Medicare

Questions and Answers

ABOUT...

...The Original Medicare Plan

...Other Medicare Health Plans

...Medicare Protections and Rights

Introduction

This booklet answers many of the questions you may have about Medicare. It is divided into four sections:

Phone numbers of important contacts are included in *Medicare & You,* which was mailed to all Medicare beneficiaries in November of 1998. For more information about Medicare call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired), or visit our website at www.medicare.gov. Your local library or senior center may be able to help you get information using their computers.

Q: What is Medicare?

A: Medicare is a health insurance program for:

- People 65 years of age and older.
- Certain younger people with disabilities.
- People with End-Stage Renal Disease (people with permanent kidney failure who need dialysis or a transplant, sometimes called ESRD).

Q: What is the Original Medicare Plan?

A: The Original Medicare Plan is the traditional pay-per-visit arrangement. You can go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Then Medicare pays its share, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Q: What is Part A (Hospital Insurance)?

A: Part A (Hospital Insurance) helps pay for care in hospitals and skilled nursing facilities, and for home health and hospice care. If you are eligible, Part A is premium-free, that is, you don't pay a premium because you or your spouse paid Medicare taxes while you were working. Your Fiscal Intermediary* can answer your questions on what Part A services Medicare will pay for and how much will be paid.

* You can find phone numbers for your area in your copy of *Medicare & You* or on the Internet at www.medicare.gov under Important Contacts.

Q: Who is eligible for premium-free Part A?

A: You are eligible for premium-free Part A (Hospital Insurance) if:

- You are 65 or older. You are receiving or eligible for retirement benefits from Social Security or the Railroad Retirement Board, or
- You are under 65. You have received Social Security disability benefits for 24 months, or
- You are under 65. You have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or
- You or your spouse had Medicare-covered government employment, or
- You are under 65 and have End-Stage Renal Disease.

If you don't qualify for premium-free Part A, and you are 65 or older, you may be able to buy it. (Call your local Social Security Administration office or call 1-800-772-1213.)

Q: What is Part B (Medical Insurance)?

A: Part B (Medical Insurance) helps pay for doctors, outpatient hospital care and some other medical services that Part A doesn't cover, such as the services of physical and occupational therapists. Part B covers all doctor services that are medically necessary. Beneficiaries may receive these services anywhere (a doctor's office, clinic, nursing home, hospital, or at home). Your Medicare carrier can answer questions about Part B services and coverage.

Q: Who is eligible for Part B (Medical Insurance)?

A: You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible if you are a United States citizen or permanent resident age 65 or older. Part B costs $45.50* per month in 1999. You have a choice whether or not to keep Part B.

Q: If I choose to have Part B, how do I pay for it?

A: If you choose to have Part B, the monthly premium is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement payment. Beneficiaries who do not receive any of the above payments are billed by Medicare every 3 months.

Q: If I didn't take Part B when I was first eligible, when can I sign up?

A: If you didn't take Part B when you were first eligible, you may be able to sign up during two enrollment periods:

General Enrollment Period: If you didn't take Part B, you can only sign up during the general enrollment period, January 1 through March 31 of each year. Your Part B coverage is effective July 1. Your monthly Part B premium may be higher. **The Part B premium increases 10% for each 12-month period that you could have had Part B but did not take it, unless you sign up during the Special Enrollment Period.**

Special Enrollment Period: If you didn't take Part B because you or your spouse currently work and have group health plan coverage through your current employer or union, you can sign up for Part B during the special enrollment period. Under the special enrollment period, you can sign up at any time you are covered under the group plan. In

* New Part A and Part B premium, coinsurance, and deductible amounts will be available by January 1, 2000.

Q: If I didn't take Part B when I was first eligible, when can I sign up? (continued)

addition, if the employment or group health coverage ends, you have eight months to sign up. The eight-month period starts the month after the employment ends or the group health coverage ends, whichever comes first. Generally, your monthly Part B premium is not increased when you sign up for Part B during the special enrollment period. Call the Social Security Administration at 1-800-772-1213.

Railroad retirees should call the Railroad Retirement Board to sign up for Part B.

Q: What are my out-of-pocket costs in the Original Medicare Plan?

A: The Original Medicare Plan pays for much of your health care, but not all of it. Your out-of-pocket costs for health care will include your monthly Part B premium. In addition, when you get health care services, you will also have to pay deductibles and coinsurance (see page 33). Generally, you will pay for your outpatient prescription drugs. You also pay for routine physicals, custodial care, most dental care, dentures, routine foot care, hearing aids, and routine eye care. Physical therapy and occupational therapy services, except for those you get in hospital outpatient departments, have yearly limits on coverage. The Original Medicare Plan does pay for some preventive care, but not all of it.

Q: What do my out-of-pocket costs depend on in the Original Medicare Plan?

A: Your out-of-pocket costs depend on:

- Whether your doctor accepts assignment.
- How often you need health care.
- What type of health care you need.

If you choose another Medicare health plan or purchase a Supplemental Insurance Policy, your out-of-pocket costs may also depend on:

- Which Medicare health plan you choose.
- What extra benefits are covered by the plan.
- What your Supplemental Health Insurance Policy covers.

Q: What is Assignment?

A: In the Original Medicare Plan, doctors and other providers who accept assignment accept the amount Medicare approves for a particular service or supply as payment in full. (You are still responsible for any coinsurance amount.) Doctors who don't accept assignment can require you to pay the full amount of the bill at the time of service. Medicare will then reimburse you for its share of the bill. Always ask your doctors and medical suppliers whether they accept assignment of Medicare claims. That could mean savings for you.

In certain situations, all doctors and medical suppliers are required to accept assignment. For instance, all doctors and qualified laboratories must accept assignment for clinical laboratory services covered by Medicare. Doctors also must accept assignment if you have a

Q: What is Assignment? (continued)

low-income and Medicaid pays your Medicare coinsurance. Doctors and other health care providers who don't accept assignment may not charge more than 15% over Medicare's approved payment amount (the limiting charge). The limiting charge does not apply to services you get from doctors with whom you have a private contract (see page 8), or for certain items and services, such as durable medical equipment, ambulance services, vaccinations, and anti-nausea drugs that are covered by Medicare. Call your Medicare Carrier* with questions.

For example, assume that your $100 Part B deductible has been paid for the year. You receive a medical service and the Medicare-approved payment amount for the service is $100. If your doctor accepts assignment, the most you would pay is $20. If your doctor does not accept assignment, the most you would pay is $33.25 after Medicare pays its share of the bill. (Note: The approved amount is reduced by 5% if assignment is not accepted.)

Q: What is Medicaid?

A: Medicaid is a joint Federal and State program that provides payment for medical costs for certain individuals who have low incomes and limited assets. Coverage and eligibility vary from State to State, but most of your health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid recipients may also receive benefits such as nursing home care and outpatient prescription drugs.

* You can find phone numbers for your area in your copy of *Medicare & You* or on the Internet at www.medicare.gov under Important Contacts.

Q: How can Medicaid help low-income Medicare beneficiaries?

A: Medicaid has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain persons who are older or disabled, have low incomes and limited assets. You must have Part A (Hospital Insurance). If you are not sure if you have Part A, look on your Medicare card (red, white, and blue card). It will show "Hospital Insurance (Part A)" on the lower left corner of the card. You can also call your local Social Security office, or call them at 1-800-772-1213.

If you have Part A, your income is limited (see below) and your bank accounts, stocks, bonds, or other resources are not more than $4,000 for an individual, or $6,000 for a couple, you may qualify for assistance as a Qualified Medicare Beneficiary **(QMB)**, Specified Low-Income Medicare Beneficiary **(SLMB)**, or Qualifying Individual **(QI)**.

1999 Monthly Income Limit*

	Individual	Couple	Benefit - Pays Medicare's...
QMB	$707	$942	Premiums, deductibles, and coinsurance
SLMB	$844	$1,126	Part B premium
QI-1	$947	$1,265	Part B premium
QI-2	$1,222	$1,633	Part of the Part B premium

If you think you may qualify, contact your State, county, or local medical assistance office - not a Federal office.

*Slightly higher amounts are allowed in Alaska and Hawaii. Monthly income limits will change slightly in 2000.

Q: What is a Private Contract?

A: A private contract is a contract between a Medicare beneficiary and a doctor or other practitioner who has decided not to provide services through the Medicare program (not bill for any service or supplies to any Medicare beneficiary for at least 2 years).

Under a private contract:

- No Medicare payment will be made for the services you receive.
- You will have to pay whatever the doctor or practitioner charges you with no limit on the charges (the limiting charge will not apply).
- Medicare managed care plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is.
- If you have a Supplemental Insurance (Medigap) Policy, it will not pay anything for this service. Contact your insurer before you receive the service.
- Many other insurance plans also will not pay for the service.

The private contract only applies to the services provided by the doctor who asked you to sign it. You cannot be asked to sign a private contract when you are facing an emergency or urgent health situation. You may want to talk with someone in your State Health Insurance Assistance Program* before signing a private contract. If you want to pay on your own for services the Original Medicare Plan doesn't cover, your doctor does not have to leave Medicare or ask you to sign a private contract. You are always free to obtain non-covered services on your own if you choose to pay for the service yourself.

* You can find phone numbers for your area in your copy of *Medicare & You* or on the Internet at www.medicare.gov under Important Contacts.

Q: What is a Medicare Supplemental Insurance (Medigap) Policy?

A: There are many types of private health insurance/coverage that will pay for some or all of your health care costs not covered by Medicare. These types of private health insurance/coverage include:

- Employee Coverage (from your employer or union);
- Retiree Coverage (from your employer or union); and
- Medigap Insurance (from a private company or group).

People often refer to all of these types of private health insurance/coverage as "supplemental." However, "Medicare Supplemental" or "Medigap" insurance is a specific type of private insurance that is subject to federal and state laws.

If you choose the Original Medicare Plan rather than a Medicare managed care plan, you may decide that you need more coverage than the Original Medicare Plan provides. Medigap policies only work with the Original Medicare Plan. Many private insurance companies sell Medigap policies for the specific purpose of filling the "gaps" in Original Medicare Plan coverage. These policies must be clearly identified as Medigap policies and must provide specific benefits that help fill in gaps in your Original Medicare Plan coverage. Similar coverage may also be available to retirees through an employer or union health coverage. Other types of insurance may also be available to you to help with out-of-pocket health care costs, but they are not Medigap policies.

For more information about Supplemental Insurance Policies, call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) and ask for a copy of the *Guide to Health Insurance for People with Medicare.*

Q: What is a Medicare Supplemental Insurance (Medigap) Policy? (continued)

In all States except Minnesota, Massachusetts, and Wisconsin, federal law limits the Medigap policies that companies may sell up to 10 standardized supplemental policies. These 10 plans must be labeled with the letters A through J to make it simple to compare plans. State law may limit the types of Medigap policies that are actually sold in your State.

Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance amounts and may provide coverage for the Original Medicare Plan deductibles. Some of the 10 standardized plans pay for services not covered by Medicare such as outpatient prescription drugs, preventive screening, and emergency medical care while traveling outside the United States. Some Medigap policies cover health care provider charges in excess of Medicare's approved amount, and for some care in your home.

Medicare SELECT is a type of standardized Medigap insurance policy. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans. The only difference between Medicare SELECT and standardized Medigap insurance is that each insurance company has specific hospitals, and in some cases specific doctors, that you must use, except in an emergency, to be eligible for full supplemental insurance benefits. Medicare SELECT policies generally have lower premiums because of this requirement.

For more information on Medigap policies, you may get a copy of the *Guide to Health Insurance for People with Medicare* from the Health Care Financing Administration by calling 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Q: What happens if I retire and I or my spouse has employer or union-provided health insurance?

A: You may have health coverage through your or your spouse's current employer or union membership. If you have this kind of coverage, find out if it can be continued after you retire. Check the price and the benefits, including benefits for your spouse.

Group health coverage continued after retirement usually has the advantage of having no waiting periods or exclusions for pre-existing conditions. Coverage is usually based on group premium rates, which may be lower than the premium rates for a policy you buy yourself.

Caution: If you have a spouse under age 65 who was covered under your group health plan, make sure you know what effect your continued coverage will have on his or her insurance protection. Call your health plan administrator for more information.

Q: What health benefits must be provided if I am age 65 or older and still work?

A: Employers with 20 or more employees must offer the same benefits, including health benefits under the same conditions, to current employees age 65 and over as they offer to younger employees. If they offer coverage to spouses, they most offer the same coverage to spouses age 65 and over that they offer to spouses under age 65. If your employer and/or employer group health coverage does not follow this rule, you should call the Department of Labor.

Caution: If you drop your employer-based group health coverage, you probably won't be able to get it back. Call your health plan administrator for more information.

Q: What happens if I or my spouse stops working and I am already enrolled in Part B?

A: If you or your spouse stops working and you are already enrolled in Part B, you should:

- Tell your Medicare Carrier by phone or in writing that your or your spouse's employment situation has changed.
- Give the Medicare Carrier the name and address of the employer plan, your policy number with the plan, the date coverage stopped, and why.
- When you get health care services, tell the doctor or hospital that Medicare now pays first and should be billed first. Give the date your group health plan coverage stopped.

Q: Are there other types of private insurance I can purchase?

A: The following types of policies are generally limited in coverage and are not substitutes for Medigap insurance or comprehensive health coverage. Benefits under these policies are not designed to fill gaps in your Medicare coverage.

Hospital indemnity insurance pays a fixed cash amount for each day you are hospitalized up to a certain number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

Specific disease insurance, which is not available in some States, provides benefits for only a single disease, such as cancer, or for a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Remember, Medicare and any Medigap policy you have will very likely cover costs associated with any specified diseases you may have.

Long-term care insurance may cover some of the many different services that may include help with daily activities at home, or fill some gaps in the coverage that you and/or your spouse may need in the future.

If you are shopping for long-term care insurance, find out which types of nursing home and long-term care services are covered by the different policies available. For more information about long-term care insurance, ask for a copy of *A Shopper's Guide to Long-Term*

Q: Are there other types of private insurance I can purchase? (continued)

Care Insurance from either your State Insurance Department or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105-1925. You may also get a copy of the *Guide to Choosing a Nursing Home* from the Health Care Financing Administration by calling 1-800-MEDICARE (1-800-633-2447 or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Q: When would other insurance pay first? (That is, Medicare would be a secondary payer.)

A: If you are age 65 or over, and covered by a group health plan because of current employment or the current employment of a spouse of any age, Medicare is the secondary payer if the employer has 20 or more employees. This means that the plan coverage pays first on your hospital and medical bills. If the plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services after the benefits paid by the group health plan.

Medicare is also the secondary payer for people under age 65 who are entitled to Medicare because of disability and are covered by a large group health plan (LGHP) because of their current employment or the current employment of a family member. A LGHP is a plan of, or contributed to by, an employer or employee organization that covers the employees of at least one employer with 100 or more employees. The secondary payer requirement applies to employers, employees, and members of their families covered by large group health coverage or employer and union sponsored health plans. It also applies to those who have LGHP coverage as a self-employed person, business associate of an employer, or as a family member of one of these people. A LGHP must not treat any of

Q: When would other insurance pay first? (Medicare would be a secondary payer.) (continued)

these beneficiaries differently because they are disabled and have Medicare.

Medicare is the secondary payer to a group health plan for 30 months for beneficiaries who have Medicare because of End-Stage Renal Disease (ESRD) (permanent kidney failure being treated with dialysis or a transplant). This applies only to those with ESRD, whether you have plan coverage of your own or as a dependent. The group health plan coverage is the primary payer during this period without regard to the size of the employer-based coverage, the number of employees, or whether the individual or a family member is currently employed.

For more information on Medicare secondary payer issues, you may get a copy of the *Guide to Health Insurance for People with Medicare* from the Health Care Financing Administration by calling 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired).

Q: What is an Advance Beneficiary Notice?

A: An Advance Beneficiary Notice is a written notice that tells you why Medicare probably (or certainly) will not pay for a service. A doctor or supplier might give you this notice before you are given the service. If you still want to get the service, you will be asked to sign an agreement that you will pay for the service yourself if Medicare does not pay for it. Advance Beneficiary Notices are used in the Original Medicare Plan, but not in Medicare managed care plans.

Q: How are my bills (claims) paid in the Original Medicare Plan?

A: When you receive services covered by the Original Medicare Plan, your provider sends the bill (claim) to a private insurance company that contracts with Medicare. These companies are called the Fiscal Intermediary (for Part A services) or the Medicare Carrier (for Part B services). After they process the claim, you receive a Medicare Benefits Notice (for Part A services) or a Medicare Summary Notice (MSN), or an Explanation of Medicare Benefits (EOMB) for Part B services.

You have a right to request an itemized statement from the provider of the service. You must receive it within 30 days of your request. Please check the notice to be sure you were not billed for services, medical supplies, or equipment that you did not receive. If you have any questions about bills or services listed on the notice, call the Fiscal Intermediary or Medicare Carrier (the name and phone number are on the notice). If you disagree with a claims decision, you have the right to file an appeal. The notices tell you how to file an appeal (see page 17).

Q: How do I appeal a Medicare payment or coverage decision under the Original Medicare Plan?

A: If you are dissatisfied, you have a right to appeal any decision concerning your Medicare-covered services in the Original Medicare Plan. You can file an appeal if you believe Medicare did not pay enough for services or should have paid for health care services you received. Your appeal rights are written on the back of the Medicare Summary Notice or Explanation of Medicare Benefits that is mailed to you.

Q: What can I do if I think I'm being discharged from the hospital too soon?

A: If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization* (PRO). You can stay in the hospital at no charge and cannot be discharged before the PRO makes a decision.

Q: Are there rules that protect me in a Skilled Nursing Facility (SNF)?

A: Every Medicare Skilled Nursing Facility (SNF) must meet quality standards. They can't require you to pay a deposit or other payment to be admitted to the facility unless it is clear that Medicare does not cover the cost of services. If the SNF staff decides you don't need the level of skilled care covered by Medicare, you must be told immediately. If you disagree with this decision, the SNF must request an official Medicare decision on coverage. The SNF can't require you to pay a deposit for services that Medicare may not cover until Medicare gives its decision. You must pay for any coinsurance while your claim is being processed, and for services not covered by Medicare. If you have questions about SNF care, call your Fiscal Intermediary*.

* You can find phone numbers for your area in your copy of *Medicare & You* or on the Internet at www.medicare.gov under Important Contacts.

Q: What is Medicare + Choice?

A: Congress passed a law in 1997 which made many changes in the Medicare program. The law includes a section called Medicare + Choice which, starting in 1999, lets more private insurance companies offer coverage to people with Medicare. If you live in an area with Medicare managed care plans, you may now have choices in how you get your health care.

Q: Will other types of Medicare health plans be available in the future?

A: Medicare Medical Savings Accounts and Private-Fee-for-Service plans may be available in the future. At the time this book was printed, no private companies had decided to offer these plans. For more information or to find out if either of these plans have become available in your area, call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired).

Q: Who can join Medicare managed care plans?

A: To be eligible for Medicare managed care plans:

- You must have both Part A (Hospital Insurance) and Part B (Medical Insurance).
- You must not have End-Stage Renal Disease. (ESRD is permanent kidney failure that requires dialysis or a transplant.) However, ESRD beneficiaries currently in a health plan will be able to remain in the plan they are in.
- You must live in the service area of a health plan. The service area is the geographic area where the plan accepts enrollees. For plans that require you to use their doctors and hospitals, it is also the area where services are provided.

Q: Do I have to change to a Medicare managed care plan?

A: If you are happy with the way you receive your Medicare benefits, you don't have to do anything. You will continue to receive Medicare benefits the same way that you do now. Whether you are in the Original Medicare Plan or a Medicare managed care plan, you are still in the Medicare program.

Q: How do I get information on the Medicare health plans available in my area?

A: You can ask for information on Medicare health plans available in your area by calling 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired). You can get up-to-date information about Medicare on the Internet at **www.medicare.gov**. Your local library or senior center may be able to help you find this information on their computers. The State Health Insurance Assistance Program* in your area can also help you with Medicare questions about health plan decisions.

Q: If I want to make a change in my health plan, are there other things that I should consider?

A: If you or your spouse has health care coverage that supplements Medicare, check the information provided by your former employer or union, or contact them before you choose a new plan. If you have Medigap coverage, check the information provided by your Medigap insurance company, or call the State Health Insurance Assistance Program* in your State. If you have Medicaid coverage, do not make changes until you call the State Medical Assistance Office*.

* You can find phone numbers for your area in your copy of *Medicare & You* or on the Internet at www.medicare.gov under Important Contacts.

Q: What are my out-of-pocket costs if I am enrolled in one of the new Medicare health plans?

A: Your out-of-pocket costs may depend on:

- Which Medicare health plan you choose.
- How often you need health care.
- What type of health care you need.
- Which extra benefits are covered by the plan.

Q: How can I find out which Medicare managed care plans are available where I live?

A: To find out which Medicare managed care plans are available where you live, you can call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) for an up-to-date list. You can also look on the Internet at **www.medicare.gov** in the Medicare Compare section. Phone numbers for each available plan will be included in the information you will receive.

Q: How do I join/leave a Medicare managed care plan?

A: To join: Call the plan to request an enrollment form.

- Complete the form, and mail it to the plan.
- You will get a letter from the plan telling you when your membership begins.
- The plan cannot refuse to enroll you.

To leave: Call the plan or the Social Security Administration (1-800-772-1213 or TTY/TDD: 1-800-325-0778) and tell them you want to disenroll. Your disenrollment becomes effective as early as the first day of the month after your request for disenrollment is received.

During 1999 and 2000 you can leave a plan at any time for any reason.

Caution: Special rules may apply if you choose to disenroll from a Medicare managed care plan and return to the Original Medicare Plan with a Medicare Supplemental Insurance (Medigap) Policy, or your employer's health insurance policy (see pages 23-25).

Q: What is the role of a primary care doctor in Medicare managed care plans?

A: Primary care doctors are trained to give basic care. In many Medicare managed care plans, they coordinate and give most or all of your health care. Many plans require you to see your primary care doctor for a referral to a specialist. When you join a Medicare managed care plan, you may be asked to choose a primary care doctor from among the doctors who belong to the plan. If you already have a doctor you would like to keep seeing, ask your doctor if he or she is in the plan and accepting new patients under that plan.

Q: May I change my primary care doctor if I am in a Medicare managed care plan? What if my primary care doctor leaves the plan?

A: You may change your primary care doctor. Check your health plan member handbook for instructions. You may also call the plan's member services number. In some cases, the effective date of such a change may be the end of the current month. If your doctor leaves the plan, you may choose a new doctor in the plan.

Q: What is a referral?

A: A referral is permission from your primary care doctor to see a certain specialist or receive certain services. Some Medicare managed care plans may require referrals. Important: if you either see a different doctor than the one on the referral, or the service isn't for an emergency or urgently needed care, you may be responsible for the entire bill.

Q: Can I leave a Medicare managed care plan and return to the Original Medicare Plan?

A: At the present time, you may disenroll from a Medicare managed care plan any time, for any reason. However, beginning January 1, 2002, disenrollment periods will be limited. To disenroll, give a signed written request to the plan, a Social Security Administration Office, or the Railroad Retirement Board. You must receive services from the plan until the date the plan tells you that you are disenrolled. Your Original Medicare Plan coverage can start as early as the first day of the month after your request is received.

Q: What happens to my Medigap policy if I join a Medicare managed care plan, drop my Medigap policy, and then later disenroll from the health plan?

A: You may be able to return to a Medigap policy that you dropped to enroll in a Medicare SELECT policy or a Medicare health plan other than the Original Medicare Plan (for example, a Medicare managed care plan). However (1) this must be the first time that you joined a Medicare managed care plan or Medicare SELECT policy; (2) you must leave the Medicare managed care plan or Medicare SELECT policy within one year after joining; and (3) after leaving your Medicare managed care plan or Medicare SELECT policy, you must apply for your former Medigap policy within 63 calendar days after the health plan coverage ends if your previous Medigap insurance company still sells the policy in your State.

If your previous Medigap policy is not available, you are guaranteed the right to purchase Medigap policies "A", "B", "C", or "F" from any insurance company which sells these plans in your State if you apply within 63 calendar days after coverage ends. In these cases, the insurance company may not:

- Deny you insurance coverage or change the price of a policy because of past or current health problems, or
- Delay the start of your Medigap Policy coverage if you have a pre-existing condition.

The protections and guarantees described above may apply when you lose or drop coverage under a Medicare SELECT policy. All rights to buy a Medigap policy under these protections and guarantees include the right to buy a

Q: What happens to my Medigap policy if I join a Medicare managed care plan, drop my Medigap policy, and then later disenroll from the health plan? (continued)

Medicare SELECT policy since it is a type of Medigap policy. If you currently have a Medicare SELECT policy, you also have additional rights for as long as you have this policy that might provide you with better options for changing your insurance coverage. After you have had the Medicare SELECT policy for at least 6 months, you can switch to a regular Medigap policy sold by the same company, as long as the new policy has equal, or less coverage than the Medicare SELECT policy.

Q: If I lose my health plan coverage will I be able to get a Medigap policy?

A: If you lose health coverage under certain circumstances, you will have a guaranteed right to purchase Medigap policies "A", "B", "C", or "F" that are sold in your State, as long as you apply within 63 calendar days of losing your other health coverage. The circumstances include the following:

- Your Medicare managed care plan terminates its participation in Medicare or stops providing care in your area.
- You move outside the plan's service area.
- You leave the plan because it failed to meet its contract obligations to you.
- You were in an employer group health plan that supplemented or was secondary payer to Medicare and the plan terminates coverage.

Q: If I lose my health plan coverage will I be able to get a Medigap policy? (continued)

- Your supplemental insurance company terminates your Medigap policy or Medicare SELECT policy (and you're not at fault).

You will be given credit for any previous health coverage you had to meet the pre-existing condition requirement.

Q: Does this protection cover me if I am under age 65 and am eligible for Medicare because I am disabled or have End-Stage Renal Disease?

A: If you live in a State where Medigap policies are sold to people under age 65 who are eligible for Medicare due to disability or ESRD, you may have the same protection as those over age 65 if your health insurance ends or is lost. If Medigap insurance companies in your State sell Medigap policies "A", "B", "C", or "F" to people under age 65, they must also make these policies available to you when your health coverage ends or is lost. Call your State Health Insurance Assistance Program* for more information.

Q: Is there any other time when I may be guaranteed issuance of a Medigap policy?

A: You are guaranteed issuance of ANY Medigap policy if:

- When you first become eligible for Medicare at age 65, you joined a Medicare health plan other than the Original Medicare Plan, and

- You then disenroll from that plan within 12 months of the effective date of when you joined.

You must apply for the Medigap policy within 63 calendar days of disenrolling from the health plan. If you are denied Medigap coverage, you should call your state insurance department.*

* You can find phone numbers for your area in your copy of *Medicare & You* or on the Internet at www.medicare.gov under Important Contacts.

Q: What is a medical emergency? How do I get emergency care if I am in a Medicare managed care plan?

A: A medical emergency includes severe pain, an injury, sudden illness, or suddenly worsening illness that you believe may cause serious danger to your health if you do not get immediate medical care. Your plan is required to provide access to emergency and urgently needed care services 24 hours a day, 7 days a week. Your plan must pay for your emergency care and cannot require prior authorization for emergency care you receive from any provider. You can receive emergency care anywhere in the United States. When you receive emergency care, the doctor or hospital that provides the service will bill either you or your plan. If you receive the bill, give it to your plan, and keep a copy for your own record. Following a medical emergency, your plan must also pay for care you need before your condition is stable enough for you to return to your plan's provider. If your condition lets you return to the plan service area, you will need to get follow-up care from your Medicare managed care plan. You should let your plan know of emergencies as soon as medically possible. If what you believed was an emergency turns out not to be, the plan must still pay. Your plan can require that you pay the entire cost of care received in an emergency room for a problem that you knew was not an emergency. You can appeal a denial of payment for emergency services (see pages 29-30).

Q: What is "urgently needed care"? How do I get urgently needed care if I am in a Medicare managed care plan?

A: Unexpected illness or injury that needs immediate medical attention, but is not life threatening, is urgently needed care. Your primary care doctor generally provides urgently needed care. If you are temporarily out of the plan's service area and cannot wait until you return home, the health plan must pay for urgently needed care.

Q: Does travel affect my health care? How does the Medicare managed care plan handle coverage when I'm not in the service area?

A: If you travel a lot or live in another State part of the year, you should contact the plan and ask if the plan provides coverage for services when you are out of the service area. The Original Medicare Plan does not cover care outside the United States. Some Medicare managed care plans, as well as some of the more expensive Supplemental Insurance (Medigap) policies, cover care outside of the U.S.

Railroad retirees have different rules. Call the Railroad Retirement Board at 1-800-808-0772 for information.

Q: Will Medicare managed care plans pay for services under a private contract?

A: No. See the information on private contracts on page 8.

Q: If I join a Medicare managed care plan will I lose any of my Medicare covered services?

A: When you join a Medicare managed care plan, you are still entitled to all the covered services of the Medicare program. All Medicare managed care plans must provide, at least, all the services covered under the Original Medicare Plan. This includes Part A (Hospital Insurance) and Part B (Medical Insurance). Hospice benefits are provided by a Medicare-approved hospice in your service area. Medicare managed care plans also may provide additional benefits.

Q: How do I question or appeal a Medicare managed care plan coverage decision?

A: You have a right to appeal many decisions about your Medicare-covered services. You have this right if you are enrolled in a Medicare managed care plan. Your health plan must provide you with written instructions on how to appeal. You may file an appeal if your health plan denies a service, or terminates or refuses to pay for services that you believe should be covered. After you file an appeal, the health plan reviews its decision. Then, if your health plan does not decide in your favor, the appeal automatically goes to an independent review organization that contracts with Medicare. You may be eligible for a fast decision (within 72 hours) if your health or ability to function could be seriously harmed by waiting the amount of time needed for a standard decision. See the health plan's membership materials or call your health plan for details about your Medicare appeal rights.

Q: How do I question or appeal a Medicare managed care plan coverage decision? (continued)

If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization* (PRO). During the immediate review, you may be able to stay in the hospital at no charge and the hospital cannot discharge you before the PRO reaches a decision.

Q: Can I find out how a Medicare managed care plan pays its doctors?

A: Medicare managed care plans' current members and those interested in joining the plan have a legal right to know (in writing) how the plan pays its doctors. If you want this information, call the plan.

* You can find phone numbers for your area in your copy of *Medicare & You* or on the Internet at www.medicare.gov under Important Contacts.

Q: Does the Medicare program protect me from discrimination?

A: Yes. Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, sex, national origin, disability, or age. If you think that you have not been treated fairly for any of these reasons, call the Office for Civil Rights* in your State.

Q: What can I do to protect myself and Medicare from fraud and abuse?

A: You can help protect Medicare and yourself by reporting all suspected instances of fraud and abuse. Whenever you receive a payment notice from Medicare, review it for errors. Make sure Medicare did not pay for services, medical supplies, or equipment that you did not receive. If you have a questionable charge on your bill, call the provider, your Fiscal Intermediary* (for Part A bills) or your Medicare Carrier* (for Part B bills). If you believe that a health care provider may be cheating or abusing the Medicare program, call the Fiscal Intermediary or Medicare Carrier that sent you the payment notice. The Fiscal Intermediary's or Medicare Carrier's name, address, and telephone number will be on the payment notice. You may also call the Inspector General's hotline 1-800-HHS-TIPS (1-800-447-8477 or TTY/TDD: 1-800-377-4950 for the speech and hearing impaired) to report suspected cases of fraud. Medicare will not disclose your name if you request confidentiality.

* You can find phone numbers for your area in your copy of *Medicare & You* or on the Internet at www.medicare.gov under Important Contacts.

Q: What are my rights as a Medicare patient?

A: If you have Medicare, you have certain guaranteed rights. You have them whether you are in the Original Medicare Plan or a Medicare managed care plan.

- You have the right to get emergency care when and where you need it, without prior approval. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.

- You have the right to appeal if Medicare does not pay for a covered service you have been given, or if your doctor or hospital does not give you a service that you believe should be covered. See pages 16 and 28 for more information about appeals.

- You have the right to know all your treatment options from your health care provider in language that is clear to you. Medicare must give you information about what is covered and how much you have to pay. Medicare managed care plans cannot have rules that stop a doctor from telling you everything you need to know about your health care, including treatment options.

- You have the right to have any personal information that Medicare collects kept private. Medicare may collect information about you as part of its regular business, such as paying your bills. The law requires Medicare to keep this information private. When Medicare asks for this kind of information, we must tell you that the law lets us collect it for payment and health treatment purposes. You have the right to know why we need it, whether it is required or optional, what happens if you don't give the information, and how it will be used. If you want this information, call 1-800-MEDICARE (1-800-633-4227) and ask for more information about how Medicare uses personal information.

What are my rights if I am in a Medicare Managed Care Plan?:

- You have a right to choose a women's health specialist from your plan's list of doctors to meet your women's health care needs.

- If you have a complex or serious medical condition, you have a right to have enough visits to a specialist to deal with your needs.

- You have a right to know how your plan pays its doctors. If you want to know how your plan pays its doctors, the plan must tell you in writing. You also have the right to know whether your doctor owns all or part of a health care facility. For example, a lab that he or she refers you to for a blood test.

- If you have concerns or problems with your plan which are not about payment or service requests, you have a right to file a grievance. A grievance is a type of complaint. For example, if you believe your plan's hours of operation should be different, you can file a grievance. If you believe you are not getting a high quality of care, you may either file a grievance with your plan or with the Peer Review Organization (PRO) in your State (see page 33).

If you think any of your rights have been violated, please call the State Health Insurance Assistance Program in your State. Their number appears in your copy of *Medicare & You* or can be found on the Internet at www.medicare.gov.

Coinsurance - The percent of the approved charge that you have to pay either after you have paid the Part A deductible, or after you pay the first $100 deductible each year for Part B.

Deductible - The amount you must pay before Medicare begins to pay either each benefit period for Part A, or each year for Part B.

Fiscal Intermediary - A private insurance company that has contracted with Medicare to process bills (claims) for Part A services.

Medicare Carrier - A private insurance company that has contracted with Medicare to process beneficiary bills (claims) for Part B services.

Peer Review Organizations (PROs) - Groups of practicing doctors and other health care professionals paid by the federal government to monitor the care given to Medicare patients. They are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; Medicare managed care plans and ambulatory surgical centers.

Premium - Monthly payment for health care coverage to Medicare, an insurance company, or a health care plan.

State Health Insurance Assistance Program (SHIP) - A State organization that receives money from the Federal government to give free health insurance counseling to Medicare beneficiaries. Most of these counselors are volunteers. They are trained to answer questions about: health insurance, Medicare bills, Medigap insurance to supplement Medicare, paying for long-term care, payment denials and appeals, Medicare rights and protections, and choosing a Medicare managed care plan.

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NOTES:

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