

CENTERS FOR MEDICARE & MEDICAID SERVICES

Your Medicare

Rights and Protections

- ★ your right to file a complaint,
- ★ your right to get health care services you need,
- ★ your right to privacy, and
- ★ where you can get help with your questions.

This official government booklet has important information about

“Your Medicare Rights and Protections” booklet isn’t a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Protect Your Medicare Number!

You should always keep your Medicare card and Medicare number as safe as you would any of your personal information.

You also want to keep your plan membership card safe if you are in a Medicare Health Plan. This will help protect against someone using your information without your knowledge.

If you lose your Medicare card or it is stolen, you can order a replacement card at www.socialsecurity.gov on the web. Or, you can call the Social Security Administration at 1-800-325-0778.

TTY users should call 1-800-325-0778.

If you find out that someone is using your Social Security Number, you can call

- the Federal Trade Commission’s ID Theft hotline at 1-877-438-4338 to make a report (TTY users should call 1-866-653-4261), or
- the Social Security Administration at 1-800-772-1213 to replace your Medicare card or to get a new Social Security Number.

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The information in this booklet was correct when it was posted to www.medicare.gov on the web. To find out if this booklet is available in print, other formats, or if the information has been updated, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Welcome

How this booklet can help you

This booklet is about your Medicare rights and protections. As a person with Medicare, you have certain guaranteed rights and protections that

- protect you when you get health care,
- make sure you get the health care services that the law says you can get,
- protect you against unethical practices, and
- protect your privacy.

Remember, you have rights no matter if you are in the Original Medicare Plan, a Medicare Health Plan, have a Medicare drug plan, or have a Medigap (Medicare Supplement Insurance) policy.

This booklet provides you with valuable information and helps you understand

- your Medicare plan choices,
- your rights and protections in the Original Medicare Plan,
- your rights and protections in a Medicare Health Plan,
- your rights and appeals in a Medicare drug plan, and
- where to get help with your questions.

“It is nice

to have ways

to get my

Medicare questions answered.”

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Section 1: Medicare Basics

What is Medicare?

Medicare is a health insurance program for

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

What are my Medicare plan choices?

Depending on where you live, you may be able to get your health care in several ways. Your Medicare plan choices include the following:

- The Original Medicare Plan (see below)
- Medicare Health Plans (see page 4)
- Medicare drug plans (see page 5)

What is the Original Medicare Plan?

The Original Medicare Plan is a “fee-for-service” plan. You are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. You are in the Original Medicare Plan unless you choose to join a Medicare Health Plan. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care.

To help cover the costs the Original Medicare Plan doesn’t cover, you may want to get a Medigap (Medicare Supplement Insurance) policy (see page 5).

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Section 1: Medicare Basics

What are Medicare Advantage Plans?

Medicare Advantage Plans are a type of Medicare Health Plan that are part of the Medicare Program. If you join one of these plans, you generally get all your Medicare-covered health care through that plan. This coverage can include prescription drug coverage, but doesn't have to. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use services. In most of these plans, generally there are extra benefits and lower copayments than in the Original Medicare Plan. However, you may also have to see doctors that belong to the plan or go to certain hospitals to get services.

Medicare Advantage Plans include

- Medicare Health Maintenance Organization Plans (HMOs),
- Medicare Preferred Provider Organization Plans (PPOs),
- Medicare Special Needs Plans, and
- Medicare Private Fee-for-Service Plans (PFFS).

What are the other Medicare Health Plans?

There are some types of Medicare Health Plans that aren't part of Medicare Advantage. However, they are still part of the Medicare Program. In some of these plans, you generally get all your Medicare-covered health care from that plan. This coverage can include prescription drug coverage, but doesn't have to. Medicare pays a set amount of money for your care every month to these private health plans.

These other types of Medicare Health Plans include

- Medicare Cost Plans,
- Demonstrations, and
- PACE (Programs of All-inclusive Care for the Elderly).

Note: You can choose to join a Medicare Advantage Plan or another Medicare Health Plan depending on your needs and your circumstances. In this booklet, these plans are referred to as Medicare Health Plans.

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Section 1: Medicare Basics

What is Medicare Prescription Drug Coverage?

As of January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. Everyone with Medicare can get this coverage, which may help lower prescription drug costs and help protect against higher costs in the future. Medicare prescription drug coverage is insurance. Private companies provide the coverage. You choose the Medicare drug plan and pay a monthly premium. If you decide not to enroll in a Medicare drug plan when you are first eligible, you may pay a penalty if you choose to join later.

What is a Medigap (Medicare Supplement Insurance) policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill the “gaps” in Original Medicare Plan coverage such as coinsurance amounts.

Medigap policies must follow federal and state laws that protect you. There are 12 standardized Medigap policies called “Plan A” through “Plan L.” The front of a Medigap policy must clearly identify it as “Medicare Supplement Insurance.” Each Medigap Plan A through L has a different set of benefits. For more information about Medigap policies, visit www.medicare.gov and view the booklet, “Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare” (CMS Pub. No. 02110) or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you are in the Original Medicare Plan, see pages 20–21 for information about your right to buy a Medigap policy.

Note: If you have End-Stage Renal Disease and have a complaint about your care, call the ESRD Network for your state. To get this telephone number, visit www.medicare.gov on the web. Select “Search Tools” at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Section 2: Your Medicare Rights

If you have Medicare, you have certain guaranteed rights and protections. You have these rights whether you have the Original Medicare Plan (with or without a Medigap policy) or a Medicare Health Plan. You have the right to the following:

- 1. Be treated with dignity and respect at all times**
- 2. Be protected from discrimination**

Discrimination is against the law. Every company or agency that

works with Medicare must obey the law. You can't be treated differently because of your

- race,
- color,
- national origin,
- disability,
- age,
- religion, or
- sex (under certain conditions).

Also, your rights to health information privacy are protected. If you think that you haven't been treated fairly for any of these reasons, call the Office for Civil Rights in your state. Call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr on the web for more information.

3. Get information about Medicare that you can understand to help you make health care decisions

This information includes

- what is covered,
- what costs are paid,
- how much you have to pay, and
- what to do if you want to file a complaint.

You can have someone help you make decisions when you need it.

4. Have your questions about the Medicare Program answered

You can call 1-800-MEDICARE (1-800-633-4227) to get your questions answered or get the telephone number of your State Health Insurance Assistance Program. TTY users should call 1-877-486-2048. If you enrolled in a Medicare Health Plan, you can also call your plan.

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Section 2: Your Medicare Rights

5. Culturally competent services

You have the right to get health care services in a language you can understand and in a culturally sensitive way. For more information

about getting health care services in languages other than English, call the Office for Civil Rights in your state or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr on the web for more information.

6. Get emergency care when and where you need it

A medical emergency is when you think your health is in serious danger—when every second counts. If you think your health is in danger because you have a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.

If you are enrolled in a Medicare Health Plan, your plan materials describe your emergency care costs. You don't need to get permission from your primary care doctor before you get emergency care. Your primary care doctor is the doctor you see first for health problems. If you are admitted to the hospital, you, a family member, or your primary care doctor should contact your Medicare Health Plan as soon as possible so the plan can manage your care.

If you get emergency care, you will have to pay your regular share of the cost (copayment). Then, your plan will pay its share. If your plan doesn't pay its share for your emergency care, you have the right to appeal (see page 9).

7. Learn about all of your treatment choices in clear language that you can understand

You have the right to fully participate in all your health care decisions. If you can't fully participate, you can ask family members, friends, or anyone you trust to help you make a decision about what treatment is right for you. Medicare Health Plans can't have rules that stop your doctor from telling you what you need to know about your treatment choices.

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Section 2: Your Medicare Rights

8. File a complaint

You can file a complaint about payment, services you received, other

concerns or problems you have in getting health care, and the quality of the health care you received.

Your Medicare Quality of Care Concerns

You have a right to file a complaint if you think you aren't getting quality services or you have quality of care issues. This type of complaint is called a "grievance" if you are enrolled in a Medicare Health Plan or a Medicare drug plan. If you are enrolled in the Original Medicare Plan or a Medicare Health Plan and if you want to file a complaint about the quality of health care you have received, you can call your plan or call the Quality Improvement Organization in your state. To get this telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

9. Your Medicare Appeal Rights

You have the right to appeal decisions relating to your claims for benefits. For more information on appeals, see Sections 3–5 in this booklet or call the State Health Insurance Assistance Program in your state. To get this telephone number call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Important: If you need help with filing an appeal, you can have someone else help you. This process is called an "Appointment of Representative." You can name a family member, friend, advocate, attorney, doctor, or someone else to act on your behalf. Medicare has a form you and your representative can fill out to complete this process. This form is available at www.medicare.gov/basics/forms/default.asp on the web (CMS Form Number 1696). You can also appoint a representative with a letter signed and dated by you and the person helping you. The form or letter must be sent with your appeal request. If you have questions about appointing a representative, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Section 2: Your Medicare Rights

10. Have your health information that Medicare

collects about you kept private

Medicare may collect information about you as part of its regular business, such as paying your health care bills and making sure you get quality health care. Medicare keeps the information it collects about you private. When Medicare asks for your health information, they must tell you the following:

- Why it is needed
- Whether it is required or optional
- What happens if you don't give the information
- How it will be used

If you want to know more about how Medicare uses your personal information, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your state may have additional privacy laws that protect your personal information. If you want to know about the laws in your state, call your State Health Insurance Assistance Program. To get this telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

11. Know your health information privacy rights

You have privacy rights under a Federal law that protects your health information. Your health care provider or health plan must follow this law to protect your privacy rights. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected. If you are enrolled in the Original Medicare Plan, see the "Notice of Privacy Practices for the Original Medicare Plan" on pages 22–24. If you are enrolled in a Medicare Health Plan or a Medicare drug plan, your plan materials describe your privacy rights.

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Section 3: Your Rights and Protections in the Original Medicare Plan

In addition to the rights listed in Section 2, if you are in the Original Medicare

Plan, you have the following rights and protections:

1. Access to doctors, specialists (including women's health specialists), and hospitals

You can see any doctor or specialist, or go to Medicare-certified hospitals that participate in Medicare.

2. Timely information on Medicare payment, and fair and efficient appeal processes

If you have the Original Medicare Plan, you can get certain information, notices and appeal rights that help you resolve issues when Medicare doesn't pay for health care including

- **Advance Beneficiary Notices (ABNs)**—You are given this notice by your doctor, health care provider, or supplier before you get an item or service that Medicare may not pay for (see below and pages 12–15).
- **Important Message from Medicare**—You are given this notice about your rights once you are admitted to a hospital (see page 15).
- **Fast Appeals**—You are given a notice of non-coverage that will explain your appeal rights before you are discharged from care or before Medicare stops paying for certain types of care (see pages 16–17).
- **Billing Information**—You can ask for this information after you get an item or service (see page 18).
- **General Appeal Rights**—You have these rights if you disagree with the coverage or payment decision Medicare makes on your claim (see page 18).

Advance Beneficiary Notices (ABNs)

If your doctor, health care provider, or supplier thinks that Medicare won't pay for an item or service, they will give you a written notice. This written notice is called an "Advance Beneficiary Notice" (ABN). The ABN explains what items or services Medicare won't pay for, the reasons why Medicare won't pay, and gives you an estimate of costs. The ABN helps you make an informed choice about whether or not you want to get this health care knowing that you or your other insurance may be responsible for payment.

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Section 3: Your Rights and Protections in the

Original Medicare Plan

2. (continued)

Advance Beneficiary Notices (ABNs) (continued)

When your doctor, health care provider, or supplier gives you an ABN, you have to decide if you want the items or services listed. Your options will be explained on the ABN. You will have to sign and date the ABN to show you understand your options. Generally, by signing the ABN, you are agreeing to pay for the item or service yourself or through other insurance you might have. If Medicare later pays for the items or services on the ABN, you will be refunded the money you paid.

The following are the five types of ABNs:

- Advance Beneficiary Notice—General (ABN-G), see below
- Advance Beneficiary Notice—Laboratory (ABN-L), see page 13
- Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) or Denial Letters, see page 13
- Home Health Advance Beneficiary Notice (HHABN), see page 14
- Hospital-Issued Notice of Non-coverage (HINN), see pages 14–15

Advance Beneficiary Notice—General (ABN-G)

The ABN-G is used by doctors, durable medical equipment suppliers, and certain health care providers (for example, independent physical and occupational therapists and outpatient hospitals). The ABN-G gives you the following two options:

Option 1 Check this box if you want to get items or services Medicare may not cover.

Option 2 Check this box if you don't want to get those items or services.

If you select Option 1 and Medicare doesn't pay, you will have the right to appeal.

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Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Advance Beneficiary Notice—Laboratory (ABN-L)

The ABN-L is used only for laboratory services. The ABN-L has two options that are very similar to those of the Advance Beneficiary Notice—General (see page 12).

Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

or Denial Letters

The SNFABNs or denial letters are used only for skilled nursing facility care. The SNFABN gives you options to choose from like the Advance Beneficiary Notice—General (see page 12). The skilled nursing facility denial letters aren't notices like the SNFABN, and don't have options to check off, but they give you similar information and you must sign and date these letters. You will get either SNFABN or a denial letter when you have used all the skilled nursing facility care that Medicare will pay for.

When you meet certain requirements, Medicare Part A pays up to 100 days of room, board, and covered services, as part of skilled nursing facility care when you stay in a facility. When a skilled nursing facility decides Medicare may not continue to cover your stay, the facility will give you a SNFABN or denial letter telling you when you will be responsible for payment. You don't have to pay for services at that time, you pay only after a claim is filed and an official Medicare decision is made to deny payment. However, you still continue to pay any other costs that you would normally have to pay while the claim is being processed. These costs include the daily coinsurance and the costs for services and supplies Medicare never pays for, such as telephone or television services. If you have questions about Medicare Part A services, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Home Health Advance Beneficiary Notice (HHABN)

The HHABN is used only by home health agencies. The HHABN is given in most instances where your home health agency is either giving you home health care Medicare won't pay for, or when your home health agency will reduce or end care for other reasons.

The HHABN gives you the following three options:

Option 1 Check this box if you don't want to get the items or services listed.

Option 2 Check this box if you want to get the items or services and pay for them yourself.

Option 3 Check this box if you want to get the items or services, and have Medicare and/or your other insurance billed.

If you select Option 3 and Medicare doesn't pay, you will have the right to appeal.

Hospital Issued Notice of Non-coverage (HINN)

If you are getting inpatient hospital care, you may get a notice called a "Hospital Issued Notice of Non-coverage" (HINN) when the hospital thinks Medicare may not pay for your care. You may get one of these notices before you are admitted, at admission, or at any point during your hospital stay. These notices will tell you why the hospital thinks Medicare won't pay, what you have to pay if you keep getting services, and what rights you have to appeal the hospital's decision. This notice is in the form of a letter, so it doesn't have options to check off like Advance Beneficiary Notices, though you will sign and date this letter to show that you Words in understand your options.

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Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Services that Medicare Never Covers

Doctors, health care providers, and suppliers don't have to give you an Advance Beneficiary Notice for services that Medicare never covers, such as the following:

- Routine physical exams*
- Dental services
- Hearing aids
- Routine eye exams
- Routine foot care

* Medicare Part B covers a one-time "Welcome to Medicare" physical

exam within the first six months of having Medicare Part B. You may have to pay a coinsurance or copayment for this physical exam. Your doctor, health care provider, or supplier may still choose to give you a notice for items or services that Medicare never covers. They may give you a notice called a “Notice of Exclusion from Medicare Benefits” (NEMB).

Important Message from Medicare

If you are admitted to a Medicare hospital, you should be given the “Important Message from Medicare” notice. It explains your rights as a hospital inpatient. If you aren’t given this notice, ask for it. The “Important Message from Medicare” notice tells you the following:

- Your right to get all of the hospital care you need, and any follow-up care that is covered by Medicare after you leave the hospital
- Your right to appeal if you think the hospital is making you leave too soon
- Who to contact for help

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Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Fast appeals in Hospitals and Other Health Care Settings

You also have the right to a “fast appeals” process. This option is available if you are getting Medicare-covered inpatient hospital care (see below) or certain care in other settings, such as a skilled nursing facility or home health agency (see page 17).

Fast appeals in Hospitals

If you are admitted to a hospital, and the hospital decides you no longer need inpatient hospital care, you have the right to a fast appeal (also known as an “immediate” appeal) of the hospital’s decision while you are in the hospital. During a fast appeal, an independent reviewer called a Quality Improvement Organization looks at your case and decides if you need to stay in the hospital.

If you think you are being asked to leave the hospital too soon, tell the

hospital that you would like a fast appeal. The hospital will give you a notice that explains why you are being discharged and information about how to contact the Quality Improvement Organization. If you don't get this notice, ask for it.

Important: If the hospital doesn't give you a notice about these rights, and you decide to stay in the hospital after your discharge date, you can't be charged for the cost of your care until the Quality Improvement Organization makes its determination.

If you decide to ask for a fast appeal, you should call the Quality Improvement Organization within the timeframe listed on the notice.

The Quality Improvement Organization may ask you some questions about your case. You may ask your doctor for any information that may help, and you may submit other evidence to the Quality Improvement Organization.

You may be able to stay in the hospital at no charge while the Quality Improvement Organization reviews your case. If so, the hospital can't force you to leave before the Quality Improvement Organization makes a decision.

If you miss the deadline for a fast appeal, you may still have the Quality Improvement Organization review your case, but different rules apply.

If you have any questions about fast appeals in hospitals, call the Quality Improvement Organization at the number listed on the notice. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Fast appeals in Other Health Care Settings

If you are getting Medicare-covered services from a skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, hospice, or hospital swing bed, you have the right to a fast appeal (also known as an “immediate” appeal) if you think your Medicare-covered services are ending too soon. During a fast appeal, an independent reviewer called a Quality Improvement Organization looks

at your case and decides if your health care needs to be continued. Your health care provider will give you a notice called a “Notice of Medicare Provider Non-coverage” that will tell you when your Medicare-covered services will end and how to contact the Quality Improvement Organization to ask for a fast appeal. If you don’t get this notice, ask for it.

Important: If you are getting services from a home health agency or a comprehensive outpatient rehabilitation facility, you also need to ask your doctor for certification that your health may be at risk if the services stop.

If you decide to ask for a fast appeal, you should call the Quality Improvement Organization within the timeframe listed on the notice. When you request a fast appeal, your health care provider will give you a second notice called the “Detailed Explanation of Non-coverage” with more information about why your care is ending. The Quality Improvement Organization may ask you questions about your case. You may ask your doctor for any information that may help, and you may submit other evidence to the Quality Improvement Organization. If you miss the deadline for a fast appeal, you may still have the Quality Improvement Organization review your case, but special rules apply. If you have any questions about fast appeals in these health care settings, call the Quality Improvement Organization at the number listed on the notice. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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2. (continued)

Billing Information

After you get care, if you aren’t sure if Medicare was billed for the items or services that you got, write or call your doctor, health care provider, or supplier and ask for an itemized statement. This statement will list each Medicare item or service you got. You should get your copy of the itemized statement within 30 days. You can also check your Medicare Summary Notice to see if Medicare was billed.

You have the right to insist your doctor, health care provider, or supplier bill Medicare if you receive an item or service from them. Sometimes,

this right is referred to as a “demand bill.” For example, if you have been told your Medicare Part A skilled nursing facility care is coming to an end, you can ask that a claim be submitted so that Medicare makes a final decision on whether you still qualify for this care.

3. General Appeal Rights

After Medicare makes a decision on a claim, you have the right to a fair, efficient, and timely process for appealing health care payment decisions or initial determinations on items or services you received. Reasons you may appeal include the following:

- A service or item you received isn’t covered, and you think it should be
- A service or item is denied, and you think it should be paid

The Medicare Summary Notice is mailed to you by the company that handles claims for Medicare. This notice indicates if your claim is approved or denied. If the claim is denied, the reason for the denial will be included on the notice. The notice will also include information about how to file an appeal. You can file an appeal if you disagree with Medicare’s decision on payment or coverage for the items or services you received. If you appeal, ask your doctor, health care provider, or supplier for any information that might help your case. You should keep a copy of everything you send to Medicare as part of your appeal.

Section 3: Your Rights and Protections in the Original Medicare Plan

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Section 3: Your Rights and Protections in the Original Medicare Plan

The following are the five levels in the appeals process:

A. Redetermination by Medicare. The company that handles claims for Medicare will make the first decision on your appeal. This is called a redetermination. You can request a redetermination by sending a written request to the company that sends your Medicare Summary Notice. Details of how, where, and when to file are on the Medicare Summary Notice. You will get a decision on your appeal about 60 days after you send your request. If you aren’t satisfied with this decision, you

can request a second appeal. The Medicare Redetermination Notice will provide more information and a form to fill out if you want this second appeal.

B. Reconsideration by a Qualified Independent Contractor. The second appeal decision will be made by a contractor that didn't take part in the first decision. This appeal is known as a reconsideration. You must request this appeal in writing within 180 days of getting your Medicare Redetermination Notice. If you aren't satisfied with the decision about payment and coverage you can request a third appeal by an Administrative Law Judge. The Medicare Reconsideration Notice will provide details about how to ask for this third appeal.

In most cases, the Qualified Independent Contractor (QIC) will issue a decision in about 60 days after getting your appeal request. If the QIC can't issue a decision on time, you will get a letter that will ask you if you want to skip to the next level of appeal.

C. Hearing by an Administrative Law Judge. The third appeal is a hearing before an Administrative Law Judge (ALJ). To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. You must make the request in writing within 60 days from the date you receive the reconsideration notice from the Qualified Independent Contractor. If you disagree with the judge's decision, you can request a fourth appeal. The ALJ's decision letter will provide details about how to file a request for this fourth appeal.

In most cases, the ALJ will issue a decision in 90 days after getting your appeal request. If the ALJ can't issue a decision on time, you will get a letter that will ask you if you want to skip to the next level of appeal.

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Section 3: Your Rights and Protections in the Original Medicare Plan

D. Review by the Medicare Appeals Council. If the Administrative Law Judge doesn't change the previous decision on your appeal, you can request a review by the Medicare Appeals Council in writing. The Medicare Appeals Council generally has 90 days to make a decision after getting the request

for a review. If the Medicare Appeals Council can't issue a decision on time, you will get a letter that will ask you if you want to skip to the next level of appeal.

E. Review by Federal Court. If you disagree with the decision by the Medicare Appeals Council, you can request a review by a Federal court. To get a review by a Federal court, the amount of your case must meet a minimum dollar amount.

4. Your rights to buy a Medigap policy

In some situations, you have the right to buy a Medigap policy outside of your Medigap open enrollment period. These rights are called "Medigap Protections." They are also called guaranteed issue rights because the law says that insurance companies must issue you a Medigap policy.

There are a few situations involving health coverage changes where you may have a guaranteed issue right to buy a Medigap policy.

In these situations, an insurance company

- must sell you a Medigap policy,
- must cover all your pre-existing conditions, and
- can't charge you more for a Medigap policy because of your health problems.

To learn about the situations where you have a guaranteed issue right to buy a Medigap policy because you lost certain kinds of health coverage, you can

- visit www.medicare.gov on the web and view the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare" (CMS Pub. No. 02110).
- call 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048.

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Section 3: Your Rights and Protections in the Original Medicare Plan

4. (continued)

For more detailed Medigap information

- visit www.medicare.gov on the web.
- Select “Search Tools” at the top of the page.
- call 1-800-MEDICARE (1-800-633-4227).
- TTY users should call 1-877-486-2048.
- A customer service representative will help you.
- call the State Health Insurance Assistance Program in your state. Ask if they have a Medigap rate comparison shopping guide for your state. To get this telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you think any of your Medigap rights have been violated, call your State Health Insurance Assistance Program.

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Section 3: Your Rights and Protections in the Original Medicare Plan

Notice of Privacy Practices for the Original Medicare Plan

The Notice of Privacy Practices for the Original Medicare Plan describes how Medicare uses and gives out your personal health information and tells you your individual rights. The notice is below, and on pages 23 and 24.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET

ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, Medicare is required to protect the privacy of your personal medical information. Medicare is also required to give you this notice to tell you how Medicare may use and give out (“disclose”) your personal medical information held by Medicare.

Medicare must use and give out your personal medical information to provide information

- to you or someone who has the legal right to act for you (your personal representative),
- to the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- where required by law.

Medicare has the right to use and give out your personal medical information to pay for your health care and to operate the Medicare Program. For example,

- Medicare Carriers use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), or to prepare your Medicare Summary Notice.
- Medicare may use your personal medical information to make sure you and other Medicare beneficiaries get quality health care, to provide customer services to you, to resolve any complaints you have, or to contact you about research studies.

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Notice of Privacy Practices for the Original Medicare Plan (continued)

Medicare may use or give out your personal medical information for the following purposes under limited circumstances

- to State and other Federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/State Medicaid programs),
- for public health activities (such as reporting disease outbreaks),
- for government health care oversight activities (such as fraud and abuse investigations),
- for judicial and administrative proceedings (such as in response to a court order),
- for law enforcement purposes (such as providing limited information to locate a missing person),
- for research studies, including surveys, that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- to avoid a serious and imminent threat to health or safety,
- to contact you about new or changed benefits under Medicare, and
- to create a collection of information that can no longer be traced back to you.

By law, Medicare must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that isn’t set out in this notice. You may take back (“revoke”) your written permission at any time, except if Medicare has already acted based on your permission.

By law, you have the right to

- see and get a copy of your personal medical information held by Medicare.
- have your personal medical information amended if you believe that it is wrong or if information is missing, and Medicare agrees.

If Medicare disagrees, you may have a statement of your

disagreement added to your personal medical information.

Section 3: Your Rights and Protections in the Original Medicare Plan

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Section 3: Your Rights and Protections in the Original Medicare Plan

Notice of Privacy Practices for the Original Medicare Plan (continued)

- get a listing of those getting your personal medical information from Medicare. The listing won't cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for Medicare operations, or that was given out for law enforcement purposes.
- ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare Program.

Please note that Medicare may not be able to agree to your request.

- get a separate paper copy of this notice.

Visit www.medicare.gov on the web for more information on

- exercising your rights set out in this notice.
- filing a complaint, if you believe the Original Medicare Plan has violated these privacy rights. Filing a complaint won't affect your benefits under Medicare.

You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. Ask to speak to a customer service representative about Medicare's privacy notice. TTY users should call 1-877-486-2048.

You may file a complaint with the Secretary of the Department of Health and Human Services. Visit www.hhs.gov/ocr/hipaa on the web or call the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

By law, Medicare is required to follow the terms in this privacy notice.

Medicare has the right to change the way your personal medical information is used and given out. If Medicare makes any changes to the way your personal medical information is used and given out, you will get a new notice by mail within 60 days of the change.

The Notice of Privacy Practices listed above and on pages 22 and 23 became effective April 14, 2003.

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In addition to the rights and protections listed in Section 2, if you are in a Medicare Health Plan, you have the following rights and protections. If you are in one of these plans and want to know more about your rights and protections, including rights and protections you may have in addition to those discussed in this booklet, read your plan's membership materials or call your plan.

Note about PACE (Programs of All-inclusive Care for the Elderly): To get a detailed list of your PACE rights and protections, visit www.cms.hhs.gov/pace/downloads/prtemp.pdf on the web. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Note about Medicare Cost Plans: If you have a Medicare Cost Plan and you want to appeal services that were provided outside the plan's network (without the plan's involvement), you will need to follow the Original Medicare Plan appeal process as described in Section 3.

1. Choice of health care providers

You may have the right to choose health care providers within the plan so you can get the health care you need.

2. Access to health care providers

If you have a complex or serious medical condition, you have the right to get a treatment plan from your doctor. This treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need.

Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.

3. Know how your doctors are paid

You have the right to know how your health plan pays its doctors.

When you ask your health plan how it pays its doctors, the health plan must tell you. Medicare doesn't allow a health plan to pay doctors in a way that wouldn't let you get the care you need.

Section 4: Your Rights and Protections in a Medicare Health Plan

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33–37.

Section 4: Your Rights and Protections in a

Medicare Health Plan

4. A fair, efficient, and timely appeals process

You have the right to a fair, efficient, and timely process to resolve differences with your health plan. This process includes the initial decision made by the health plan, an internal review and an independent external review.

You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours if

- it determines your life or health could be seriously harmed if the plan took the normal 14 days to respond, or
- a doctor supports your request and certifies you would be harmed.

If the plan denies what you asked for, the plan must tell you, in writing, why they won't pay for a service, and how to appeal this decision. After you file your appeal, the plan will review its decision. You also have the right to ask your plan for a copy of the file that contains your medical and other information about your appeal. You may want to call or write your plan and ask for a copy of your file. The plan may charge you a fee for copying this information and sending it to you.

Then, if the plan doesn't decide in your favor, your appeal is automatically sent to an independent organization that works for Medicare, not for the plan. This independent organization will review your appeal. You have a right to get a copy of the case file that the plan sends to the independent organization, if you ask for it.

Note: If you have drug coverage through a Medicare Health Plan, see Section 5 for the appeal timeframes.

5. Fast appeals in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities

You also have the right to a fast appeals process. This option is available whenever you are getting services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility.

Words in
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on pages
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Section 4: Your Rights and Protections in a Medicare Health Plan

5. (continued)

You will get a notice from your provider that will tell you how to ask for an appeal if you think your health plan is ending coverage of these services too soon. You will be able to get a quick review of this decision, with independent doctors looking at your case and deciding if your services need to continue.

See your plan's membership materials or call your plan for details about your appeal rights.

6. File a grievance about other concerns or problems

You have a right to file a grievance if you have concerns or problems with your Medicare Health Plan. For example, if you believe your plan's hours of operation should be different, or there aren't enough specialists in the plan to meet your needs, you can file a grievance. Check your plan's membership materials or call your plan to find out how to file a grievance.

7. Fast appeals in Hospitals

If you are admitted to a hospital that participates in Medicare, you should be given a copy of the "Important Message From Medicare" notice. It explains your rights as a hospital patient. If you aren't given a copy, ask for it. The "Important Message From Medicare" notice tells you

- that you have the right to get all of the hospital care you need, and any follow-up care that is covered by your Medicare Health Plan after you leave the hospital,
- what to do if you think the hospital is making you leave too soon,
- what your appeal rights are, and
- what you may have to pay.

When your health plan thinks you no longer need inpatient hospital care, they will give you another notice about your discharge and appeal rights if you think your hospital care should continue. You have to tell someone in the hospital (like a doctor or nurse) if you think your hospital care should continue. If you aren't given a notice, ask for it. This notice explains

- why you are being discharged,
- how to get a fast appeal,
- when to ask for a fast appeal, and

- what you may have to pay.

Words in
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on pages
33–37.
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Section 4: Your Rights and Protections in a Medicare Health Plan

7. (continued)

When you get this notice, if you still think the hospital is making you leave too soon, you can call or write the Quality Improvement Organization in your state to get a fast appeal. If you file timely, you will be able to stay in the hospital at no charge while the Quality Improvement Organization reviews your case. The hospital can't force you to leave before the Quality Improvement Organization makes a decision. To get this telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Important: Before you are discharged from the hospital, the hospital must give you a notice about your discharge and appeal rights if you tell someone in the hospital that you think your hospital care should continue. If the hospital doesn't provide you with a notice explaining your discharge and appeal rights, and you decide to stay in the hospital after your discharge date, you can't be charged for the costs of your care. If you have questions about your rights as a hospital patient, call your Medicare Health Plan or the Quality Improvement Organization in your state. Their telephone number is on the notice of discharge and appeal rights the hospital gives you. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

8. Call your Medicare Health Plan

- before you get a service or supply to find out if it will be covered. Your plan must tell you if you ask.
- to get information about skilled nursing facility coverage.
- if you have questions about home health care rights and protections.

9. Privacy of Personal Health Information

You have the right to have the privacy of your health information protected. For more information about your rights to privacy, look in your plan materials or call your plan.

Section 5: Your Rights and Appeals in a Medicare Drug Plan

If your pharmacist tells you that your Medicare drug plan won't cover a drug you believe should be covered, or that you will have to pay more for the drug than you think is required, you have the right to request a coverage determination by your plan. You may also pay for the prescription and request that the plan pay you back by requesting a coverage determination.

You, your doctor, or your appointed representative can call your plan or write them a letter to request that the plan cover the prescription you need. Once your plan has received the request, it generally has 72 hours (for a standard request for coverage or to pay you back) or 24 hours (for an expedited request for coverage) to notify you of its decision.

Note: For some types of coverage determinations called exceptions, you will need a

supporting statement from your doctor explaining why you need a particular drug. Check with your plan to find out if the supporting statement is required. Once your plan gets the statement, its decision-making time period begins.

Tip: Any person you appoint, such as a family member or your doctor, may help you request a coverage determination or an appeal. If you have questions about appointing a representative, you can call 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can also get a copy of the

"Appointment of Representative" form at

www.medicare.gov/basics/forms/default.asp

on the web (CMS Form Number 1696).

If the plan decides not to cover the drug, you can appeal the decision. There are **five levels** of appeal that you can use. All of these levels are available to you but may not be necessary.

1. Appeal through your plan. You must request the appeal, called a redetermination, within 60 calendar days from the date of the notice of the decision. A standard request must be made in writing unless your plan accepts requests by telephone. You can call your plan or write to them for an expedited (fast) request. The plan's coverage determination decision will explain how you can request this appeal. Once your plan receives your request for an appeal, the plan has seven calendar days (for a standard request for coverage or reimbursement) or 72 hours (for an expedited request for coverage) to notify you of its decision.

2. Review by a Qualified Independent Contractor. If the plan again decides not to cover the drug, you can request a review, called a reconsideration, by

a Qualified Independent Contractor. You must make the request within 60 days from the date of the notice of the decision. The request must be made in writing. The plan's redetermination decision will explain how you can request this appeal. Once the request for review has been filed, the Qualified Independent Contractor has seven calendar days (for a standard request for coverage or reimbursement) or 72 hours (for expedited requests for coverage) to notify you of its decision.

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Section 5: Your Rights and Appeals in a Medicare Drug Plan

3. Hearing by an Administrative Law Judge. If the Qualified Independent Contractor (QIC) agrees with your plan's decision, you can request a hearing with an Administrative Law Judge. You must make the request in writing within 60 days from the date of the notice of the Qualified Independent Contractor decision. To get an Administrative Law Judge hearing, the projected value of your denied coverage must meet a minimum dollar amount. The QIC's decision will explain how you can request this appeal and give the minimum dollar amount that you must meet.

4. Review by the Medicare Appeals Council. If the Administrative Law Judge (ALJ) agrees with your plan's decision, you can request (in writing) a review by the Medicare Appeals Council. The ALJ's decision will explain how you can request this appeal.

5. Review by a Federal court. If the Medicare Appeals Council (MAC) agrees with your plan's decision, you can request (in writing) a review by a Federal court. To get a review by a Federal court, the projected value of your denied benefits must meet a minimum dollar amount. The MAC's decision will explain how you can request this appeal and give the minimum dollar amount that you must meet.

Important: When you enroll in a Medicare drug plan, the plan will send you information about the plan's appeal procedures. Read the information carefully and call your plan if you have questions.

Privacy of Personal Health Information

You have the right to have the privacy of your health and prescription drug information protected. For more information about your right to privacy, look in

your plan material or call your plan.

What can I do if I have a complaint about my Medicare drug plan?

If you have a complaint about your Medicare drug plan, you have the right to file a complaint (called a “grievance”) with the plan. You should file your complaint within

60 days of the event that led to your complaint. Some examples of why you might file a complaint include the following:

- You believe your plan’s customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The company offering your plan is sending you materials not related to the drug plan that you didn’t ask to get.

Medicare Booklets

Health care decisions are important. Medicare tries to give you information to help you make good decisions. You can get free booklets from Medicare to learn more about the topics that are of interest to you. We are always adding new booklets with detailed information about important subjects to www.medicare.gov on the web.

How do I get these Medicare booklets?

To get these Medicare booklets, you can do the following:

1. Visit www.medicare.gov on the web. Select “Search Tools” at the top of the page. Then, select “Find a Medicare Publication.” You can read, print, or download copies of Medicare booklets.
2. Put your name on the web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select “Mailing List” at the top of the page.

Many booklets are available in English and Spanish. Visit www.medicare.gov on the web for a list of available booklets. To find out if a booklet is available in print, on Audiotape (English and Spanish), Braille, or Large Print (English and Spanish), call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Section 6: For More Information

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Section 7: Words to Know

Appeal—A special kind of complaint you make if you disagree with certain kinds of decisions made by Original Medicare, your health plan, or prescription drug plan. You can appeal if you request a health care service, supply, or prescription that you think you should be able to get, or you request payment for health care service, supply, or prescription you already received, and Medicare, a health plan, or prescription drug plan denies the request. You can also appeal if you are already receiving coverage and Medicare or the plan stops paying. There are specific processes your Medicare Advantage Plan, other Medicare Health Plan, Medicare drug plan, or the Original Medicare Plan must use when you ask for an appeal.

Coinsurance—The amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.

Comprehensive Outpatient

Rehabilitation Facility—A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

Copayment—In some Medicare

health and prescription drug plans, the amount you pay for each medical service, like a doctor's visit or prescription. A copayment is usually a set amount you pay. For example, this could be \$10 or \$20 for a doctor's visit or prescription. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Coverage Determination—A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

End-Stage Renal Disease (ESRD)—Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

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Exception—A type of coverage determination made by a Medicare drug plan. You may request a formulary exception if you or your doctor believe that you need a drug that isn't on your plan's list of covered drugs. You may request a tiering exception if you or your doctor believe that you should pay the preferred cost-sharing amount for a nonpreferred drug. Your doctor must provide a supporting statement demonstrating the medical reason why you need a drug that isn't on your plan's list of covered

drugs, or why you should be allowed to pay a lower cost-sharing amount for a non-preferred drug.

Grievance—A complaint about the way your Medicare Health Plan or prescription drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved towards you. A grievance isn't the way to deal with a complaint about a service, supply, or prescription that isn't covered (see Appeal).

Guaranteed Issue Rights (also called "Medigap Protections")—Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a policy or place conditions on a policy, such as exclusions for pre-existing conditions, and can't charge you more for a policy because of past or present health problems.

Health Maintenance Organization Plan (Medicare)—A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your costs may be lower than in the Original Medicare Plan.

Home Health Agency—An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy,

speech therapy, and personal care by home health aides.

Home Health Care—Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speechlanguage pathology services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services covered under Medicare Part A and B.

Hospice—A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver as well. Hospice care is covered under Medicare Part A (Hospital Insurance).

Section 7: Words to Know

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Section 7: Words to Know

Inpatient Hospital Care—Health care that you get when you are admitted to a hospital.

Medicare Advantage Plan—A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plans, and aren't paid for under Original Medicare.

Medicare Cost Plans—Medicare Cost Plans are a type of HMO that contracts as a Medicare Health Plan. As with other HMOs, the plan only pays for services outside its service area when they are emergency or urgently needed services. However, when you are enrolled in a Medicare Cost Plan, if you get routine services outside of the plan's network without a referral, your Medicare-covered services will be paid for under the Original Medicare Plan, and you will be responsible for the Original Medicare Plan deductibles and coinsurance.

Medicare Health Plan—A plan offered by a private organization that contracts with Medicare to provide you with your Medicare Part A and/or Part B benefits. Medicare Health Plans include Medicare Advantage Plans (including HMOs, PPOs, or Private Fee-for-Service Plans); Medicare Cost Plans; PACE plans; and Special Needs Plans.

Medicare Summary Notice—A notice you get after the doctor files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medigap Policy—Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are up to 12 standardized plans labeled Medigap Plan A through Plan L. Medigap policies only work with the Original Medicare Plan.

Medigap Open Enrollment

Period—A one-time only six month period when you can buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B **and** you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

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Section 7: Words to Know

Original Medicare Plan—A fee-for-service health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases, you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

PACE (Programs of All-inclusive Care for the Elderly)—PACE combines medical, social, and longterm care services for frail people to help people stay independent and living in their community as long as possible, while getting the high-quality care they need. PACE is a joint Medicare and Medicaid program that is only available in states that include the PACE program as a Medicaid benefit. To be eligible, you must

- be 55 years old or older,
- live in the service area of the PACE

program,

- be certified as eligible for nursing home care by the appropriate state agency, and
- be able to live safely in the community.

Preferred Provider Organization

Plan(Medicare)—A type of Medicare Advantage Plan in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Private Fee-for-Service Plan—A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare Program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Quality Improvement

Organization—Groups of practicing doctors and other health care experts. They are paid by the federal government to improve the care given to Medicare patients. They must review patients' complaints about the quality of any Medicare-covered services. These organizations must also review discharges from hospitals, and may in some cases review discharges from other institutional providers.

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Section 7: Words to Know

Skilled Nursing Facility—A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitative services and other related health services.

Skilled Nursing Facility Care—This is a level of care that requires daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can't be provided on an outpatient basis. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (for example, assistance with activities of daily living, like bathing and dressing) can't, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for coverage based on your need for skilled nursing or rehabilitation, Medicare will cover all of your care needs in the facility, including assistance with activities of daily living.

Special Needs Plan—A special type of plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, or those who reside in a nursing home, or who have certain chronic medical conditions.

State Health Insurance Assistance Program—A State program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

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