

Making the Most of Your Medicare Benefits

A GUIDE TO NAVIGATING MEDICARE WITH CONFIDENCE



Welcome to Our Guide - *Making the Most of Your Medicare Benefits*

Medicare is a government-sponsored health insurance program designed for individuals over the age of 65 and those under 65 with a disability. While more than 65 million people are insured by this program, many are left with questions and are unfamiliar with how to maximize their Medicare benefits to their fullest potential.

Patient Advocate Foundation wants to help you understand the basics of Medicare. This resource will give you the skills to make informed decisions about your coverage, the benefits offered by Medicare, and how to use your insurance confidently.

We will introduce you to Medicare Parts A, B, C, D, and Medigap Plans. We will also review enrollment periods and the process of applying for Medicare. Additionally, the guide will cover denials, and your rights and protections when it comes to appeals.

- ▶ If you wish to order a printed copy of this publication, please visit www.patientadvocate.org.
- ▶ For further information, you can visit our Medicare Resource Center website, where you can learn about recent Medicare changes, identify available resources, and request assistance from PAF. The website can be accessed at www.patientadvocate.org/medicare.
- ▶ We also offer the Medicare Eligibility and Enrollment Training Series, a 7-module course that walks you through Medicare basics, the enrollment process, using your coverage, and more. To access this training, please visit <https://education.patientadvocate.org>.
- ▶ Patient Advocate Foundation is dedicated to helping individuals with chronic and life-threatening diseases by providing direct patient services to address issues related to accessing care and maintaining financial stability. To learn more about the Patient Advocate Foundation, please visit www.patientadvocate.org.

This guide is for informational purposes only. PAF understands that everyone's financial and medical situations are different, and there is no one-size-fits-all Medicare plan. We support readers in making their own decisions about which Medicare options are best for them and their circumstances.

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Selecting your Medicare coverage can be a challenging process. It involves reviewing your options, choosing which type of Medicare coverage is right for you, electing your benefits, and understanding how the coverage works. It may feel like a lot to handle.

At Patient Advocate Foundation, we can assist you in gaining the skills needed to make informed decisions and advocate for yourself while using your Medicare coverage. This guide is designed to provide valuable information and empower you to navigate Medicare with confidence.



MEDICARE BASICS (MEDICARE A, B, C, D, AND MEDIGAP PLANS)

Medicare is a federal health insurance program overseen by the Centers for Medicare and Medicaid Services (CMS). It provides coverage for individuals 65 and older, those on Social Security Disability Insurance (SSDI) for more than 24 months, and individuals with End-Stage Renal Disease (ESRD) or amyotrophic lateral sclerosis (ALS). Medicare offers different parts, including Part A (hospital bills), Part B (medical bills), Part D (prescription bills), and Part C (Medicare Advantage Plans). Additionally, Medicare Supplement Plans (Medigap) are available to fill coverage gaps left by Original Medicare.

Medicare is a federal health insurance program that was established in 1965. It is overseen by the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Medicare provides coverage for people 65 years or older, people younger than 65 on Social Security Disability Insurance (SSDI) for more than 24 months, and people with End-Stage Renal Disease (ESRD) or amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease).

Medicare gets its funding from two trust fund accounts within the U.S. Treasury. These funds come from employee/employer payroll taxes, Social Security income taxes, premiums paid by Medicare beneficiaries, and funds authorized by Congress.

Medicare helps to pay your hospital bills (Part A), medical bills (Part B), and prescription bills (Part D). Original Medicare includes Medicare Part A and Medicare Part B only. Medicare Part C, often called a Medicare Advantage Plan, is an alternative

to Original Medicare that bundles Part A, Part B, and usually Part D in one plan.

Medicare Part A

Covers inpatient hospital stays, skilled nursing facility care, home healthcare, and hospice. You may not pay a premium for Part A if you or your spouse paid Medicare taxes (also called FICA taxes) for a certain amount of time while working. The amount you pay per month for your premium is based on how long you paid Medicare taxes.



Monthly premiums, deductibles, and coinsurance for Medicare change each year. You can find the current amount of these Medicare charges by checking out [Medicare.gov](https://www.medicare.gov), contacting your local Social Security office, calling Social Security's toll-free number at (800) 772-1213, or by contacting the State Health Insurance Assistance Program at www.shiphelp.org.

With Medicare Part A and B, you must pay a yearly deductible and usually a 20% coinsurance for approved services. There is no limit to how much you could pay out-of-pocket for these services in a year.

Medicare Part B

Covers a range of healthcare services, including doctor's visits and tests, mental healthcare, durable medical equipment and supplies, most preventive services, and certain outpatient prescription drugs under limited conditions.

The amount you pay (also known as a premium) for Part B depends on your income from your IRS tax return two years ago. For example, your 2024 tax return will be used to determine your 2026 Part B premium. Most people pay the standard Part B premium, but you may have to pay more if your past income is above a certain amount. This additional charge is called an Income-Related Monthly Adjustment Amount (IRMAA).

Medicare Advantage Plans (Part C)

Considered "All-in-One" or "Bundled" plans and can be an alternative to Original Medicare. The Advantage Plans include Part A, Part B, and usually Part D in one plan and are offered by Medicare-approved private insurance companies. These plans must follow Medicare's coverage rules. Sometimes Advantage plans offer extra benefits not included in Original Medicare,

such as vision, hearing, dental, transportation, over-the-counter drugs, and services that promote health and wellness (for example, a gym membership). We will discuss the advantages and disadvantages of Medicare Advantage Plans later in this guide.

Medicare Part D

Provides prescription drug coverage. These plans, sold by private insurance companies, help you pay for medications. Each plan covers different drugs at different prices. Medicare D plan premiums will depend on the plan you choose. To enroll in a Medicare Part D plan, you must already be enrolled in Medicare Part A and/or Part B.

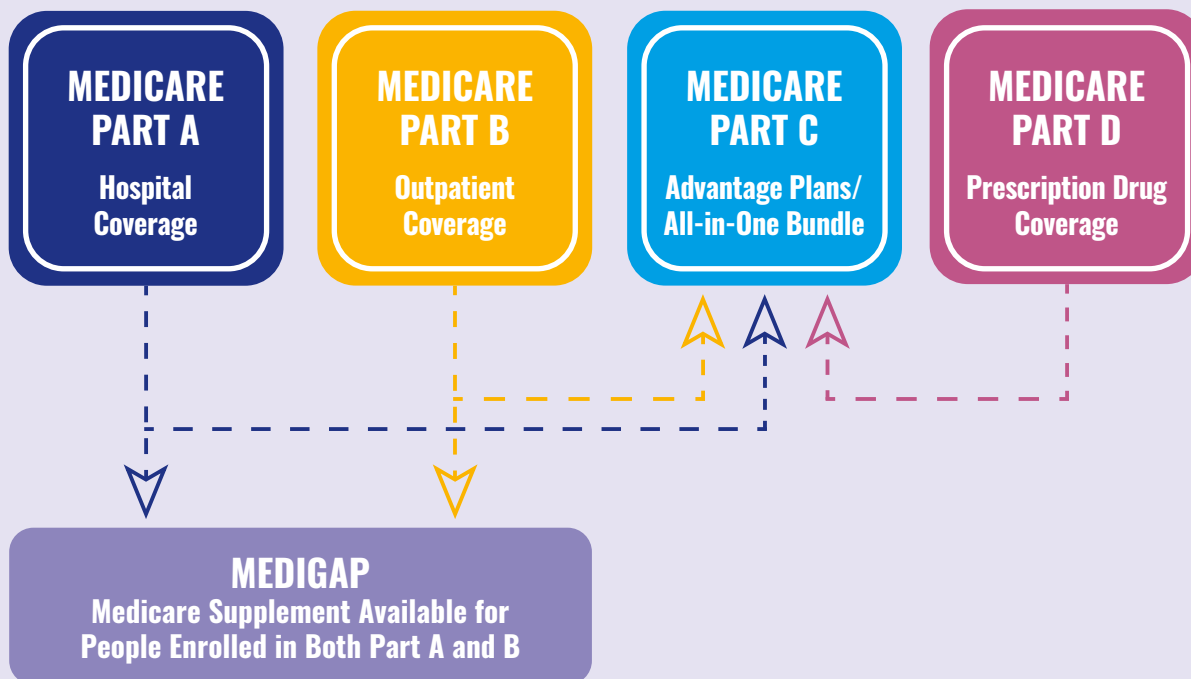
Medicare Supplement Plans (Also known as Medigap)

Designed to "fill the gap" in coverage left by Original Medicare. These plans help pay for costs like copayments, coinsurance, and deductibles that you would otherwise have to pay yourself. To enroll in a Medicare Supplement/ Medigap plan, you must have both Original Medicare Part A and Part B. The cost of the premium and the coverage level depends on the specific policy you choose.

Medicare is individual insurance, so spouses or dependents cannot be on the same Medicare plan together. If more than one person in a family is eligible for Medicare, each person is responsible for their own monthly premiums,

deductibles, and copayments. This is true for both Original Medicare and Medicare Advantage plans, as well as Part D plans. There are no discounts for married couples.

MEDICARE PLAN TYPES



MEDICARE ELIGIBILITY

Medicare eligibility depends on factors such as age, citizenship or residency status, work history, and specific medical conditions. It's important to understand your options for enrollment and the rules for each part (Parts A, B, and D, Medicare Advantage, and Medigap plans.)

Medicare provides health insurance to Americans 65 and older as well as to qualified people with disabilities. But qualifying for the program is not always automatic.

If you're **65 or older**, you qualify for Medicare benefits if:

- You are a U.S. citizen or a permanent legal resident who has lived in the United States for at least five years AND
- You are receiving Social Security or Railroad Retirement benefits or have worked long enough to be eligible for those benefits but are not yet collecting them OR
- You or your spouse is a government employee or retiree who has not paid into Social Security but has paid Medicare payroll taxes while working.

You may be able to help eligible family members get Medicare benefits based on your work record. For example, if your spouse does not have enough work credits to qualify for premium-free Part A hospital benefits, they can qualify on your work record. The same is true for your divorced spouse if you were married for at least 10 years.

In addition, a younger person with end-stage renal disease (ESRD) can qualify for Medicare based on a parent's work record.

However, these are only eligibility requirements. Your family members will not be automatically covered by Medicare. They will still need to enroll in a Medicare plan.



To find out when you should apply for Medicare, you can use Medicare's eligibility calculator here: www.medicare.gov/eligibilitypremiumcalc. If you are eligible, this tool will also give you premium information.

You may qualify for Medicare benefits **under the age of 65** if:

- You've been receiving Social Security disability benefits for at least 24 months (not necessarily consecutive), OR
- You get a disability pension from the Railroad Retirement Board and meet certain conditions, OR
- You have ALS and are deemed disabled, which qualifies you immediately, OR
- You have permanent kidney failure requiring regular dialysis or a kidney transplant, and you or your spouse paid Social Security taxes for a specified period depending on your age.

If You are Working at 65

If you're still employed and have health insurance coverage from your job (or your spouse's job) when you become Medicare-eligible, things work a little differently. Whether you need to sign up for Medicare when you turn 65 depends on how you get your health insurance and the number of employees at your company.

If you have health insurance through your current job or your spouse's, you don't have to sign up for Medicare while you (or your spouse) are still working. You can wait to enroll until you (or your spouse) stop working or you lose your health insurance.

If you're still working and plan to keep your employer's group health coverage, speak to your benefits administrator so they can help you decide when you should enroll in Part B. You should be eligible for Special Enrollment Period (SEP) through your employer to change, drop, or add coverage when you turn 65.

- If you're self-employed or have health insurance that's not available to everyone at the company: Ask your insurance provider if your coverage is an employer-group health plan. If it's not, sign up for Medicare when you turn 65 to avoid a monthly Part B late enrollment penalty.
- If the employer has less than 20 employees: You might need to sign up for Medicare when you turn 65 to avoid gaps in your job-based health insurance. Check with your employer.

COBRA and Medicare

If you have COBRA coverage (temporary coverage for certain situations when you lose job-based coverage), it's best to sign up for Medicare as soon as you are eligible to avoid a lapse in coverage and a Part B late enrollment penalty. If you have COBRA before signing up for Medicare, your COBRA coverage will likely end once you enroll in Medicare. You should enroll in Part B immediately because you are not entitled to a SEP when COBRA ends.



If you have Medicare Part A or Part B and then become eligible for COBRA, you can choose to enroll in COBRA. Medicare will be your primary insurance, and COBRA will be your secondary. This means that Medicare will pay for most of your healthcare costs, and COBRA will only pay for the costs that Medicare doesn't cover.

COBRA can be expensive, so you should weigh the pros and cons before deciding whether to enroll. COBRA may be a good option if you have high medical expenses and your COBRA plan covers your Medicare cost-sharing or offers other needed benefits.

However, if you don't have many medical expenses, you may be better off just sticking with Medicare.

Buying Into Medicare if You Don't Have Enough Work Credits

If you do not qualify for Medicare based on your own or your spouse's work record but are a U.S. citizen or have been a legal resident for at least five years, you can still get full Medicare benefits at age 65 or older by buying into them. This involves:

- **Paying premiums for Part A.** How much you pay for Part A depends on how long

you've worked. The longer you work, the more work credits you will earn. Work credits are based on your income; the amount of income it takes to earn a work credit changes each year. You can earn a maximum of 4 work credits annually. If you have fewer than 30 work credits, you pay the maximum. If you have 30 to 39 credits, you pay less, and if you continue working until you gain 40 credits, you will no longer have to pay premiums for Part A.

- **Paying the same monthly premiums for Part B** as other enrollees pay, with higher rates for people with higher incomes.
- **Paying the same monthly premium for Part D** prescription drug coverage as others enrolled in the drug plan you choose, with higher rates for higher incomes. Just as with Part B, you may be subject to an IRMAA if your income is above a certain level. If you must pay an IRMAA, you will pay your premium plus an additional charge.

If you are eligible for Medicare coverage, you are also eligible for the Medicare drug benefit (Part D). To enroll in Part D, you must be enrolled in Medicare Part A and/or Part B. **Regardless of income, health status, or prescription drug usage, everyone with Medicare can enroll in Part D prescription drug coverage.** Medicare drug coverage is only available through Medicare-approved private plans. If you have Medicare Part A and/or Part B and do not have other creditable drug coverage ("creditable" means the drug coverage you have is as good as what is offered by a Part D plan), you should enroll in a Part D plan, even if you do not currently take any prescription drugs. If you receive outpatient care, you will likely need prescribed medications.

SPECIAL RULES TO KEEP IN MIND

1

You can enroll in Medicare Part B without buying Part A, but if you buy Part A, you also must enroll in Part B.

2

You can enroll in Part D if you have either Medicare Part A or Part B.

3

You cannot enroll in a Medicare Advantage plan or buy a Medigap supplemental insurance policy unless you're enrolled in both Parts A and B.

MEDICARE PRESCRIPTION DRUG COVERAGE (PART D)

Medicare Part D is an optional prescription drug coverage available to everyone with Medicare. It can be obtained through two options- a Medicare drug plan or bundled with a Medicare Advantage Plan. Before selecting, it is important to consider factors such as formulary coverage (are your medications covered and if so at what cost), out-of-pocket costs, pharmacy options, and coverage phases. Once you choose a plan, you must stay in it until the next Open Enrollment period each year on October 15th.

Medicare Part D helps pay for prescription medications. It is optional, but even if you don't have any prescribed medications, it's a good idea to consider purchasing drug coverage.

Medicare Part D is available to everyone with Medicare, and the plans are managed by Medicare-approved private insurance companies. Each stand-alone plan has different costs and a list of covered drugs called a formulary. All plans must cover both brand name and generic drugs, but the specific drugs covered, and the cost structure may vary. **If you decide not to join a Medicare drug plan when you're first eligible, you may have to pay a penalty if you join later.**

You can get drug coverage through either a Medicare drug plan OR a Medicare Advantage plan:

- Medicare drug plans add drug coverage to Original Medicare. You must have Medicare Part A and/or Medicare Part B to join a separate Medicare drug plan.
- Medicare Advantage Plans (or other Medicare Health Plans) bundle all your coverage into one plan. It includes Part A, Part B, and drug coverage. However, not all Medicare Advantage Plans offer prescription drug benefits. If you choose a Medicare Advantage Plan, make sure to ask about drug coverage and review the formulary to see if your prescribed medicines are included before you enroll.

If you don't apply for drug coverage when you are first eligible, you can apply during the annual Open Enrollment Period which runs from October 15 to December 7.

Your coverage will start on January 1 of the following year. During this time, you can:

- Join a Medicare drug plan
- Switch from one Medicare drug plan to another Medicare drug plan
- Drop your Medicare drug coverage completely

If you want to join, leave, or switch plans outside of open enrollment, you may be able to if you:

- Move into a nursing home or skilled nursing facility
- Relocate out of your plan's coverage area
- Lose medication coverage (like if your employer benefits end)
- Have Medicaid (If you are enrolled in a Low-Income Subsidy program you can change plans 3 times a year)

- Want to switch to a plan with a higher star rating

Medicare rates Medicare Advantage and Part D plans by using a star ranking system. A 5-star rating is the best, while a 1-star rating is the worst. The rating is based on many factors, including plan participants' ratings, quality of care, and member complaints. Star ratings can be found at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare). You can use the ratings, along with considerations such as cost and coverage, to choose the right plan for you.

Part D plans must also cover most vaccines (except for just a few that are covered by Part B). Vaccines are free under Medicare, which means there should be no copay, coinsurance, or deductible charges.

MEDICATION QUESTIONS TO ASK DURING OPEN ENROLLMENT

- Are the medications I'm currently taking covered?
- How much will I pay monthly for my medications included in the formulary?
- How much will I pay monthly for my medications not included in the formulary?
- Can I choose my pharmacy?
- Is there a mail-order pharmacy option?
- What other out-of-pocket costs should I be aware of?
- Does the plan offer coverage in multiple states?

DRUG CATEGORY

A drug category is a group of drugs that treat the same symptoms or have similar effects on the body. All Part D plans must include at least two drugs from most categories and must cover all drugs available in the following categories:

- HIV/AIDS treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for seizure disorders
- Immunosuppressant drugs
- Anticancer drugs (unless covered by Part B)

Part D may cover insulin and medical supplies used to inject insulin (like syringes, gauze, and alcohol swabs), if your doctor gives you a prescription for these items and they are on the plan’s formulary. Part D-covered insulin copays are capped at \$35 per month with no deductible.

All plans are required to cover a wide range of brand-name and generic prescription drugs, including most drugs for conditions like cancer and HIV.

Each plan has its own list of covered medications called a “formulary,” and the covered drugs can vary. Plans often categorize drugs into different tiers on their formularies, with lower-tier drugs costing less than higher-tier drugs. Plans can make changes to their formularies after you enroll to keep up with new drugs or medical information.

Your Part D plan may also send you a denial (called a coverage determination) stating that your drug does not meet Food and

PART D PLAN RULES THAT LIMIT MEDICATION COVERAGE



PRIOR AUTHORIZATION

You and/or your prescriber (a doctor or other healthcare provider who is allowed to write prescriptions) must contact the drug plan before you can fill certain prescriptions. You may need to show that the drug is medically necessary for the plan to pay for the medication.



QUANTITY LIMITS

These indicate the maximum amount of medication you can get within a specific time period (e.g., per month).



STEP THERAPY

You may need to try lower-cost drugs before the plan covers a prescribed drug.

If you think these coverage rules shouldn’t apply in your situation, you can ask for an exception by working with your prescriber and completing the necessary forms.

Drug Administration (FDA) standards. The FDA is a federal agency responsible for protecting public health by ensuring medications, biological products, and medical devices are safe, effective, and secure. Drugs that are found to be less than effective by FDA's evaluation are excluded from coverage by Part D. If your doctor prescribes medication on your plan's formulary for a reason other than the use approved by the FDA (or listed in one of Medicare's three drug compendia, a kind of medical encyclopedia), your drug may not be covered.

If the medication your provider has prescribed is not on your drug formulary, you have a few options. You can work with your physician to ask for an exception or file an appeal, or you can pay out of pocket for the medication yourself.

You can request an exception to your health plan's coverage rules if:

- You need a drug that is not on your plan's formulary.
- You believe that a coverage rule, such as prior authorization, should be waived.
- You think you should pay less for a higher tier (more expensive) drug because you or your prescriber believes you can't take any of the lower tier (less expensive) drugs for the same condition.

Note: You cannot request a tiering exception for a drug on a specialty tier.

If your network pharmacy cannot fill a prescription, they will provide you with a notice that explains how to contact your Medicare drug plan to request an exception. This notice will include the contact information for your plan, as well as the specific steps you need to take to request an exception.

If the pharmacist does not provide you with this notice, you should ask to see it. You have the right to request an exception, and the pharmacist is required to provide you with the information you need to do so.



Over-the-counter medications that are usually not covered by Part D plans include:

- Vitamins, minerals, or supplements
- Any medications for cosmetic or weight loss purposes
- Medications used to treat cold or cough symptoms
- Most other non-prescription drugs



Medicare Part D Cost

The Inflation Reduction Act of 2022 transformed Medicare, mainly in the way Medicare pays for medications. The new benefit design simplifies prescription coverage. You will only have one coverage phase, and there is no longer a coverage gap. After paying your deductible (if applicable), you will pay for prescriptions until you reach your annual out-of-pocket limit of \$2,100 (for 2026). Additionally, the Medicare Prescription Payment Plan lets you spread out your Part D prescription costs over monthly payments instead of paying them all upfront. It's optional, so you need to opt in to the program. Anyone with Part D coverage can join at any time. This plan applies to Part D and Medicare Advantage plans with Part D benefits. When you join the program, you won't pay for prescriptions at the pharmacy. Your Part D plan will pay the pharmacy, and you'll receive monthly bills for your portion of the cost. This is called "smoothing" and helps you spread out your annual out-of-pocket costs up to \$2,100. All Medicare Part D drugs are included in the program. Your Part D plan can't exclude any covered medication.



The Medicare Prescription Payment Plan doesn't reduce your overall prescription costs. However, it can make it easier to manage these costs by spreading them out over monthly payments instead of paying them all at once.

Once you join the Payment Plan, all your out-of-pocket prescription costs will be billed monthly as long as you're enrolled. Beginning in 2026, you will be automatically re-enrolled the following year unless you opt out. If you decide to opt out, your request will be processed within three calendar days. If you don't pay your Part D plan's bills, you might be removed from the Payment Plan and owe the entire balance. But, you won't lose your Part D coverage. Your insurance company can't send you to collections or charge you fees for unpaid prescription costs. To rejoin the Payment Plan in the future, you'll need to pay off any outstanding balances. The Payment Plan can be helpful if you have high prescription costs and reach the \$2,100 out-of-pocket limit early in the year. If you already receive charity assistance for medications, this program might not be as beneficial. It's important to evaluate your annual medication costs and any outside assistance before deciding if the Payment Plan is right for you.

During the 2026 Open Enrollment period (and anytime after that), individuals with Part D or Medicare Advantage plans that cover prescriptions can enroll in the Medicare Prescription Payment Plan. Contact your Part D plan provider and follow the enrollment process to enroll. You or your authorized representative can submit an election request to join the program. You can submit this request by paper, phone, or online. Your Part D plan will process your enrollment request within 24 hours.

SHOULD I OPT IN? Medicare Prescription Payment Plan Case Studies



THERESA

Social History | Theresa is a 73-year-old retired accountant. She lives with her husband in a suburban community.

Financial Situation | Between Theresa's retirement and her husband's, as well as their Social Security, their annual income falls at 675% FPL. Theresa has Medicare benefits through Original Medicare and a Part D plan. She also holds Medigap coverage.

Medical History | Stage 2 Breast Cancer, Diabetes, Hypertension, and recently had a mastectomy.

Current Medications | Theresa is undergoing chemotherapy and has a complex regimen of medications including insulin. She also requires ongoing hormonal therapy to reduce the risk of recurrence.

SHOULD THERESA OPT IN?

Probably so.

Theresa's medications are expensive, and her out-of-pocket costs are likely to exceed the \$2,100 annual limit. However, her household income exceeds the eligibility criteria for most charitable assistance programs.

By opting into the Medicare Prescription Payment Plan, she can spread out these costs over the year, making them more manageable. This will help her avoid financial strain and ensure she can continue her necessary treatments without interruption.



ROGER

Social History | Roger is a 68-year-old widowed retiree living on a fixed income. He resides in a rural community.

Financial Situation | Roger's Social Security income puts him at 115% FPL, qualifying him for Low Income Subsidy. He has Original Medicare and Part D.

Medical History | Chronic Kidney Disease, Hypertension, and requires dialysis treatments.

Current Medications | Roger is on a complex regimen of medications to manage his CKD, including dialysis-related medications and medications to control blood pressure and other comorbidities.

SHOULD ROGER OPT IN?

Maybe not.

While the Medicare Prescription Payment Plan might seem beneficial at first glance, it's important to consider Roger's specific circumstances.

Given his low income and existing financial assistance, he may not benefit significantly from the plan. Additionally, the plan doesn't reduce the overall cost of his medications.



Applying for Part D

Once you choose a Medicare drug plan, you can apply for prescription drug coverage by:

- Applying on the Medicare plan finder or on the plan's website
- Completing a paper application form
- Calling the plan directly
- Calling 1-800-MEDICARE or the SHIP

When you join a Medicare drug plan, you need to provide your Medicare Number and the date your Part A and/or Part B coverage started. This information will be provided to you upon enrollment and is also printed on your Medicare card.

Before you decide on a Medicare drug plan:

- Read all the materials you get from your insurer or plan provider if you have (or are eligible for) other types of drug coverage (like an employer-provided plan)

- Compare your current coverage to Medicare drug coverage
- Ask questions about how Part D works with any other drug coverage you may have
- Choose if you want to have your monthly premium deducted from your Social Security or Railroad Retirement Board payment

It's important to choose a plan that works for your needs. Once you choose a plan, you must stay in it until the next Open Enrollment period, which starts on October 15, unless you meet a special situation (more on this on page 25).

MEDICARE PART A OR PART B DRUG COVERAGE

Medicare Part A pays for medications during a Medicare-covered hospital or skilled nursing facility stay, while Part B covers drugs administered by a healthcare provider in settings like doctor's offices or outpatient facilities. Part B also covers intravenous treatments, tube feeding, and certain drugs related to organ transplants. If you're unsure about coverage, consult your doctor or contact your drug plan for clarification.

Sometimes, instead of Medicare Part D, Medicare Part A or B may pay for a drug. Part A covers the medications you need during a Medicare-covered stay in a hospital or skilled nursing facility. Part B covers drugs you wouldn't usually give to yourself, such as those you receive at a doctor's office or hospital outpatient setting. These injectable and infused drugs are covered by Part B in most instances because they aren't usually self-administered. Part B also covers intravenous treatments, tube feeding, and certain drugs used for transplant or to prevent rejection of transplanted organs. If Medicare helped pay

for your organ transplant, Part B can cover the medications related to it. If you are under age 65, are living with a kidney transplant, and meet other criteria, you will be eligible for Medicare coverage of your immunosuppressive drugs for the life of your transplant. Additionally, Medicare Part B can help pay for certain oral cancer drugs if there is an injectable version of the same drug available.

If you are unsure about which part of Medicare covers your drugs, you can talk to your doctor or call your drug plan to ask.



MEDICARE SUPPLEMENT (MEDIGAP) POLICIES

Medicare Supplement (Medigap) policies are private insurance plans designed to help cover the out-of-pocket expenses that Original Medicare doesn't fully cover, such as deductibles, copayments, and coinsurance. Some states have different options, but in general, there are ten options labeled A, B, C, D, F, G, K, L, M and N. It's important to choose a Medigap plan that suits your current and future healthcare needs and your financial situation.

Medicare Parts A and B cover many services, but they do not cover everything. This means that many Medicare beneficiaries often struggle with paying out-of-pocket expenses such as deductibles, copayments, and coinsurance. To help reduce these out-of-pocket expenses, you can choose to buy a Medicare Supplement policy, also known as Medigap.

Private companies sell Medigap plans, but they are required to follow rules set by the federal government to protect you. If you have Original Medicare, you can buy a Medigap plan, but if you have a Medicare Advantage Plan, this option is not available because the benefits offered by Medigap are already included in your Medicare Advantage Plan. Medigap policies cannot pay for your Medicare Advantage deductibles, copayments, or coinsurance.

When selecting a plan, you should consider which benefit(s) you need now, what you might need in the future, and what your income will be in the future. Then, use that information to select the policy that suits your needs best.

During your Initial Enrollment Period, you are protected by "guaranteed issue rights" which require Medigap insurance providers to sell you a plan without restrictions or increasing the premium rates based on pre-existing health conditions. Guaranteed issue rights only apply when you first enroll in a Medigap plan, during the following times:

- Within 6 months of enrollment in Medicare Part B if you're 65 or older
- You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) that pays after Medicare pays and that plan is ending

After your Medigap Open Enrollment Period ends, you may not be able to buy a policy. If you're able to buy one or want to switch policies later, it may cost more. Because of this, it is in your best interest to purchase a Medigap policy when you are first eligible.



- Within 12 months of disenrolling from a Medicare Advantage plan if you enrolled in a Medicare Advantage plan when first eligible for Medicare
- If your Medicare Advantage plan is no longer being offered in your area
- If you moved out of the Medicare Advantage plan area

Medigap policies offer the same basic benefits regardless of the insurance company, but costs can vary. There are ten options labeled A, B, C, D, F, G, K, L, M, and N. These letters have nothing to do with the Medicare program you choose. Some plans may not accept new enrollees, and some states like Massachusetts, Minnesota, and Wisconsin have different plan options.



If you're under 65, you may not be able to buy a Medigap policy, or you may have to pay more because the federal government does not require companies to sell Medigap policies to people under 65.

You should check with your State Department of Insurance to find out your rights.



Buying a Medigap policy is voluntary, and you are responsible for paying the premium, which is in addition to the monthly Part B premium that you pay to Medicare. As long as you keep paying your Medigap policy and Part B premium, you can keep your policy even if you have health problems.

SELECTING THE BEST MEDICARE OPTION FOR YOU

When selecting the best Medicare option for you, take time to make an informed decision. Consider factors such as the plan's costs, your medical needs, your prescribed drugs, and coverage for your providers. For Medicare Advantage Plans, be aware of the out-of-pocket costs, network restrictions, and prescription drug coverage. Utilize resources like the [Medicare.gov Plan Compare tool](#) to compare different plans and their coverage in your area.

Here are some tips to consider when looking at a plan and deciding what is right for you:

- Make sure you understand the costs of the plan, including premiums, deductibles, and other out-of-pocket costs.
- Ensure that the plan covers the specific services you need. While all Medicare plans cover services provided by Original Medicare, some plans such as a Medicare Advantage Plan may offer additional benefits that you may need.
- Verify that your chosen plan is accepted by your current providers and/or facilities. If you choose Original Medicare, you can go to any provider or facility that accepts Medicare. However, if you choose an Advantage plan, you will have a network of providers to choose from. Networks consist of providers who have contracted with your plan to provide services. Sometimes, you may also have out-of-network benefits that allow you to receive services from a provider or facility not contracted with your plan, but it will likely cost you more than staying in-network.
- Check the plan's drug formulary to see if it covers your current prescriptions. Drug formularies can vary by plan, but all plans must offer a standard level of coverage set by Medicare.
- Take the necessary time to choose your Medicare plan and understand the available options. Understanding which plan fits your health needs and the associated costs is important when making your decision.

Considerations for Medicare Advantage Plans

Medicare Advantage out-of-pocket costs—including your monthly premium—vary. Advantage Plans place a limit on the amount you must pay each year. Once you reach this limit, in-network services will be covered completely (100%). Your out-of-pocket costs may be lower with an Advantage Plan compared to Original Medicare. The type of Advantage plan you choose can also affect how you get healthcare. You may need referrals to see specialists, or you may need to use specific providers or facilities that are part of the plan's network.

Most, but not all Medicare Advantage Plans include prescription drug coverage. If you are enrolled in an Advantage Plan without prescription drug coverage, you can enroll in a separate Part D Plan. **Be aware, if you enroll in a separate Part D Plan while you have prescription drug coverage through your Advantage plan, you will be disenrolled and placed back into Original Medicare.**

If you frequently travel or live in different locations throughout the year, you should carefully consider the potential coverage limitations of a Medicare Advantage plan before enrolling. These plans have a more limited network of providers than Original Medicare, so you may not be able to get the care you need if you are outside of your plan’s service area. If you do need to see a doctor

Check the Boxes for Features That Matter Most to You

ORIGINAL MEDICARE	FEATURES	MEDICARE ADVANTAGE
No ☐	Require Pre-approval for Services?	☐ Yes
Most providers accept Medicare across the US ☐	Participating Providers	☐ Have a smaller network of providers
No out-of-pocket cap ☐	Limits on Costs	☐ Has a maximum out-of-pocket cap which may vary depending on the plan, county, and year
No coverage for benefits like eye exams, most dental care, and hearing aids ☐	Extra Benefits	☐ May offer extra benefits like vision, hearing, and dental services

Expected Premiums and OOP Costs

Total premiums for Original Medicare and Medicare Advantage plans can be very similar. If a plan’s monthly premiums are low, its deductible or copayments may be higher. Out-of-pocket costs can vary considerably across plans.

while traveling, you may have to pay more out of pocket.

Comparing Plans

To find what plan may be best for you, you can compare different Medicare plans and

the coverage they offer in your area. You can do this using the [Medicare.gov Plan Compare tool](#). This is a great tool that lets you search for plans, check the providers they include, and see the list of drugs they cover. You can also use the chart below to compare options.

MEDICARE PARTS AND COVERAGE

	MEDICARE PART A	MEDICARE PART B	MEDICARE PART C Advantage Plan	MEDICARE PART D Must Have Part A OR B to Enroll	MEDIGAP Must Have Part A AND B to Enroll
Hospital Stays	✓	✗	✓	✗	✗
Home Healthcare	✓	✗	✓	✗	✗
Hospice Care	✓	✗	✓	✗	✗
Outpatient Care	✗	✓	✓	✗	✗
Doctor's Visits & Tests	✗	✓	✓	✗	✗
Mental Healthcare	✗	✓	✓	✗	✗
Medical Equipment & Supplies	✗	✓	✓	✗	✗
Vision, Hearing & Dental	✗	✗	✓	✗	✗
Transportation	✗	✗	✓	✗	✗
Over-the-Counter Drugs	✗	✗	✓	✗	✗
Health & Wellness Services	✗	✗	✓	✗	✗
Prescription Drug	✗	✗	varies	✓	✗
Copayment & Deductible	✗	✗	✗	✗	✓

ENROLLMENT PERIODS

Medicare enrollment periods include an Initial Enrollment Period, Annual Open Enrollment, General Enrollment Period, and Special Enrollment Periods. It's important to understand each period's specific dates and conditions to ensure timely enrollment and avoid potential late enrollment penalties.

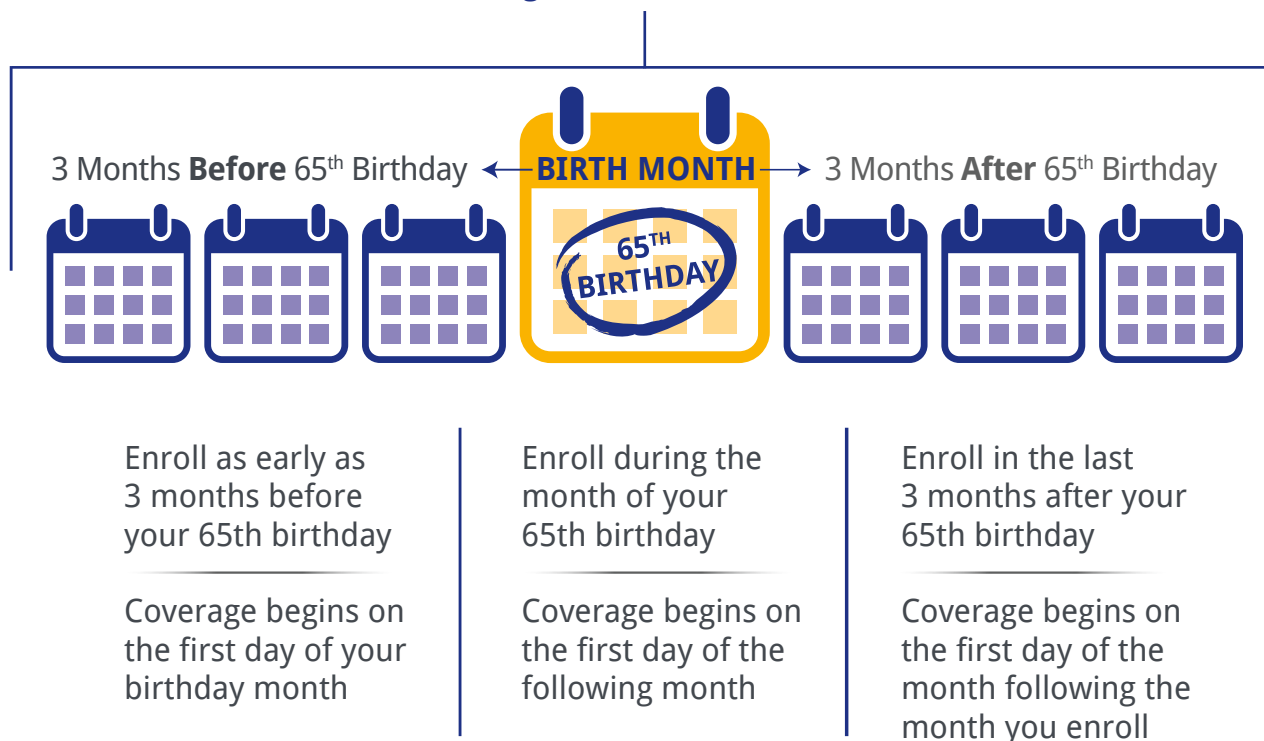
Initial Enrollment

When you first become eligible for Medicare, you can sign up for Part A and/or Part B during a 7-month Initial Enrollment Period (IEP). The IEP begins 3 months before you turn 65 and ends 3 months after you turn 65. During this time, you can choose to enroll in Original Medicare with or without Part D or a Medicare Advantage plan. If you are under age 65 and newly eligible for Medicare due to a disability, you also have a 7-month IEP to select your

Medicare coverage. This initial enrollment begins 3 months before the 25th month of receiving Social Security Disability or Railroad Benefits and ends 3 months after your 25th month of receiving benefits.

If you sign up for Medicare in the first 3 months of your eligibility, your coverage will start on the first day of the month you turn 65. If you sign up during the month you turn 65, your coverage begins on the first day of the following month. If you enroll in Medicare

7-Month Long Initial Election Period (IEP)





during the last three months of your Initial Enrollment Period, your Medicare coverage will start the first day of the month following the month you enroll.

If you enrolled in a Medicare Advantage plan during your IEP, you have the option to switch to another Medicare Advantage plan (with or without drug coverage) or switch back to Original Medicare (with or without a drug plan) within the first 3 months of having Medicare Part A and Part B.

Annual Open Enrollment

Medicare's Open Enrollment period takes place from October 15 to December 7. During this time, you can make changes to your Medicare coverage. This is a good opportunity to review your current plan to see if there is a better option for you, especially if your health needs have changed over the past year. Any changes you make to your Medicare coverage during this enrollment period will go into effect on January 1 of the following year.

During this enrollment period, you can:

- Switch from Original Medicare to an Advantage Plan
- Switch back to Original Medicare from an Advantage Plan
- Change your Medicare Advantage Plan to a different Advantage Plan
- Join, change, or drop your Part D Plan

General Enrollment Period

This annual Open Enrollment runs from January 1 to March 31. During this time, you can sign up for Medicare Part A and/or Part B, only if you didn't sign up when you were first eligible and if you're not eligible for a Special Enrollment Period.

Medicare Advantage Open Enrollment Period

A yearly Open Enrollment Period takes place from January 1 to March 31 only if you are in a Medicare Advantage Plan. Your Medicare coverage will start on the first day of the month after you sign up.

If you are in a Medicare Advantage Plan you can:

- Switch to a different Medicare Advantage Plan
- Switch to Original Medicare and join a Part D Plan

During this enrollment period, you are unable to switch from Original Medicare to a Medicare Advantage Plan or join or

switch your Medicare Drug Plan if you are in Original Medicare.

Special Enrollment Periods

Special circumstances may allow you to enroll in Medicare under a Special Enrollment Period (SEP). If you did not join Medicare Part A and/or B during your initial enrollment because you had employer-based coverage through yourself or your spouse's employer, you will qualify for a SEP when you decide to enroll in Part A and/or Part B.

You can use your SEP to enroll in Original Medicare at any time while you're covered under employer-based insurance or during the 8-month enrollment period that you have after your employer-based coverage ends.

If you do not enroll during this 8-month Special Enrollment Period, your next chance to enroll will be during the next General Enrollment Period.

You may be eligible for a SEP for other reasons, such as a recent move, and will be able to switch to a new Medicare Advantage Plan or Prescription Drug Plan.

The timeframe for the SEP and the effective date of your new coverage will vary depending on the circumstances that qualified you for a SEP. If you decide not to enroll in Medicare during your Initial Enrollment Period and do not meet any of the certain conditions for a SEP, you may have to pay a Late Enrollment Penalty.

OTHER CIRCUMSTANCES FOR A SEP

- Losing your current health insurance coverage (including Medicaid)
- You choose to leave your employer-sponsored or union plan (including COBRA)
- Your current plan changes its contract with Medicare
- You receive a notice of error from Medicare for your plan
- A government-declared disaster or emergency
- Your employer or group health plan made an error or misrepresented your coverage
- You were formerly incarcerated and missed your Initial Enrollment Period, or you were enrolled in Medicare before you were incarcerated and stopped paying premiums

Plus others, found here: www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods

Late Enrollment Penalties

Part A Late Enrollment Penalty

If you need to purchase Medicare Part A because you do not qualify for a premium-free plan or did not enroll during your Initial Enrollment Period, your monthly premium may increase by 10% for double the number of years you didn't have Part A.



EXAMPLE: If you could have had Part A coverage for three years but did not enroll (and did not qualify for a SEP), you will pay 10% more than the usual cost, each year for a total of six years.

Part B Late Enrollment Penalty

If you did not enroll in Medicare Part B during your Initial Enrollment Period, your penalty will increase by 10% for each full year you continue without Part B coverage. This penalty will last for as long as you have Medicare Part B.



EXAMPLE: If you could have had Part B coverage for three years but did not enroll (and did not qualify for a SEP) you will pay an extra 30% fee when you do sign up, for as long as you are enrolled.

Part D Late Enrollment Penalty

If you go 63 days or more after your Initial Enrollment Period without Part D or other creditable drug coverage (like a prescription plan through your employer or a spouse's employer), you will be penalized for late enrollment. The Late Enrollment Penalty dollar amount will depend on how long you go without Part D or other drug coverage and will usually last for as long as you have Medicare drug coverage. The penalty amount is 1% of the national average of the premium for Part D plans (called the national beneficiary base premium) times the number of full, uncovered months you did not have Part D or other creditable drug coverage. The monthly premium is rounded to the nearest \$.10 and added to your monthly Part D premium. The national beneficiary base premium can change by year, which will affect the penalty amount you pay.



EXAMPLE: In 2023, if you were eligible for Medicare but waited three years to join a Medicare drug plan (and did not have other drug coverage) you would pay an additional 36% penalty for your plan's monthly premium.

APPLYING FOR MEDICARE

When applying for Medicare, if you're already receiving Social Security or Railroad Retirement Board benefits, you're automatically enrolled in Part A. If you're not receiving benefits, you need to sign up for Medicare Part A and B through the [SSA.gov](https://www.ssa.gov) website or by contacting Social Security. Coverage begins based on when you sign up, with Part A starting the month you turn 65 and Part B based on your enrollment month. After the Initial Enrollment Period, you can sign up during the General or Special Enrollment Period. Additionally, you can choose to enroll in Part D, a Medigap policy, or a Medicare Advantage Plan simultaneously.

When you apply for retirement or disability benefits from Social Security or the Railroad Retirement Board, that counts as your application for Medicare. Once you get approved for Social Security or Railroad Retirement Board benefits, you're automatically enrolled in Part A coverage (without having to pay a premium for it) when you're eligible for Medicare.

If you're receiving benefits from Social Security (or the Railroad Retirement Board) at least four months before you turn 65, you'll

automatically get Part A coverage. You'll also be enrolled in Part B. However, because you pay a monthly premium for Part B coverage, you can choose to drop those benefits.

If you're not already receiving or ready to apply for Social Security benefits, you need to sign up for Medicare Part A and B through the [SSA.gov](https://www.ssa.gov) website. You need to enroll in Part D at the [Medicare.gov](https://www.medicare.gov) site. By default, you'll be enrolled in Medicare Part A and B unless you choose differently. You may have other insurance that offers coverage for the

HOW TO APPLY FOR MEDICARE



- Apply online at www.ssa.gov/medicare/sign-up



- Visit your local Social Security office (you can find the office locator at www.ssa.gov/locator)



- Call Social Security at (800) 772-1213
- If you or your spouse worked for a railroad, call the Railroad Retirement Board at (877) 772-5772 to apply

medical services covered under Part B. You can also choose to enroll in a Part D plan, Medigap policy, or a Medicare Advantage Plan at this time.

If you are within three months of turning 65 or older and not ready to start your monthly Social Security benefits, you can use the online retirement application to sign up for Medicare only and apply for retirement or spouse's benefits later.

If you are already enrolled in Medicare Part A and need to enroll in Part B, you'll need to [complete Form CMS-40B \(found at cms.gov\)](#) and mail or fax it to your local Social Security office. You can also call Social Security at (800) 772-1213 or contact your local Social Security office for help. It's a good idea to check the status of your Medicare

application on your online account, by phone, or by visiting your local Social Security Administration office.

If you want to request a Special Enrollment Period, you'll need to [complete Form CMS-10797 \(found at cms.gov\)](#) and send it to your local Social Security office by mail or fax. You can check on your Medicare application on your online account, by phone, or by visiting your local Social Security Administration office.

It usually takes four to eight weeks for your Medicare application to be approved, so if you want to have Medicare coverage by the time you turn 65, you will have to complete and send your application at least two months before your birthday.

YOU MAY CHOOSE TO UTILIZE A LICENSED AGENT OR BROKER TO HELP YOU ENROLL IN YOUR CHOICE OF MEDICARE COVERAGE.

If so, here are some questions to ask them about your enrollment and coverage:

- When do I need to start Medicare enrollment to avoid penalties or delays in coverage?
- Will I still be covered if I travel outside of the state?
- If I am not happy with the coverage, can I get out of it?
- Are any new benefits available in my area?
- Am I eligible for any programs to help me lower my healthcare costs?
- What will my total costs be for the upcoming year?

USING YOUR MEDICARE COVERAGE

Know your coverage start date which depends on when you signed up. Once you sign up for Medicare, you will receive a Medicare card with your welcome packet. If you elected Part D, a Medicare Supplement or Medicare Advantage, you will receive separate insurance cards for those coverages. You will next check if your provider accepts Medicare (or Advantage plan if applicable) and be aware of services covered vs. not covered. If applicable, also coordinate benefits with other health coverage you may have as there are rules that decide which one pays first. Be sure to tell providers about all medical and drug insurance plans you have to ensure your bills are paid in the correct order.

Coverage always starts on the first day of the month, but which month depends on when you signed up:

INITIAL ENROLLMENT PERIOD

If you qualify for premium-free Part A, your Part A coverage starts the month you turn 65. If your birthday is on the first of the month, coverage starts the month before you turn 65. Part B coverage starts based on the month you sign up.

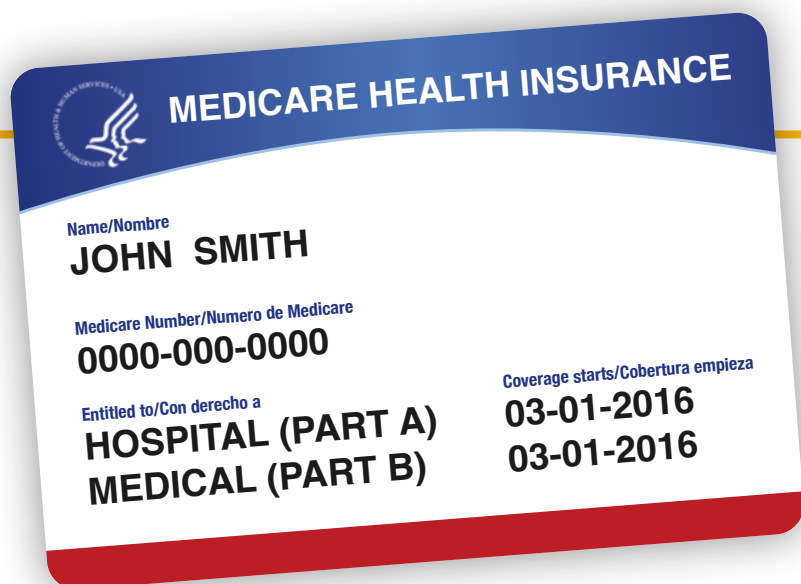
After your Initial Enrollment Period ends, you can only sign up for Part B and Part A (with a premium) during one of the other enrollment periods.

GENERAL ENROLLMENT PERIOD

If you sign up between January 1 and March 31 General Enrollment Period, your coverage starts the month after you sign up.

SPECIAL ENROLLMENT PERIOD

If you qualify for a special enrollment period, coverage normally starts the month after you sign up. To find out more about your particular situation, visit www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods



Once you're signed up for Medicare, your Medicare card will be mailed to you in your welcome packet. You can also log into (or create) your secure Medicare account to print your official Medicare card. Your card has a unique Medicare Number, which is different from your Social Security Number, to protect your identity.

The card is often referred to as your Red, White and Blue card and shows:

- You have Medicare Part A (listed as HOSPITAL), Part B (listed as MEDICAL), or both
- The date your coverage begins

HOW TO USE YOUR CARD IF YOU HAVE ORIGINAL MEDICARE

- Carry your Medicare card with you
- Show your Medicare card to your doctor, treatment facility, or healthcare provider when you receive care
- If you have Medicare Part D or other supplemental coverage, carry that plan card with you as well

HOW TO USE YOUR CARD IF YOU HAVE MEDICARE ADVANTAGE

- Use your Medicare Advantage plan card to get your services, not your Medicare card
- Keep your Medicare card safe at home in case you want to switch plans or change back to Original Medicare later

When you have Original Medicare, you do not need to choose a primary care provider, and in most cases, you don't need a referral to see a specialist. However, you will need to double-check if your doctor or healthcare provider accepts Medicare before you receive treatment.

Medicare Provider Costs

If you have original Medicare, before you get services, ask your healthcare provider if they charge the Medicare-approved amount.

If they do, you won't be billed for more than the standard Medicare deductible and coinsurance (so you end up paying less out-of-pocket). If they don't, they can charge you

more than the amount Medicare approves for that service, and they may require you to pay the full cost at the time of service.

If you have a Medicare Advantage plan, call your plan to see if they have a network and check if your provider is in-network. Some plans allow you to use providers out-of-network, but it may cost you more out-of-pocket. Remember, you can always get emergency care and urgent care, even if the doctor or hospital isn't in-network, but let your Advantage Plan know as soon as possible if you have received those services.

If you have Part D, check with your plan to find out what pharmacies in your area are in-network. You will be able to look that up online or by calling the plan. In-network pharmacies are “preferred” and normally offer the lowest cost for drugs. There may be circumstances where it is cheaper to forego using your Part D to cover medications, but any amount you pay for non-covered drugs will not go toward your deductible. If you use an out-of-network pharmacy, you might have to pay the full cost.

Costs While in the Hospital

With Medicare Part A, you may have to pay a deductible for each benefit period when you stay in the hospital or receive mental healthcare as an in-patient. After you pay the deductible, you will have to pay a portion of the costs, called coinsurance. Your benefit period starts the day you are admitted as an in-patient and ends when you have not

received any in-patient care for 60 days in a row. If you stay in the hospital after a benefit period ends, a new benefit period will begin. There is no limit to the number of benefit periods you may have. When you are in-patient for more than 90 days, Medicare will pay for additional days called Lifetime Reserve days. You are given a total of 60 reserve days that can be used throughout your lifetime. When using reserve days, Medicare will pay all covered costs except for your daily coinsurance. If you need to be in the hospital longer than your benefit period and Lifetime Reserve days, you would be responsible for 100% of the costs unless you had additional benefits through Medigap or another insurance coverage.

For services approved by Medicare under Part B, you will usually have to pay a 20% coinsurance after you meet your yearly deductible.

There are some services that Medicare does not cover. If you need these services, you will have to pay for them out-of-pocket or have other insurance coverage that covers them.

To find out if the items, services, or tests you need are covered under Medicare, you can visit the website www.medicare.gov/coverage.

You can also talk to your provider's office to ask questions about Medicare coverage for recommended treatment. If your provider recommends a service or treatment that is usually covered by Medicare but your provider thinks it may not be covered in your case, you



Some services not covered by Medicare include:

- Long-term care/ custodial care
- Most dental care
- Dentures
- Eye exams to prescribe eyeglasses
- Cosmetic surgery
- Acupuncture
- Hearing aids
- Routine foot care

will be asked to sign a form called the **Advanced Beneficiary Notice of Coverage (ABN)**. The ABN explains that you may have to pay for the service if Medicare doesn't approve it.

Coordination of Benefits

If you have Medicare and other health or drug insurance, each one is called a "payer." When there are multiple payers, there are rules that decide which one pays first, called Coordination of Benefits (COB). The first payer pays what they owe (up to the limits of the coverage), and then sends the rest of the bill to the second payer. The second payer only pays if there are costs the first payer didn't cover, and they may not pay all of the uncovered costs. In some cases, there might even be a third payer.

If the first payer denies coverage, the second payer may or may not pay some part of the cost.

It's important to tell your doctor, hospital, and all other healthcare providers about all of your health or drug insurance. This will help make sure your bills go to the right payers in the right order.

If you are still working, to ensure your healthcare services get paid correctly, you need to know:

- Whether your job-based insurance will pay first or second and,
- If your job-based insurance pays after Medicare, you need to know if and how it will pay if you don't enroll in Part A and/or Part B. Most retiree and small employer plans (employers with 20 or fewer employees) require enrollment in Part A and Part B.



COORDINATION OF BENEFITS

How Coverage Works With Medicare A & B

I'M STILL WORKING AND...	RULES THAT DECIDE WHICH "PAYER" PAYS FIRST
My (or my spouse's) job has less than 20 employees	• Medicare pays for services first, and your job-based insurance pays second. • If you don't sign up for Part A and Part B, your job-based insurance might not cover the costs for services you get. • Ask your employer if you need to sign up for Part A and Part B when you are eligible.
My (or my spouse's) job has more than 20 employees	• Your job-based insurance pays first, and Medicare pays second. • If you don't have to pay a premium for Part A, you can choose to sign up when you are eligible (or anytime later). • You can wait until you stop working (or lose your health insurance, if that happens first) to sign up for Part B, and you won't pay a late enrollment penalty.
I (or my spouse) get money from my employer to buy my own health insurance OR I (or my spouse) am still working, but I don't have health insurance through that job.	• Medicare probably doesn't work with your insurance. • Once you sign up, Medicare pays first. • Some private insurance have rules that lower what they pay (or don't pay at all) for services you get if you're eligible for other coverage, like Medicare. • Ask your health insurance company if you need to sign up for Part A and Part B when you are eligible.



Medicare and TRICARE For Life

TRICARE is government-sponsored health insurance provided to active duty and retired military personnel and their dependents. There are several different TRICARE programs. TRICARE For Life (TFL) is a Medicare supplement program for TRICARE-eligible retirees and their dependents. It helps to pay for Medicare cost-sharing, such as deductibles, coinsurances, and copayments. TFL may

also pay for services that are not covered by Medicare, or when you have used up your Medicare benefits. The specific coverage and cost-sharing rules for TFL may vary depending on your circumstances. Generally, once you visit an authorized provider, your provider files your claim with Medicare. Medicare pays its portion and forwards the claim to TRICARE For Life who will then pay the provider directly for the TRICARE-covered services.

WHAT TO DO WHEN MEDICARE DENIES YOUR CARE: MEDICARE APPEALS

When facing a denial from Medicare, you may have the option to appeal the decision through a multi-level process. There are five levels of appeals with each level based on a specific dollar amount of the claim. The five levels include Redetermination, Reconsideration, Administrative Law Judge (ALJ) Hearing, Appeal to Medicare Appeal Council, and Appeal to the Federal District Court.

The appeals process works differently for each part of Medicare and depends on whether you are denied healthcare services, supplies, or prescription drugs. The State Health Insurance Assistance Program (SHIP) offers free services to help people with Medicare questions or concerns. We will discuss SHIP more in this guide on page 40.

What Can You Appeal Under Medicare?

- You can request a healthcare service, supply, item, or prescription drug that you think you should be able to get
- You can request payment for a healthcare service, supply, item, or prescription drug that you have already received
- You can request a change in the amount you have to pay for a healthcare service, supply, item, or prescription drug

You can ask for an expedited (faster) appeal decision for services received from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation, or hospice. The Beneficiary and Family-Centered Care Quality Improvement Organization (BF CC-QIO) conducts the review. [You can find the contact information for the QIO on Medicare.gov.](#)

What Cannot be Appealed?

You cannot appeal a service or item that is not considered a covered benefit under Medicare.

Medicare beneficiaries usually learn about denials on their Medicare Summary Notice (MSN). The MSN is an explanation of benefits over three months, so you will not receive a separate MSN for every service, test, or procedure. The MSN shows all the services or supplies that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and the maximum amount you may owe the provider. There are very few services requiring Prior Authorization in Original Medicare, so most appeals for Medicare Parts A and B take place after the service is provided.

The last page of the MSN gives you step-by-step directions on when, where, and how to file an appeal. To appeal, you need to explain the reason you are appealing the coverage, sign the form, and send it back with supporting documentation. This documentation usually includes health records provided by your doctor, a letter from their office detailing your medical history and why you need this treatment, and any peer-reviewed journal articles

supporting the need for this care
(your doctor can help with this too).

There are **5 Levels** of Medicare
Appeals: Redetermination,
Reconsideration, Administrative Law

Judge Hearing, Medicare Appeals
Council Review, and Federal District
Court Judicial Review.

Each level is based on a specific dollar
amount of the claim.

5 LEVELS OF MEDICARE APPEALS



1. Redetermination

The first level of appeal is called **Redetermination**. At this level, the Medicare Administrative Contractor (MAC) reviews the claim. You can formally request a redetermination of the coverage or payment decision by submitting a request verbally or in writing. The denial is based on information provided with the claim. Claims at this level can be any dollar amount. The appeal must be filed within 120 days (Original Medicare) and 60 days (Medicare Advantage or Part D plan) of receipt of the MSN.

If you want to appeal, contact the provider who submitted the claim to find out what information was included and if there is any additional information they can provide for the appeal (such as new test results or updated treatment results). All documentation submitted should support the reasoning that Medicare should cover the claim. A representative (for example, a friend, family member, social worker, or patient advocate) can complete the appeal on your behalf, but they need to submit an Appointment of Representative form.

2. Reconsideration

The second level of appeal is called **Reconsideration**. You can file a reconsideration if you don't agree with the decision made during the first-level appeal. If you have Original Medicare, your case will be reviewed by a Qualified Independent Contractor (QIC), and the

QIC should send a written response within 60 days of receiving your request.

If the case involves a Medicare Advantage plan and the denial was upheld after the level one review, the plan will automatically send the case for a level two review. This review will be completed by an Independent Review Entity (IRE) or Part C QIC if it applies to a Medicare Advantage or Part D drug plan denial. You can submit new information, but it must be done within ten days of being sent to level two.

Claims at this level can be of any dollar amount, and second-level appeals must be filed within 120 days (Original Medicare) and 60 days (Medicare Advantage or Part D plan) of receiving the MSN or IRE's decision. Instructions for filing will be provided in the Redetermination Notice.

3. Administrative Law Judge (ALJ) Hearing

The third level appeal is the **Administrative Law Judge (ALJ) Hearing** or attorney adjudicator. A request for an ALJ hearing can be filed with the Office of Medicare Hearings and Appeals (OMHA). If you decide to appeal at this level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal, but this is not required. At this level, the case is reviewed by an independent judge who reviews the facts of the appeal and listens to testimony before making an impartial decision. The hearings are done via phone



or video conference. You can be present at the hearing, but this is not required.

To request an ALJ hearing, you need to send the paperwork within 60 days of receiving the second-level appeal decision. Your claim must meet a certain minimum dollar amount as stated on the Medicare Reconsideration Notice. If you have more than one denial, you can combine the claims to meet the minimum dollar amount. However, be prepared for a long wait, as it can take a year or more to get a date for the ALJ Hearing.

4. Medicare Appeals Council Review

If you disagree with the decision made during the ALJ hearing, you can file an appeal (the fourth level) called a review by the **Medicare Appeals Council (The Council)**. To request this review, you need to submit the request within 60 days of receiving the third-level appeal decision. Your claim must meet a minimum dollar amount as stated on the ALJ Hearing notice. You can complete the "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal"

form OR write a request to the Appeals Council. If the Appeals Council does not make a decision in time, you can ask the Appeals Council to move your case to the fifth-level appeal. If you disagree with the Appeals Council's decision at the fourth level, you have 60 days after receiving the decision to request a hearing at the Federal District Court Judicial Review.

5. Federal District Court Judicial Review

A fifth-level appeal is called a **Federal District Court Judicial Review**. To be able to request a federal review, your case must meet a minimum dollar amount. To proceed, you must follow the instructions in the Medicare Appeals Council decision letter on how to file a complaint.

LEVEL OF APPEAL	DEADLINE TO FILE	DEADLINE FOR DECISION	DEADLINE FOR URGENT DECISION
Redetermination	60 days	7 days	72 hours
Reconsideration	60 days	7 days	72 hours
Administrative Law Judge (ALJ) Hearing	60 days	90 days	10 days
Appeal to Medicare Appeal Council	60 days	90 day	10 days
Appeal to Federal District Court	60 days	No decision deadline	N/A

RIGHTS AND PROTECTIONS WITH MEDICARE

There are many agencies in place to help people navigate Medicare benefits, and Medicare complaints, and ensure the quality of care as well as health and safety standards. The State Health Insurance Assistance Program (SHIP) provides free one-on-one assistance to help eligible individuals understand their Medicare coverage, evaluate benefits, explore plan options, offer guidance on Medicare rights, and help find financial support for prescription medications. Medicare Beneficiary Ombudsmen (MBO) work alongside SHIP to help with Medicare-related complaints, grievances, or appeals. Additionally, Beneficiary and Family-Centered Care Quality Improvement Organizations and State Survey Agencies oversee healthcare facilities, by handling quality of care complaints, and ensuring health and safety standards are met.

▶ The **State Health Insurance Assistance Program (SHIP)** offers free one-on-one help for people who are eligible for Medicare, along with their families and caregivers. SHIP counselors are experts who can help you understand your Medicare coverage.

SHIP counselors can do many things to assist you. They can help you figure out if you qualify for Medicare, help you evaluate your benefits, and explore different plan options during Medicare Open Enrollment periods. They can also help you find programs that provide financial support for prescription medications and other expenses. The counselors can give you guidance on Medicare coverage and

how it works with other benefits you may have. They will also make sure you know your rights as a Medicare beneficiary. You can find the SHIP office nearest you by visiting www.shiphelp.org.

▶ **Medicare Beneficiary Ombudsmen (MBO)** work with organizations like SHIP to help people with their Medicare-related concerns. The Ombudsman can help you if you have complaints or grievances with Medicare. They can help with appeals if Medicare has denied payment, and they can handle requests for information. If you have issues while joining or leaving a Medicare Advantage plan, you can reach out to

them too. Ombudsmen are vital to the Medicare system because they share information on trends and patterns (not personal information) with the Secretary of Health and Human Services, Congress, and other advocacy organizations to improve the quality of the care you receive through Medicare. The Ombudsman is there to help make sure your question or complaint gets resolved. If you can't resolve your concern with your plan, you can call Medicare and ask a representative to submit your complaint or question to the MBO.

When you contact the Medicare Ombudsman, you will likely talk with a representative who will listen to your concerns and provide you with information and support. It's a good idea to be prepared with any relevant information about your situation like medical bills or correspondence from your healthcare providers before your call. The representative may ask you questions to better understand your issue or complaint. Once the information is gathered, your case is assigned to a Medicare Ombudsman who will review your case and contact you to make a plan for resolving your issue or complaint.

► **Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIO)** handle complaints about the quality of care for people with Medicare. They also review appeals if you or your healthcare provider believe that your Medicare coverage is ending too soon while you are in the hospital or another healthcare setting. You can file a complaint if you are unhappy with a doctor, hospital, or other healthcare provider, or if you have concerns about the quality of care, durable medical equipment, or your Medicare plan. [To find the contact information for your local BFCC-QIO, you can visit: www.medicare.gov/contacts.](http://www.medicare.gov/contacts)

► **State Survey Agencies** oversee healthcare facilities that participate in Medicare and/or Medicaid. They inspect healthcare facilities and investigate complaints to ensure that they meet health and safety standards. If you have concerns about things like abuse, neglect, mistreatment, poor care, not enough staff, unsafe or unsanitary conditions, or dietary problems in a healthcare facility, you can contact the State Survey Agency. [To find the contact information for your State Survey Agency, you can visit this website: www.medicare.gov/contacts.](http://www.medicare.gov/contacts)

File a Complaint
If you would like to submit feedback about your Medicare health or prescription drug plan, you can visit **Medicare.gov** and select "File a complaint" under "Claims and Appeals."

ADDITIONAL MEDICARE PROGRAMS, PLANS, AND SAVINGS

Patients have access to a range of additional Medicare programs, plans, and savings options including Medicare Savings Programs, Extra Help for prescription costs, PACE (Program for the All-Inclusive Care for the Elderly), Medicare Cost Plans, Medicare Medical Savings Account Plans (MSA), Special Needs Plans (SNP), and Demonstration and Pilot Programs. These programs aim to offer individuals ways to access essential healthcare services while effectively managing expenses and/or direct assistance to help pay for premiums, copays, coinsurance, etc.

Extra Help

Extra Help (also known as Part D Low-Income Subsidy or LIS) is a Medicare program that helps people with limited income and assets pay for Medicare drug coverage (Part D) premiums and prescription costs. Some people qualify for Extra Help automatically, while others need to apply.

You will receive Extra Help automatically if you have Medicaid coverage, are enrolled in a Medicare Savings Program, or receive Supplemental Security Income (SSI) benefits from Social Security.

In most cases, to qualify for Extra Help, your income and resources must be below a certain limit. These limits are adjusted annually. The income limit is based on your previous year's income. If you qualify for Extra Help, Medicare will enroll you automatically in a Medicare drug plan (Part D), if you

don't already have one. The Part D Late Enrollment penalty is discontinued when you qualify for Extra Help.

This program is jointly administered by the Social Security Administration (SSA) and Medicare. [To apply, visit SSA.gov](https://www.ssa.gov) or contact your local Social Security office.

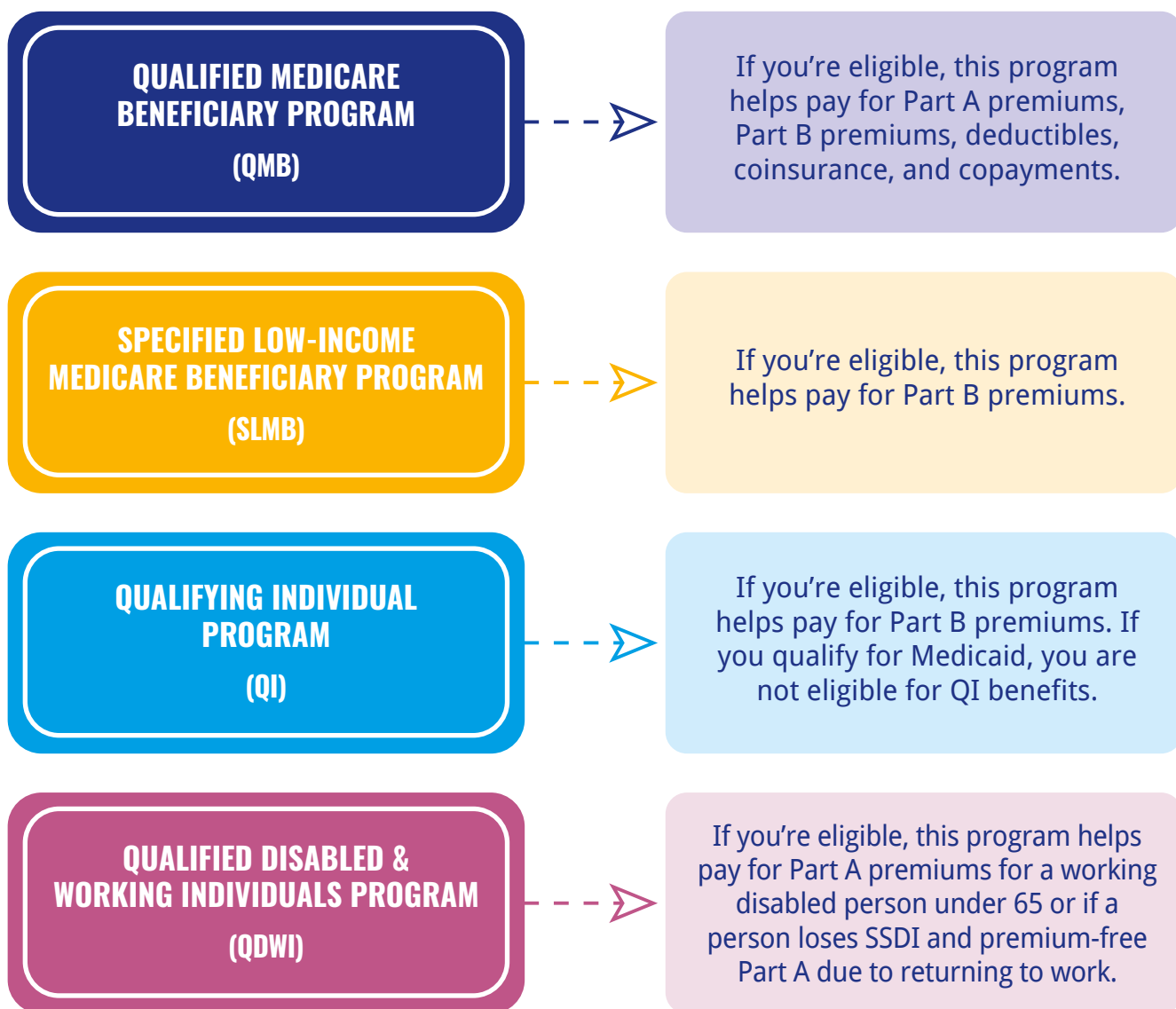
Medicare Savings Programs

Medicare Savings Programs (MSP) are federally funded programs administered by individual states. There are four types of Medicare Savings Programs. If you are eligible for these savings programs, they may help pay for Medicare premiums, deductibles, coinsurance, and copays. Eligibility is based on income and resources, and the income and resource limits for each program vary and can change each year. Resources that count toward these limits include money in your checking or savings

account, stocks, and bonds. Resources that do not count include your home, one car, burial plot, up to \$1,500 for burial expenses, furniture, and other household or personal items.

To apply for any of the Medicare Savings Programs, call your state Medicaid program. [You can find their contact information here: www.medicaid.gov/about-us/contact-us/index.html.](http://www.medicaid.gov/about-us/contact-us/index.html)

MEDICARE SAVINGS PROGRAMS & BENEFITS



PACE (Program for the All-Inclusive Care for the Elderly)

PACE is a joint Medicare and Medicaid program designed to help people meet their healthcare needs within the community instead of moving to a nursing home or other care facility. To qualify for PACE, you must be 55 or older, live in a PACE service area, require nursing home-level care, and be able to live in the community with support from PACE.

With PACE, you will have an all-inclusive healthcare team dedicated to ensuring that you receive coordinated care to maintain your well-being while living in the community. In most cases, you will be required to see a PACE-preferred doctor for your care. All Medicare and Medicaid services deemed necessary by your PACE team to improve and maintain your health are covered under PACE.

Some of the services PACE covers are:

- Adult day primary care (including doctor and nursing services)
- Dentistry
- Emergency services
- Home care
- Hospital care
- Laboratory/x-ray services
- Meals
- Nursing home care
- Nutritional counseling
- Occupational, physical, and recreational therapy
- Prescription drugs

- Social services including counseling, caregiver training, support groups, and respite care
- Transportation from your home to the PACE center for activities or medical appointments, if medically necessary
- Limited transportation to some medical appointments in the community

The cost of participating in PACE is determined based on your financial situation, but it is possible to pay for PACE privately. If you qualify for Medicaid, you will not have to pay a premium for the long-term care portion of the PACE benefit. There is no deductible or copayment for any medication, service, or care approved by your healthcare team. If you do not qualify for Medicaid but are enrolled in Medicare, you will be charged a monthly premium for the long-term care portion and a premium for Medicare Part D.

To apply for PACE, you can search for a PACE program in your area or contact your local Medicaid office.

Medicare MSA Plans

Medicare Medical Savings Account Plans (MSA) are a type of Medicare Advantage Plan that includes a high deductible along with a medical savings account. MSA plans are required to offer the same benefits, rights, and protections as Original Medicare, but may also provide additional benefits such as vision and hearing care. It is important to note that

MSA plans do not include Part D coverage, so you will need to purchase a separate prescription plan.

The medical savings account associated with your MSA plan is established with a bank selected by your plan. Medicare provides the plan with a specific amount of money each year for your healthcare costs and the plan deposits this money into the Medical Savings Account. The exact amount in your account depends on the plan you choose. The money in your account, along with any interest earned, is not subject to taxes if the money is used for healthcare costs. You have the option to transfer the money to another bank.

The money in your account can be used to help pay for your healthcare costs, including services that are not covered by Medicare such as dental or vision care. However, only money used for Medicare-approved covered services will count toward your deductible. If you use all the money within your account, you will be responsible for paying out-of-pocket for any additional costs until you meet your plan deductible. Any remaining money left over in your account at the end of the year will carry over and can be used for future healthcare expenses.

Enrolling in a Medicare MSA Plan is optional, and availability may vary by location. If you are interested in this type of plan, it's a good idea to contact Medicare to see if this is an option in your area.

Special Needs Plans

If you meet the qualifications for both Medicare and Medicaid, you are considered "Dual Eligible." Medicaid is a joint federal and state program that assists in covering healthcare costs for individuals and families with limited income and resources. If you are Dual Eligible, you have the option to choose Original Medicare with additional coverage through Medicaid. Medicaid will pay for some of the Medicare costs such as premiums, deductibles, and other out-of-pocket expenses.

There is another option available to you. As a Dual Eligible individual, you can enroll in a Special Needs Plan (SNP). A Dual Eligible Special Needs Plan (D-SNP) is a type of Medicare Advantage Plan offered through Medicare-approved private insurance companies, designed to streamline access to both Medicare and Medicaid benefits. These plans can vary based on location. They are particularly helpful for individuals who may require additional assistance due to income, disabilities, age, and/or health conditions. Eligibility criteria for SNP plans are determined by states, so it's important to check with your state before applying for a SNP. SNP plans include all the benefits of Original Medicare and must also provide prescription drug coverage. Many SNP plans offer extra benefits such as routine dental, vision, and hearing care. Another important benefit is care coordination to ensure you receive



appropriate healthcare services and information.

Other SNP plans for which you may qualify include:

- **Chronic Condition SNP (C-SNP)**

If you have one or more severe or disabling chronic conditions such as end-stage liver disease, dementia, chronic lung disorders, and more.

[You can find the complete list on Medicare.gov.](#)

- **Institutional SNP (I-SNP):** If you live in an institution like a nursing home or require nursing care at home.

Medicare Cost Plans

Medicare Cost plans are available in some states. Cost plans are similar to Medicare Advantage Plans. They are provided by Medicare-approved private insurance companies and offer at least the same benefits as Original Medicare. Cost plans provide more flexibility, allowing you to utilize Original Medicare for coverage when you require care outside of the plan's network. If you receive a service covered by Original Medicare outside the plan's network, you will be responsible for paying the Part A and Part B coinsurance and deductible.

You can enroll in a Medicare Cost plan even if you only have Part B. You can join a Medicare Cost plan whenever the plan is accepting new members, and you can disenroll at any time to

return to Original Medicare. If available, you can also have Medicare drug coverage from a Medicare Cost plan, or you can join a separate Medicare drug plan. [You can find out if a Medicare Cost plan is available in your area by using Medicare's Plan Compare feature: \[www.medicare.gov/plan-compare\]\(https://www.medicare.gov/plan-compare\).](#)

Demonstration and Pilot Programs

Demonstration and Pilot Programs are special programs or research studies designed to improve Medicare benefits, payments, and the quality of care. These programs are typically short-term and target specific groups of people in certain locations. Participating in a Medicare pilot program may grant you access to new benefits not currently provided by Medicare. However, this access is temporary and limited to the duration of the program. Additionally, even if a pilot program is available in your area, it does not automatically mean you are eligible to join. Your costs and benefits may differ under the pilot program compared to your usual Medicare coverage. Eligibility, location, and availability may vary between the Medicare Demonstration and Pilot Programs. [To learn about program availability and eligibility, contact Medicare or visit the dedicated hub on the CMS website at: <https://innovation.cms.gov>.](#)

A GLOSSARY OF TERMS

A glossary of key terms defines words associated with Medicare in an easy way so Medicare recipients can familiarize themselves or reference as they come across them through their healthcare journey using Medicare.

ABN (Advanced Beneficiary Notice of Noncoverage) | Is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare beneficiaries in situations where Medicare payment is expected to be denied.

BFCC-QIO (Beneficiary and Family Centered Care-Quality Improvement Organizations) | Help if you have a concern about the quality of care you receive from a Medicare provider.

CMS (Centers for Medicare and Medicaid Services) | Is the federal agency within the U.S. Department of Health and Human Services that administers the Medicare program.

COBRA | Temporary coverage available in certain situations if you lose job-based coverage.

Coinsurance | A portion of the medical cost you pay after your deductible has been met.

Copayment | A fixed amount you pay for a covered healthcare service after you've paid your deductible.

Custodial Care | Non-medical care that helps individuals with their activities of daily living (ADLs) such as bathing, dressing, and eating.

Creditable Coverage | Drug coverage that is expected to pay on average as much as the standard Medicare prescription drug coverage.

Deductible | The amount you pay for covered healthcare services before your insurance plan starts to pay.

Donut Hole | Most Medicare drug plans have a coverage gap or temporary limit on what the drug plan will cover for drugs.

Dual Eligible | Individuals who may be enrolled in both Medicare and Medicaid.

Extra Help | Sometimes called Part D Low Income Subsidy, a program sponsored by Social Security that lowers your Part D drug coverage costs. Depending on your situation, Extra Help will cover a portion of your drug costs or all your drug costs.

Formulary | A list of approved drugs covered by a prescription drug program.

HMO (Health Maintenance Organization) | A health insurance plan that provides health services through a network of doctors.

Inflation Reduction Act of 2022 | A law that improves Medicare by expanding available benefits, reducing medication costs, and keeping prescription drug premiums stable.

IRMAA (Income-Related Monthly Adjustment Amount) | An amount you may pay in addition to your Part B or Part D premium if your income is above a certain level.

Medicaid | A federal and state program that helps with healthcare costs for some people with limited income and resources.

Medicare | A federal health insurance for people 65 or older, some younger people with disabilities, and people with end-stage renal disease.

Medicare Advantage | Also called Part C. Alternative to Original Medicare. The Advantage Plans include Part A, Part B, and usually Part D in one plan and are offered by Medicare-approved private insurance companies. These plans must still follow Medicare's coverage rules.

MBO (Medicare Beneficiary Ombudsman) | Works on behalf of beneficiaries to help with Medicare-related complaints, grievances, appeals, and information requests.

Medicare Part A | Medicare Part A is hospital insurance, which is included in Original Medicare. It covers hospital stays, skilled nursing facility care, hospice, and some home healthcare.

Medicare Part B | Medicare Part B is another part of Original Medicare that covers outpatient care, certain doctor services and tests, home health services, durable medical equipment and supplies, preventive services, and certain outpatient prescription drugs under limited conditions.

Medicare Part C | Also called Medicare Advantage. Alternative to Original Medicare. The Advantage Plans include Part A, Part B, and usually Part D in one plan and are offered by Medicare-approved private insurance companies. These plans must still follow Medicare's coverage rules.

Medicare Part D | Provides coverage for prescription drugs. There are specific Medicare-approved plans that you can choose to enroll in for your prescription coverage.

Medicare Prescription Payment Plan | Program that lets you spread out your Part D prescription costs over monthly payments instead of paying them all up front.

Medigap Plan | Also called Medicare Supplemental Insurance. These plans help cover the remaining healthcare costs you have after Original Medicare pays its share. Your costs will include copayments, coinsurance, and deductibles. You must have Medicare Part A and B to enroll in a Medigap plan.

Medicare Savings Programs | Programs that may help pay Medicare premiums, deductibles, coinsurance, and copays. Eligibility is based on income and certain assets.

Network | Medical providers that have contracted with your plan to provide your care at a reduced negotiated rate. This group of providers is referred to as your network or your insurer's network.

Open Enrollment | A defined period each year when individuals may select their health insurance plan for the following plan year.

Original Medicare | Medicare Parts A and B.

PACE (Program of All-Inclusive Care for the Elderly) | A joint Medicare and Medicaid program intended to help people meet their healthcare needs in the community instead of being placed in a nursing home or other care facility.

PFFS (Private Fee-For-Service) | A type of Medicare Advantage Plan offered by a private insurance company that determines how much it will pay doctors, other healthcare providers, and hospitals, and how much you must pay when you get care.

PPO (Preferred Provider Organization) | A health insurance plan in which you can go out of network for care, but in-network providers cost less.

Premium | A fee you pay each month for health insurance coverage.

QDWI (Qualified Disabled and Working Individuals) | This savings program can help pay for Part A premiums for a working disabled person under 65 or if a person loses SSDI and premium-free Part A due to returning to work.

QI (Qualified Individual Program) | Helps pay for Part B premiums.

QMB (Qualified Medicare Beneficiary Program) | This savings program helps pay for Part A premiums, Part B premiums, deductibles, coinsurance, and copayments.

SEP (Special Enrollment Period) | A time outside annual open enrollment when you can enroll in a private health insurance plan if you qualify.

SHIP (State Health Insurance Assistance Program) | Provides free one-on-one assistance for Medicare-eligible persons and/or beneficiaries, their families, and caregivers.

SLMB (Specified Low-Income Medicare Beneficiary Program) | Savings program that can help pay for Part B premiums and may help you get reimbursed for Part B premiums paid during the previous calendar year.

SNP (Special Needs Plan) | Medicare Advantage Plans that limit membership to people with specific diseases/characteristics.

Tier | Medications on a formulary are grouped into tiers, and the tier your medication is on determines your portion of the drug cost.

TFL (TRICARE For Life) | A program for Medicare-eligible military retirees and their dependents that acts as a Medicare supplement.

MEDICARE RESOURCES

This Medicare resources guide provides a comprehensive list of financial assistance programs, local/national help organizations, health insurance-related resources, and contact information. These resources can connect patients with assistance for various needs, including copayment assistance, additional Medicare financial assistance, finding local and national help, understanding health insurance, and accessing relevant agencies and programs.

FINANCIAL ASSISTANCE RESOURCES

Copayment Assistance Programs

Accessia Health

(Formerly Patient Services Incorporated, PSI)

Phone: 800-366-7741

Apply Online: www.accessiahealth.org

Blood Cancer United Co-Pay Assistance Program

(Formerly Leukemia Lymphoma Society)

Phone: 877-557-2672

Apply Online: www.bloodcancerunited.org/financial-assistance/co-pay-assistance-program

CancerCare Co-Payment Assistance Foundation

Phone: 866-552-6729

Apply Online: www.cancercare.org/copayfoundation

Good Days

Phone: 877-968-7233

Apply Online: www.mygooddays.org

HealthWell Foundation

Phone: 800-675-8416

Apply Online: www.healthwellfoundation.org

National Organization for Rare Disorders (NORD)

Phone: Telephone numbers vary by program

Apply Online: Application formats vary, for more information visit www.rarediseases.org/patient-assistance-programs

PAF Co-Pay Relief

Phone: 866-512-3861

Apply Online: www.copays.org

Patient Access Network Foundation (PAN Foundation)

Phone: 866-316-7263

Apply Online: www.panfoundation.org

The Assistance Fund (TAF)

Phone: Phone numbers vary by disease fund

Apply Online: www.taftcares.org

Additional Medicare Financial Programs

Extra Help with Medicare Part D Costs

Phone: 800-772-1213

Website: www.ssa.gov/medicare/part-d-extra-help

Medicare Savings Programs

Find your state's program here:
www.medicaid.gov/about-us/beneficiary-resources/index.html#statemenu

Website: www.medicare.gov/medicare-savings-programs

LOCAL AND NATIONAL HELP

American Association of Retired People (AARP)

Phone: 888-687-2277
Website: www.aarp.org

Area Agencies on Aging (AAA)

Phone: 800-677-1116
Website: www.eldercare.acl.gov/home

Community Action Agency

Phone: 202-265-7546
Website: www.communityaction-partnership.com

Department of Veterans Affairs

If you're a veteran or have served in the United States Military

Phone: 800-698-2411 | TTY: 711
Website: www.va.gov

Medpac.gov

A nonpartisan independent legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program

Website: www.medpac.gov

National Council on Aging

Resources and information about Medicare

Website: www.ncoa.org

Salvation Army

Phone: 800-725-2769
Website: www.salvationarmyusa.org

Senior Centers Online Directory

Website: www.seniorcenters.com

U.S. Administration on Community Living

Phone: 202-401-4634
Website: www.acl.gov

United Way

Phone: Dial 2-1-1 from your service area
Website: www.211.org

U.S. Social Security Administration

Phone: 800-772-1213
Website: www.ssa.gov

HEALTH INSURANCE-RELATED RESOURCES

Centers for Medicare & Medicaid

Phone: 800-633-4227
Website: www.cms.gov

Medicare.gov

Phone: 1-800-MEDICARE (1-800-633-4227)
Website: www.Medicare.gov

Medicare Ombudsman

Call if you have a Medicare complaint or concern

Phone: 800-633-4227 | TTY: 877-486-2048
Website: www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home

National Association of Insurance Commissioners

Call for questions regarding Medigap plans

Phone: 816-842-3600
Website: www.naic.org

Office of Personnel Management

Get information about the Federal Employee Health Benefits Program for current and retired federal employees

Phone: 202-606-1234
Website: www.opm.gov/healthcare-insurance

Railroad Retirement Board (RRB)

If you have benefits from the RRB, call them to change your address or name, check eligibility, enroll in Medicare, replace your Medicare card, or report a death

Phone: 877-772-5772
Website: www.rrb.gov/Benefits

State Health Insurance Assistance Program

Call if you need help with enrollment, understanding your benefits, or filing an appeal

Phone: 877-839-2675

TRICARE For Life (TFL)

Call if you have questions about how your TRICARE coverage works with Medicare

Phone: 1-866-773-0404
Website: www.tricare.mil/tfl

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NOTES



 patientadvocate.org

 (800) 532-5274

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