


## Part A-Covered Services

<b>Blood</b>	In most cases, the hospital gets blood from a blood bank at no charge, and you won’t have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.
<b>Home Health Services</b>	Limited to medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment (see page 30), and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort.
<b>Hospice Care</b>	For people with a terminal illness. Your doctor must certify that you are expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, social services; and other covered services as well as services Medicare usually doesn’t cover, such as grief counseling. A Medicare-approved hospice usually gives hospice care in your home (or other facility like a nursing home). Medicare covers some short-term inpatient stays for pain and symptom management that can’t be addressed in the home. These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility. Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren’t related to your terminal illness. You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you are terminally ill.

**Copayments, coinsurance, and deductibles** may apply for each service. See page 120 for specific costs and other information about these services.

## Part B-Covered Services

<b>Doctor Services</b>	Services that are <b>medically necessary</b> (includes outpatient and some doctor services you get when you are a hospital inpatient) or covered preventive services. Doesn’t cover routine physicals except for the one-time “Welcome to Medicare” physical exam. See “Physical Exam.” You pay 20% of the <b>Medicare-approved amount</b> , and the Part B <b>deductible</b> applies.
<b>Durable Medical Equipment (like walkers)</b>	Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds your doctor orders for use in the home. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. You must get your covered equipment or supplies from a supplier enrolled in Medicare. You should also check if the supplier is a participating supplier. Participating suppliers must accept assignment (see page 47), and your out-of-pocket costs may be less.
 <b>NEW EKG Screening</b>	Medicare covers a one-time screening EKG if you get a <b>referral</b> for it as a result of your one-time “Welcome to Medicare” physical exam. See “Physical Exam.” You pay 20% of the Medicare-approved amount, and the Part B deductible applies. An EKG is also covered as a diagnostic test. See page 36.
<b>Emergency Room Services</b>	When you believe your health is in serious danger. You may have a bad injury, a sudden illness, or an illness that quickly gets much worse. You pay a specified <b>copayment</b> for the hospital emergency department visit, and you pay 20% of the Medicare-approved amount for the doctor’s services. The Part B deductible applies.
<b>Eye Exams for People with Diabetes</b>	Checks for diabetic retinopathy once every 12 months by an eye doctor who is legally allowed by the state to do the test. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
<b>Eyeglasses (limited)</b>	One pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Part B deductible and **coinsurance** amounts are on page 121.

## Keeping Your Costs Down (“Assignment” in Original Medicare)

Assignment means that your doctor, provider, or supplier has signed an agreement with Medicare to accept the **Medicare-approved amount** as full payment for covered services.



Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. You may also want to find out how much you have to pay for each service or supply before you get it. In some cases they must accept assignment, like when they have a participation agreement with Medicare and give you Medicare-covered services.

If your doctor, provider, or supplier **accepts** assignment:

- Your out-of-pocket costs may be less.
- They agree to only charge you the Medicare **deductible** and **coinsurance** amount and wait for Medicare to pay its share.
- They have to submit your claim to Medicare directly. They can't charge you for submitting the claim.


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

- They still must submit a claim to Medicare when they give you Medicare-covered services. If they don't submit the claim, ask them to file a Medicare claim for your services. If they still don't file your claim, call 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048. You might have to pay the entire charge at the time of service, and then submit your claim to Medicare to get paid back.
- They may charge you more than the Medicare-approved amount, but there is a limit called “the limiting charge.” They can only charge you up to 15% over the Medicare-approved amount. The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment.

Blue words in the text are defined on pages 115–118.

To find doctors and suppliers who accept assignment (participate in Medicare), visit [www.medicare.gov](http://www.medicare.gov) and select, “Find a Doctor or Other Healthcare Professional” or “Find Suppliers of Medical Equipment in Your Area.” You can also call 1-800-MEDICARE.

## Part B-Covered Services

<b>Home Health Services</b>	<p>Limited to medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor must order it, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort. No cost to you for home health services. For Medicare-covered durable medical equipment, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.</p>
<b>Kidney Dialysis Services and Supplies</b>	<p>For people with End-Stage Renal Disease (ESRD). Medicare covers dialysis either in a facility or at home when your doctor orders it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.</p>
<b>NEW Kidney Disease Education Services</b>	<p>Medicare may cover kidney disease education services if you have kidney disease, and your doctor refers you for the service. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.</p>
 <b>Mammograms (screening)</b>	<p>A type of X-ray to check women for breast cancer before they or their doctor may be able to find it. Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35–39. You pay 20% of the Medicare-approved amount.</p>

Part B deductible and **coinsurance** amounts are on page 121.

Medicare may cover some services and tests more often than the timeframes listed if needed to diagnose a condition.

## What you pay if you have Original Medicare

### Part A Costs for Covered Services and Items

Blood	In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated.
Home Health Care	<p><b>You pay:</b></p> <ul style="list-style-type: none"> <li>▪ \$0 for home health care services</li> <li>▪ 20% of the Medicare-approved amount for durable medical equipment</li> </ul>
Hospice Care	<p><b>You pay:</b></p> <ul style="list-style-type: none"> <li>▪ \$0 for hospice care</li> <li>▪ A <b>copayment</b> of up to \$5 per prescription for outpatient prescription drugs for pain and symptom management</li> <li>▪ 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest)</li> </ul> <p>Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).</p>
Hospital Stay	<p><b>In 2010, you pay:</b></p> <ul style="list-style-type: none"> <li>▪ \$1,100 <b>deductible</b> and no <b>coinsurance</b> for days 1–60 each <b>benefit period</b></li> <li>▪ \$275 per day for days 61–90 each benefit period</li> <li>▪ \$550 per “<b>lifetime reserve day</b>” after day 90 each benefit period (up to 60 days over your lifetime)</li> <li>▪ All costs for each day after the lifetime reserve days</li> <li>▪ Inpatient mental health care in a psychiatric hospital limited to 190 days in a lifetime</li> </ul> <p>See “Medical and Other Services” on page 121 for what you pay for doctor services while you are a hospital inpatient.</p>
Skilled Nursing Facility Stay	<p><b>In 2010, you pay:</b></p> <ul style="list-style-type: none"> <li>▪ \$0 for the first 20 days each benefit period</li> <li>▪ \$137.50 per day for days 21–100 each benefit period</li> <li>▪ All costs for each day after day 100 in a benefit period</li> </ul>

**Note:** If you are in a Medicare Advantage Plan, costs vary by plan and may be either higher or lower than those noted above. Check with your plan.