visit; you don't 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 the charges. (1)(2)	B B
Equipment	See Durable Medical Equipment on pages 31–32.		
Eye Exams	Medicare doesn't cover routine eye exams. Medicare covers some preventive eye tests and screenings: • See yearly eye exams under Diabetes Supplies and Services on page 25. • See Glaucoma Screening on page 35. • See Macular Degeneration on page 40.	You pay 100% for routine eye exams.	

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THE ORIGINAL MEDICARE PLAN

	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
E	**Eyeglasses/ Contact Lenses**	Generally, Medicare doesn't cover eyeglasses or contact lenses. However, **following cataract surgery with an implanted intraocular lens,** Medicare helps pay for corrective lenses (spectacles or contact lenses) provided by a licensed and Medicare-approved opthalmologist. Services provided by a licensed and Medicare-approved opthalmologist may be covered, if they are authorized to provide this service 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 pay 20% of the Medicare-approved amount for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. (1)(2) You pay any additional cost for upgraded frames.	B
	Eye Refractions	Medicare doesn't cover eye refractions.	You pay 100%.	
F	**Flu Shots**	Medicare covers one flu shot per flu season. You can get a flu shot in the winter and the fall flu season of the same calendar year. All people with Medicare are covered.	You pay $0 for a flu shot.	B

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THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Foot Care	Medicare generally doesn't 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, bunion deformities, and heel spurs). See Therapeutic Shoes and Foot Exam under Diabetes Supplies and Services starting on page 25.	You pay 100%. You pay 20% of the Medicare-approved amount. (1)(2)	B
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, African Americans age 50 and older, or Hispanic Americans age 65 and older. The screening must be done or supervised by an eye doctor who is legally allowed to do this service in your state.	You pay 20% of the Medicare-approved amount. (1)(2)	B
Health Education/ Wellness Programs	Medicare generally doesn't cover health education and wellness programs. However, Medicare does cover medical nutrition therapy for some people and diabetes education for people with diabetes (see page 25).	Generally, you pay 100%.	
Hearing Exams/Hearing Aids	Medicare doesn't cover routine hearing exams, hearing aids, or exams for fitting hearing aids. In some cases, Medicare covers diagnostic hearing exams.	You pay 100%. You pay 20% of the Medicare-approved amount. (1)(2)	B

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THE ORIGINAL MEDICARE PLAN

H

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Hepatitis B Shots	Medicare covers this preventive service (three shots) for people at high or medium (intermediate) to high risk for Hepatitis B. Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), or a condition that lowers your resistance to infection. Other factors may also increase your risk for Hepatitis B. Check with your doctor to see if you are at high to medium risk for Hepatitis B.	You pay 20% of the Medicare-approved amount for the Hepatitis B shots given in a doctor's office. (1)(2) For Hepatitis B shots given in a hospital outpatient department, you pay a copayment.	B
Home Health Care	Medicare covers some home health care if the following conditions are met: 1. Your doctor decides you need medical care in your home and makes a plan for your care at home, and 2. You need reasonable and necessary part-time or intermittent skilled nursing care and home health aide services, and physical therapy, occupational therapy, and speech-language pathology ordered by your doctor and provided by a Medicare-certified home health agency. This includes medical social services, other services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), and medical supplies for use at home.	You pay $0 for all covered home health visits. **(continued)**	A&B or A or B

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	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 your state or accredited to furnish adult day care services in your state, and 4. The home health agency caring for you must be approved by Medicare. Medicare covers durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) see page 31.		
	Note for Women with Osteoporosis: Medicare helps pay for an injectable drug for osteoporosis in women who have Medicare Part B, meet the criteria for the Medicare home health benefit, and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. You must also be certified by a doctor as unable to learn or unable to give yourself the drug by injection, and that family and/or caregivers are unable or unwilling to give the drug by injection.	You pay 20% of the Medicare-approved cost of the drug.	A&B if you are under a home health care plan
	Medicare covers the visit by a home health nurse to give the drug.	You pay $0 for the home health nurse visit to give the drug.	A or B

	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
H	**Hospice Care**	Medicare covers hospice care if • you are eligible for Medicare Part A, • your doctor and the hospice medical director certify that you are terminally ill and probably have less than six months to live, • you accept palliative (care to comfort) instead of care to cure your illness, • you sign a statement choosing hospice care instead of routine Medicare-covered benefits for your terminal illness, **and** • you get care from a Medicare-approved hospice program. Medicare allows a nurse practitioner to serve as an attending doctor for a patient who elects the hospice benefit. Nurse practitioners are prohibited from certifying a terminal diagnosis.	You pay $0 for hospice care. You may need to pay a copayment of up to $5 for outpatient prescription drugs. Room and board aren't covered by Medicare if you get hospice care in your home or if you live in a hospice residential facility. In certain cases, if the hospice staff determines that you need inpatient care in a hospice facility or your caregiver needs a short period of respite, the costs for room and board are included in Medicare's payment.	A A
		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 five days each time you get respite care. Medicare will still pay for covered services for any health problems that aren't related to your terminal illness.	You pay 5% of the Medicare-approved amount for inpatient respite care. The amount you pay for respite care can change each year.	A

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Hospital Bed	See Durable Medical Equipment on page 31.		
Hospital Care (Inpatient) (For Outpatient Services, see page 44.)	Medicare covers inpatient hospital care when all of the following are true: • A doctor says you need inpatient hospital care to treat your illness or injury. • You need the kind of care that can be given only in a hospital. • The hospital is enrolled in Medicare. • The Utilization Review Committee of the hospital approves your stay while you are in the hospital. • A Quality Improvement Organization approves your stay after the bill is submitted. Medicare-covered hospital services include the following: a semiprivate room, meals, general nursing, and other hospital services and supplies. This includes care you get in critical access hospitals and inpatient mental health care (see page 41). This doesn't include private-duty nursing, a television, or telephone in your room. It also doesn't include a private room, unless medically necessary.	For each benefit period you pay: Days 1 - 60: $992 deductible Days 61 - 90: $248 each day Days 91 - 150: $496 each day Beyond 150 days: all costs For information about benefit periods and lifetime reserve days, see pages 63–64. You pay for private-duty nursing, a television, or telephone in your room. You pay for a private room unless it is medically necessary.	A

THE ORIGINAL MEDICARE PLAN

	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
I	**Implantable Cardiac Defibrillator**	Medicare covers defibrillators for many people diagnosed with congestive heart failure.	Inpatient or outpatient coinsurance and/or deductibles may apply.	A or B
K	**Kidney (Dialysis)**	See Dialysis on page 29.		
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 enrolled in Medicare. For more information, see Diagnostic Tests on page 28.	You pay $0 for Medicare-approved services.	B
M	**Macular Degeneration**	Medicare covers certain treatments for some patients with age-related macular degeneration (AMD) like ocular photodynamic therapy with verteporfin (Visudyne®).	You pay 20% of the Medicare-approved amount for diagnosis and treatment of diseases and conditions of the eye. (1)(2)	B

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THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Mammogram (Screening)	Medicare covers a screening mammogram once every 12 months (11 full months must have gone by from the last screening) for all women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.	You pay 20% of the Medicare-approved amount. (2)	B
Mental Health Care	Medicare covers mental health care given by a doctor or a qualified mental health professional. Before you get treatment, ask your doctor, psychologist, social worker, or other health professional if they accept Medicare payment.		
	Inpatient Mental Health Care: Medicare covers inpatient mental health care services. These services can be given in psychiatric units of a general hospital or in a specialty psychiatric hospital that cares for people with mental health problems. Medicare helps pay for inpatient mental health services in the same way that it pays for all other inpatient hospital care.	You pay the same deductible and copayments as inpatient hospital care (see Hospital Care (Inpatient) on page 39).	A
	Note: If you are in a specialty psychiatric hospital, Medicare only helps for a total of 190 days of inpatient care during your lifetime.		
	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 the Medicare-approved amount. (1)(2) You also pay a copayment or coinsurance for the facility service when provided in a hospital outpatient department or clinic. (1)	B

(continued)

(1) In 2007, you must pay an annual $131 deductible for Part B services and supplies before Medicare begins to pay its share.
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THE ORIGINAL MEDICARE PLAN

	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
M	**Mental Health Care** (continued)	**Partial Hospitalization:** Partial hospitalization may be available for you. It is a structured program of active psychiatric treatment that is more intense than the care you get in your doctor or therapist's office. For Medicare to cover a partial hospitalization program, a doctor must say that you would otherwise need inpatient treatment.	You pay a set copayment amount for each day of service. (1)(2)	B
		Medicare covers the services of specially qualified non-physician practitioners such as clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants, as allowed by state and local law for medically-necessary services.	You pay 20% of the Medicare-approved amount for certain services (like medication management or diagnostic testing). (1)(2)	B
			You pay 50% of the Medicare-approved amount for mental health therapy services.	B
N	**Nursing Home Care**	Most nursing home care is custodial care. Generally, Medicare doesn't cover custodial care. Medicare Part A only covers skilled nursing care given in a certified skilled nursing facility (SNF) or in your home (if you are homebound) if medically necessary, but not custodial care (such as helping with bathing or dressing).	You pay 100%.	
	Nutrition Therapy Services (Medical)	Medicare covers medical nutrition therapy services, when ordered by a doctor, for people with kidney disease (but who aren't on dialysis) or who have a kidney transplant, or people with diabetes. These services can be given by a registered dietitian or Medicare-approved nutrition professional and include nutritional assessment, one-on-one counseling, and therapy through an interactive telecommunications system. See Diabetes Supplies and Services on page 25.	You pay 20% of the Medicare-approved amount. (1)(2)	B

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Occupational Therapy	See Physical Therapy/Occupational Therapy/Speech-Language Pathology on page 46.		
Orthotics	Medicare covers artificial limbs and eyes, and arm, leg, back and neck braces. Medicare doesn't pay for orthopedic shoes unless they are a necessary part of the leg brace. Medicare doesn't pay for dental plates or other dental devices. See Diabetes Supplies and Services (Therapeutic Shoes) on page 25.	You pay 20% of the Medicare-approved amount. (1)(2)	B
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.	You pay 20% of the Medicare-approved amount for the doctor's services and supplies. (1)(2)	B

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THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
O **Outpatient Hospital Services**	Medicare covers medically-necessary services you get as an outpatient from a Medicare-participating hospital for diagnosis or treatment of an illness or injury. Covered outpatient hospital services include • services in an emergency room or outpatient clinic, including same-day surgery, • laboratory tests billed by the hospital, • mental health care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it, • X-rays and other radiology services billed by the hospitals, • medical supplies such as splints and casts, • screenings and preventive services, and • certain drugs and biologicals that you can't give yourself.	You pay 20% of the Medicare-approved amount for the doctor. (1)(2) For other than doctors' services, you pay a copayment for each service you get in an outpatient hospital setting.	B B
Oxygen Therapy	Medicare covers the rental of oxygen equipment. Or, if you own your own equipment, Medicare will help pay for oxygen contents and supplies for the delivery of oxygen when all of these conditions are met: • 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 failed.	You pay 20% of the Medicare-approved amount. (1)(2) **(continued)**	B

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Oxygen Therapy **(continued)**	Under the above conditions Medicare helps pay for • systems for furnishing oxygen, • containers that store oxygen, • tubing and related supplies for the delivery of oxygen, and • oxygen contents. If oxygen is provided only for use during sleep, portable oxygen wouldn't be covered. Portable oxygen isn't covered when provided only as a backup to a stationary oxygen system.		B
Pap Test/Pelvic Exam	Medicare covers Pap tests and pelvic exams (and a clinical breast exam) for all women once every 24 months. Medicare covers this test and exam once every 12 months if you are at high risk for cervical or vaginal cancer or if you are of childbearing age and have had an abnormal Pap test in the past 36 months. 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 aren't covered by Medicare, except for the one-time "Welcome to Medicare" physical exam (see page 46).	You pay $0 for the lab Pap test. (2) You pay 20% of the Medicare-approved amount (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 copayment.	B

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THE ORIGINAL MEDICARE PLAN

P

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Physical Exams (routine) ("One-time Welcome to Medicare" physical exam)	Routine physical exams aren't generally covered by Medicare. Medicare covers a **one-time** review of your health, as well as education and counseling about the preventive services you need, including certain screenings and shots. Referrals for other care, if you need them, will also be covered. **Important:** You must have the physical exam within the first six months you have Medicare Part B (deductibles and coinsurance apply).	You pay 100% for routine physical exams. You pay 20% of the Medicare-approved amount. (1)(2)	 B
Physical Therapy/ Occupational Therapy/Speech-Language Pathology	Medicare helps pay for medically-necessary outpatient physical and occupational therapy and speech-language 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 need therapy. You can get outpatient services from a Medicare-approved outpatient provider such as a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or a comprehensive outpatient rehabilitation facility. Also, you can get services from a Medicare-approved physical or occupational therapist, in private practice, in his or her office, or in your home. (Medicare doesn't pay for services given by a speech-language pathologist in private practice.) In 2007, there may be limits on physical therapy, occupational therapy, and speech-language pathology services. If so, there may be exceptions to these limits.	You pay 20% of the Medicare-approved amount. (1)(2)	B

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Pneumococcal Shot	Medicare covers the pneumococcal shot to help prevent pneumococcal infections. Most people only need this preventive shot once in their lifetime. Talk with your doctor to see if you need this shot.	You pay $0 for a pneumococcal shot if the doctor or health care provider accepts assignment.	B
Prescription Drugs (Outpatient) Very Limited Coverage	Part B covers a limited number of outpatient prescription drugs. Your pharmacy or doctor must accept assignment on Medicare-covered prescription drugs. Part B covers drugs that aren't usually self-administered when you are given them in a hospital outpatient department. You can get comprehensive drug coverage by joining a Medicare drug plan (also called "Part D"). For more information, see page 7. **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 note for women with osteoporosis, under Home Health Care on page 37. • **Erythropoisis–stimulating Agents (such as Epogen,® Epoetin alfa, or Darbepoetin alfa Aranesp®):** 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.	You pay 100% for most prescription drugs you take at home. You pay a copayment for prescription drugs that you are given when you are in a hospital outpatient department. You pay 20% of the Medicare-approved amount for covered prescription drugs. (1) Coverage is very limited. **(continued)**	B B B

(1) In 2007, you must pay an annual $131 deductible for Part B services and supplies before Medicare begins to pay its share.

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
P **Prescription Drugs** (Outpatient) Very Limited Coverage **(continued)**	• **Blood Clotting Factors:** If you have hemophilia, Medicare will help pay for clotting factors you give yourself by injection.		B
	• **Injectable Drugs:** Medicare covers most injectable drugs given by a licensed medical practitioner, if the drug is considered reasonable and necessary for treatment.		B
	• **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.		B
	• **Oral Cancer Drugs:** Medicare will help pay for some cancer drugs you take by mouth if the same drug is available in injectable form. Currently, Medicare covers the following cancer drugs you take by mouth: • Capecitabine (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 become available, Medicare may cover them.	**(continued)**	B

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Prescription Drugs (Outpatient) Very Limited Coverage **(continued)**	• **Oral Anti-Nausea Drugs:** Medicare will help pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered within 48 hours and must be used as a full therapeutic replacement for the intravenous anti-nausea drugs that would otherwise be given. Medicare also covers some drugs used in infusion pumps and nebulizers if considered reasonable and necessary.		B
Preventive Services	Medicare covers the following preventive services: • Bone Mass Measurement on page 20. • Cardiovascular Screening Blood Tests on page 21. • Colorectal Cancer Screening on page 22. • Diabetes Screenings on page 25. • Glaucoma Screening on page 35. • Mammogram Screening on page 41. • Nutrition Therapy Services on page 42. • Pap Test/Pelvic Exam on page 45. • Prostate Cancer Screening on page 50. • Shots on page 52 including - flu shot on page 34, - pneumococcal shot on page 47, and - Hepatitis B shot on page 36. • Smoking Cessation Counseling on page 55. • One-time "Welcome to Medicare" physical exam on page 46.	Information about the cost of each of these services is listed on the page of the specific service.	B

P

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Prostate Cancer Screening	Medicare covers prostate screening tests once every 12 months for all men age 50 and older with Medicare (coverage begins the day after your 50th birthday). Covered tests include the following:	You pay 20% of the Medicare-approved amount. You don't pay a deductible for lab services. You do pay a deductible for non-lab services. (1)(2)	B
	• Digital Rectal Examination	Generally, you pay 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 amount for other related services. (1)(2)	B
Prosthetic Devices	Medicare covers prosthetic devices needed to replace an internal body part or function. These include Medicare-approved corrective lenses needed after a cataract operation (see Eyeglasses/Contact Lenses on page 34), ostomy bags and certain related supplies (see Ostomy Supplies on page 43), and breast prostheses (including a surgical brassiere) after a mastectomy (see Breast Prostheses on page 20).	You pay 20% of the Medicare-approved amount. (1)(2)	B

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Radiation Therapy	Medicare covers radiation therapy for patients who are hospital inpatients or outpatients or patients in freestanding clinics.	If you are a hospital inpatient, you pay the inpatient deductible and coinsurance (if applicable). If you are a hospital outpatient, you pay a set copayment. If you get radiation therapy in a freestanding facility, you pay 20% of the Medicare-approved amount. (1)(2)	A B B
Religious Nonmedical Health Care Institution (RNHCI)	Medicare doesn't cover the religious portion of RNHCI care. Medicare covers inpatient nonmedical care when the following conditions are met: • The RNHCI has agreed and is currently certified to participate in Medicare, and the Utilization Review Committee agrees that you'd require hospital or skilled nursing facility care if it weren't for your religious beliefs. • You have a written agreement with Medicare indicating that your need for this form of care is based on your religious beliefs. The agreement must also indicate that if you decide to accept standard medical care, you may have to wait longer to get RNHCI services in the future. You're always able to access medically-necessary Medicare Part A services. • The care provided is reasonable and necessary.	For each benefit period you pay: Day 1 - 60: $992 deductible Day 61 - 90 $248 each day Days 91 - 150: $496 each day Beyond day 91: all costs For information about benefit periods and lifetime reserve days, see pages 63–64.	A

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THE ORIGINAL MEDICARE PLAN

	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
R	**Respite Care**	Medicare covers respite care for hospice patients (see Hospice Care on page 38).		
S	**Second Surgical Opinions**	Medicare covers a second opinion before surgery that isn't an emergency. A second opinion is when another doctor gives his or her view about your health problem and how it should be treated. Medicare will also help pay for a third opinion if the first and second opinions are different.	You pay 20% of the Medicare-approved amount. (1)(2) You pay $0 for a second opinion for Ambulatory Surgical Center procedures done in a hospital outpatient department.	B
	Shots (Vaccinations)	Medicare covers the following shots:		
		Flu Shot: Once per flu season. You can get a flu shot in the fall and the winter flu seasons of the same year.	You pay $0 for flu shots if the doctor or health care provider accepts assignment.	B
		Hepatitis B Shot: Certain people with Medicare at medium to high risk for Hepatitis B.	You pay 20% of the Medicare-approved amount for the Hepatitis B shot given in a doctor's office. (1)(2) For Hepatitis B shots given in a hospital outpatient department, you pay a copayment.	B
		Pneumococcal Shot: One shot may be all you ever need. Ask your doctor.	You pay $0 for a pneumococcal shot if the doctor or health care provider accepts assignment.	B

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
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. Care that can be given by non-professional staff isn't 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 if all these conditions are met: 1. You have Medicare Part A (Hospital Insurance) and have days left in your benefit period to use.	For each benefit period (following at least a related three-day covered hospital stay): Days 1 - 20: $0 each day Days 21 - 100: up to $124 each day Beyond 100 days: You pay 100%. There is a limit of 100 days of Medicare Part A SNF coverage in each benefit period. For information about benefit periods and lifetime reserve days, see pages 63–64. **(continued)**	A

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	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
S	**Skilled Nursing Facility (SNF) Care** **(continued)**	2. You have a qualifying hospital stay. This means an inpatient hospital stay of three consecutive days or more, including the day you're admitted to the hospital, but not including the day you leave the hospital. You must enter the SNF within a short time (generally 30 days) of leaving the hospital and require skilled services related to your hospital stay (see item 5). After you leave the SNF, if you reenter the same or another SNF within 30 days, you don't need another three-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 five or six days a week, as long as you need and get the therapy services each day they are offered. 4. You get these skilled services in a SNF that is certified by Medicare.	While you are in the Medicare-certified part of the facility, your therapy services (physical therapy, occupational therapy, and speech-language pathology) must be billed by the facility. No other therapy service may be billed by another setting, such as an outpatient hospital department. If you leave the Medicare-certified part of the facility, your therapy services in the non-Medicare-certified part of the facility are limited by a specific dollar amount each year unless you get the services from an outpatient hospital setting. **(continued)**	A

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
Skilled Nursing Facility (SNF) Care **(continued)**	5. You need these skilled services for a medical condition that • was treated during a qualifying three-day hospital stay, or • started while you were getting care in the SNF for a medical condition that was treated during a qualifying three-day hospital stay. For example, if you are in the SNF because you had a stroke, and you develop an infection that requires I.V. antibiotics and you meet the conditions listed in items 1–4 (pages 53–54), Medicare will cover skilled care.		A
Smoking Cessation (Counseling to stop smoking)	Medicare covers minimal regular doctor's office visits, and up to eight face-to-face visits in a 12-month period if you are diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco.	If you get this service in a hospital outpatient department, you pay a copayment for each session.	B
Speech-Language Pathology	See Physical Therapy/Occupational Therapy/Speech-Language Pathology on page 46.		
Substance-Related Disorders	Medicare covers treatment for substance-related disorders in inpatient or outpatient settings. Certain limits apply.	See Mental Health Care (Inpatient or Outpatient) on page 41.	A&B

THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
S **Supplies** (you use at home)	Medicare generally doesn't cover common medical supplies like bandages and gauze. Supplies furnished as part of a doctor's service are covered by Medicare, and payment is included in Medicare's doctor payment. Doctors don't bill for supplies. Medicare covers some diabetes and dialysis supplies. See Diabetes Supplies and Services on page 25 and Dialysis (Kidney) on page 29. For items such as walkers, oxygen, and wheelchairs, see Durable Medical Equipment on page 31.	You pay 100% for most common medical supplies you use at home.	B
Surgical Dressings	Medicare covers surgical dressings when medically necessary for the treatment of a surgical or surgically-treated wound.	You pay 20% of the Medicare-approved amount for doctor services. (1)(2)	
T **Therapeutic Shoes**	See Diabetes Supplies and Services (Therapeutic Shoes) on page 26.	You pay 20% of the Medicare-approved payment amount for doctor services. (1)(2)	B
Transplants (Doctor Services)	Medicare covers doctor services for transplants, see Transplants (Facility Charges) on page 57.	You pay 20% of the Medicare-approved amount for doctor services. (1)(2)	B

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Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or 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, intestine/multivisceral, and some pancreas transplants. Bone marrow and cornea transplants aren't limited to approved facilities. Transplant coverage includes necessary tests, labs, and exams before surgery. It also includes immunosuppressive drugs (under certain conditions), follow-up care for you, and procurement of organs and tissues. Medicare pays for the costs for a living donor for a kidney transplant.	The amount varies. For Inpatient Transplants, see Hospital Care (Inpatient) on page 39.	A (inpatient transplants) B (cornea and bone marrow transplants)
Transportation (Routine)	Medicare generally doesn't cover transportation to get routine health care. For more information, see Ambulance Services on page 18.	You pay 100% for transportation to get routine health care.	
Travel Outside of the United States (Health Care Coverage During Travel)	Medicare generally doesn't cover health care while you are traveling outside the United States. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States. There are some exceptions. In some cases, Medicare may pay for services that you get while on board a ship within the territorial waters adjoining the land areas of the United States.	In most cases, you pay 100% of charges. Health care services and supplies are NOT covered outside the United States except under limited circumstances. **(continued)**	

	Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
T	**Travel Outside of the United States (Health Care Coverage During Travel)** **(continued)**	In rare cases, Medicare can pay for inpatient hospital services that you get in a foreign country. Medicare can pay only under the following circumstances: 1. You are in the United States when a medical emergency occurs and the foreign hospital is closer than the nearest United States hospital that can treat the emergency. 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 foreign hospital is closer to your home than the nearest United States hospital that can treat your medical condition, regardless of whether an emergency exists. Medicare also pays for doctor and ambulance services you get in a foreign country as part of a covered inpatient hospital stay.	You pay the part of the charge that you would normally pay for covered services.	A (inpatient services) B (outpatient services)
W	**Walker/Wheelchair**	Medicare covers power-operated vehicles (scooters), walkers, and wheelchairs as durable medical equipment that your doctor prescribes for use in your home. For more information, see Durable Medical Equipment on page 31. **Power Wheelchair:** You must have a face-to-face examination and a written prescription from a doctor or other treating provider before Medicare helps pay for a power wheelchair.	You pay 20% of the Medicare-approved amount. (1)(2)	B

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THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2007?	Part A or B
X-rays	Medicare covers medically-necessary diagnostic X-rays that are ordered by your treating doctor. For more information, see Diagnostic Tests on page 28.	You pay 20% of the Medicare-approved amount. (1)(2) For X-rays in a hospital outpatient setting, you pay a copayment.	B B

X

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NOTES

FOR MORE INFORMATION

Free Booklets About Medicare and Related Topics

Health care decisions are important. Medicare provides information to help you make informed decisions. You can view free booklets from Medicare to learn more about the topics that interest you.

Detailed booklets are available on Medicare topics such as preventive services, hospice care, home health care, Medicare prescription drug coverage, choosing a nursing home, skilled nursing care, and rights and protections.

To get these booklets

- Look at www.medicare.gov on the web. Select "Find a Medicare Publication." You can read, print, or order these publications. This is the fastest way to get a copy.

- Put your name on the mailing list to get an e-mail every time a new publication is available. To sign up, go to www.medicare.gov on the web and select "Mailing List" at the top of the page. Then, select the list called "MEDICARE GOV_PUBS," and choose "Subscribe."

Note: Some publications are only available at www.medicare.gov on the web, not in print.

1-800-MEDICARE Helpline

The 1-800-MEDICARE (1-800-633-4227) helpline has a speech-automated system to make it easier for you to get the information you need 24 hours a day, including weekends. The system will ask you questions that you answer with your voice to direct your call automatically. Speak clearly, call from a quiet area, and have your Medicare card in front of you (see sample card on page 4). If you need help, you can say "Agent" at any time to talk to a customer service representative.

Mymedicare.gov

Mymedicare.gov is an exciting new service on the web. With this tool, you can see your health care claims, track which preventive services you need, and get the most current details about how to get the most out of your Medicare benefits. If you don't have access to the web, the same information is available by calling 1-800-MEDICARE (1-800-633-4227) and through Medicare's many partners in the community.

www.medicare.gov

www.medicare.gov helps you manage your Medicare. You can

- see what Medicare plans are in your area,
- find doctors enrolled in Medicare,
- see what Medicare covers, including preventive services,
- get Medicare appeals information and forms,
- get information on the quality of care provided by nursing homes, hospitals, home health agencies, plans, and dialysis facilities,
- look up helpful telephone numbers for your area, and
- view Medicare publications.

FOR MORE INFORMATION

Other Important Contacts

Below are telephone numbers for organizations that provide nationwide services.

These numbers were correct at the time of printing. Sometimes these numbers change.

Social Security
1-800-772-1213
TTY 1-800-325-0778

Coordination of Benefits Contractor
1-800-999-1118
1-800-318-8782

Department of Defense

TRICARE
1-888-363-5433

TRICARE for Life
1-866-773-0404

Department of Health and Human Services

Office of the Inspector General
1-800-447-8477
TTY 1-800-377-4950

Office for Civil Rights
1-800-368-1019
TTY 1-800-537-7697

Department of Veterans Affairs
1-800-827-1000
TTY 1-800-829-4833

Railroad Retirement Board (RRB)
(RRB beneficiaries only)
Local RRB office or 1-800-808-0772

WORDS TO KNOW

Appeal—A special kind of complaint you make if you disagree with certain kinds of decisions made by Medicare or your health or prescription drug plan. You can appeal if you request a health care service, supply, or prescription that you think you should be able to get, or you request payment for health care you already got, and Medicare or a plan denies the request.

Assignment—An agreement between a person with Medicare, a doctor or supplier, and Medicare. The person with Medicare agrees to let the doctor or supplier request direct payment from Medicare for covered Part B services, equipment, and supplies. Doctors or suppliers who agree to (or must by law) accept assignment from Medicare can't try to collect more than the Medicare deductible and coinsurance amounts from the person with Medicare, the person's other insurance (if any), or from anyone else.

Benefit Period—The way that the Original Medicare Plan 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 had any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods, although inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Coinsurance—An amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.

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

Creditable Prescription Drug Coverage—Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

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

Deductible—The amount you must pay for health care or prescriptions, before the Original Medicare Plan, your prescription drug plan, or other insurance begins to pay. For example, in the Original Medicare Plan, you pay a new deductible for each benefit period for Part A and each year for Part B. These amounts can change every year.

WORDS TO KNOW

Health Maintenance Organization (HMO)—A type of health plan available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your costs may be lower than in the Original Medicare Plan.

Lifetime Reserve Days—In the Original Medicare Plan, these are additional days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($496 in 2007).

Limiting Charge—The highest amount 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 doesn't 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 needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare Advantage Plan (Part C)—A type of Medicare plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called Part C, Medicare Advantage Plans are HMOs, PPOs, Private Fee-for-Service Plans, or Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under the Original Medicare Plan. Some Medicare Advantage Plans offer prescription drug coverage.

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

Medicare Medical Savings Account (MSA) Plan—MSA Plans combine a high-deductible Medicare Advantage Plan (like an HMO or PPO) with a Medical Savings Account for medical expenses.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, all Medigap policies must be one of 12 standardized Medigap policies labeled Medigap Plan A through Plan L. Medigap policies **only** work with the Original Medicare Plan.

WORDS TO KNOW

Preferred Provider Organization (PPO) Plan—A type of health plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost. Many Medicare Advantage Plans are PPOs.

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

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

Special Needs Plan—A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

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