A Clear View to Medicare

Making the Most of Your Benefits

Patient Advocate Foundation
Solving Insurance and Healthcare Access Problems | since 1996

A CLEAR GUIDE TO MEDICARE... Making The Most of Your Benefits

Patient Advocate Foundation (PAF) is a 501c3 non-profit patient services organization whose mission is to eliminate obstacles for patients trying to access quality healthcare. PAF seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability relative to their diagnosis of a chronic, life threatening or debilitating condition.

It is through our experiences that we are aware that there are many decisions to make when you become eligible for Medicare coverage that can create a great deal of confusion. It can be overwhelming, and we want to help you understand all of the basic information surrounding Medicare and ensure that you have coverage to protect you for the years ahead. This publication has been created to explain what Medicare covers, as well as to provide some things to consider while you are deciding which coverage to select. We have included some of the frequently asked questions that we receive. We believe in empowering you to advocate for yourself as you navigate through the Medicare system.

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Chapter 1: Medicare A & B

What is Medicare and when am I eligible?

Medicare is a national health insurance program that is administered by the federal government. It was originally designed for people age 65 or older who are citizens or permanent residents of the United States. Generally, to be eligible you must have worked for a minimum of 10 years and paid Social Security taxes. Medicare coverage has been expanded through the years which will be discussed in the following chapters.

Medicare provides basic coverage for the cost of healthcare, but it does not cover all medical expenses or the cost of most long-term care. In addition to the monthly premiums for Medicare, you are responsible for other "out-of-pocket" costs for medical care. Out-of-pocket expenses are the amounts you must pay when you receive care and includes deductibles and co-insurance.

You are eligible for Medicare Part A if you:

- are 65 or older
- receive or are eligible to receive Social Security benefits; or
- receive or are eligible to receive railroad retirement benefits; or
- You or your spouse (living or deceased, including divorced spouses if not remarried) worked long enough in a job where Medicare taxes also known as FICA (Federal Income Contribution Act) were paid; or
- are unable to work for at least 12 months, and are considered disabled by Social Security Administration (SSA) and have received Social Security Disability benefits (SSDI) for **24 months**

Congress expanded Medicare coverage for individuals who have been diagnosed with certain medical conditions and have been determined to be disabled by the Social Security Administration (SSA). Guidelines and eligibility for for each diagnosis vary, but include:

- Individuals of any age diagnosed with End-Stage Renal Disease (ERSD) who are receiving dialysis and are eligible for Social Security benefits. Medicare coverage will begin based on where the dialysis is being received:
    - Home self dialysis: Coverage begins the first month of dialysis treatment **IF** you complete a self dialysis home training program at a Medicare approved site (or you expect to complete).
    - In a Medicare approved facility: Coverage will begin the first day of the fourth month of dialysis.

Or

- The month you receive a kidney transplant (special guidelines apply, call 1-800-MEDICARE (800-633-4227) for additional information).
- If you are diagnosed with Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease, Medicare will begin the 1st day of the month following being deemed disabled.

There are a couple conditions that you need to be aware of during initial enrollment into Medicare Part A.

- You are eligible for Medicare Part A and TRICARE (insurance coverage for active duty military or retirees and their families), you must have Part B benefits to maintain your TRICARE coverage. Your TRICARE will now be called TRICARE for Life (TFL).
- You are 65, and still working and have not begun to collect Social Security benefits, you need to sign up for Medicare at your local Social Security office or you can enroll online at www.socialsecurity.gov or www.ssa.gov.

Enrolling in Medicare Part A:

There are a number of ways to enroll in Medicare. Prior to becoming eligible for Medicare the Social Security Administration will mail you a “Medicare and You” handbook that explains important enrollment information. If you have specific questions and prefer to speak to a Social Security Administration representative you can call them directly at: 1-800-772-1213 (TTY 1-800-325-0778).

For general information about enrolling you can visit the Medicare website at www.medicare.gov.

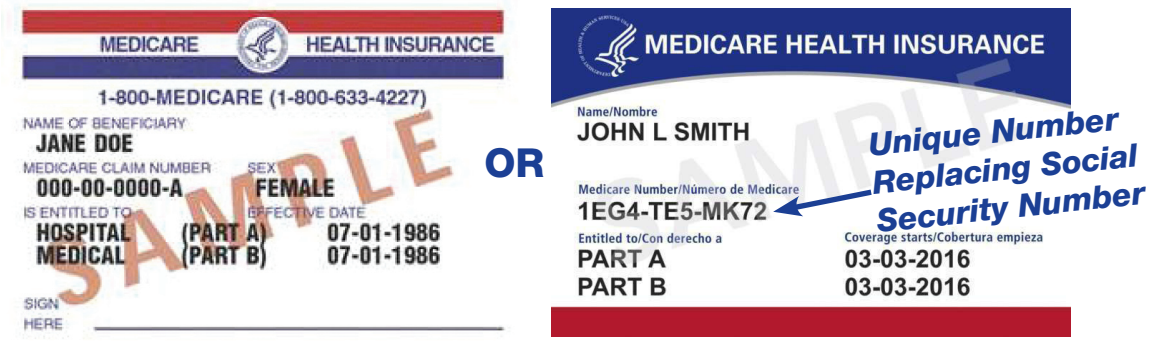
Another useful website is www.mymedicare.gov. On this site you can learn about preventive services, personal health records and the basics of all Medicare plans.

You can also compare the different health plans, locate a doctor, compare hospitals and find suppliers of medical equipment. This website will allow you to register for a personalized password protected account in which you can access your personal Medicare information and track your claims electronically for your convenience.

During the time when you are first eligible for Medicare, you are eligible for a “guarantee issue” period to enroll into a Medicare Supplemental policy (also known as MediGap). This means that any pre-existing medical history cannot be held against you.

Making Sense of Medicare:

When you become eligible for Medicare Part A, you will receive a Medicare card in the mail; this is often referred to as the “Red, White and Blue card”. Be sure you keep this in a safe place. **DO NOT DISCARD**.



When you speak with a Medicare or a Social Security representative keep a record of the date and time of your call, what was discussed and the name of the person you spoke with. Keeping good records can be important in the event you have issues in the future.

As you get started, it is important for you to understand how Medicare works. Medicare pays for services provided in both inpatient and outpatient settings. To accomplish this, Medicare has been divided into four parts; what your benefits will be depends on which options you choose.

The following chart lists **basic** Medicare covered benefits:

Medicare Part A (Hospital Insurance)

- Helps pay for care received while in an inpatient setting such as critical access hospital, inpatient rehabilitation, long term care facility or skilled nursing facility
- Helps pay for care provided in an outpatient setting such as home health care or hospice
- Allows people to choose their own doctors, hospitals and other providers
- Many individuals do not have to pay a monthly premium for Medicare Part A because they paid Medicare (FICA) taxes while working. If you do not automatically get premium-free Part A, you may still be able to enroll and pay a premium *

Medicare Part B (Medical Insurance)

- Helps pay for doctor services and outpatient hospital care including physical, speech or occupational therapy
- Pays for some preventive services with no cost share
- Many people pay the standard monthly Medicare Part B premium as an automatic deduction from their social security check*
- Generally pays 80% of the approved Medicare amount for covered services after deductible is met
- It is your choice to enroll in the Part B benefit

Medicare Part C (Medicare Advantage Plans)

- Provides Medicare benefits through private companies
- You choose the type of plan such as a HMO or PPO (see glossary)
- You must be enrolled in Medicare Part A & Part B to enroll
- Often includes benefits traditional Medicare does not cover
- Usually requires enrollees to use plan doctors, hospitals and providers Most plans have drug coverage. This plan would be a MAPD (Medicare Advantage Prescription Drug)
- Usually has a monthly premium in addition to the Medicare Part B premium and can require a copayment for covered services

Medicare Part D (Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- Plans vary in cost and drugs covered
- Each plan has their own formulary
- Available to everyone that is eligible for Medicare Part A or Part B
- Usually pay a monthly premium in addition to Part B premium

*Monthly premiums, deductibles and co-insurance for Medicare change each year. You can find out the current amount of these Medicare charges by contacting your local Social Security office or www.medicare.gov/your-medicare-costs

Before you make a final decision regarding your Medicare coverage choices and you are currently covered under an employer sponsored group health plan, verify with your current or former Human Resources department or your insurance agent if there are any specific requirements or exclusions associated with you becoming Medicare eligible. **Read your employee policy and benefit information**. Coverage is often not allowed in group health or retiree health plans when you or a family member becomes eligible for Medicare. If your group or retiree policy REQUIRES that as an employee you must enroll in Medicare Part B when you are initially eligible, and this is not done, the "primary" group health policy will not consider claims for services normally covered under Medicare Part B.

Medicare Part B:

Medicare Part B helps pay for doctor services, outpatient hospital care-including physical, speech or occupational therapy-and some preventative services. Enrollment in Medicare Part B is voluntary. If you decide not to enroll in Medicare Part B, you must **notify Medicare** by following the instructions that come with your initial Medicare packet. This is an important decision. Before you choose not to have Part B, be sure you have other coverage for doctor and outpatient services. If you do not have any other coverage and **"opt out"**, Medicare will not consider any of the charges for outpatient services covered under the Part B plan, and you will be responsible for paying the entire amount. If you are making a decision not to have Part B because you cannot afford the Part B premium, there are government savings programs that may be able to assist depending on your specific situation. These savings programs are described in further detail In Chapter 4.

Enrolling in Medicare Part B:

When you turn 65, there is a 7 month period that begins 3 months before you turn 65, includes the month you turn 65, and ends 3 months after you turn 65, during which you can enroll in part B. An exception to this is if your date of birth falls on the 1st day of the month. If this applies to you, Medicare will become effective the 1st day of the month before your birthday, as long as you apply for Medicare within the first 3 months of your Initial Enrollment Period.

To better explain this, the following chart[1] shows when you become eligible based on if you enroll in Medicare before or after your birth date: ***Do not put off enrolling.***

YOUR INITIAL ENROLLMENT PERIOD:	YOUR COVERAGE STARTS:
3 months before you turn 65	The month you turn 65
2 months before you turn 65	The month you turn 65
1 month before you turn 65	The month you turn 65
The month you turn 65	1 month after enrollment
1 month after you turn 65	2 months after enrollment
2 months after you turn 65	3 months after enrollment
3 months after you turn 65	3 months after enrollment

1 http//www.medicare.gov/pubs/pdf/02179.pdf

Premium Penalties: Medicare Part B

If you make the decision not to enroll in Medicare Part B when you first become eligible for coverage and do not have proof of other primary coverage, you may be required to pay a penalty to obtain Medicare Part B coverage. For every 12 month period of delay in your enrollment into Part B, there will be a 10% penalty added to your Part B premium, unless you qualify for a Special Enrollment Period. This penalty will be included in your monthly premium as long as you are enrolled in Part B. There is an annual General Enrollment period for Medicare Part B, between January 1 and March 31. If you enroll during this period your Medicare Part B coverage will begin on July 1 of that year.

Special Enrollment Period

There is a Special Enrollment period during which you may have an opportunity to enroll into Medicare Part B as a result of a qualifying event. If you meet these guidelines, you will not be subject to a late enrollment penalty. To be eligible to enroll in Medicare Part B after you have passed your initial enrollment period, without paying the penalty, you must be able to prove that you had other insurance coverage that was as good as Medicare. These rules would apply in the following situations:

- You did not enroll in Medicare Part B when you were first eligible for Medicare due to you or your spouse working and being eligible for group health plan coverage through your or your spouse's employer or union
- Anytime you are still covered by the employer or union group health plan through your own or your spouse's **active** employment, or
- During the 8 months following the month the employer or union group health plan coverage ends or when the employment ends (whichever is first).
- You are deemed disabled and continue to work (or have health coverage through a family member who is actively employed)

HINTS: You are not eligible to sign up during a Special Enrollment period if you are enrolled for COBRA coverage or a retiree health plan. The covered employee (the person entitled to insurance coverage) must be actively working; you cannot be on retirement benefits, medical leave or family leave etc.

Chapter 2: Medicare Advantage (Medicare Part C) & Medicare Advantage Special Needs Plans

Another option you can consider would be *Medicare Advantage Plans*. These plans are known by different names including Medicare Part C or by the abbreviations "MA" and "MAPD". The plans are offered by private health insurance companies which have been approved by Medicare to administer benefits. To be eligible to enroll in a Medicare Advantage Plan you must be eligible and enrolled in Medicare Part A and Part B.

Medicare Advantage plans have features that are not standard under traditional Medicare, such as:

- You may need to use in-network doctors, hospitals, and other providers or you pay more or all of the costs
- You may have to pay a monthly premium (in addition to your Part B premium) and a co-payment or co-insurance for covered services
- Deductibles, co-insurance and coverage areas vary by plans
- Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs
- If you choose a Medicare Advantage plan that does not offer a prescription plan you may not be able to enroll in a separate Part D (stand alone) prescription plan
- You must live in an area where the Medicare Advantage plan is offered and the plan must be accepting new members

You can switch plans or drop your Medicare Advantage plan during the open enrollment period which is between October 15th and December 7th every year. Your coverage will begin on January 1.

You can make changes outside of the open enrollment period, if you have a qualifying event. This can include moving to a different state, your current Medicare Advantage plan being discontinued, or you are no longer eligible for insurance coverage through your employer.

5-Star enrollment period

At any point during the year you will be able to enroll in a 5-star Medicare Advantage plan, Prescription Drug Plan or Medicare Advantage Prescription Drug Plan. Your new plan coverage will start the 1st day of the following month after enrollment.

Medicare Advantage Disenrollment Period:

There is an opportunity to change Medicare Advantage plans every year between January 1st and February 14th. Any changes made during this period will become effective on the first day of the following month.

Changes allowed during this time include:

- Medicare Advantage plans with a Prescription Drug (MAPD) benefit included can switch to original Medicare with or without a Prescription Drug benefit
- Medicare Advantage Plans (MA) with a separate Prescription Drug Plan (PDP) can switch to original Medicare but **MUST** keep the Prescription Drug Plan you are currently enrolled in.

Medicare Special Needs Plans (SNP)

In addition to general Medicare Advantage Plans described above, Medicare Special Needs Plans were formed to assist people with chronic diseases and conditions. These plans typically provide access to a network of providers who serve people with a specific condition(s). Some examples of these diseases are diabetes, chronic obstructive pulmonary disease (COPD) and cardiac conditions. You can join one of these plans if you meet the eligibility criteria, which includes:

- You have both Medicare Part A and Part B
- You live in the plan's service area
- You have one or more specific chronic and/or disabling conditions (diabetes, congestive heart failure, etc)
- You live in an institution or long term care facility, or require nursing care in your home.
- Some plans may require that you are eligible for both Medicare and Medicaid (referred to as dual eligible)

People who join these plans get benefits customized to their condition and have their care coordinated through the Medicare Special Needs Plan.

Chapter 3: Medicare Prescription Drug Coverage (Part D)

Medicare Part D is the fourth component and provides prescription drug coverage. Drug plans are available to all individuals eligible for Medicare Part A and/or Part B if you live in the plan coverage area. Medicare Part D plans are available no matter what your income, illness, or drug costs and are managed by an insurance company or private company approved by Medicare. You may decide not to enroll in a Medicare drug plan when you are first eligible due to having other insurance coverage for prescription drugs; however, your current coverage must offer the same or better coverage as Medicare Part D (this is referred to as creditable coverage). If you choose to enroll in a Medicare Part D plan at a later date, you will need to provide proof of creditable prescription coverage or you may be required to pay a late enrollment fee. Medicare Part D prescription drug benefits are not the same as the medical insurance benefits.

You are responsible for paying your deductible before the Part D plan begins to pay. **This amount changes on a yearly basis.**

You are responsible to pay a co-payment or co-insurance and the drug plan will pay their share for each covered drug until a set amount is paid. **This amount changes on a yearly basis.**

Once you exceed the prescription drug coverage limit, you are responsible for a percentage of your prescription drugs until your out-of-pocket expense reaches a set amount. This coverage gap is also known as “the donut hole”, the **amount changes on a yearly basis and is expected to remain at 25%** by the year 2020.

Once you reach the set amount, known as the catastrophic coverage period, the coverage gap ends and your Medicare drug plan will pay 95%of the costs of your covered drugs for the remainder of the year. You will then be responsible for a small co-payment or 5% of the drug price.

You have the opportunity to switch your Part D coverage plan during the open enrollment period every year. There can be many reasons that changing plans may be a good decision for you. Some of these reasons could be if you had changes in medications, changes in your health status, some of your current medications may not be covered or your out-of-pocket expenses will be higher. Keep in mind that plans can vary in cost as well as drugs covered on the formulary.

The **Medicare Drug Plan Finder** www.medicare.gov/find-a-plan helps you find and compare plans in your area. Once you decide on a Medicare prescription drug plan, you can enroll in the plan by:

- Completing a paper application
- Calling the plan
- Enrolling on the plan's web site
- Applying on the Medicare Drug Plan Finder website

Note: Annual enrollment is from October 15th to December 7th each year; your coverage will begin on January 1.

Plans may have the following coverage rules:

Prior authorization—You and/or your prescriber (a doctor or other health care 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—This indicates the amount of medication you can get during a set amount of time (e.g. per month).

Step therapy—You must try one or more similar, lower cost drugs before the plan will cover the prescribed drug.

If you or your prescriber believes that one of these coverage rules should not apply in your situation, you can ask for an exception. Medicare prescription drug plans are required to cover all approved medications in six disease categories. These categories include: cancer, HIV/AIDS treatments, antidepressants, antipsychotic medications, anticonvulsive treatments and other immunosuppressants.

HINT: If you have employer or union coverage and you choose to join a Medicare drug plan, you may lose your coverage options through your employer or union drug plan even if you qualify for Extra Help. This could affect your dependents. Call your employer's benefits administrator before you join.

Chapter 4: There is Help for Your Medical and Drug Costs

Programs have been established to assist with the out-of-pocket expenses you are required to pay for your care. Each of these programs has their own criteria you must meet in order to qualify. A description of each of these programs is discussed in more detail below:

Low Income Subsidy

Low Income Subsidy (LIS) or "Extra Help" is available for people with limited resources and income. This program covers monthly premiums, annual deductibles, and prescription co-payments related to a Medicare prescription drug plan.

You can apply for the Low Income Subsidy by contacting the Social Security Administration, in one of the following ways:

- Apply online at ***www.socialsecurity.gov/medicare/prescriptionhelp***
- Apply at your local Social Security office
- Call Social Security at **1-800-772-1213** to apply over the phone

Medicare Savings Programs

If you are having difficulty paying your Medicare Part B premiums or other costs associated with accessing health care, Medicaid offers programs that may be able to assist. The programs listed below help pay specific benefits, if you meet the income and resource guidelines.

- Qualified Medicare Beneficiary (QMB)
  - Covers Medicare Part A and B premiums, and other cost-sharing (such as deductibles, co-insurance and co-payments)
  - Based on 100% of the Federal Poverty Guideline (FPL)
- Specified Low-Income Medicare Beneficiary (SLMB)
  - Covers Medicare Part B premiums only
  - Based on 100-120% of FPL
- Qualifying Individual (QI)
  - Covers Medicare Part B premiums only
  - Based on 120- 135% of FPL
- Qualified Disabled & Working Individuals (QDWI)
  - Based on up to 200% FPL
  - Covers Medicare Part A premiums only

The share-of-cost program, also known as Medicaid spend-down, available in some states, is similar to an insurance deductible. You must meet your spend-down amount which is determined by Medicaid, before Medicaid will pay anything towards your medical bills.

Some people may meet the eligibility requirements for both Medicare and Medicaid; this is called being "dual eligible."

If you have Medicare and Medicaid, Medicare pays first; however, Medicaid may be able to cover services when the Medicare benefit has been exhausted or the requested service is not normally covered by Medicare. This includes:

- Nursing home and home healthcare
- Help with personal care and rides to appointments
- Prescription drug coverage

Additional Assistance Programs

State Health Insurance Program Assistance Programs (SHIPs) are available in each state. Counselors are available to answer questions and help you understand your health plan options, resolve claims and billing problems, provide information on public benefit programs for those with limited income and assets, and help you understand your Medicare rights and protections. To get the phone number for your state you can call 1-800-MEDICARE (800-633-4227) or visit the Medicare website www.medicare.gov. [2]

The Program for All Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program offered in many states that allows people who need a nursing home level of care to continue to live at home while receiving services rather than be admitted to a nursing home setting.

State Pharmaceutical Assistance Programs (SPAP) assist low income, elderly or people with disabilities who do not qualify for Medicaid. These programs can help with the cost of prescriptions, premiums and deductibles. Contact your local Department of Aging to obtain information for your area.

Medicare provides an option to help you lower your drug costs on their website www.medicare.gov You will be required to enter the names of medications you are currently taking, and will be provided an option to "lower your drug cost" for a medication. These choices can include a mail order option, the ability to choose a generic or "similar" drug, or may provide a link to a manufacturer drug program.

Each pharmaceutical program has specific guidelines and information on assistance available for specific medications on the internet or by contacting the individual pharmaceutical program.

2 http//www.medicare.gov/Publications/Pubs/pdf/11173.pdf My Health, My Medicare

Chapter 5: Medicare Supplement (Medigap) policies

Medicare Parts A and Part B pay for many services, but they do not provide coverage at 100%. Many Medicare beneficiaries experience difficulty in being able to afford the out-of-pocket expenses after Medicare has paid their portion. There are two ways to help reduce your out-of-pocket costs: the first was discussed in Chapter 2 with Medicare Advantage Plans. The second and most common method of reducing your out-of-pocket costs is by purchasing a Medicare Supplement or Medigap policy.

You may be considering purchasing a Medicare Supplement Insurance policy to cover the amount not paid by your Medicare policy, including co-payments, co-insurance, and deductibles. When selecting a plan you should consider which benefit(s) you need now, what your possible future healthcare needs might be, what your income will be in the future, and then use that information to select the policy that best meets your needs. Medicare Supplement plans are considered to be private insurance; these plans can determine if they will accept new members.

During your initial enrollment period, you are protected by "guaranteed issue rights" which require Medigap insurance providers to sell you a plan without placing limitations or increase the premium rates on your policy for pre-existing health conditions. You are protected by "guaranteed issue rights" during the following times:

- Within 6 months of turning age 65 and have enrolled in Medicare Part B
- Within 6 months of enrolling in Medicare Part B during your initial enrollment, if you are over age 65 with creditable coverage
- 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
- Within the 30 day initial trial period

Medicare Supplement Insurance policies follow federal and state guidelines for your protection. They are clearly marked as "Medicare Supplement Insurance". These policies are standardized and offer the same basic benefits regardless of which insurance company sells the policy.

Purchasing a Medicare Supplement policy is voluntary and you are responsible to pay the monthly or quarterly premium, which is in addition to the monthly premiums that you pay to Medicare. You need to purchase a separate supplemental policy for each qualified person.

You are not eligible to purchase a Medicare Supplement policy if you are enrolled in a Medicare Advantage plan. The benefits offered by a Supplemental policy are already included in your Medicare Advantage Plan. Medicare Supplemental policies can not pay your Medicare Advantage deductibles, co-payments, or co-insurance.

HINT: When choosing a Medigap plan you want to look at the basic coverage. There are standardized plans to choose from, premiums vary but the coverage is mandated by the plan letter.

Chapter 6: Medicare Coverage and Preventive Services

America is moving towards a team approach for health care services, with care being provided at multiple locations and by more than one healthcare provider. As a consumer of healthcare it is important for **you** to become more aware of what **your** Medicare policy covers. Read the Medicare handbook. It is your responsibility to know what your policy requires. Medicare does not require you to have a referral to see a specialist, but you want to make sure that any provider you see is a Medicare provider. Does your Medicare Advantage policy require prior authorization for diagnostic procedures or a referral to see a specialist? Following Medicare or your Medicare Advantage plan requirements will help you contain your out-of pocket expenses.

A Medicare Summary Notice (MSN) provides information on charges for medical services billed and paid during that period of time. This is NOT a bill. Do not send money to Medicare when you receive this notice. Your provider will bill you separately.

For **Medicare Part A** claims, the MSN will include:

- The date(s) of service
- The number of benefit days used (in a benefit period)
- Any non-covered charges that apply
- Any applicable deductibles or co-insurance you owe
- How much you can be billed by your provider

For **Medicare Part B** claims, the MSN will include:

- The date of service
- Service(s) provided
- The amount each provider charged
- How much Medicare approved and paid
- How much you can be billed by the provider

If you are unsure about the form, ask your healthcare provider, a friend or family member to assist you; or you can contact Medicare.

You want to get the most out of your Medicare benefits. It is important to understand that while Medicare does not cover everything, it does cover certain medical services and supplies in hospitals, medical facilities, doctor's offices and other healthcare settings. Medical services can be either covered under Part A or Part B or Part C. A detailed list of covered services is found in the Medicare handbook, "Your Medicare Benefits". You can view this document on the Medicare website, www.medicare.gov, downloadable applications are available for electronic devices (e.g., cell phone, tablets).

If you receive a MSN for services that you did not receive, contact your provider to discuss your concern. If you are not satisfied with your providers explanation; you can contact 1-800-MEDICARE (800-633-4227).

Advance Beneficiary Notice (ABN)

Your healthcare provider or a medical product supplier may ask you to sign an "Advance Beneficiary Notice of Noncoverage" (ABN). This notice says Medicare probably (or in some cases certainly) will not pay for a medical service that has been ordered. You have the right to decide whether to get the item or service; however, if you choose to proceed with the service being ordered, and Medicare denies the claim, you will be responsible for the full cost of the item or service. The ABN rules only apply to regular Medicare and not to Medicare Advantage Plans.

If you should have received an ABN but did not, in most cases, Medicare requires that your provider return any money you paid for that particular item or service.

- Be sure you keep a copy of the signed ABN for your records
- The ABN can be sent to you via mail, email, fax and can be done over the phone

HINT: If you do not understand what you are signing, DO NOT SIGN until your questions have been answered to your satisfaction.

Medicare Preventive Healthcare Services

Medicare pays for the preventative services necessary to keep you healthy and active as you age. Preventive services include exams, shots, lab tests and yearly screenings. Also included are counseling and education that helps you be in control of your health. Complete information about preventative healthcare can be found in the *Medicare and You* book or on www.mymedicare.gov

Clinical Trials:

In addition to routine care, as a Medicare beneficiary you are covered to participate in a clinical trial. A clinical trial is a study of new medications or emerging therapies. The study may consist of new medications or combinations of medications to see how well they work. Each study has guidelines about who can participate such as age, sex, state of disease and previous treatments. Any care normally paid by Medicare is covered when it is part of a clinical trial. There are some items that are not currently covered by Medicare when participating in a clinical trial:

- Investigational medications, items, or services being tested in a trial that are being provided free of charge in the trial
- Anything being provided free by the sponsor of the trial
- Any co-insurance and deductibles

To learn more about clinical trials and coverage refer to Patient Advocate Foundation's publication, "A Practical Guide to Clinical Trials".

Chapter 7: Medicare Parts A, B, C and D Appeals

You may not agree with the initial decision regarding coverage or payment of a service you have received. Fortunately, you have the right to file an appeal with Medicare. The Medicare Summary Notice (MSN) will advise you of the reason your claim was denied and will outline the process to follow if you want to submit an appeal.

To appeal a decision by your Medicare or Medicare Advantage Plan:

- Revew the MSN, and circle any items that you question
- Explain the reason you are appealing the coverage decision-this can either be directly on the MSN or on a separate piece of paper
- Sign the form/paper, being sure to include your telephone number, your Medicare number and the date of service. MAKE A COPY for your record
- Send the form/paper to the Medicare address listed on the MSN
- Include any other documentation that supports your reasoning for why services should be covered

Famiily members, caregivers, friends or advocates can be appointed as a patient representative. There is a form available on medicare.gov or you can send a written request with your appeal.

Medicare Parts A and B:

You **CAN** appeal if Medicare denies one of the following:

- A request for a health care service, supply, or prescription that you think should be covered
- A request for payment of health care services, supplies, or prescription drugs you already received but have been denied payment or reimbursement
- A request to change the amount you must pay for a prescription drug
- Medicare or your plan stops providing or paying for all or part of an item or service you think you still need

You **CANNOT** appeal if Medicare or your plan denies one of the following:

- A service or item that is not considered a covered benefit under Medicare

There are five levels of the Medicare appeals process which will be described in further detail. There are dollar amounts applied to appeals beginning at the third level of appeal. The MSN will advise you if this applies in your case.

The first level appeal is called a **redetermination**:

- This is your formal request to reconsider the amount of coverage or payment decision made by Medicare, and can be done on the phone or in writing.
- Medicare denials are based on information provided when the claim was submitted for payment.
- If you are notified that Medicare is not paying for care you received, talk to your doctor or other health care provider to see if they will assist with your appeal. Learn what information the provider submitted with the claim and see if they can provide any additional information that may help your case.
- Claims at this level can be for any amount.
- The appeal must be filed within **120** days of the date you receive the medicare summary notice (MSN).
- Include any documentation that supports your reasoning for why services should be covered.

The second level appeal is called a **reconsideration**:

- If you do not agree with the decision made during your first level appeal you can file a second level of appeal for your claim.
- Second level appeals are completed by a Qualified Independent Contractor (QIC).
- Claims for any dollar amount can be appealed at this level.
- The appeal needs to be submitted within **180** days from the date of your first level decision.
- Directions will be on the Redetermination Notice.

The third level of appeal is a hearing by an **Administrative Law Judge** (ALJ):

- If you are disappointed with the outcome of your second level appeal, you can request a hearing by an Administrative Law Judge (ALJ).
- This is the third level of appeal.
- This request needs to be submitted within **60** days from the date of your second level decision.
- Claims being appealed must meet a minimum dollar amount stated in the second level denial letter.

The fourth level of appeal is a review by the **Medicare Appeals Council (MAC).** If you disagree with the decision you get from the third level of appeal.

- You have **60** days after you receive the decision letter to submit your request for a fourth level.
- Follow the directions in the third level decision letter to submit your request for a fourth level.
- Claim must meet minimum dollar limit.

The fifth level of appeal is a review by a **Federal District Court.**

- If you disagree with the decision rendered at the fourth level, you have **60** days to file a complaint in Federal District Court and have a Judicial Review.
- Follow the directions in the fourth level decision letter to submit your request.
- To proceed to a Federal District Court, the projected value of your denied coverage must meet the minimum dollar amount stated in the fourth level denial letter.

Medicare Advantage Plans (Part C):

If you have chosen to receive your care through a Medicare Advantage plan, you have the right to appeal if:

- Your plan denies coverage before you receive a needed item or service
- Your plan does not pay for a service already received
- You think that denying coverage will put your health at risk. The plan is required by law to provide a response within 72 hours.

Your Medicare Advantage plan is required to mail you a denial notice. This notice explains exactly what was denied, the reason for the denial (e.g., not a covered benefit, annual benefit exhausted), as well as the appeal process. You must request reconsideration within **60** days of the determination date. The request needs to include your name, Medicare number, address and signature.

If the Medicare Advantage plan denies your first level reconsideration and stands by their decision, the appeal will automatically be forwarded to an Independent Review Entity (IRE).

- The IRE is an independent contracted board of medical professionals tasked with making objective determinations from the clinical evidence provided to them surrounding your denied claim.
- You are allowed to submit additional information about your issue at this point, but it must be received by your plan within **10** days from the date you receive a notice that the IRE is in receipt of your case file.
- The IRE has **60** days to review your appeal and make a decision about if the denial should be upheld or overturned.

Prescription Drug Appeal (Medicare Part D):

If your pharmacy is unable to fill your prescription, the pharmacist is required to give you an explanation, in writing, on why they did not fill your prescription along with the contact information for your drug plan. You or your health care provider must contact your Medicare Part D drug plan to request a coverage determination or an exception. At this time you may want to talk with your health care provider to see if there is a different drug that may be covered under your plan.

A coverage determination will provide you information on drug benefits for a specific medication. Information provided includes if the medication is covered, if there are requirements you must meet before they can approve the medication such as other medications you must have tried, referred to as step therapy, or prior authorization.

You can ask your drug plan for a formulary exception if you or your healthcare provider feel you need a drug that is not on your drug plan formulary or that a coverage rule, such as prior authorization, should not apply to you. Another reason for requesting an exception is if you and your doctor feel that a medication listed on a higher tier should be given at the lower cost because you are medically unable to take any of the lower tier medications for the same condition.

You can request an expedited appeal to your plan by phone or in writing if you have not received your prescription or your health care provider feels that your life or health may be at risk with a delay.

If your Medicare Prescription drug plan doesn't respond to your request, you can file a grievance by calling 1-800-MEDICARE (800-633-4227).

Helpful Tips:

- Keep a record of all calls you make including date, time and who you spoke with, as well as keeping any letters or paper work you receive in a folder which is easy to access. Dates do matter and it is up to you to provide the proof if requested;
- When sending in letters be sure to send certified mail or return receipt so you have proof the document(s) were received;
- Send read receipts on any emails;
- Keep the verification form on any faxes you send showing the number you faxed to, date, time and that the transmission was completed.

Additional Resources:

- Your "Medical Rights and Protections" is a publication found on www.medicare.gov or you can call 1-800-MEDICARE (800-633-4227) and request a copy be mailed to you.

Chapter 8: Coordination of Benefits (Who Pays First)?

Some people are eligible for Medicare and have other health insurance coverage that must pay their share of the bill before or after Medicare. If you have Medicare and other health insurance coverage, make sure your medical provider or pharmacy have all of your insurance information to ensure the claims are sent to the appropriate insurance company to avoid delays in payment the following chart outlines some of the most common situations. If you have questions about who pays first, or if your insurance situation changes, talk to your provider or you can call the Medicare Coordination of Benefits Contractor at: 1-800-MEDICARE (800-633-4227).

Age 65 or older and covered by a group health insurance plan OR Covered by a group health insurance plan of a working spouse of any age	• Medicare is primary when the employer has less than 20 employees • Medicare is secondary when the employer has more than 20 employees • Check the specific policy
Age 65 or older and have an employer group health insurance plan after retiring	• Medicare is primary • The retiree coverage is secondary
Disabled and covered by a large group health insurance plan from a family member who is working	• Medicare is primary when the employer has less than 100 employees • Medicare is secondary when the employer has more than 100 employees
End Stage Renal Disease (ESRD) and group health plan coverage includes retiree plan	• Group health plan is primary for the first 30 months of eligibility or entitlement to Medicare • Medicare becomes primary after 30 months of eligibility or entitlement to Medicare

If you are eligible for both Medicare and TRICARE:

If you are a military retiree, you or your covered family members may be eligible for both TRICARE (military benefits) and Medicare when you retire. When you turn 65 you need to enroll in Medicare Part B to continue eligibility for TRICARE benefits. Your TRICARE will become TRICARE for Life. Special rules apply when paying claims such as:

- If a service is a benefit under both Medicare and TRICARE, you will have no out-of-pocket expense.
- If a service is covered under both Medicare and TRICARE, but Medicare cannot pay because you have used your annual Medicare benefit, TRICARE can process the claim as the primary payer. You will be responsible for any applicable TRICARE deductibles and cost shares.
- If a service is covered by Medicare but not by TRICARE, there will be no payment made by TRICARE regardless of any payment by Medicare on the claim. You are responsible for the Medicare deductible and cost shares.
- If a service is a benefit under TRICARE but not Medicare, TRICARE will process the claim as primary payer after they receive an Explanation of Benefits from Medicare. You are responsible for TRICARE deductibles and cost shares.
- If a service is not covered by MEDICARE or TRICARE, neither will make a payment on the claim. You are responsible for the entire bill.

If you are eligible for both Medicare and Veterans Benefits:

The Veterans Affairs (VA) benefits program is separate from Medicare. Veterans may be enrolled in both programs, but the enrollment processes and eligibility criteria are different for both programs. Veterans who are enrolled in the VA healthcare are eligible for the entire medical benefits package, including prescription drugs; however, some veterans may be subject to a co-payment for care or medications.

- The VA does not recommend that veterans cancel or decline coverage in Medicare (or other health care or insurance program) because they are entitled to Veterans Benefits.
- Veterans enrolled in both programs would have access to non-VA physicians and non-VA formulary prescription drugs if obtained under their Medicare benefits.
- Enrolling for Medicare Part B is optional, but you could be subject to a late enrollment penalty if you did not sign up for Medicare Part B when you were first eligible, even if you are enrolled in VA healthcare.

If you are enrolled in a private insurance plan:

Speak with your insurance agent to see how your private plan relates to Medicare. This is especially important if you have family members who are covered under the same policy.

HINT: Do not cancel any health insurance you have until your Medicare coverage actually begins**.**

Quality of Care:

Medicare has a Quality Improvement Organizations (QIO) in each state. Their mission is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. QIOs are private, mostly not-for-profit organizations, which are staffed by doctors and other health care professionals. These professionals are trained to review medical care and help beneficiaries with issues and complaints about their quality of care and to implement improvements.

Examples of quality of care concerns that your QIO can address are:

- Medication errors
- Unnecessary or inappropriate surgery or treatment
- Your condition changed and was not treated
- Discharged from the hospital too soon
- Incomplete discharge instructions and/or arrangements

Medical Provider:

If you have a concern about a doctor, such as unprofessional conduct, incompetent practice or licensing questions, you may contact your state medical board at 1-202-463-4000 or on the web at www.fsmb.org.

Medical Facility:

If you have a complaint about conditions at a hospital contact the Department of Health for your state. Specific state contacts can be found at www.medicare.gov/contacts.

Nursing Home or Long Term Care Facility Care:

If you have a complaint about care received in a nursing home setting you should contact the National Long Term Care Ombudsman Resource Center at 1-202-332-2275 or on the web at www.ltcombudsman.org

If you have a concern about the quality of care for services that Medicare doesn't cover, such as services in a nursing home, assisted living facility, adult day care, or hospice agency not related to quality of care, contact the Department of Aging for your state at 1-202-619-0724 or on the web at www.acl.gov

Medicare Advantage or Supplement Plan:

If you have complaints against a specific Medicare Advantage plan first call your Advantage plan to seek resolution. If your complaint is not resolved to your satisfaction, contact Medicare at 1-800-633-4227 or online at www.medicare.gov. Medicare's rating system allows you to see a plan's scorecard.

If you have a complaint about a Medicare Supplement (or Medigap) Plan, there are some protections under guaranteed issue rights. We suggest you contact your State Department of Insurance if you feel you have been denied a plan unfairly. You can contact the National Association of Insurance Commissioners at www.naic.org

Definitions and Terminology to Know

Appeal: A formal complaint you make when you do not agree with Medicare's decision to pay for a medication or service.

Approved amount: The price Medicare will pay for a specific medical service. If your doctor charges more than the approved amount but is a Medicare approved provider, you are not required to pay the difference.

Co-insurance: The amount you must pay for a medical service or prescription drug. It is a percentage of the cost of that service or drug.

Co-payment: The amount you must pay for a medical service or prescription drug. It is a fee set by your insurance plan.

Community rated: This applies to Medigap policies and is also called "no age rated". The same monthly premium is charged to everyone who has the same Medigap policy, regardless of age.

Custodial care: Nonskilled Care that assists with activites such as bathing, eating or dressing.

Coverage gap: For Medicare Part D prescription drug benefits, the time during which you are responsible for paying the cost of the medication. The coverage gap is currently scheduled to close by 2020. The amount renews and changes annually. This is also referred to as the "doughnut hole."

Creditable prescription drug coverage: Verification of prior prescription drug coverage from a different insurance plan. Previous benefits must be "as good as or better than" what Medicare offers.

Deductible: The amount you are required to pay for medical care before your Medicare coverage begins.

Dual eligible: This is when people meet the eligibility requirements for both Medicare and Medicaid.

Durable medical equipment (DME): This is the reusable equipment such as wheelchairs, walkers, and hospital beds that your doctor orders for you to use at home. Medications which are infused in a home setting or doctor's office can be billed under this benefit.

Enrollment period: A limited period of time when you can enroll in or switch Medicare plans.

Extra help: Financial assistance for people with very limited incomes and assets that helps cover Medicare Prescription Drug Plan costs.

Grievance: A formal complaint that you can make to Medicare if you have been treated poorly by either your plan or a medical provider.

Home health care: Skilled care received at home while you recover from an injury or illness.

Hospice care: Care for people who are terminally ill, which is covered by Medicare Part A. It includes physical care and counseling. Hospice care can be provided at home or in a facility.

Long-term care: Ongoing help with personal and health care which might be provided by a nursing home or assisted living facility. Medicare does not cover this level of care.

Occupational therapy: Therapy that helps you get back to a normal state after an illness, includes assistance with meals, bathing, and housekeeping.

Original Medicare: The initial coverage provided under Medicare- includes Medicare Part A and Medicare Part B.

Out-of-pocket costs: The amount you are responsible to pay after Medicare processes the claim and pays their share.

Premium: The amount you must pay monthly or annually to be eligible for coverage in a health plan.

Frequently Asked Questions

Q. I retired at 62 and was denied Medicare. Can you explain why?

A. Currently you become eligible for Medicare benefits when you turn age 65. You would only be eligible for Medicare at age 62 if you had been deemed disabled by the Social Security Administration and had collected Social Security Disability benefits for 24 months.

Q. I am retiring at age 65 and will be getting Medicare, my spouse who is 61 has never worked, will she be eligible for Medicare benefits?

A. Your spouse will need to be 65 and then he/she can receive Medicare benefits under your sponsorship. Medicare is individual coverage-there is no family coverage.

Q. I am over 65 and did not enroll in Medicare, now what can I do?

A. Every year there is a General Enrollment Period. You can go to your local Social Security office and sign up between January and March each year. Your effective date will be on July 1, of the same calendar year. There is an application available on the Social Security Administration website at: www.ssa.gov

Q. I am retiring from the federal government – do I need to enroll in Medicare?

A. If you have Federal Employee Health Benefits (FEHB) then it is your choice to enroll in Medicare Part B. You are eligible to enroll in a Medicare Part D plan, but this may not be necessary since you will have access to a prescription plan that offers benefits as good as or better than Medicare, and will be creditable coverage.

Q. Does Medicare provide coverage for dental services?

A. Medicare does not cover dental services on a routine basis. Some very limited exceptions are covered, such as paying for the removal of teeth in order for you to have radiation treatment for head and neck cancer.

Q. How do I find a doctor that accepts Medicare patients?

A. You can call the provider office you would like to be seen at and ask specifically if they accept Medicare patients, or you can search for participating providers on the Medicare website, www.medicare.gov. Providers who have agreed to participate in Medicare agree to accept the Medicare approved amount as payment. An example of this would be that if your chemotherapy charge is $5,000.00, but the Medicare approved amount is $2,000.00. The doctor must accept the $2,000.00 amount. This does not mean you are not responsible for the co-insurance.

Q. What happens if my family member is being released from a medical facility or home health agency before we feel they are ready?

A. If you have Medicare and think the services that Medicare are covering are ending before it is medically safe, this can be from a home health agency, skilled nursing home, hospital facility, comprehensive outpatient rehabilitation facility or hospice, you can request an expedited appeal (refer to chapter 7). The provider is required to give you a notice in writing

telling you when your services will be ending. This notice will explain your rights of filing the appeal which can be done verbally or in writing.

Q. How many days of skilled nursing does Medicare cover? What are my options if I have reached my limit?

A. Standard Medicare covers days 1-20 in full in a skilled nursing facility, as long as you meet the criteria for that level of care. The facility must be an approved Medicare nursing home. If you meet these criteria, Medicare will cover the stay as follows:

Days 21-100 with a co-payment

Days 100 and beyond will be your responsibility in full. Check your secondary insurance coverage plans to see if they offer any additional benefits.

Q. Will Medicare cover my care in a nursing home?

A. Medicare covers care received in a nursing home setting as long as you meet the criteria for skilled care, have a 3 day minimum qualifying hospital admission and care must be prescribed by a doctor.

Q. Will Medicare provide coverage if I need home healthcare?

A. Medicare does cover home healthcare but only under certain circumstances. Your doctor must order the care and the home health provider must be approved by Medicare. You must be for the most part homebound and have a skilled need. Skilled services such as physical therapy, speech therapy, occupational therapy or skilled nursing care are not intended as a long term solution. Medicare does not pay for services that are considered custodial care. Custodial care (non-skilled care), assists you with activities of daily living such as bathing or dressing.

Q. I am enrolled in the low income subsidy (LIS) and need to change plans, how can I do this?

A. If you meet the requirements and are currently enrolled in low income subsidy, you are able to change plans anytime during the year. Your change becomes effective the 1st day of the following month. To change plans you can call the plan you are currently enrolled in, call 1-800 Medicare or visit www.medicare.gov and choose the enrollment option.

Q. Does Medicare cover the cost of an ambulance?

A. Medicare considers charges for medically necessary ambulance services if transportation in any other vehicle could endanger your health. If the ambulance goes to a facility other than the closest one, at your request, you will be responsible for any additional mileage.

Q. Can I keep my Medicare coverage if I return to work after being deemed disabled?

A. If you are able to return to work, there is a program through the Social Security Administration called the 9 month Trial Work Period. You will continue to receive Hospital Insurance (Medicare Part A) for at least 93 consecutive months, Outpatient Insurance (Medicare Part B) if enrolled and premiums paid and Prescription Drug coverage (Medicare Part D),

if enrolled. If you continue to work longer, your SSDI benefits may stop, but you will have continued health insurance for the remainder of the 93 months. Contact Social Security for additional information.

Q. If I did not sign up for Part B when I became eligible for Medicare due to disability, and I did not have other health coverage, can I sign up later with no penalty?

A. If you are younger than age 65, have Medicare because of a disability and are charged the Part B penalty, it will be waived when you turn 65 and qualify for Medicare based on age. This is considered a second initial enrollment period based on turning 65.

Q. Who is the primary insurance billed if I have both Medicare and COBRA health coverage?

A. Medicare coverage is primary to COBRA unless you are eligible for Medicare as a result of being diagnosed with End Stage Renal Disease (special rules apply). If you are eligible for Medicare but not enrolled, you will need to enroll into Medicare part B before the 8th month of your COBRA coverage. If you do not enroll, the Medicare Coordination of Benefits Contractor COBRA coverage could refuse to pay health benefits as the primary payer.

Q. Can I buy Medicare? And if so, how much would it cost?.

A. Yes, you can buy Medicare coverage as long as you meet the qualifications (see page1). Each year the costs will be listed on www.medicare.gov

Q. Does Medicare cover clinical trials?

A. Yes, Medicare covers the routine costs while you are participating in a clinical trial. If you have a Medicare Supplement plan your co-payments will be covered. Medicare Advantage plans do NOT cover clinical trials, but basic Medicare does.

Q. My doctor ordered a procedure but the medical facility is telling me that Medicare will not cover the procedure, what should I do?

A. You need to discuss your concerns with your doctor. If you feel this procedure is necessary then you must decide what is best for your situation. If you decide to proceed, the facility will ask you to sign an Advance Beneficiary Notice (ABN). This states that you are aware that Medicare may not pay but you have the right to appeal Medicare's decision. In order for you to be able to appeal the charges, you should select the option on the ABN that says you want Medicare to reconsider.

You need to be aware that when you sign the ABN and Medicare does not pay, you are responsible for the entire payment. There are no Medicare charge limits which apply to the provider charges. Good news is that balance billing limits do NOT apply. The provider must specify what amount you will be charged in the Cost Estimator Section of the ABN. Make sure all fields are complete and that you understand **before you sign**.

Q. My Medicare card has incorrect information, how can I correct this?

A. You can correct and order a new card online at www.ssa.gov or contact your local Social Security office.

Q. I have diabetes. What will Medicare cover?

A. Medicare Part B will cover certain quantities of glucose test strips, lancets, lancet devices and the glucometer. Medicare Part B covers the glucose control solutions for checking accuracy of monitors and strips. Medicare Part D covers insulin including the insulin pens. The insulin received thru a pump is covered by Medicare Part B under the Durable Medical Equipment (DME) benefit. Therapeutic shoes or shoe inserts are covered one time a year if you have diabetic foot disease. These shoes and shoe inserts need to be prescribed and certified by a qualified doctor (prosthetist, pedorthist or podiatrist).

Q. Who determines the Federal Poverty Level?

A. The U.S. Department of Health and Human Services (HHS) issues new Federal Poverty Guidelines every year, commonly referred to as the "Federal Poverty Level" (FPL). FPL is one of the indicators for determining eligibility in a wide variety of federal and state programs.

Q. How do I know what Medicare will cover?

A. You can find this information on the Medicare website www.medicare.gov, refer to your *Medicare and You* book, or call Medicare.

Q. I have a HMO Medicare Advantage plan and I am going on vacation. What do I need to know?

A. If you will be out of your home area less than 6 months, payment will depend on the type of care you receive as well as the type of plan you chose. If you will be out of your home area 6 months or longer, your plan will probably require you to disenroll from your current plan. You can choose a new plan or return to regular Medicare. If you receive emergency care out of your local area, the charges must be covered. You cannot be charged out-of-network rates for emergency services.

Q. Is Medicare required to send my claim to my secondary insurance plan after they have considered the charges?

A. Your secondary insurance might have a contract with Medicare. If they do, it gives them the authority to submit a crossover claim automatically for payment. Private insurance companies are not required (but most do) to have this kind of contract. Contact your insurance company for information on how to submit a claim after Medicare has paid.

Q. How do I know if my medication will be covered under Medicare Part B or Medicare Part D?

A. Medicare Part B covers medications that are given at the provider's office or in an outpatient setting and given by infusion or injection (chemotherapy or nausea medications). Medicare Part D medications are taken by the patient at home.

Q. I went to the doctor and did not have a co-payment. Then I went to a different doctor and had to pay a co-payment. Can you explain why?

A. The deductible is determined when the claim is received at Medicare not by the date of service. The second doctor's bill may have been received by Medicare first, or there was no deductible applied to a service; for example, the welcome to Medicare exam.

Q. What is the role of the Medicare Beneficiary Ombudsman?

A. The Medicare Ombudsman makes sure that beneficiaries get assistance with any Medicare question, complaint or appeal. The Ombudsman works within the Centers for Medicare and Medicaid Services to ensure that Medicare programs serve beneficiaries and that information about rights and protections is available. The Ombudsman will work with the Medicare program to understand system-wide problems and bring about improvements to the agency's programs for beneficiaries.

Visit the Beneficiary Ombudsman section of www.medicare.gov for additional information. If you have a particular question or concern regarding Medicare, you can call 1-800-MEDICARE (800-633-4227).

Q. What is the difference between a complaint and an appeal?

A. A **complaint** relates to a concern about the **quality** of care or services you get from a Medicare provider. If your issue relates to Medicare **coverage** or **payment decisions**, you file an **appeal**.

Q. Do I need to do anything different now that there are Marketplace plans?

A. No, if you are over 65 and enrolled in Medicare or are Medicare-eligible, there is no need for you to utilize the Marketplace.

For Medicare Specific Information:

www.medicare.gov
Select Find out what Medicare covers.
Select *your state* and *topic* and hit search
This will give you a general overview of the coverage available by Medicare
Phone: 1-800-633-4227
TTY: 1-877-486-2048

To Report Fraudulent Activity Related to Medicare:

www.snpresource.org
Senior Medicare Patrol
Phone: 877-808-2468

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Toll Free: 1-800-532-5274
www.patientadvocate.org