

Part A-Covered Services

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 by you or someone else.
Home Health Services	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.
Hospice Care	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.

Medicare Advantage Plans (Part C)

A Medicare Advantage Plan (like an HMO or PPO) is another health coverage choice you may have as part of Medicare.

Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by private companies approved by Medicare.

If you join a Medicare Advantage Plan, the plan will provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. In all plan types, you are always covered for emergency and urgent care.

Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care. Original Medicare covers hospice care even if you are in a Medicare Advantage Plan. Medicare Advantage Plans aren’t considered supplemental coverage.

Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage. In addition to your Part B premium, you usually pay one monthly **premium** for the services provided.



Medicare pays a fixed amount for your care every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a **referral** to see a specialist or if you have to go to only doctors, facilities, or suppliers that belong to the plan).

Medicare Advantage Plans include the following:

- Health Maintenance Organization (HMO) Plans. See page 55.
- Preferred Provider Organization (PPO) Plans. See page 55.
- Private Fee-for-Service (PFFS) Plans. See page 56.
- Medical Savings Account (MSA) Plans. See page 56.
- Special Needs Plans (SNP). See page 57.



Make sure you understand how a plan works before you join. See pages 55–57 for more information about Medicare Advantage Plan types.

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>You pay:</p> <ul style="list-style-type: none"> ▪ \$0 for home health care services ▪ 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	<p>You pay:</p> <ul style="list-style-type: none"> ▪ \$0 for hospice care ▪ A copayment of up to \$5 per prescription for outpatient prescription drugs for pain and symptom management ▪ 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest) <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>In 2010, you pay:</p> <ul style="list-style-type: none"> ▪ \$1,100 deductible and no coinsurance for days 1–60 each benefit period ▪ \$275 per day for days 61–90 each benefit period ▪ \$550 per “lifetime reserve day” after day 90 each benefit period (up to 60 days over your lifetime) ▪ All costs for each day after the lifetime reserve days ▪ Inpatient mental health care in a psychiatric hospital limited to 190 days in a lifetime <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>In 2010, you pay:</p> <ul style="list-style-type: none"> ▪ \$0 for the first 20 days each benefit period ▪ \$137.50 per day for days 21–100 each benefit period ▪ All costs for each day after day 100 in a benefit period

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.