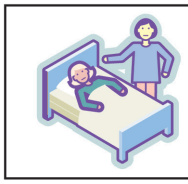
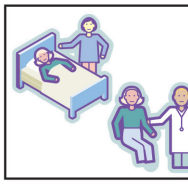
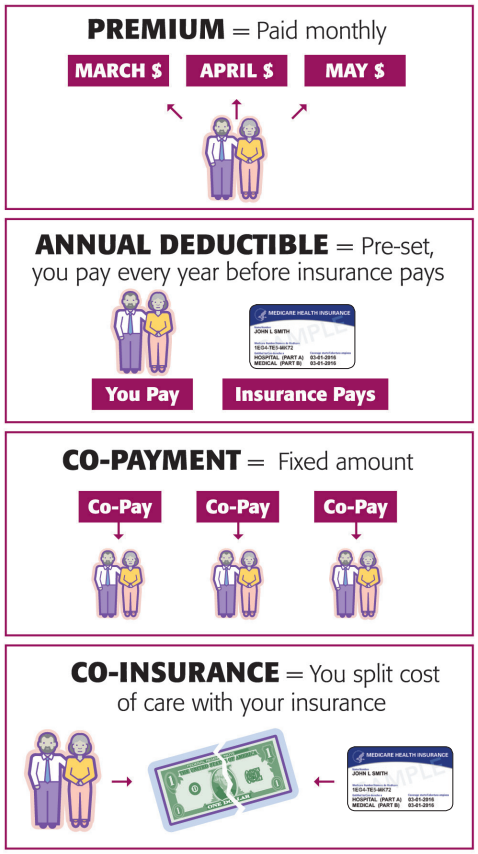
RETINA ASSOCIATES
OF FLORIDA
Diseases & Surgery of the Retina & Macula

Important Information Regarding Medicare

What is Medicare?
Medicare is a federal government health program for people 65 and older or people under 65 with some disabilities. Medicare has 4 parts – Part A, Part B, Part C and Part D. Medicare Part A and Part B are considered "traditional Medicare" or just "Medicare." This chart is an overview of each Part:

A		Helps with costs from hospital stays and skilled nursing facilities (nursing homes, rehabilitation centers & hospices for example)
B		Helps with doctor care and outpatient care
C		Combines Parts A and B coverage in a single plan
D		Helps pay for prescription drugs

What can I expect to pay if I have traditional Medicare?
Traditional Medicare is a cost sharing plan. That means you share the cost of your care with Medicare. Your share of the health care costs may be large, depending on on the care you receive. Although the cost of care under traditional Medicare may be higher than other types of plans, you will have more flexibility when it comes to choosing doctors and hospitals. It's important to remember there are no limits on the amount you may have to pay for care. If you have a chronic condition like wet macular degeneration that requires on-going care or another serious illness, you may have to pay a large amount for your care. You can expect to make four kinds of payments as part of your cost sharing responsibility:



Why do I have to pay an annual deductible if I have traditional Medicare?
This situation usually is noticed in January and February because the annual deductible starts January 1 of each year. **Medicare requires you to pay an annual deductible before coverage begins.** When you pay the annual deuctible, your doctor reports that to Medicare. Sometimes there is a delay between the time you pay the annual deductible and the time Medicare records the payment. In this case, you will be asked to pay the annual deductible more than once. After your charges and payments are calculated by Medicare, if you paid too much, you should get a refund from your doctor(s) as determined by Medicare.

Why won't my supplemental insurance pay my Medicare deductible?
Not all supplemental insurance plans pay the Medicare annual deductible. Also, some supplemental insurance plans have a deductible and out-of-pocket requirement before coverage begins.

What are Part C/Medicare Advantage Plans?
These are plans provided by private companies that combine coverage for hospital costs, doctor's visits and other medical services and may also include prescription drug coverage. The Medicare Advantage plan concept was created to give Medicare participants more options about how to receive their health care.

How are Part C/Medicare Advantage plans different from traditional Medicare?
Each Medicare Advantage plan is unique because the company offering the plan has flexibility in setting the terms of its plan. These plans often include additional care designed to help you stay healthy. Unlike traditional Medicare, these plans may have some limits on your choice of doctors

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and hospitals depending on the type of plan you join. Some of these plans can have co-pays as high as several hundred dollars for each injection of Lucentis/Eylea/Avastin. This makes it very expensive for most people with these plans to receive Lucentis/Eylea/Avastin injections. Remember, if you have a Medicare Advantage Plan, you no longer have traditional Medicare!

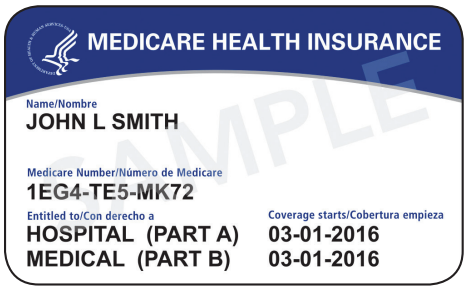
What's important to know about Part C/Medicare Advantage Plans

There are five important differences:

- The terms of the plans vary based on the company.
- All plans have service areas where they offer coverage – a plan's service area could be a county, a state, a region, or the entire United States. If Retina Associates of Florida is not within the geographic area of such a plan, a lesser amount will be paid as an "out-of-area-benefit." The balance must be paid by you, the patient. This can lead to out-of-pocket expenses of several hundred dollars in some cases.
- All plans must offer nationwide emergency care, urgent care and renal dialysis.
- Prescription drug coverage is included in many plans, but not all.
- These plans do not cover hospice care (which is still covered by Medicare).

What insurance card do I use?

1. If you have traditional Medicare, your Medicare card will look like this.



At the top of the card are the words "Medicare Health Insurance." The card has your name, Medicare Claim Number, sex, benefits descriptions and effective dates. Show your Medicare card to doctors, hospitals and outpatient facilities.

2. If you have traditional Medicare and a drug plan, you will also have a card for the drug plan. Show both your Medicare card and your supplemental card to doctors, hospitals and outpatient facilities.

3. If you have a Part C/Medicare Advantage plan, you will have a card from your Part C plan with the name of the insurance company, your name, member number and benefits and effective date information on it. This is the card you should show to doctors, hospitals and outpatient facilities. In this case, your Medicare card is no longer your "insurance card."

4. If your Part C/Medicare Advantage Plan covers drugs, show the card from your Part C plan to pharmacies.

5. If your Part C/Medicare Advantage Plan covers drugs, show the card from your Part C plan to pharmacies.

6. If you have a Part C/Medicare Advantage Plan and a separate drug plan, you should have a card for the drug plan. Show the card from your Part C/Medicare Advantage Plan and the card from your drug plan.

What if Medicare does not cover a service or it is not clear whether Medicare covers a service?

Certain medical services will not be reimbursed by Medicare. If it seems likely that Medicare will not pay, we will: 1) notify you; 2) ask you to sign a form called an Advance Beneficiary Notice also referred to as an "ABN;" and 3) expect you to pay for this service if it is denied by Medicare. In the case of services for which Medicare's reimbursement policy has been erratic or is unknown, we will also ask you to sign an ABN. If after billing Medicare, reimbursement is denied you will be expected to pay. The coverage of a service often depends on what diagnosis is associated with a specific injection such as Lucentis, Eylea, Avastin, Ozurdex, Iluvien, Kenalog, Triescence, or Visudyne.

What if I am in a skilled nursing facility?

Skilled nursing facilities are for rehabilitation and are not regular nursing homes. Many charges, such as those for Lucentis/Eylea/Avastin, become the responsibility of the skilled nursing facility for payment. When you are admitted into a skilled nursing facility, your traditional Medicare Part B coverage changes to Part A. The skilled nursing facility is paid directly by Medicare for all medical services provided outside of the skilled nursing facility. The skilled nursing facility then pays the doctor's office for services rendered. Any patient admitted into a skilled nursing facility must notify the doctor's office and an authorization must be obtained from the skilled nursing facility prior to the scheduled appointment. If proper authorization is not obtained, the patient will have to reschedule.