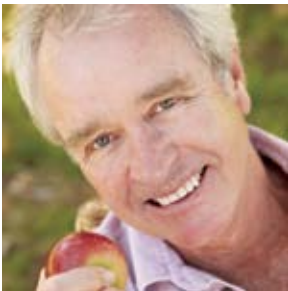


& Medicare You

2015



This is the **official U.S. government** Medicare handbook.

- ★ What's important in 2015 (page 12)
- ★ What Medicare covers (page 35)



CENTERS FOR MEDICARE & MEDICAID SERVICES

Section 7—

Get Information about Prescription Drug Coverage (Part D)

How does Medicare prescription drug coverage (Part D) work?

Medicare offers prescription drug coverage to everyone with Medicare. Even if you don't take many prescriptions now, you should consider joining a Medicare drug plan. If you decide not to join a Medicare drug plan when you're first eligible, and you don't have other [creditable prescription drug coverage](#), or you don't get [Extra Help](#), you'll likely pay a late enrollment penalty if you join a plan later. See pages 104–105. To get Medicare prescription drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and specific drugs covered.

There are 2 ways to get Medicare prescription drug coverage:

1. **Medicare Prescription Drug Plans.** These plans (sometimes called “PDPs”) add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) plans, and Medicare Medical Savings Account (MSA) plans.
2. **Medicare Advantage Plans (like HMOs or PPOs) or other Medicare health plans that offer Medicare prescription drug coverage.** You get all of your Part A, Part B, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called “MA-PDs.” Remember, you must have Part A and Part B to join a Medicare Advantage Plan, and not all of these plans offer drug coverage.

In either case, you must live in the [service area](#) of the Medicare drug plan you want to join. **Both types of plans are called “Medicare drug plans” in this handbook.**

Important!**If you have employer or union coverage**

Call your benefits administrator before you make any changes, or before you sign up for any other coverage. If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union **drug** coverage without also dropping your employer or union **health** (doctor and hospital) coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependents. If you want to know how Medicare prescription drug coverage works with other drug coverage you may have, see pages 108–110.

When can I join, switch, or drop a Medicare drug plan?

- **During your 7-month Initial Enrollment Period, when you first become eligible for Medicare.** You can join a Medicare drug plan during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65. Your coverage will begin the first day of the month after you ask to join a plan. If you join during one of the 3 months before you turn 65, your coverage will begin the first day of the month you turn 65.
- **During your 7-month period around your 25th month of disability.** If you get Medicare due to a disability, you can join during the 7-month period that begins 3 months before your 25th month of entitlement to disability payments, includes your 25th month, and ends 3 months after your 25th month of entitlement to disability payments. Your coverage will begin the first day of the month after you ask to join a plan. If you join during one of the 3 months before you first get Medicare, your coverage will begin the first day of your 25th month of entitlement.
- **During Open Enrollment, between October 15–December 7 each year.** Your coverage begins on January 1 of the following year, as long as the plan gets your request during Open Enrollment.
- **At any time if you qualify for [Extra Help](#).** See pages 111–115.

Definitions of [blue](#) words are on pages 141–144.

Special Enrollment Periods

You generally must stay enrolled for the calendar year. However, in certain situations, you may be able to join, switch, or drop Medicare drug plans at other times. Some examples are if you:

- Move out of your plan's [service area](#).
- Lose other [creditable prescription drug coverage](#).
- Live in an [institution](#) (like a nursing home).
- Have Medicaid.
- Qualify for [Extra Help](#). See pages 111–115.

5-Star Special Enrollment Period

You can switch to a Medicare Prescription Drug Plan that has **5 stars for its overall star rating** between December 8, 2014–November 30, 2015. The overall star ratings are available at Medicare.gov/find-a-plan. These ratings are updated each fall and can change each year. See page 87 for more information.

- You can only switch to a 5-star Medicare Prescription Drug Plan if one is available in your area.
- You can only use this Special Enrollment Period once during the time noted above.

For more information about overall star ratings, visit Medicare.gov.

Important!

If you have a Medicare Advantage Plan

If your Medicare Advantage Plan includes prescription drug coverage and you join a Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.

How do I switch?

You can switch to a new Medicare drug plan simply by joining another drug plan during one of the times listed on pages 98–99. **You don't need to cancel your old Medicare drug plan.** Your old Medicare drug plan coverage will end when your new drug plan begins. You should get a letter from your new Medicare drug plan telling you when your coverage with the new plan begins.

How do I drop a Medicare drug plan?

If you want to drop your Medicare drug plan and you don't want to join a new plan, you can only do so during certain times. See pages 98–99. You can disenroll by calling 1-800-MEDICARE (1-800-633-4227). [TTY](#) users should call 1-877-486-2048.



You can also send a letter to the plan to tell them you want to disenroll. If you drop your plan and want to join another Medicare drug plan later, you have to wait for an enrollment period. You may have to pay a late enrollment penalty. See pages 104–105.

How much do I pay?

Below and continued on the next page are descriptions of what you pay in your Medicare drug plan. **Your actual drug plan costs will vary depending on:**

- Your prescriptions and whether they're on your plan's [formulary](#) (drug list).
- The plan you choose.
- Which pharmacy you use (whether it offers preferred or standard cost sharing, is out-of-network, or mail order).
- Whether you get [Extra Help](#) paying your Part D costs. See pages 111–115.

Monthly premium

Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. If you're in a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium may include an amount for prescription drug coverage.

Note: Contact your drug plan (not Social Security or the Railroad Retirement Board (RRB)) if you want your premium deducted from your monthly Social Security or RRB payment. If you want to stop premium deductions and get billed directly, contact your drug plan.

Definitions of [blue](#) words are on pages 141–144.

Important!

If you have a higher income, you might pay more for your Part D coverage. If your income is above a certain limit, you'll pay an extra amount in addition to your plan premium. This doesn't affect everyone, so most people won't have to pay a higher amount.

Usually, the extra amount will be deducted from your Social Security check. If you get benefits from the Railroad Retirement Board (RRB), the extra amount will be deducted from your RRB check starting in 2015. **If you're billed the amount by Medicare or the RRB, you must pay the extra amount to Medicare or the RRB and not your plan.**

If you have to pay an extra amount and you disagree (for example, you have a life event that lowers your income), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

If your yearly income in 2013 was			You pay (in 2015)
File individual tax return	File joint tax return	File married & separate tax return	
\$85,000 or less	\$170,000 or less	\$85,000 or less	Your plan premium
above \$85,000 up to \$107,000	above \$170,000 up to \$214,000	N/A	\$12.30 + your plan premium
above \$107,000 up to \$160,000	above \$214,000 up to \$320,000	N/A	\$31.80 + your plan premium
above \$160,000 up to \$214,000	above \$320,000 up to \$428,000	above \$85,000 up to \$129,000	\$51.30 + your plan premium
above \$214,000	above \$428,000	above \$129,000	\$70.80 + your plan premium

Yearly deductible

This is the amount you must pay before your drug plan begins to pay its share of your covered drugs. Some drug plans don't have a deductible.

Copayments or coinsurance

These are the amounts you pay for your covered prescriptions after the deductible (if the plan has one). You pay your share and your drug plan pays its share for covered drugs. These amounts may vary.

Coverage gap

Most Medicare drug plans have a coverage gap (also called the “donut hole”). The coverage gap begins after you and your drug plan together have spent a certain amount for covered drugs. In 2015, once you enter the coverage gap, you pay 45% of the plan’s cost for covered brand-name drugs and 65% of the plan’s cost for covered generic drugs until you reach the end of the coverage gap. Not everyone will enter the coverage gap because their drug costs won’t be high enough.

These items all **count** toward you getting out of the coverage gap:

- Your yearly **deductible**, **coinsurance**, and **copayments**
- The discount you get on covered brand-name drugs in the coverage gap
- What you pay in the coverage gap

The drug plan **premium** and what you pay for drugs that aren’t covered **don’t count** toward getting you out of the coverage gap.

Some plans offer additional cost-sharing reductions in the gap beyond the standard benefits and discounts on brand-name and generic drugs, but they may charge a higher monthly premium. Check with the plan first to see if your drugs would have additional cost-sharing reductions during the gap.

In addition to the discount on covered brand-name prescription drugs, there will be increasing coverage for brand-name and generic drugs in the coverage gap each year until the gap closes in 2020.

Catastrophic coverage

Once you get out of the coverage gap, you automatically get “catastrophic coverage.” With catastrophic coverage, you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

Note: If you get **Extra Help**, you won’t have some of these costs. See pages 111–115.

Important!

Usually, the amount you pay for a covered prescription is for a month’s supply of a drug. However, you can request less than a month’s supply for most types of drugs. Some examples of when you might do this would be if you’re trying a new medication that’s known to have significant side effects or you want to synchronize the refills for all your medications. In these cases, the amount you pay is reduced based on the day’s supply you actually get. Talk with your prescriber, because he or she will need to write you a prescription for this smaller supply.

Definitions of **blue** words are on pages 141–144.

The example below shows costs for covered drugs in 2015 for a plan that has a coverage gap.

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2015. She doesn't get **Extra Help** and uses her Medicare drug plan membership card when she buys prescriptions.

Monthly premium—Ms. Smith pays a monthly premium throughout the year

1. Yearly deductible	2. Copayment or coinsurance (what she pays at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first \$320 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment , and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches \$2,960.	Once Ms. Smith and her plan have spent \$2,960 for covered drugs, she's in the coverage gap. In 2015, she pays 45% of the plan's cost for her covered brand-name prescription drugs and 65% of the plan's cost for covered generic drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.	Once Ms. Smith has spent \$4,700 out-of-pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.

Important!

Visit [Medicare.gov/find-a-plan](https://www.Medicare.gov/find-a-plan) to compare the costs of plans in your area. You can also call 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048. For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP). See pages 141–144 for the phone number.

What's the Part D enrollment penalty?



The late enrollment penalty is an amount that's added to your Part D **premium**. You may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Part D or other **creditable prescription drug coverage**.

Note: If you get **Extra Help**, you don't pay a late enrollment penalty.

3 ways to avoid paying a penalty:

1. **Join a Medicare drug plan when you're first eligible.** Even if you don't take many prescriptions now, you should consider joining a Medicare drug plan to avoid a penalty. You may be able to find a plan that meets your needs with little to no monthly premiums.
2. **Don't go 63 days or more in a row without a Medicare drug plan or other creditable coverage.** Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Services, the Department of Veterans Affairs, or health coverage. Your plan must tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
3. **Tell your plan about any drug coverage you had if they ask about it.** When you join a Medicare drug plan, and the plan believes you went at least 63 days in a row without other creditable prescription drug coverage, the plan will send you a letter. The letter will include a form asking about any drug coverage you had. Complete the form, and return it to your drug plan. If you don't tell the plan about your creditable prescription drug coverage, you may have to pay a penalty.

Definitions
of **blue** words
are on pages
145–148.

How much more will I pay?

The cost of the late enrollment penalty depends on how long you didn't have [creditable prescription drug coverage](#). Currently, the late enrollment penalty is calculated by multiplying 1% of the “national base beneficiary premium” (\$33.13 in 2015) by the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest \$.10 and added to your monthly premium. Since the “national base beneficiary premium” may increase each year, the penalty amount may also increase each year. You may have to pay this penalty for as long as you have a Medicare drug plan. After you join a Medicare drug plan, the plan will tell you if you owe a penalty and what your premium will be.

Example:

Mrs. Martin didn't join when she was first eligible—by June 2012. She doesn't have prescription drug coverage from any other source. She joined a Medicare drug plan during the 2014 Open Enrollment Period, and her coverage began on January 1, 2015.

Since Mrs. Martin was without creditable prescription drug coverage from July 2012–December 2014, her penalty in 2015 is 30% (1% for each of the 30 months) of \$33.13 (the national base beneficiary premium for 2015), which is \$9.93. The monthly penalty is rounded to the nearest \$.10, so she'll be charged \$9.90 each month in addition to her plan's monthly premium in 2015.

Here's the math:

.30 (30% penalty) × **\$33.13** (2015 base beneficiary premium) = **\$9.93**

\$9.93 (rounded to the nearest \$0.10) = **\$9.90**

\$9.90 = Mrs. Martin's monthly late enrollment penalty for 2015

What if I don't agree with the penalty?

If you don't agree with your late enrollment penalty, you can ask for a review or reconsideration. You'll need to fill out a reconsideration request form (that your Medicare drug plan will send you), and you'll have the chance to provide proof that supports your case, like information about previous creditable prescription drug coverage.

If you need help, call your plan.

Which drugs are covered?

Information about a plan's list of covered drugs (called a “**formulary**”) isn't included in this handbook because each plan has its own formulary. Many Medicare drug plans place drugs into different “tiers” on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier. In some cases, if your drug is in a higher tier and your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) thinks you need that drug instead of a similar drug in a lower tier, you or your prescriber can ask your plan for an exception to get a lower **copayment** for the drug in the higher tier.

Contact the plan for its current formulary, or visit the plan's website. You can also visit the Medicare Plan Finder at [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan), or call 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048. Your plan will notify you of any formulary changes.

Important!

Each month that you fill a prescription, your drug plan mails you an “Explanation of Benefits” (EOB) notice. This notice gives you a summary of your prescription drug claims and your costs. Review your notice and check it for mistakes. Contact your plan if you have questions or find mistakes. If you suspect fraud, call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). See page 130 for more information about the MEDIC.

Plans may have these coverage rules:

- **Prior authorization**—You and/or your prescriber must contact the drug plan before you can fill certain prescriptions. Your prescriber may need to show that the drug is **medically necessary** for the plan to cover it.
- **Quantity limits**—Limits on how much medication you can get at a time.
- **Step therapy**—You must try one or more similar, lower cost drugs before the plan will cover the prescribed drug.

If you or your prescriber believe that one of these coverage rules should be waived, you can ask for an exception. See page 122.

Definitions of **blue** words are on pages 141–144.

NEW!

Starting in mid-2015, your prescribers need to be enrolled in Medicare or have an “opt-out” request on file with Medicare for your prescriptions to be covered by your Medicare drug plan. Contact your plan or your prescribers for more information.

Do you get automatic prescription refills in the mail?

Some people with Medicare get their prescription drugs by using an “automatic refill” service that automatically delivers prescription drugs when you’re about to run out. To make sure you still need a prescription before they send you a refill, prescription drug plans should get your approval to deliver a new or refilled prescription before each delivery, except when you ask for the refill or new prescription. Be sure to give your drug plan the best way to reach you so you don’t miss the refill confirmation call or other communication. The plan won’t automatically ship your refills unless you confirm you still want to get the order. If you get a prescription automatically by mail that you don’t want, and you weren’t contacted to see if you wanted it before it shipped, you may be eligible for a refund. Did you know you can also sign up online for automatic refills with some pharmacies or get your prescription history? Visit bluebuttonconnector.healthit.gov to learn how.

Medication Therapy Management (MTM) Program

If you’re in a Medicare drug plan and take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a MTM program. This program helps you and your doctor make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You’ll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You’ll also get a personal medication list that will include all the medications you’re taking and why you take them. Have this summary available when you talk with your health care providers.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Your drug plan may enroll you in this program if you meet all of these conditions:

1. You have more than one chronic health condition.
2. You take several different medications.
3. Your medications have a combined cost of more than \$3,138 per year. This dollar amount (which can change each year) is estimated based on your out-of-pocket costs and the costs your plan pays for the medications each calendar year. Your plan can help you find out if you may reach this dollar limit.

Visit [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan) to get general information about program eligibility for your Medicare drug plan or for other plans that interest you. Contact each drug plan for specific details.

How do other insurance and programs work with Part D?

The charts on this page and the next 2 pages provide information about how other insurance you have works with, or is affected by, Medicare prescription drug coverage (Part D).

Employer or union health coverage—Health coverage from your, your spouse's, or other family member's current or former employer or union. If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your prescription drug coverage is creditable. **Keep the information you get.** Call your benefits administrator for more information before making any changes to your coverage. **Note:** If you join a Medicare drug plan, you, your spouse, or your dependents may lose your employer or union health coverage.

COBRA—This is a federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. As explained on pages 26–27, there may be reasons why you should take Part B instead of, or in addition to, COBRA coverage. However, if you take COBRA and it includes **creditable prescription drug coverage**, you’ll have a Special Enrollment Period to join a Medicare drug plan without paying a penalty when the COBRA coverage ends. Talk with your State Health Insurance Assistance Program (SHIP) to see if COBRA is a good choice for you. See pages 141–144 for the phone number.

Medicare Supplement Insurance (Medigap) policy with prescription drug coverage—You may choose to join a Medicare drug plan because most Medigap drug coverage isn’t creditable, and you may pay more if you join a drug plan later. See pages 104–105. Medigap policies can no longer be sold with prescription drug coverage, but if you have drug coverage under a current Medigap policy, you can keep it. If you join a Medicare drug plan, tell your Medigap insurance company so they can remove the prescription drug coverage under your Medigap policy and adjust your **premiums**. Call your Medigap insurance company for more information.

Note: Keep any creditable prescription drug coverage information you get from your plan. You may need it if you decide to join a Medicare drug plan later. Don’t send creditable coverage letters or certificates to Medicare.

How does other government insurance work with Part D?

These types of insurance are all considered creditable prescription drug coverage, and in most cases it will be to your advantage to keep this coverage if you have it.

Federal Employee Health Benefits (FEHB) Program—This is health coverage for current and retired federal employees and covered family members. FEHB plans usually include prescription drug coverage, so you don’t need to join a Medicare drug plan. However, if you decide to join a Medicare drug plan, you can keep your FEHB plan, and in most cases the **Medicare plan** will pay first. For more information for retirees, visit [opm.gov/healthcare-insurance/healthcare](https://www.opm.gov/healthcare-insurance/healthcare) or contact the Office of Personnel Management at 1-888-767-6738. **TTY** users should call 1-800-878-5707. If you’re an active federal employee, you should contact your Benefits Officer. Visit apps.opm.gov/abo for a list of Benefits Officers. You can also call your plan if you have questions.

How does other government insurance work with Part D? (continued)

Veterans' benefits—This is health coverage for veterans and people who have served in the U.S. military. You may be able to get prescription drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a Medicare drug plan, but if you do, you can't use both types of coverage for the same prescription at the same time. For more information, visit va.gov, or call the VA at 1-800-827-1000. TTY users should call 1-800-829-4833.

TRICARE (military health benefits)—This is a health care plan for active-duty service members, military retirees, and their families. **Most people with TRICARE who are entitled to Part A must have Part B to keep TRICARE prescription drug benefits.** If you have TRICARE, you don't need to join a Medicare Prescription Drug Plan. However, if you do, your Medicare drug plan pays first, and TRICARE pays second.

If you join a Medicare Advantage Plan (like an HMO or PPO) with prescription drug coverage, your Medicare Advantage Plan and TRICARE may coordinate their benefits if your Medicare Advantage Plan network pharmacy is also a TRICARE network pharmacy. Otherwise, you can file your own claim to get paid back for your out-of-pocket expenses. For more information, visit tricare.mil, or call the TRICARE Pharmacy Program at 1-877-363-1303.

TTY users should call 1-877-540-6261.

Indian Health Services (IHS)—The IHS is the primary health care provider to the American Indian/Alaska Native (AI/AN) Medicare population. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services through a network of hospitals, clinics, and other entities. Many Indian health facilities participate in the Medicare prescription drug program. If you get prescription drugs through an Indian health facility, you'll continue to get drugs at no cost to you, and your coverage won't be interrupted. Joining a Medicare drug plan may help your Indian health facility because the drug plan pays the Indian health facility for the cost of your prescriptions. Talk to your local Indian health benefits coordinator who can help you choose a plan that meets your needs and tell you how Medicare works with the Indian health care system.

Note: If you're getting care through an IHS or tribal health facility or program without being charged, you can continue to do so for some or all of your care. Getting Medicare doesn't affect your ability to get services through the IHS and tribal health facilities.

Section 8—

Get Help Paying Your Health & Prescription Drug Costs

What if I need help paying my Medicare prescription drug costs?

If you have limited income and resources, you may qualify for help to pay for some health care and prescription drug costs.

Note: [Extra Help](#) isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. See page 118 for information about programs that are available in those areas.

Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs. You may qualify for Extra Help if your yearly income and resources are below these limits in 2014:

- Single person—income less than \$17,505 and resources less than \$13,440 per year
- Married person living with a spouse and no other dependents—income less than \$23,595 and resources less than \$26,860 per year

These amounts may change in 2015. You may qualify even if you have a higher income (like if you still work, live in Alaska or Hawaii, or have dependents living with you). Resources include money in a checking or savings account, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs). Resources **don't** include your home, car, household items, burial plot, up to \$1,500 for burial expenses (per person), or life insurance policies.

Definitions of [blue](#) words are on pages 145–148.

If you qualify for **Extra Help** and join a Medicare drug plan, you'll:

- Get help paying your Medicare drug plan's monthly **premium**, yearly **deductible**, **coinsurance**, and **copayments**.
- Have no coverage gap.
- Have no late enrollment penalty.
- Have the chance to switch plans at any time. Any change you make will take effect the first day of the following month.

You automatically qualify for Extra Help if you have Medicare and meet any of these conditions:

- You have full Medicaid coverage.
- You get help from your state Medicaid program paying your Part B premiums (in a Medicare Savings Program). See pages 115–116.
- You get Supplemental Security Income (SSI) benefits.

To let you know you automatically qualify for Extra Help, Medicare will mail you a purple letter that you should keep for your records. You don't need to apply for Extra Help if you get this letter.

- If you aren't already in a Medicare drug plan, you must join one to use this Extra Help.
- If you don't join a Medicare drug plan, Medicare may enroll you in one so that you'll be able to use the Extra Help. If Medicare enrolls you in a plan, you'll get a yellow or green letter letting you know when your coverage begins.
- Different plans cover different drugs. Check to see if the plan you're enrolled in covers the drugs you use and if you can go to the pharmacies you want. Visit [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan), or call 1-800-MEDICARE (1-800-633-4227) to compare with other plans in your area. **TTY** users should call 1-877-486-2048.
- If you're getting Extra Help, you can switch to another Medicare drug plan anytime. Your new coverage will be effective the first day of the next month.
- If you have Medicaid and live in certain **institutions** (like a nursing home) or get home- and community-based services, you pay nothing for your covered prescription drugs.

Definitions
of **blue** words
are on pages
141–144.

If you don't want to join a Medicare drug plan (for example, because you want only your employer or union coverage), call the plan listed in your letter, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Tell them you don't want to be in a Medicare drug plan (you want to “opt out”). If you continue to qualify for **Extra Help** or if your employer or union coverage is **creditable prescription drug coverage**, you won't have to pay a penalty if you join later.

Important!

If you have employer or union coverage and you join a Medicare drug plan, you may lose your employer or union coverage even if you qualify for Extra Help. Call your employer's benefits administrator before you join a Medicare drug plan.

If you didn't automatically qualify for Extra Help, you can apply at anytime:

- Visit socialsecurity.gov/i1020 to apply online.
- Call Social Security at 1-800-772-1213 to apply for Extra Help by phone or to get a paper application. TTY users should call 1-800-325-0778.
- Visit your State Medical Assistance (Medicaid) office. Visit Medicare.gov/contacts, or call 1-800-MEDICARE to get the phone number.

Note: With your consent, Social Security will forward information to the Medicaid office in your state to start an application for a Medicare Savings Program. See pages 115–116.



Drug costs in 2015 for most people who qualify will be no more than \$2.65 for each generic drug and \$6.60 for each brand-name drug. Look on the Extra Help letters you get, or contact your plan to find out your exact costs.

To get answers to your questions about Extra Help and help choosing a drug plan, call your State Health Insurance Assistance Program (SHIP). See pages 141–144 for the phone number. You can also call 1-800-MEDICARE.

Paying the right amount

Medicare gets information from your state or Social Security that tells whether you qualify for [Extra Help](#). If Medicare doesn't have the right information, you may be paying the wrong amount for your prescription drug coverage.

If you automatically qualify for Extra Help, you can show your drug plan the colored letter you got from Medicare as proof that you qualify. If you applied for Extra Help, you can show your "Notice of Award" from Social Security as proof that you qualify.

You can also give your plan or pharmacy any of the documents listed in the chart below (also called "Best Available Evidence") as proof that you qualify for Extra Help. **Your plan must accept these documents.** Each item must show that you were eligible for Medicaid during a month after June 2014.

Proof you have Medicaid and live in an institution or get home- and community-based services	Other proof you have Medicaid
<ul style="list-style-type: none"> ▪ A bill from the institution (like a nursing home) or a copy of a state document showing Medicaid payment to the institution for at least a month ▪ A print-out from your state's Medicaid system showing that you lived in the institution for at least a month ▪ A document from your state that shows you have Medicaid and are getting home- and community-based services 	<ul style="list-style-type: none"> ▪ A copy of your Medicaid card (if you have one) ▪ A copy of a state document that shows you have Medicaid ▪ A print-out from a state electronic enrollment file or from your state's Medicaid system that shows you have Medicaid ▪ Any other document from your state that shows you have Medicaid

Definitions of [blue](#) words are on pages 145–148.

If you aren't already enrolled in a Medicare drug plan and paid for prescriptions since you qualified for Extra Help, you may be able to get back part of what you paid. **Keep your receipts**, and call Medicare's Limited Income Newly Eligible Transition (NET) Program at 1-800-783-1307 for more information. [TTY](#) users should call 711.

For more information, visit [Medicare.gov/publications](https://www.Medicare.gov/publications) to view the fact sheet “If You Get [Extra Help](#), Make Sure You’re Paying the Right Amount.” You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

Note: Keep all information you get from Medicare, Social Security, the Railroad Retirement Board (RRB), your [Medicare plan](#), Medicare Supplement (Medigap) Insurer, employer, or union. This may include notices of award or denial, “Annual Notices of Change,” notices of [creditable prescription drug coverage](#), or “Medicare Summary Notices.” You may need these documents to apply for the programs explained in this section. Also keep copies of all applications you submit.



What if I need help paying my Medicare health care costs?

Medicare Savings Programs

If you have limited income and resources, you may be able to get help from your state to pay your Medicare costs if you meet certain conditions.

There are 4 kinds of Medicare Savings Programs:

1. **Qualified Medicare Beneficiary (QMB) Program**—Helps pay for Part A and/or Part B [premiums](#), [deductibles](#), [coinsurance](#), and [copayments](#).
2. **Specified Low-Income Medicare Beneficiary (SLMB) Program**—Helps pay Part B premiums only.
3. **Qualifying Individual (QI) Program**—Helps pay Part B premiums only. You must apply each year for QI benefits and the applications are granted on a first-come first-served basis.
4. **Qualified Disabled and Working Individuals (QDWI) Program**—Helps pay Part A premiums only. You may qualify for this program if you have a disability and are working.

Important!

The names of these programs and how they work may vary by state. Medicare Savings Programs aren’t available in Puerto Rico and the U.S. Virgin Islands.

How do I qualify?

In most cases, to qualify for a Medicare Savings Program, you must have:

- Part A
- Monthly income less than \$1,333 and resources less than \$7,160—single person
- Monthly income less than \$1,790 and resources less than \$10,750—married and living together

Note: The amounts above are for 2014 and may change each year.

Many states figure your income and resources differently, so you may qualify in your state even if your income or resources are higher than the amounts listed above. If you have income from working, you may qualify for benefits even if your income is higher than the limits above.

Resources include money in a checking or savings account, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs). Resources **don't** include your home, car, burial plot, burial expenses up to your state's limit, furniture, or other household items. Some states don't have any limits on resources.

For more information

- Call or visit your State Medical Assistance (Medicaid) office, and ask for information on Medicare Savings Programs. To get the phone number for your state, visit Medicare.gov/contacts. You can also call 1-800-MEDICARE (1-800-633-4227), and say “Medicaid.” TTY users should call 1-877-486-2048.
- Contact your State Health Insurance Assistance Program (SHIP). See pages 141–144 for the phone number.

Medicaid

Medicaid is a joint federal and state program that helps pay medical costs if you have limited income and resources and meet other requirements. Some people qualify for both Medicare and Medicaid and are called “**dual eligibles**.”

What does Medicaid cover?

- If you have Medicare and full Medicaid coverage, most of your health care costs are covered. You can get your Medicare coverage through Original Medicare or a Medicare Advantage Plan (like an HMO or PPO).
- If you have Medicare and full Medicaid coverage, Medicare covers your Part D prescription drugs. Medicaid may still cover some drugs and other care that Medicare doesn't cover.

Definitions of blue words are on pages 141–144.

- People with Medicaid may get coverage for services that Medicare may not or may partially cover, like nursing home care, personal care, and home- and community-based services.

How do I qualify?

- Medicaid programs vary from state to state. They may also have different names, like “Medical Assistance” or “Medi-Cal.”
- Each state has different income and resource requirements.
- Many states have expanded their Medicaid programs to cover more people. Even if you were told you didn’t qualify for Medicaid in the past, you may qualify under the new rules.
- In some states, you may need to be enrolled in Medicare, if eligible, to get Medicaid.
- Call your State Medical Assistance (Medicaid) office for more information and to see if you qualify. Visit [Medicare.gov/contacts](https://www.medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227) and say “Medicaid” to get the phone number. TTY users should call 1-877-486-2048.

Demonstration plans for people who have both Medicare and Medicaid

Medicare is working with several states and health plans to create [demonstration](#) plans for certain people who have both Medicare and Medicaid, called Medicare-Medicaid Plans. These plans include all your Medicare and Medicaid benefits, and prescription drug coverage. They’re designed to help better coordinate your benefits. If you’re interested in joining a Medicare-Medicaid Plan, visit [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan) to see if one is available in your area and if you qualify. Call your State Medical Assistance (Medicaid) office for more information. Visit [Medicare.gov/contacts](https://www.medicare.gov/contacts), or call 1-800-MEDICARE and say “Medicaid” to get the phone number.

State Pharmacy Assistance Programs (SPAPs)

Many states have SPAPs that help certain people pay for prescription drugs based on financial need, age, or medical condition. Each SPAP makes its own rules on how to provide drug coverage to its members. To find out if there’s an SPAP in your state and how it works, call your State Health Insurance Assistance Program (SHIP). See pages 141–144 for the phone number.

Pharmaceutical Assistance Programs (also called Patient Assistance Programs)

Many major drug manufacturers offer assistance programs for people with Medicare drug coverage who meet certain requirements. Visit [Medicare.gov/pharmaceutical-assistance-program](https://www.Medicare.gov/pharmaceutical-assistance-program), to learn more about Pharmaceutical Assistance Programs.

Programs of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare and Medicaid program offered in many states that allows people who need a nursing home-level of care to remain in the community. See page 89 for more information.

Supplemental Security Income (SSI) benefits

SSI is a cash benefit paid by Social Security to people with limited income and resources who are disabled, blind, or 65 or older. SSI benefits help people meet basic needs for food, clothing, and shelter. SSI benefits aren't the same as Social Security benefits.

You can visit [benefits.gov/ssa](https://www.benefits.gov/ssa), and use the “Benefit Eligibility Screening Tool” to find out if you're eligible for SSI or other benefits. Call Social Security at 1-800-772-1213 or contact your local Social Security office for more information. **TTY** users should call 1-800-325-0778.

Note: People who live in Puerto Rico, the U.S. Virgin Islands, Guam, or American Samoa can't get SSI.

Programs for people who live in the U.S. territories



There are programs in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to learn more, or call 1-800-MEDICARE (1-800-633-4227) and say “Medicaid” for more information. **TTY** users should call 1-877-486-2048.

Definitions of **blue** words are on pages 141–144.

Section 9—

Know Your Rights & Protect Yourself from Fraud

What are my Medicare rights?

No matter how you get your Medicare, you have certain rights and protections. All people with Medicare have the right to:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Have their personal and health information kept private
- Get information in a way they understand from Medicare, health care providers, and Medicare contractors
- Have questions about Medicare answered
- Have access to doctors, other health care providers, specialists, and hospitals
- Learn about their treatment choices in clear language that they can understand, and participate in treatment decisions
- Get emergency care when and where they need it
- Get a decision about health care payment, coverage of services, or prescription drug coverage
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage
- File complaints (sometimes called “grievances”), including complaints about the quality of their care

What if my plan stops participating in Medicare?

Medicare health and prescription drug plans can decide not to participate in Medicare for the coming year. Plans that choose to leave Medicare entirely or in certain areas are “non-renewing.” In these cases, your coverage under the plan will end after December 31. The plan will send you a letter about your options before Open Enrollment. You can choose another plan during Medicare Open Enrollment between October 15–December 7. Your coverage will begin January 1. If your plan is non-renewing for the next year, you’ll also have a special right to join another [Medicare plan](#) until February 28, 2015.

If you want to continue to have Medicare prescription drug coverage (Part D) or a Medicare Advantage Plan (like an HMO or PPO), without any interruption in coverage, you’ll need to join a new plan by December 31. If you **don’t** join a new Medicare Advantage Plan by December 31, you’ll continue to have Medicare coverage through Original Medicare on January 1, but if you don’t join a Medicare drug plan by that date, you won’t have Medicare drug coverage.

- Generally, if you’re in a [Medicare health plan](#), you’ll automatically return to Original Medicare if you don’t choose to join another Medicare health plan. You’ll also have the right to buy certain Medigap policies within 63 days after your plan coverage ends. If you return to Original Medicare, you can also join a Medicare Prescription Drug Plan.
- If you’re in a Medicare drug plan, you’ll have the right to join another Medicare drug plan or a Medicare health plan with drug coverage. If you don’t join a new plan, you won’t have Medicare drug coverage.

What’s an appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision by Medicare or your Medicare plan. For example, you can appeal if Medicare or your plan denies:

- A request for a health care service, supply, item, or prescription drug that you think you should be able to get.
- A request for payment of a health care service, supply, item, or prescription drug you already got.
- A request to change the amount you must pay for a health care service, supply, item, or prescription drug.

Definitions of [blue](#) words are on pages 141–144.



You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

If you decide to file an appeal, you can ask your doctor, supplier, or other health care provider for any information that may help your case. Keep a copy of everything you send to Medicare or your plan as part of your appeal.

How do I file an appeal?

How you file an appeal depends on the type of Medicare coverage you have:

If you have Original Medicare

1. Get the “Medicare Summary Notice” (MSN) that shows the item or service you’re appealing. Your MSN is the notice you get every 3 months that lists all the services billed to Medicare and tells you if Medicare paid for the services. See pages 69–70.
2. Circle the item(s) you disagree with on the MSN, and write an explanation of why you disagree with the decision on the MSN or on a separate piece of paper and attach it to the MSN.
3. Include your name, phone number, and Medicare number on the MSN, and sign it. Keep a copy for your records.
4. Send the MSN, or a copy, to the company that handles bills for Medicare listed on the MSN. You can include any other additional information you have about your appeal. Or you can use CMS Form 20027, and file it with the Medicare Administrative Contractor at the address listed on the MSN. To view or print this form, visit [cms.gov/cmsforms/downloads/cms20027.pdf](https://www.cms.gov/cmsforms/downloads/cms20027.pdf), or call 1-800-MEDICARE (1-800-633-4227) to have a copy mailed to you. TTY users should call 1-877-486-2048.
5. You must file the appeal within 120 days of the date you get the MSN in the mail.

You’ll generally get a decision from the Medicare Administrative Contractor within 60 days after they get your request. If Medicare will cover the item(s) or service(s), it will be listed on your next MSN.

If you have a Medicare health plan

Learn how to file an appeal by looking at the materials your plan sends you, calling your plan, or visiting [Medicare.gov/appeals](https://www.Medicare.gov/appeals).

In some cases, you can file a fast appeal. See materials from your plan and page 123.

If you have a Medicare Prescription Drug Plan

You have the right to do all of these (even before you buy a certain drug):

- Get a written explanation (called a “coverage determination”) from your Medicare drug plan. A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your benefits, including whether a certain drug is covered, whether you’ve met the requirements to get a requested drug, how much you pay for a drug, and whether to make an exception to a plan rule when you request it.
- Ask for an exception if you or your prescriber (your doctor or other health care provider who’s legally allowed to write prescriptions) believes you need a drug that isn’t on your plan’s [formulary](#).
- Ask for an exception if you or your prescriber believes that a coverage rule (like prior authorization) should be waived.
- Ask for an exception if you think you should pay less for a higher tier (more expensive) drug because you or your prescriber believes you can’t take any of the lower tier (less expensive) drugs for the same condition.

How do I ask for a coverage determination?

You or your prescriber must contact your plan to ask for a coverage determination or an exception. If your network pharmacy can’t fill a prescription, the pharmacist will give you a notice that explains how to contact your Medicare drug plan so you can make your request. If the pharmacist doesn’t give you this notice, ask for a copy.

You or your prescriber may make a standard request by phone or in writing, if you’re asking for prescription drug benefits you haven’t gotten yet. If you’re asking to get paid back for prescription drugs you already bought, your plan can require you or your prescriber to make the standard request in writing.

Definitions of blue words are on pages 141–144.

You or your prescriber can call or write your plan for an expedited (fast) request. Your request will be expedited if you haven't gotten the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting.

Important!

If you're requesting an exception, your prescriber must provide a statement explaining the medical reason why the exception should be approved.

What are my rights if I think my services are ending too soon?

If you're getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your Medicare-covered services are ending too soon, you can ask for a fast appeal. Your provider will give you a notice before your services end that will tell you how to ask for a fast appeal. The notice might call it an "expedited determination." You should read this notice carefully. If you don't get this notice, ask your provider for it.

With a fast appeal, an independent reviewer, called a Beneficiary and Family Centered Care [Quality Improvement Organization](#) (BFCC-QIO), will decide if your services should continue.

- It's important to call your BFCC-QIO to request a fast appeal no later than the time shown on the notice you get from your provider. Use the phone number for your BFCC-QIO listed on your notice to request your appeal.
- Ask your doctor or other health care provider to submit any information to the BFCC-QIO that may help your case.
- If you miss the deadline, you may still have appeal rights:
 - If you have Original Medicare, call your BFCC-QIO.
 - If you're in a [Medicare health plan](#), call your plan.

How can I get help filing an appeal?

For more information about the different levels of appeals, visit [Medicare.gov/appeals](https://www.Medicare.gov/appeals). You can also get help filing an appeal from your State Health Insurance Assistance Program (SHIP). See pages 141–144 for the phone number.

What's an "Advance Beneficiary Notice of Noncoverage" (ABN)?



If you have Original Medicare, your doctor, other health care provider, or supplier may give you a notice called an "Advance Beneficiary Notice of Noncoverage" (ABN). This notice says Medicare probably (or certainly) won't pay for some services in certain situations.

What happens if I get an ABN?

- You'll be asked to choose whether to get the items or services listed on the ABN.
- If you choose to get the items or services listed on the ABN, you're agreeing to pay if Medicare doesn't.
- You'll be asked to sign the ABN to say that you've read and understood it.
- Doctors, other health care providers, and suppliers don't have to (but still may) give you an ABN for services that Medicare never covers. See page 62.
- An ABN isn't an official denial of coverage by Medicare. You could choose to get the items listed on the ABN and still ask your health care provider or supplier to submit the claim to Medicare or another insurer. If Medicare denies payment, you can still file an appeal. However, you'll have to pay for the items or services if Medicare determines that the items or services aren't covered (and no other insurer is responsible for payment).

Can I get an ABN for other reasons?

- You may get a "Skilled Nursing Facility ABN" when the facility believes Medicare will no longer cover your stay or other items and services.
- You may get an ABN if you're getting equipment or supplies that are in the DMEPOS Competitive Bidding Program and the supplier isn't a contract supplier.

Definitions of blue words are on pages 141–144.

What if I didn't get an ABN?

If your provider was required to give you an ABN but didn't, in most cases your provider must pay you back what you paid for the item or service.

Where can I get more information about appeals and ABNs?

- Visit [Medicare.gov/appeals](https://www.Medicare.gov/appeals).
- Visit [Medicare.gov/publications](https://www.Medicare.gov/publications) to view the booklet “Medicare Appeals.” You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. **TTY** users should call 1-877-486-2048.
- If you're in a [Medicare plan](#), call your plan to find out if a service or item will be covered.

How does Medicare use my personal information?

Medicare protects the privacy of your health information. The next 2 pages describe how your information may be used and given out by law and explain how you can get this information.

Notice of Privacy Practices for Original Medicare

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, someone you name (“designate”), 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
- 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. Examples include:

- Companies that pay bills for Medicare use your personal medical information to pay or deny your claims, to collect your **premiums**, to share your payment information 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 people with Medicare get quality health care, to provide customer service to you, to resolve any complaints you have, or to contact you about research studies.

Medicare may use or give out your personal medical information for these purposes under limited circumstances:

- Where allowed by federal law to state and other federal agencies that need Medicare data for their program operations (like to make sure Medicare is making proper payments or to coordinate benefits between programs)
- To your health care providers so they know what other treatments you’ve gotten and to coordinate your care (for example, for programs to ensure the delivery of quality health care)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like fraud and abuse investigations)
- For judicial and administrative proceedings (like in response to a court order)
- For law enforcement purposes (like providing limited information to locate a missing person)
- For research studies, including surveys, that meet all privacy law requirements (like 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 coverage under Medicare

- 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. Medicare will not sell or market your personal medical information without your written permission. You may take back (“revoke”) your written permission anytime, except to the extent that 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.
- 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 if it would likely get in the way of these 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.
- Be told about any breach of your personal medical information.
- Get a separate paper copy of this notice.

Visit Medicare.gov for more information on:

- Exercising your rights set out in this notice.
- Filing a complaint, if you believe Original Medicare has violated these privacy rights. Filing a complaint won’t affect your coverage 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. Call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit hhs.gov/ocr/privacy.

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’ll get a new notice by mail within 60 days of the change.

The Notice of Privacy Practices for Original Medicare is effective September 23, 2013.

How can I protect myself from identity theft?

Identity theft happens when someone uses your personal information without your consent to commit fraud or other crimes. Personal information includes things like your name and your Social Security, Medicare, credit card, or bank account numbers. Guard your cards and protect your Medicare and Social Security numbers. **Keep this information safe.**

Only give personal information, like your Medicare number, to doctors, other health care providers, and plans approved by Medicare; any insurer who pays benefits on your behalf; and to trusted people in the community who work with Medicare, like your State Health Insurance Assistance Program (SHIP) or Social Security. Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a provider is approved by Medicare. **TTY** users should call 1-877-486-2048.

If you suspect identity theft, or feel like you gave your personal information to someone you shouldn't have, call your local police department and the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338. TTY users should call 1-866-653-4261. Visit ftc.gov/idtheft to learn more about identity theft.

How can I protect myself and Medicare from fraud?

Most doctors, pharmacists, plans, and other health care providers who work with Medicare are honest. Unfortunately, there may be some who are dishonest. One common form of Medicare fraud is when Medicare is billed for services you never got. Medicare fraud costs everyone a lot of money each year.

Definitions
of **blue** words
are on pages
141–144.

Check your statements for mistakes



When you get health care services, record the dates on a calendar and save the receipts and statements you get from providers to check for mistakes. If you think you see an error or are billed for services you didn't get, do these to find out what was billed:

- Check your “Medicare Summary Notice” (MSN) if you have Original Medicare to see if the service was billed to Medicare. If you're in a [Medicare plan](#), check the statements you get from your plan.
- If you know the health care provider or supplier, call and ask for an itemized statement. They should give this to you within 30 days.
- Visit [MyMedicare.gov](#) to view your Medicare claims if you have Original Medicare. Your claims are generally available online within 24 hours after processing. You can also download your claims information by using Medicare's Blue Button. See page 136. The sooner you see and report errors, the sooner we can stop fraud. You can also call 1-800-MEDICARE (1-800-633-4227). [TTY](#) users should call 1-877-486-2048.

If you've contacted the provider and you suspect that Medicare is being charged for a service or supply that you didn't get, or you don't know the provider on the claim, call 1-800-MEDICARE.



For more information on protecting yourself from Medicare fraud and tips for spotting and reporting fraud, visit [stopmedicarefraud.gov](#), or contact your local Senior Medicare Patrol (SMP) Program. See page 130.

You can also visit [oig.hhs.gov](#) or call the fraud hotline of the Department of Health and Human Services Office of the Inspector General at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950.

Plans must follow rules

Medicare plans must follow certain rules when marketing their plans and getting your enrollment information. They can't ask you for credit card or banking information over the phone or via email, unless you're already a member of that plan. Medicare plans can't enroll you into a plan over the phone unless you call them and ask to enroll, or you've given them permission to contact you.

Important!

Call 1-800-MEDICARE (1-800-633-4227) to report any plans that:

- Ask for your personal information over the phone or email
- Call to enroll you in a plan
- Use false information to mislead you

You can also call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). The MEDIC helps prevent inappropriate activity and fights fraud, waste, and abuse in Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) Programs.

For more information on the rules that Medicare plans must follow, visit [Medicare.gov/publications](https://www.Medicare.gov/publications) to view the booklet "Protecting Medicare and You from Fraud." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. **TTY** users should call 1-877-486-2048.

What's the Senior Medicare Patrol (SMP) Program?

The SMP Program educates and empowers people with Medicare to take an active role in detecting and preventing health care fraud and abuse. The SMP Program not only protects people with Medicare, it also helps preserve Medicare. There's an SMP Program in every state, the District of Columbia, Guam, the U.S. Virgin Islands, and Puerto Rico. Contact your local SMP Program to get personalized counseling, find out about community events in your area, or volunteer. For more information or to find your local SMP Program, visit [smpresource.org](https://www.smpresource.org), or call 1-877-808-2468. You can also call 1-800-MEDICARE.

Fighting fraud can pay

You may get a reward if you help us fight fraud and meet certain conditions. For more information, visit [stopmedicarefraud.gov](https://www.stopmedicarefraud.gov) or [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE.

Definitions of **blue** words are on pages 141–144.

Investigating fraud takes time

Every tip counts. Medicare takes all reports of suspected fraud seriously. When you report fraud, you may not hear of an outcome right away. It takes time to investigate your report and build a case — but rest assured that your information is helping us protect Medicare.

Is my right to my own health information protected?

In most cases, you have the right to request and receive copies of your personal health records in an electronic or paper format from any health care provider. Your health information rights include the right to:

- Access your health information in a paper or electronic format
- Know who has seen your health information
- Correct or amend your health information
- Receive a notice of privacy practices (a privacy policy)
- File a complaint

For more information, or if you think your rights have been violated, visit [hhs.gov/ocr](https://www.hhs.gov/ocr) or call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

What's the Medicare Beneficiary Ombudsman?

An “ombudsman” is a person who reviews complaints and helps resolve them. The Medicare Beneficiary Ombudsman makes sure you have information about:

- Your Medicare coverage
- Making good health care decisions
- Your Medicare rights and protections
- Getting issues resolved

The Ombudsman reviews the concerns raised by people with Medicare through 1-800-MEDICARE and through your State Health Insurance Assistance Program (SHIP).

Visit [Medicare.gov](https://www.Medicare.gov) for information on inquiries and complaints, activities of the Ombudsman, and what people with Medicare need to know.

What are advance directives?

Advance directives are legal documents that allow you to put in writing what kind of health care you would want or name someone who can speak for you if you were too ill to speak for yourself.

These legal documents help ensure your wishes are followed, but it's important to talk to your family, friends, and health care providers about your wishes. You should also make sure that your family, friends, and health care providers have copies of your legal documents. It's better to think about these important decisions and have plans in place before you're ill or a crisis strikes.

Advance directives most often include:

- **A health care proxy** (sometimes called a “durable power of attorney for health care”). This is used to name the person you want to make health care decisions for you if you aren't able to make them yourself.
- **A living will.** This is another way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened.
- **After-death wishes.** These may include choices like organ and tissue donation.

Each state has its own laws for creating advance directives. Some states may allow you to combine your advance directives in one document.

What if I already have an advance directive?

Take time now to review your advance directive to be sure you're still satisfied with your decisions and the person you identify in your health care proxy is still willing and able to carry out your plans. Find out how to cancel or update it in your state if it no longer reflects your wishes.

For more information, contact your health care provider, an attorney, your local Area Agency on Aging, your state health department, or visit Eldercare.gov.

Definitions of blue words are on pages 141–144.

Section 10 —

Get More Information

Where can I get personalized help?

1-800-MEDICARE (1-800-633-4227)

TTY users call 1-877-486-2048

Get information 24 hours a day, including weekends

- Speak clearly, have your Medicare card in front of you, and be ready to provide your Medicare number. This helps reduce the amount of time you may wait to speak to a customer service representative. It also allows us to play messages that may specifically impact your coverage and may help us get you to a representative more quickly.
- To enter your Medicare number, speak the numbers and letter(s) clearly one at a time. Or, enter your Medicare number on the phone keypad. Use the star key to indicate any place there may be a letter. For example, if your Medicare number is 000-00-0000A, you would enter 0-0-0-0-0- 0-0-0-0-*. The voice system will then ask you for that letter.
- Use 1 or 2 words to briefly say what you're calling about.



Tip: You can say “Agent” at any time to talk to a customer service representative.

If you need help in a language other than English or Spanish, let the customer service representative know.

Important!

If you want someone to be able to call 1-800-MEDICARE on your behalf, you need to let Medicare know in writing. You can fill out a “Medicare Authorization to Disclose Personal Health Information” form so Medicare can give your personal health information to someone other than you. You can do this by visiting [Medicare.gov/medicareonlineforms](https://www.Medicare.gov/medicareonlineforms) or by calling 1-800-MEDICARE (1-800-633-4227) to get a copy of the form. TTY users should call 1-877-486-2048. You may want to do this now in case you become unable to do it later.



People who get benefits from the Railroad Retirement Board (RRB) should call 1-800-833-4455 with questions about Part B services and bills.

Did your household get more than one copy of “Medicare & You?”

If you want to get only one copy in the future, call 1-800-MEDICARE. If you want to get the handbook electronically and not get any future copies in the mail, visit [Medicare.gov/gopaperless](https://www.Medicare.gov/gopaperless).

What are State Health Insurance Assistance Programs (SHIPs)?

SHIPs are state programs that get money from the federal government to give local health insurance counseling to people with Medicare. SHIPs aren’t connected to any insurance company or health plan. SHIP volunteers work hard to help you with these Medicare questions or concerns:

- Your Medicare rights
- Billing problems
- Complaints about your medical care or treatment
- Plan choices
- How Medicare works with other insurance

Definitions of blue words are on pages 145–148.

See pages 141–144 for the phone number of your local SHIP. If you would like to become a volunteer SHIP counselor, contact the SHIP in your state to learn more.

Where can I find general Medicare information online?

Visit Medicare.gov

- Get detailed information about the Medicare health and prescription drug plans in your area, including what they cost and what services they provide.
- Find doctors or other health care providers and suppliers who participate in Medicare.
- See what Medicare covers, including [preventive services](#).
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, home health agencies, and dialysis facilities.
- Look up helpful websites and phone numbers.

Where can I find personalized Medicare information online?

Register at MyMedicare.gov

- Complete your “Initial Enrollment Questionnaire” so your claims can get paid correctly.
- Manage your personal information (like medical conditions, allergies, and implanted devices).
- Sign up to get this handbook electronically. You won’t get a printed copy if you choose to get it electronically.
- Manage your personal drug list and pharmacy information.
- Search for, add to, and manage a list of your favorite providers and access quality information about them.
- Track Original Medicare claims and your Part B [deductible](#) status.
- View and order copies of your “Medicare Summary Notices.”



Get access to your personal health information using Medicare's Blue Button. This feature lets you download 12–36 months of claims information for Part A and Part B and 12 months of claims information for Part D. This information can help you make more informed decisions about your care and can give your health care providers a more complete view of your health history. Visit [MyMedicare.gov](https://www.medicare.gov) to use the Blue Button today.

Once you've used the Blue Button, there are a variety of health applications and services to analyze your health information. Visit bluebuttonconnector.healthit.gov to learn more about these useful tools and how to protect your health information once it's in your hands.

How do I compare the quality of plans and providers?

Medicare collects information about the quality and safety of medical care and services given by most [Medicare plans](#) and health care providers. Medicare also has information about the experiences of people with the care and services they get.

Compare the quality of care (how well plans and providers work to give you the best care possible) and services given by health and prescription drug plans or health care providers nationwide by visiting [Medicare.gov](https://www.Medicare.gov) or by calling your State Health Insurance Assistance Program (SHIP). See pages 141–144 for the phone number.

When you, a family member, friend, or SHIP counselor visit [Medicare.gov](https://www.Medicare.gov), use these tools:

- Hospital Compare
- Nursing Home Compare
- Home Health Compare
- Dialysis Facility Compare
- Physician Compare
- Medicare Plan Finder

Definitions of [blue](#) words are on pages 145–148.

These search tools on Medicare.gov give you a “snapshot” of the quality of care and services some plans and providers give. Medicare Plan Finder and Nursing Home Compare both feature a star rating system to help you compare plans and quality of care measures that are important to you. Find out more about the quality of care and services by:

- Asking what your plan or provider does to ensure and improve the quality of care and services. Each plan and health care provider should have someone you can talk to about quality.
- Asking your doctor or other health care provider what he or she thinks about the quality of care or services the plan or other providers give. You can also talk to your doctor or other health care provider about Medicare’s information on quality of care and services.

What’s Medicare doing to better coordinate my care?

Medicare continues to look for ways to better coordinate your care and to make sure that you get the best health care possible. Health information technology (also called “Health IT”) and improved ways to deliver your care can help manage your health information, improve how you communicate with your health care providers, and improve the quality and coordination of your health care. These tools also reduce paperwork, medical errors, and health care costs.

Here are examples of how your **health care providers** can better coordinate your care:

Electronic Health Records (EHRs)—EHRs are records that your doctor, other health care provider, medical office staff, or a hospital keeps on a computer about your health care or treatments.

- EHRs can help lower the chances of medical errors, eliminate duplicate tests, and may improve your overall quality of care.
- Your doctor’s EHR may be able to link to a hospital, lab, pharmacy, or other doctors, so the people who care for you can have a more complete picture of your health. You also have the right to get a copy of your health information for your own personal use and to make sure the information is complete and accurate.

Electronic prescribing—This is an electronic way for your prescribers (your doctor or other health care provider who is legally allowed to write prescriptions) to send your prescriptions directly to your pharmacy. Electronic prescribing can save you money, time, and help keep you safe.

- You don't have to drop off and wait for your prescription. Your prescription may be ready when you arrive.
- Prescribers can check which drugs your insurance covers and may be able to prescribe a drug that costs you less.
- Electronic prescriptions are easier for the pharmacist to read than handwritten prescriptions. This means there's less chance that you'll get the wrong drug or dose.
- Prescribers can be alerted to potential drug interactions, allergies, and other warnings.

Accountable Care Organizations (ACOs)—An ACO is a group of doctors and other health care providers who agree to work together with Medicare to give you more coordinated service and care. ACOs are designed to help your doctors or primary care providers communicate closely with your other health care providers, so they can deliver high-quality care that meets your individual needs and preferences.

If you have Original Medicare and your doctor has decided to participate in an ACO, you'll be notified (either in person or by letter) that your doctor is participating in an ACO.



The notice will also inform you that Medicare may share information about care you received from your doctors and other providers. With this information, the doctors and health care providers in the ACO can have a complete picture of your health and be better able to coordinate your care. Talk with your doctor or call 1-800-MEDICARE (1-800-633-4227) if you have any questions about the information Medicare may share with the ACO in which your doctor participates. **TTY** users should call 1-877-486-2048.

Definitions of **blue** words are on pages 145–148.

Your Medicare benefits, services, costs, and protections won't change if your doctor participates in an ACO. You still have the right to visit and receive care from any doctor or hospital that accepts Medicare at any time, the same way you do now.

For more information, visit [Medicare.gov/acos.html](https://www.Medicare.gov/acos.html), or call 1-800-MEDICARE.

Are there other ways to get Medicare information?

Publications

Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view, print, or download copies of booklets, brochures, or fact sheets on different Medicare topics. You can search by keyword (like “rights” or “mental health”), or select “View all publications.” If the publication you want has an “Order” button, you can have a printed copy mailed to you. You can also call 1-800-MEDICARE (1-800-633-4227) and say “Publications” to have a printed copy mailed to you. TTY users should call 1-877-486-2048. Alternate formats are available at no cost. See the inside of the back cover for more information about auxiliary aids and services for people with disabilities.



Videos

Visit [YouTube.com/cmshhsgov](https://www.youtube.com/cmshhsgov) to see videos covering different health care topics on Medicare’s YouTube channel.

Blogs

Visit blog.medicare.gov for up-to-date news from our website.

Resources for caregivers

Medicare has resources to help caregivers get the information they need. To find out more:

- Visit [Medicare.gov/caregivers](https://www.medicare.gov/caregivers) to help someone you care for choose a drug plan, compare nursing homes, get help with billing, and more.
- Visit the Eldercare Locator, a public service of the U.S. Administration on Aging, at [Eldercare.gov](https://www.eldercare.gov), or call 1-800-677-1116 to find caregiver support services in your area.
- Visit the Patients & Families section of [HealthIT.gov](https://www.healthit.gov) for information about online resources and other eHealth tools designed to support caregivers.

NEW!

Open Payments Program

Sometimes, doctors and hospitals have financial relationships with health care manufacturing companies. These relationships can include money for research activities, gifts, speaking fees, meals, or travel. Open Payments is a federally run program that collects information about these financial relationships and makes it available to you. A public, national database is available for you to look up your health care providers, see if they have any of these relationships, and be more informed about how these relationships may impact your health care decisions. Visit [cms.gov/openpayments](https://www.cms.gov/openpayments) for more information.

State Health Insurance Assistance Program (SHIPs)

For help with questions about appeals, buying other insurance, choosing a health plan, buying a Medigap policy, and Medicare rights and protections.

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts). Thank you.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use, \$300

CMS Product No. 10050
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National Medicare Handbook

- Also available in Spanish and alternate formats, including large print, Braille, audio, or as an eBook.
- Moving? Visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get RRB benefits, contact the RRB at 1-877-772-5772. TTY users should call 1-312-751-4701.

¿Necesita usted una copia de este manual en Español?
Llame al 1-800-MEDICARE (1-800-633-4227).
Los usuarios de TTY deberán llamar al 1-877-486-2048.

If you need help in a language other than English or Spanish, call 1-800-MEDICARE and say “Agent.” Then tell the customer service representative the language you speak, so you can get free interpretation services.



Medicare.gov
1-800-MEDICARE (1-800-633-4227)
TTY 1-877-486-2048



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