Your Medicare Rights and Protections

This booklet has important information about:

- Your right to file a complaint.
- Your right to get health care services you need.
- Where you can get help with your questions.

HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

What's In This Booklet

Introduction

As a Medicare beneficiary, you have certain guaranteed rights and protections. They:

- 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.

Read this booklet so you will know about your rights and protections, and where you can get help.

How To Use This Booklet

This booklet has 8 sections. You can see which section you are reading at the top of each page. The index in Section 8 on pages 28-29 can help you find a specific topic in this booklet. Words in red are defined in Section 7 on pages 25-27.

If you have questions as you read through this booklet, write them down. Look in Section 6 on pages 22-24 to see who you can call for help with your questions. You will not find information about the benefits and costs of health plans in this booklet. If you want this information, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the health plan comparison information for your area.

Section 1: A Quick Look At Medicare (pages 3-4).
Read this section if you don't know much about Medicare. It will tell you the difference between the Original Medicare Plan, a Medicare managed care plan (like an HMO), and a Medicare Private Fee-for-Service plan. You may need to refer back to this section as you read through this booklet.

Words in red are defined on pages 25-27.

Section 2: Your Medicare Rights (pages 5-8).
Read this section to find out your rights as a Medicare beneficiary. It lists all of the rights you have no matter if you are in the Original Medicare Plan, a Medicare managed care plan (like an HMO), a Medicare Private Fee-for-Service plan, or have a Medigap (Medicare Supplement Insurance) policy.

How To Use This Booklet (continued)

Section 3: Your Rights and Protections in the Original Medicare Plan (pages 9-15).
Read this section if you have the Original Medicare Plan, or have a Medigap (Medicare Supplement Insurance) policy. It lists specific rights for people who have this plan or policy. The rights listed in this section are in addition to the rights in Section 2.

Section 4: Your Rights and Protections in a Medicare Managed Care Plan (pages 16-18).
Read this section if you have a Medicare managed care plan (like an HMO). It lists specific rights for people who have one of these plans. The rights listed in this section are in addition to the rights in Section 2.

Section 5: Your Rights and Protections in a Medicare Private Fee-for-Service Plan (pages 19-20).
Read this section if you have a Medicare Private Fee-for-Service plan. It lists specific rights for people who have one of these plans. The rights listed in this section are in addition to the rights in Section 2.

Section 6: For More Information (pages 21-24).
Read this section to find out how to get booklets on other Medicare topics and who you can call to get help with your questions. It lists telephone numbers to call in your state.

Section 7: Words To Know (pages 25-27).
Read this section to get the meaning of words in red used in this booklet.

Words in red are defined on pages 25-27.

Section 8: Index (pages 28-29).
Use this section if you are looking for a specific topic. It gives you the page(s) where that topic is found in this booklet.

The *Your Medicare Rights and Protections* booklet is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Section 1: A Quick Look At Medicare

What is Medicare?

Medicare is a health insurance program for:

- People age 65 or older.
- Some people under age 65 with disabilities.
- People with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

What are my Medicare health plan choices?

Depending on where you live, you may be able to get your health care in one of three ways:

1. The Original Medicare Plan,
2. A Medicare managed care plan (like an HMO), or
3. A Medicare Private Fee-for-Service plan.

What is the Original Medicare Plan?

The Original Medicare Plan is also known as "fee-for-service." This plan, managed by the federal government, is available nationwide. You are usually charged a fee for each health care service or supply you get. 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 does not cover, you may have a Medigap (Medicare Supplement Insurance) policy.

What is a Medigap 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 insurance must follow federal and state laws. These laws protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."

Words in red are defined on pages 25-27.

Section 1: A Quick Look At Medicare

What is a Medicare managed care plan?

A Medicare managed care plan, sometimes called an HMO, is a health plan offered by private companies in some areas to people with Medicare. If you have a Medicare managed care plan, you use your plan membership card when you get health care.

What is a Medicare Private Fee-for-Service plan?

A Medicare Private Fee-for-Service plan is a Medicare health plan offered by a private company. This plan is available in some areas of the country to people with Medicare. It is not the same as the Original Medicare Plan. If you have a Medicare Private Fee-for-Service plan, you use your plan membership card when you get health care.

If you want more specific information about these plans, look at www.medicare.gov on the web. Select "Publications" and choose the *Medicare & You* handbook. Or, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of this handbook.

Words in red are defined on pages 25-27.

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, a Medigap policy, a Medicare managed care plan, or a Medicare Private Fee-for-Service plan. These rights include:

Respect

You have the right to be treated with dignity and respect at all times.

Protection Against Discrimination

There are laws that do not allow discrimination. Every company or agency that works with Medicare must obey the law. They cannot discriminate against you (treat you unfairly) because of your:

- Race,
- Color,
- National origin,
- Religion,
- Age, or
- Mental or physical disability.

You also have the right to have someone help you overcome a language, physical, or communication barrier.

If you think you have been discriminated against for any of these reasons, call the Office for Civil Rights in your state. The telephone number for the Office for Civil Rights in your state is in your copy of the *Medicare & You* handbook, and at www.medicare.gov on the web. Select "Helpful Contacts." You can also call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for this number.

Words in red are defined on pages 25-27.

Section 2: Your Medicare Rights

Information

You have a right to get easy-to-understand information about Medicare to help you make decisions about your health care.

You have the right to get information about:

- What is covered.
- What costs are paid.
- How much you have to pay.
- What to do if you want to file a complaint.

You have the right to have someone help you make informed health care decisions when you need it.

You have a right to have your questions about the Medicare program answered. To get your questions answered, you can:

- Call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can get help in English or Spanish.

- Call the State Health Insurance Assistance Program (SHIP) in your state. These telephone numbers are listed on page 24.

Emergency Care

You have a right to 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. You may 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 in a Medicare managed care plan, you do not need to get permission from a primary care doctor before you get emergency 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 does not pay its share for your emergency care, you have the right to appeal (see page 7).

Words in red are defined on pages 25-27.

Section 2: Your Medicare Rights

Treatment Choices

You have the right to talk with your doctors about your health care and know all of your treatment choices in language that is clear to you.

You have the right to fully participate in all decisions related to your health care. 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 cannot have rules that stop your doctor from telling you what you need to know about your treatment choices.

Complaints

You have the right to 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. There are two kinds of complaints: appeals and grievances.

Appeals: Billing, Payment, or Service Issues

You have the right to appeal any official decision about your Medicare services. If Medicare does not pay for a Medicare-covered item or service you have been given, does not pay enough for an item or service you have been given, or if you are not given a Medicare-covered item or service you think you should get, you can appeal. For more information on filing an appeal, call the State Health Insurance Assistance Program (SHIP) in your state. These telephone numbers are listed on page 24.

Grievances: Quality of Care Issues

You have a right to file a complaint if you think you are not getting quality health care. This type of complaint is called a "grievance." If you want to file a grievance about the quality of health care you have received, call the Peer Review Organization (PRO) in your state. These telephone numbers are listed on page 22.

Words in red are defined on pages 25-27.

Section 2: Your Medicare Rights

Privacy of Personal Information

You have the right to have your personal 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 personal information, you have the right to know why it is needed, whether it is required or optional, what happens if you don't give the information, and 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/TDD: 1-877-486-2048 for the hearing and speech impaired).

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 (SHIP). These telephone numbers are listed on page 24.

Privacy of Health Information

You have the right to talk with health care providers in private and to have your personal health care information kept private as protected under federal and state laws.

There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used by your health care provider or your health plan. This rule will be fully effective on April 14, 2003.

Words in red are defined on pages 25-27.

If you have any questions about this privacy rule, call the Office for Civil Rights at 1-866-OCR-PRIV (1-866-627-7748; TTY: 1-866-788-4989 for the hearing and speech impaired). Or, look at http://www.hhs.gov/ocr/hipaa on the web.

If you are in a Medicare managed care plan or a Medicare Private Fee-for-Service plan, you also have the right to timely access to your medical records.

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 or have a Medigap policy, you have the following rights and protections:

Culturally Competent Services

Hospitals, home health agencies, skilled nursing facilities, and hospice facilities must give you 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. You can get this telephone number at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227).

Access to Doctors, Specialists (including Women's Health Specialists), and Hospitals

You have the right to go to any doctor, specialist, or hospital that accepts Medicare.

Appeal Billing, Payment, and Service Issues

You have the right to a fair, efficient, and timely process to resolve issues about payment for a Medicare-covered service or product. This process includes a system of internal review and an independent external review.

You can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service that you received. Your appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from the company that handles bills for Medicare. The notice will tell you why your bill was not paid, how long you have to file an appeal, and what appeal steps you can take. If you decide to file an appeal, ask your doctor or provider for any information that might help your case. You should keep a copy of everything you send to Medicare as part of your appeal.

Words in red are defined on pages 25-27.

To Know If A Service You Are Getting Will Not Be Paid For

You have the right to know if Medicare probably (or certainly) will not pay for items or services that are usually covered. Your doctor, provider, or supplier of health care items or

To Know If A Service You Are Getting Will Not Be Paid For (continued)

services should give you a written notice before they give you any item or service that they think Medicare will probably not pay for. This written notice is called an Advance Beneficiary Notice (ABN). The ABN tells you what items and services Medicare will not pay for and why Medicare won't pay for it. The ABN gives you the chance to make an informed decision about whether you are willing to get the items or services when you will probably have to pay for the items or services out of your own pocket or through other insurance you might have.

What to do if you get an ABN

If your doctor, provider, or supplier gives you an ABN, you will have to decide if you want the items or services. You will be asked to choose between Option 1 or Option 2 by marking a box and signing the ABN. If you choose Option 1, this means you want the items or services and agree to pay for them out of your own pocket or through other health insurance you may have, if Medicare does not pay. If you choose Option 2, this means you do not want the items or services. You can only get an official Medicare decision if you choose Option 1.

If you aren't sure if Medicare was billed for the items or services that you got, write or call your health care provider and ask for an itemized statement. This statement will list each Medicare item or service you got from your doctor, hospital, or any other health supplier. You should get your copy of the itemized statement within 30 days. Also, you can check your Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) to see if the service was billed to Medicare.

Services that Medicare doesn't cover

Doctors and suppliers of health care services don't have to give you an ABN for services that Medicare doesn't cover, such as:

- Routine physical exams.
- Dental services.
- Hearing aids.
- Orthopedic shoes.
- Routine eye exams.

Words in red are defined on pages 25-27.

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

When You Are in the Hospital

If you are admitted to a hospital that takes Medicare patients, you should be given a copy of the *Important Message From Medicare* notice. It explains your rights as a hospital patient. If you are not given a copy, ask for it.

The *Important Message From Medicare* notice tells you:

- You have the right to get all of the hospital care you need, and any follow-up care that is covered by the Original Medicare 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.
- What you may have to pay.

When the hospital staff thinks you no longer need inpatient hospital care, they will notify you of your discharge and appeal rights. If you are not given a notice, ask for it.

This notice explains:

- Why you are being discharged.
- How to get an immediate review.
- When to ask for an immediate review.
- What you may have to pay.

When you get this notice, you can ask for an immediate review by the Peer Review Organization (PRO). To get an immediate review, you can call or write the PRO. **You may be able to stay in the hospital at no charge while the Peer Review Organization reviews your case. The hospital cannot force you to leave before the PRO makes a decision.**

Words in red are defined on pages 25-27.

Before you are discharged from the hospital, the hospital must notify you of your discharge and appeal rights. If the hospital does not notify you of 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 the PRO in your state. Their telephone number is on the copy of the *Important Message From Medicare* notice that you get at the hospital. PRO telephone numbers are also in this booklet on page 22.

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

When You Are in a Skilled Nursing Facility

A skilled nursing facility (SNF) is a Medicare-certified facility that has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. You must meet certain conditions, such as a 3-day hospital stay, for skilled nursing facility care coverage before you are admitted. Some nursing homes give this type of skilled care.

If you are in a SNF, you are protected when your coverage ends. The SNF staff gives you a *Notice of Non-Coverage* when they think you no longer qualify for Medicare coverage. But if you think that you still need skilled nursing facility care, you have the right to have Medicare review the SNF's opinion to decide if you still qualify for Medicare coverage.

To have Medicare decide if you still qualify for SNF coverage:

1. The SNF must send a special kind of claim to Medicare. This special claim is sometimes called a Demand Bill. Check off the box on the *Notice of Non-Coverage* to show that you want a Demand Bill sent to Medicare.
2. Give the Notice to the SNF.
3. The SNF sends the Demand Bill to Medicare.
4. Medicare decides if you still qualify for Medicare-covered SNF care.
5. The SNF will let you know what the decision is.

The SNF must submit the Demand Bill and cannot make you pay a deposit for services that Medicare may not cover until Medicare makes its decision. You must continue to pay any costs that you would normally have to pay while the Demand Bill is being processed. This includes the daily coinsurance and the costs for services and supplies not covered by Medicare.

If Medicare decides your care is no longer covered, you are responsible for the cost of the care you got while you were waiting for the decision.

Words in red are defined on pages 25-27.

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

When You Are in a Skilled Nursing Facility (continued)

You can file an appeal if you do not agree with this decision. To find out how to appeal in the Original Medicare Plan, read the back of the Explanation of Medicare Benefits (EOMB), Medicare Summary Notice (MSN), or Notice of Utilization you get from the company that handles bills for Medicare.

When Your Home Health Care Ends

If you are getting home health care services, you are protected when your home health care is reduced or ends. Home health care agencies must give you a written Home Health Advance Beneficiary Notice (HHABN) that explains why and when they think Medicare will stop paying for all or part of your home health care. Also, home health care agencies must give you a written notice before you get home health care if they think Medicare will not pay for some or all of the home health care services your doctor ordered.

What to do if you get an HHABN

If your home health agency gives you an HHABN, you will have to decide if you want the services or not. You will be asked to choose between Option A, Option B, or Option C. If you choose Option A, this means you want the services and agree to pay for them out of your own pocket or through other health insurance you may have, if Medicare does not pay. If you choose Option B, this means you do not want the services. If you choose Option C, this means you want the services, but do not want the home health agency to send a claim to Medicare. The home health agency may send the claim to you or the other health insurance you may have. You can only get an official Medicare decision if you choose Option A.

To get an official decision, you should:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this decision.
- Pay the home health agency for those services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay. If Medicare does not decide in your favor, you can appeal (see page 7).

Words in red are defined on pages 25-27.

When Your Home Health Care Ends (continued)

If Medicare decides to pay, you will get back any of your payments that you are due. If Medicare decides not to pay, you will get a letter that tells you how to appeal. You can always get home health care if you want to pay for it yourself. If you have questions about home health care in the Original Medicare Plan, call the Regional Home Health Intermediary (RHHI) in your state. These telephone numbers are listed on page 23.

To Buy a Medigap Policy in Certain Situations

If you lose certain types of health care coverage, 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 policy.

The situations involving health coverage changes where you may have a guaranteed issue right to buy a Medigap policy are:

- Your Medicare managed care plan, Medicare Private Fee-for-Service plan, Program of All-Inclusive Care for the Elderly (PACE) provider, or Medicare managed care demonstration project coverage ends because the plan is leaving the Medicare program or stops giving care in your area.

- Your Medicare managed care plan, Medicare Private Fee-for-Service plan, Medicare SELECT policy, or PACE program ends your coverage because you move out of the plan's service area.

- You are in an employer group health plan that pays some of the costs not paid for by Medicare, and the plan ends your coverage.

- Your Medigap policy terminates because the insurance company goes bankrupt or insolvent, and state law does not provide for you to get conversion coverage.

Words in red are defined on pages 25-27.

To Buy a Medigap Policy in Certain Situations (continued)

- You dropped your Medigap policy to join a Medicare managed care plan, Medicare Private Fee-for-Service plan, or PACE program and then leave the plan within one year after joining, or you buy a Medicare SELECT policy for the first time and drop the policy within one year after buying.

- You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or Medicare Private Fee-for-Service plan) or a PACE program when you first became eligible for Medicare at age 65 and you leave the plan within one year of joining.

- A change in your circumstances, such as moving out of the plan's service area, gives you the right to leave (disenroll from) your plan.

The Medigap protections listed above and on page 14 are from federal law. Many states provide more Medigap protections than federal law. This information is at www.medicare.gov on the web. Select "Medigap Compare." You can also call your State Health Insurance Assistance Program (SHIP) (see page 24) or State Insurance Department for more information. You can get the telephone number for the State Insurance Department in your state at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227).

For more detailed Medigap information, look at "Medigap Compare" on the web at www.medicare.gov. Or, select "Publications" and choose the booklet the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy*. You can also call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of this booklet.

If you think any of your Medigap rights have been violated, call the State Health Insurance Assistance Program (SHIP) in your state. These telephone numbers are listed on page 24.

Words in red are defined on pages 25-27.

Section 4: Your Rights and Protections in a Medicare Managed Care Plan

In addition to the rights listed in Section 2, if you are in a Medicare managed care plan, you have the following rights and protections:

Culturally Competent Services

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

Choice of Health Care Providers

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

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 that 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 within the plan for routine and preventive health care services.

Know How Your Doctors Are Paid

You have the right to find out 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 does not allow a health plan to pay doctors in a way that would not let you get the care you need.

Appeal Billing, Payment, and Service Issues

Words in red are defined on pages 25-27.

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

You have the right to file an appeal if your plan will not pay for, does not allow, or stops a service you think should be covered or provided. This includes home health care and care you get in a skilled nursing facility. 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.

Appeal Billing, Payment, and Service Issues (continued)

The plan must tell you in writing why they will not pay for or allow you to get a service, and how to appeal this decision. After you file your appeal, the plan will review its decision. Then, if the plan does not 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. Your plan must give you a copy of your case file if you ask for it.

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

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 managed care plan that are not about payment or service requests. For example, if you believe your plan's hours of operation should be different, or there are not 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.

When You Are in the Hospital

If you are admitted to a hospital that takes Medicare patients, you should be given a copy of the *Important Message From Medicare* notice. It explains your rights as a hospital patient. If you are not given a copy, ask for it.

The *Important Message From Medicare* notice tells you:

- You have the right to get all of the hospital care you need, and any follow-up care that is covered by your Medicare managed care 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.
- What you may have to pay.

Section 4: Your Rights and Protections in a Medicare Managed Care Plan

When You Are in the Hospital (continued)

When the hospital staff thinks you no longer need inpatient hospital care, they will notify you of your discharge and appeal rights. If you are not given a notice, ask for it. This notice explains:

- Why you are being discharged.
- How to get an immediate review.
- When to ask for an immediate review.
- What you may have to pay.

When you get this notice, if you think the hospital is making you leave too soon, you can ask for an immediate review by the Peer Review Organization (PRO). To get an immediate review, you can call or write the PRO. **You may be able to stay in the hospital at no charge while the Peer Review Organization reviews your case. The hospital cannot force you to leave before the PRO makes a decision.**

Before you are discharged from the hospital, the hospital must notify you of your discharge and appeal rights. If the hospital does not notify you of 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 managed care plan or the PRO in your state. Their telephone numbers are on the notice of discharge and appeal rights the hospital gives you. PRO telephone numbers are also on the copy of the *Important Message From Medicare* notice and in this booklet on page 22.

When You Are in a Skilled Nursing Facility

If you are in a skilled nursing facility, the plan must tell you in writing when you do not need skilled care any longer. If you want to appeal this decision, the plan's *Notice of Non-Coverage* will tell you the steps you need to take. The plan may have to continue to pay the costs of your care if you do not get proper notice. Call your plan for more information about skilled nursing facility coverage.

When Your Home Health Care Ends

If you have questions about home health care rights and protections, call your plan.

Section 5: Your Rights and Protections in a Medicare Private Fee-for-Service Plan

In addition to the rights listed in Section 2, if you are in a Medicare Private Fee-for-Service plan, you have the following rights and protections:

Culturally Competent Services

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

Appeal Billing, Payment, and Service Issues

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

You have the right to file an appeal if your plan will not pay for, does not allow, or stops a service you think should be covered or provided. This includes home health care and care you get in a skilled nursing facility. 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.

The plan must tell you in writing why they will not pay for or allow you to get a service, and how to appeal this decision. After you file your appeal, the plan will review its decision. Then, if the plan does not 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. Your plan must give you a copy of your case file if you ask for it.

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

Words in red are defined on pages 25-27.

Section 5: Your Rights and Protections in a Medicare Private Fee-for-Service Plan

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 Private Fee-for-Service plan that are not about payment or service requests. For example, if you believe your plan's hours of operation should be different, or there are not 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.

Call your Medicare Private Fee-for-Service 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 find out what your protections are when you are in the hospital.
- To get information about skilled nursing facility coverage. If you are in a skilled nursing facility, the plan must tell you in writing when you do not need skilled care any longer. If you want to appeal this decision, the plan's *Notice of Non-Coverage* will tell you the steps you need to take. The plan may have to continue to pay the costs of your care if you do not get proper notice.
- If you have questions about home health care rights and protections.

Words in red are defined on pages 25-27.

Section 6: For More Information

Call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for more information about Medicare. A customer service representative can answer your questions between 8:00 a.m. and 4:30 p.m. in your time zone, Monday through Friday. The best times to call are Wednesday, Thursday, or Friday afternoons.

You can also use this telephone number 24 hours a day, 7 days a week to:

- Order Medicare publications,
- Get detailed information about the Medicare health plans in your area, and
- Listen to recorded questions and answers on topics such as Medicare health plan choices and health plan quality information.

Booklets On Other Medicare Topics

If you want more information on Medicare topics of interest, look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). Many free booklets are available in English, Spanish, audiotape (English and Spanish), Braille, and large print (English and Spanish). Some booklets are also available in Chinese.

Some of the booklets below have more information on topics covered in this booklet:

- *Medicare and Home Health Care.*
- *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy.*
- *Medicare Coverage of Skilled Nursing Facility Care.*
- *Your Guide to Private-Fee-for-Service plans.*

Pages 22-24 of this publication are intentionally left blank. They contain phone numbers. For the most recent contact information within this section, please visit the Helpful Contacts section of this site.

Section 7: Words To Know

Advance Beneficiary Notice (ABN) - A notice that a doctor or supplier should give a Medicare beneficiary to sign in the following cases:

1. Your doctor or supplier gives you a service that he or she believes that Medicare does not consider medically necessary; and
2. Your doctor or supplier gives you a service that he or she believes that Medicare will not pay for.

If you do not get an ABN to sign before you get the service from your doctor, and Medicare does not pay for it, then you do not have to pay for it. If the doctor does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor for it. ABNs are only used in the Original Medicare Plan. It does not apply if you are in a Medicare managed care plan.

Appeal - An appeal is a special kind of complaint you make if you disagree with any decision about your health care services. For example, if Medicare doesn't pay or doesn't pay enough for a service you got or would like to get. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is a special process you must use to make your complaint.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Copayment - In some Medicare health plans, the amount that you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5 or $10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

End-Stage Renal Disease (ESRD) - Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Explanation of Medicare Benefits (EOMB) - A notice that is sent to you after the doctor files a claim for Part B services in the Original Medicare Plan. This notice explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. This is being replaced by the Medicare Summary Notice (MSN), which sums up all the services (Part A and B) that were given over a certain period of time, generally monthly. (See Medicare Summary Notice.)

Grievance - A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have problems with the cleanliness of the health care facility, calling the plan, staff behavior, or operating hours. A grievance is not the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

Guaranteed Issue Rights - Rights you have in certain situations when insurance companies are required by law to issue you a Medigap policy.

Section 7: Words To Know

Home Health Care - Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury.

Hospice - Hospice is a special way of caring for people who are terminally ill, and for their family. This includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

Medicare - The Federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare Managed Care Plan - These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare SELECT - A type of Medigap policy that may require you to use doctors and hospitals within its network to be eligible for full benefits.

Medicare Summary Notice (MSN) - A notice you get after the doctor files a claim for Part A and Part B services under the Original Medicare Plan. It explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. You might also get a notice called an Explanation of Medicare Benefits (EOMB) for Part B services, or a Notice of Utilization.

Medigap - A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Open Enrollment Period (Medigap) - A one-time only, six month period after you enroll in Medicare Part B and are age 65 or older, when you can buy any Medigap policy you want. You cannot be denied coverage or charged more due to your health history during this time.

Original Medicare Plan - A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Peer Review Organization (PRO) - Groups of practicing doctors and other health care experts paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private-Fee-for-Service plans, and ambulatory surgical centers.

Section 7: Words To Know

Private Fee-for-Service Plan - A private insurance plan that accepts Medicare beneficiaries. You may go to any Medicare approved doctor or hospital you want. 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 for Medicare covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Program of All-Inclusive Care for the Elderly (PACE) - PACE is a special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

Provider - A doctor, hospital, health care professional, or health care facility.

Quality - Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person--and getting the best possible results.

Regional Home Health Intermediary (RHHI) - A private company that contracts with Medicare to pay home health bills and checks on the quality of home health care.

Skilled Nursing Facility (SNF) - A facility that provides skilled nursing or rehabilitative services to help you recover after a hospital stay.

Skilled Nursing Facility Care* - A level of care that must be given or supervised by licensed nurses. All of your needs are taken care of with this type of service. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average nonmedical person (or one's self) without the supervision of a licensed nurse is not covered.

State Health Insurance Assistance Program (SHIP) - A state program that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

*This definition in whole or in part was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology 2000.

Section 8: Index

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- Necesita usted una copia en Español? Por favor llame gratis al 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 para personas con impedimentos auditivos o del lenguaje oral).

- Do you need a copy in Chinese? Look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of this booklet.