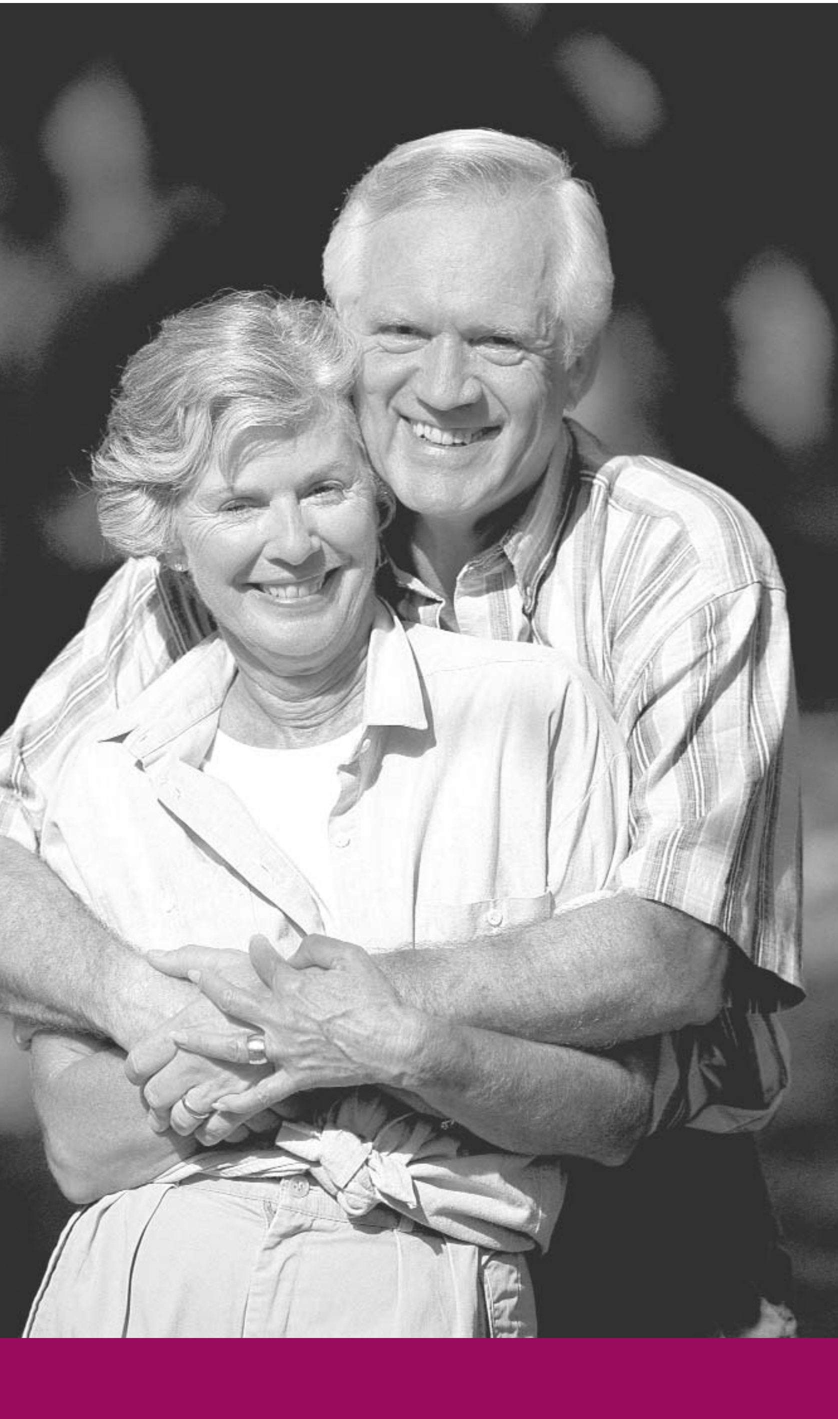

Your Guide to
Private Fee-for-Service Plans

This official government booklet has important information about

- ♦ **Understanding Private Fee-for-Service Plans**
- ♦ **Joining and Leaving Private Fee-for-Service Plans**
- ♦ **Other Important Information on Private Fee-for-Service Plans**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Table of Contents

Private Fee-for-Service Plan Basics 1–4

Private Fee-for-Service Plan Costs 5–6

Joining and Leaving Private Fee-for-Service Plans 7–9

Private Fee-for-Service Plan Covered Services 10–11

Appeal Rights... 12–13

Medigap Information 14–15

For More Information on Private Fee-for-Service Plans 16
State Health Insurance Assistance Program Telephone Numbers 17

Words to Know (Definitions of words in red) 18–19

Index 20

Note: The information in this booklet was correct when it was printed. Changes may occur after printing. For the most up-to-date version, look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). A customer service representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

Your Guide to Private Fee-for-Service Plans isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Private Fee-for-Service Plan Basics

This booklet gives you some general information on Private Fee-for-Service Plans. However, you will need more information than this booklet can give you to decide if a Private Fee-for-Service Plan is the right health care choice for you. This booklet will help you ask the right questions to get the information you need to make your health care choice. **Remember, if you join a Private Fee-for-Service Plan, you are still in the Medicare program.**

What is a Private Fee-for-Service Plan?

A Private Fee-for-Service Plan is a Medicare Advantage Plan offered by a private insurance company. It isn't the same as the Original Medicare Plan which is offered by the Federal Government. In a Private Fee-for-Service Plan, Medicare pays a set amount of money every month to the private insurance company to provide health care coverage to people with Medicare on a pay-per-service arrangement.

Where are Private Fee-for-Service Plans offered?

Because insurance companies decide where they will do business, companies may only offer Private Fee-for-Service Plans in some parts of the country. Insurance companies can decide that a plan will be available to everyone with Medicare in a state, or be open only in certain counties. Insurance companies may also offer more than one plan in an area, with different benefits and costs. Each year, insurance companies offering Private Fee-for-Service Plans can decide to join or leave the Medicare program.

How do Private Fee-for-Service Plans work?

- You can go to any Medicare-approved doctor or hospital that is willing to give you care and accepts the terms of your plan's payment.
- You can get services outside your service area.
- The insurance company, rather than the Medicare program, decides how much you pay for the services you get.

Remember, words in red are defined on pages 18–19.

How do Private Fee-for-Service Plans work? (continued)

- Although the amount you pay for these services might not be the same as the Original Medicare Plan, you get all services covered under Medicare Part A and Medicare Part B.
- You may have extra benefits the Original Medicare Plan doesn't cover. However, you may have to pay more for these extra benefits. To find out what benefits are covered in a Private Fee-for-Service Plan, call the insurance company offering the plan you want and ask for this information. You can also look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."
- Private Fee-for-Service Plans can charge you a monthly premium amount above the Medicare Part B premium.
- Private Fee-for-Service Plans can charge deductible and coinsurance amounts that are different than those under the Original Medicare Plan.
- Private Fee-for-Service Plans can charge a premium for extra benefits such as prescription drugs.
- Private Fee-for-Service Plans may let providers (such as doctors or hospitals) charge you 15% over the plan's payment amount for services. This 15% balance billing amount applies to providers who have a written contract with the Private Fee-for-Service Plan or who the company has decided to think of as having a contract (deemed) because they have met certain conditions. Ask if your Private Fee-for-Service Plan allows providers to balance bill.

  Note: If the provider doesn't have a written contract with the Private Fee-for-Service Plan or isn't deemed to have a contract with the plan, the provider can't charge you more than the plan's cost sharing amount.

Because this could affect how much you will pay for services, find out if your Private Fee-for-Service Plan allows balance billing and what other costs you may have. Even if balance billing is allowed, your provider may be willing to accept the plan's payment amount as payment in full.

Remember, words in red are defined on pages 18–19.

How do Private Fee-for-Service Plans work? (continued)

Example:

Mr. Stevens must go to the hospital for bypass surgery. The hospital he is going to has a contract with his Private Fee-for-Service Plan. This Private Fee-for-Service Plan lets contracting providers "balance bill" (charge Mr. Stevens 15% over the plan's payment amount) for services. Mr. Stevens has a 20% coinsurance amount he must pay for all inpatient hospital services he gets. The Private Fee-for-Service Plan's payment amount for Mr. Stevens' hospital services is $15,000. Mr. Stevens must pay $3,000 (the 20% coinsurance amount). The hospital also charges Mr. Stevens 15% over the $15,000 plan payment amount. This amount is $2,250. Mr. Stevens owes a total of $5,250 ($3,000 + $2,250) to the hospital for his services.

How are Private Fee-for-Service Plans different from the Original Medicare Plan?

The following chart shows some of the differences between Private Fee-for-Service Plans and the Original Medicare Plan. For more information, you can also look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder" to see information that compares all of the Medicare plans in your area.

	Private Fee-for-Service Plans	Original Medicare Plan
Premiums: Will I have to pay more than the monthly Part B premium to be in the plan?	Possibly, and there is no limit on the premium amount that Private Fee-for-Service Plans can charge. Call the insurance company offering the plan to find out.	No.
Benefits: Does the plan cover more benefits than Medicare Part A and Medicare Part B?	Possibly. You may also have to pay an additional premium. Call the insurance company offering the plan to find out.	No.
Providers: Do I have to get services from specific doctors and hospitals for the plan to cover them?	No.	No.
Cost sharing: Does the plan let providers (such as doctors or hospitals) charge me more than Medicare's deductibles, coinsurance, and copayments?	Possibly. Plans may let providers charge you 15% above the plan's payment amount for services. Call the insurance company offering the plan to find out.	No for hospitals. Possibly for doctors. Doctors who don't accept assignment can bill up to 15% above Medicare's payment amount. Call 1-800-MEDICARE (1-800-633-4227) to find out more about assignment.
Medigap: Do I also need a Medigap policy if I join this plan?	You don't need a Medigap policy if you join this plan. In fact, it is illegal for someone to sell you a Medigap policy if you are in this plan.	You may need a Medigap policy to cover services the Original Medicare Plan doesn't cover.

What is the cost of a Private Fee-for-Service Plan?

You pay

- the monthly Medicare Part B premium ($66.60 in 2004),
- any additional monthly premium the Private Fee-for-Service Plan charges above the Medicare Part B premium,
- any additional monthly premium the Private Fee-for-Service Plan charges for extra benefits, and
- any plan deductible, coinsurance, or copayment amounts that the Private Fee-for-Service Plan charges. For example, the plan may charge a set amount (copayment), like $10 or $20 every time you see a doctor.

Example:

Mrs. Jones is thinking about joining a Private Fee-for-Service Plan. The Private Fee-for-Service Plan has a $75 monthly premium, but covers additional benefits Medicare doesn't cover. To be in this plan, Mrs. Jones would have to pay the monthly Medicare Part B premium ($66.60 in 2004) and the additional monthly premium ($75) the plan charges. This plan also charges $10 for every doctor visit. If Mrs. Jones goes to her doctor three times in one month, she would have to pay the $66.60 and $75 monthly premiums, and a total of $30 for her three doctor visits ($10 per visit). Therefore, Mrs. Jones would pay $66.60 to Medicare, $75 to her Private Fee-for-Service Plan, and $30 to her doctor for that month. Her total costs for that month would be $171.60 ($66.60 + $75 + $30).

How do my out-of-pocket costs vary?

Private Fee-for-Service Plans will differ in the amount they charge for premiums, deductibles, and services. The Private Fee-for-Service Plan (rather than Medicare) decides how much you pay for the covered services you get.

Your costs depend on

- which Private Fee-for-Service Plan you choose,
- whether the plan charges an additional monthly premium,
- how much the plan charges per visit,
- whether the plan lets doctors, hospitals, and other providers bill you more than the plan pays (up to a limit) for services (If this is allowed, you must pay the difference, see page 2.),
- how often and the type of health care you get, and
- which extra benefits are covered by the plan.

How will I have to pay provider (such as a doctor or hospital) bills?

If the Private Fee-for-Service Plan pays the doctor or hospital directly, you won't have to pay the doctor or hospital bill. However, other plans may make you pay all of the doctor's or hospital's bill, and pay you back the plan's share later. Before joining any Private Fee-for-Service Plan, you should ask the plan or check plan materials to find out how you will have to pay bills.

Who can join a Private Fee-for-Service Plan?

You can join a Private Fee-for-Service Plan if

- you have both Medicare Part A and Medicare Part B and continue to pay the monthly Medicare Part B premium ($66.60 in 2004). If you aren't sure if you have Part A and Part B, look on your red, white, and blue Medicare card. You can also call your local Social Security office, or call Social Security at 1-800-772-1213.
- you live in the service area of the plan. You will need to check with the insurance company to see if you can stay in the plan if you move out of the plan's service area. If you must leave the plan, you will then be covered under the Original Medicare Plan. Or, you can choose to join another Medicare Advantage Plan if one is available in your new area.
- you don't have End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant, sometimes called ESRD).

If you join a Private Fee-for-Service Plan

- you are still in the Medicare program,
- you still get all your regular Medicare-covered services, and
- you will keep all of your rights and protections under the Original Medicare Plan except that you won't be protected against having to pay for services you got that the Private Fee-for-Service Plan says aren't medically necessary (see example on page 11).

To get more information about your Medicare-covered services, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *Medicare & You* handbook (CMS Pub. No. 10050). TTY users should call 1-877-486-2048.

Remember, words in red are defined on pages 18–19.

How do I join a Private Fee-for-Service Plan?

You can join any Private Fee-for-Service Plan that is available in your area. If you want to join

1. call the plan and ask for an enrollment form. Fill out the form and mail it to the plan, or
2. get an enrollment form from a plan representative. Fill out the form and mail it to the plan, or give it to the plan representative. The plan representative can help you fill out the form.

You will get a letter from the plan telling you when your coverage begins. The plan can't refuse to enroll you if you are eligible.

How do I leave a Private Fee-for-Service Plan?

You can leave a Private Fee-for-Service Plan at any time for any reason. Your plan will let you know, in writing, the date your coverage ends. Generally, this date will be the first day of the month after you ask the plan to disenroll you.

You can leave your Private Fee-for-Service Plan to join a new Medicare Advantage Plan by enrolling in the new plan. You don't need to tell your old plan or send them anything. You will be disenrolled automatically from your old plan when your new plan coverage begins. You should get a letter from your new plan telling you when your coverage starts.

If you want to leave your Private Fee-for-Service Plan and return to the Original Medicare Plan, you can

1. write or call your plan,
2. call 1-800-MEDICARE (1-800-633-4227), or
3. visit, call, or write the Social Security Administration.

Tell them you want to leave your Private Fee-for-Service Plan. The plan should send you a letter with the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

How do I leave a Private Fee-for-Service Plan? (continued)

Note: If you want to change to the Original Medicare Plan and buy a Medigap policy (see pages 14 and 15), you need to leave your Private Fee-for-Service Plan in one of the three ways listed on page 8. Simply signing up for the Medigap plan won't end your Private Fee-for-Service Plan coverage.

Example:

Mr. Smith wants to leave his Private Fee-for-Service Plan and go back to the Original Medicare Plan. He sends a signed letter to his plan on October 3, 2004 telling the plan he wants to leave. Mr. Smith gets a letter from his plan telling him that his coverage ends after October 31, 2004. His Original Medicare Plan coverage starts on November 1, 2004. Mr. Smith must continue to get services through his Private Fee-for-Service Plan from October 3, 2004 to October 31, 2004. On November 1, 2004, Mr. Smith must get services through the Original Medicare Plan.

Remember, if you leave your Private Fee-for-Service Plan and don't join another Medicare Advantage Plan, you will return to the Original Medicare Plan (as long as you continue to pay your Part B premium).

Note: Private Fee-for-Service Plans can leave the Medicare program at the end of the calendar year. See page 16 to find out what you can do if your Private Fee-for-Service Plan leaves the Medicare program.

What services must Private Fee-for-Service Plans cover?

Private Fee-for-Service Plans must cover

- all of the services covered under Medicare Part A and Part B, and
- all services that Medicare considers medically necessary.

They may cover extra benefits, such as extra days in the hospital, but you may have to pay more for these extra benefits.

How do I know if a service I need will be medically necessary?

Private Fee-for-Service Plans must use Medicare's coverage rules to decide what services are medically necessary. This means that if a service is medically necessary under the Original Medicare Plan, then the Private Fee-for-Service Plan must cover the service. You can also ask the plan for an advance coverage decision to make sure the service is medically necessary and will be covered. If you ask for an advance coverage decision, you have the right to get a decision from the Private Fee-for-Service Plan.

Do Private Fee-for-Service Plans cover services that Medicare doesn't consider medically necessary?

Private Fee-for-Service Plans might not cover the costs of services that aren't medically necessary under Medicare. If you need a service that the Private Fee-for-Service Plan decides isn't medically necessary you may have to pay all the costs of the service. However, you have the right to appeal the decision (see pages 12 and 13).

Remember, words in red are defined on pages 18–19.

Do Private Fee-for-Service Plans cover services that Medicare doesn't consider medically necessary? (continued)

Example:

Mrs. Jenkins had a broken arm that healed correctly. Her doctor decided to send her to physical therapy to strengthen her arm instead of showing her simple exercises she could do at home. She gets physical therapy every day for five days. The total cost of the therapy is $250. After Mrs. Jenkins has stopped going to therapy, she finds out that the plan looked at her claim and decided her therapy wasn't medically necessary because her arm healed correctly. Therefore, the plan decided not to pay for her physical therapy services. Mrs. Jenkins must pay the $250 herself. She has the right to appeal this decision if she wants.

What can I do if the Private Fee-for-Service Plan won't pay for services I think I need?

If the Private Fee-for-Service Plan won't pay for a service you think you need,

- you will have to pay all of the costs if you didn't ask for an advance coverage decision.
- you can appeal the decision (see pages 12 and 13).

If you are interested in joining a Private Fee-for-Service Plan, ask the plan or check plan materials to see how they handle medically necessary services and advance coverage decisions.

What can I do if my Private Fee-for-Service Plan won't pay for a service I think is medically necessary?

If your plan won't pay for or doesn't allow a service that you think should be covered (including medically necessary services), you can file an appeal.

How do I question or appeal a Private Fee-for-Service Plan coverage decision?

You have the right to appeal any decision about your Medicare-covered services. This is true whether you are in the Original Medicare Plan or a Private Fee-for-Service Plan. In addition, you have the right to appeal any decision about your Private Fee-for-Service Plan extra benefits.

If you are in a Private Fee-for-Service Plan, you can file an appeal if your plan won't pay for, doesn't allow, stops, or limits a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. They must answer you within 72 hours.

The Private Fee-for-Service Plan must tell you, in writing, how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan doesn't decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

If you believe you are being discharged from a hospital too soon, you have a right to immediate review by the Quality Improvement Organization in your area. A Quality Improvement Organization is a group of doctors and health professionals who monitor and review your complaints about quality of care. You will be able to stay in the hospital at no charge while they review your case. The hospital can't force you to leave before the Quality Improvement Organization reaches a decision. Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for the Quality Improvement Organization in your area or look at www.medicare.gov on the web. Select "Helpful Contacts." TTY users should call 1-877-486-2048.

How do I question or appeal a Private Fee-for-Service Plan coverage decision? (continued)

In addition, you will have the right to a fast-track appeals process. You can get a quick review whenever you are receiving services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility. You will receive a notice from your provider or plan that will tell you how to ask for an appeal if you believe that your services are ending too soon. You will be able to obtain a **quick review** of this decision, with independent doctors looking at your case and deciding if your services need to continue. You may have additional rights if you are in the hospital or a skilled nursing facility, or if your home health care ends.

Can I keep my Medigap policy if I join a Private Fee-for-Service Plan?

Yes, you may keep it. However, it may cost you a lot and you may get little benefit from it while you are in the Private Fee-for-Service Plan. You may want to keep your Medigap policy until you are sure that you are happy with the Private Fee-for-Service Plan. If you are in a Private Fee-for-Service Plan, or if you are covered by Medicaid, you don't need a Medigap policy. Generally, it isn't legal for anyone to sell you one in these cases.

What happens if my Private Fee-for-Service Plan coverage ends?

If your Private Fee-for-Service Plan coverage ends or stops providing care in your area, you can join another Medicare Advantage Plan, if one is available or you can return to the Original Medicare Plan. Generally, if you return to the Original Medicare Plan, you may also have the right to buy a Medigap policy. See page 15 to find out where you can get more information on Medigap policies and protections.

What happens if my Private Fee-for-Service Plan coverage ends and I am under age 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD)?

Depending on where you live in the country, you may have the same protections as those over age 65 if your Private Fee-for-Service Plan coverage ends. There is no federal law that requires insurance companies to sell Medigap plans to people under age 65.

Do I have any Medigap protections if I drop my Medigap policy when I join a Private Fee-for-Service Plan?

If you drop your Medigap policy when you join a Private Fee-for-Service Plan, you may have the right to get another Medigap policy later if

- your Private Fee-for-Service Plan coverage ends (through no fault of your own), or
- you join a Private Fee-for-Service Plan for the first time (and haven't been in another Medicare Advantage Plan), and within one year of joining, you leave the Private Fee-for-Service Plan. If you were new to Medicare when you joined the plan, you may be able to choose any Medigap policy you want. If you already had a Medigap policy before you joined the plan, you may be able to get the same policy back.

Remember, words in red are defined on pages 18–19.

Are there any other times I have a right to buy a Medigap policy?

You have the right to buy any Medigap policy sold in your state if

- you joined a Private Fee-for-Service Plan when you first became eligible for Medicare at age 65, and
- you leave the Private Fee-for-Service Plan within one year after joining.

You can apply for the Medigap policy as early as 60 calendar days before the date your coverage ends. You must apply for the Medigap policy no later than 63 calendar days after your Private Fee-for-Service Plan coverage ends.

Where can I get more information about Medigap policies and protections?

To get more information about Medigap policies and protections you can

- call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110). This guide gives information on buying a Medigap policy and other kinds of health insurance, including information on your Medigap rights and protections.
- call your State Health Insurance Assistance Program (see page 17). Volunteer counselors can help you understand your choices and protections.
- look at www.medicare.gov on the web.

Remember, words in red are defined on pages 18–19.

Where can I get more information about Private Fee-for-Service Plans?

For more information about Private Fee-for-Service Plans or to find out what plans are available in your area, you can

- look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder." If you don't have a computer, your local library or senior center may be able to help you access the Medicare website.
- call 1-800-MEDICARE (1-800-633-4227).
- call the insurance company offering the Private Fee-for-Service Plan you are interested in to answer any questions you have about the plan. The health plan administrator will be able to send you information about the plan and explain all the benefits the plan offers.
- call your State Health Insurance Assistance Program (see page 17).

Note: At the time of printing, the telephone numbers listed on page 17 were correct. Telephone numbers sometimes change. To get the most up-to-date telephone numbers, look at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Remember, words in red are defined on pages 18–19.

For More Information

State Health Insurance Assistance Program: Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, help choosing a Medicare health plan, or Medicare bills.

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

Words to Know

Advance Coverage Decision: A decision that your Private Fee-for-Service Plan makes on whether it will pay for a certain service.

Balance Billing: A situation in which Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill you 15% more than the plan's payment amount for services.

Coinsurance: The percentage of the Private Fee-for-Service Plan amount that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

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

Deductible: The amount you must pay for health care, before the Private Fee-for-Service Plan begins to pay. These amounts can change every year.

Deemed: Providers are "deemed" when they know, before providing services, that you are in a Private Fee-for-Service Plan, and they agree to give you care. Providers that are "deemed" agree to follow your plan's terms and conditions of payment for the services you get.

End-Stage Renal Disease (ESRD): Permanent kidney failure requiring dialysis or a kidney transplant.

Medicaid: A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary: Services or supplies that

- are proper and needed for the diagnosis, or treatment of your medical condition,
- are provided for the diagnosis, direct care, and treatment of your medical condition,
- meet the standards of good medical practice in the local area, and
- aren't mainly for the convenience of you or your doctor.

Medicare Advantage Plan: A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

Medicare Part A (Hospital Insurance): Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance): Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that aren't covered by Part A.

Medigap Policy: A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are ten standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

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

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

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

Quality Improvement Organizations (QIOs): Groups of practicing doctors and other health care experts. They are 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 given by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service Plans, and ambulatory surgical centers.

Service Area: The area where a Private Fee-for-Service Plan accepts members.

State Health Insurance Assistance Program: A State program that gets money from the Federal Government to give free local health insurance counseling to people with Medicare.

Index

Advance Coverage Decision 10, 11, 18
Appeal 12, 13
Balance Billing 2, 18
Coinsurance 2, 4, 5, 18
Copayment 4, 5, 18
Deductible 2, 4, 5, 6, 18
Deemed 2, 18
End-Stage Renal Disease 7, 14, 18
Medicaid 14, 18
Medically Necessary 7, 10, 11, 18
Medicare Advantage Plan 1, 7, 8, 9, 18
Medicare Part A (Hospital Insurance) 2, 7, 10, 18
Medicare Part B (Medical Insurance) 2, 5, 7, 10, 19
Medigap Policy 4, 8, 14, 15, 19
Original Medicare Plan 1, 2, 4, 7, 8, 9, 19
Premium 2, 4, 5, 6, 19
Prescription Drugs 2
Quality Improvement Organization 12, 19
Rights 12, 13, 15
Service Area 1, 7, 19
State Health Insurance Assistance Program 15, 16, 17, 19

Notes

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- To get this booklet in Spanish, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- ¿Necesita usted una copia en español? Llamar gratis al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.