



Your Guide to
**Medicare Private
Fee-for-Service
Plans**

This official government booklet has important information about Medicare Private Fee-for-Service Plans including

- ★ how the plans work,
- ★ joining, switching, and leaving plans, and
- ★ questions to ask to decide if this type of plan is right for you.



Table of Contents

The Basics	1–3
Costs	4–6
Covered Services	7–8
Adding Prescription Drug Coverage	9
Joining, Switching, and Leaving Medicare Private Fee-for-Service Plans	10–12
Medigap (Medicare Supplement Insurance) Policy Information	13–15
Appeal Rights	16–17
For More Information	18
State Health Insurance Assistance Program Telephone Numbers	19
Words to Know (Definitions of words in red)	20–22
Index	23

Note: The information in this booklet was correct when it was printed. Changes may occur after printing. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the most up-to-date version.

“Your Guide to Medicare Private Fee-for-Service Plans” explains one of many health care options in the Medicare Program. It isn’t a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Introduction

Medicare is working with private insurance companies to offer you ways to meet your personal health care needs through **Medicare Advantage Plans**. Use the information in this booklet to learn what questions to ask so you can make an informed decision about your health care. However, you will need more information than this booklet provides for you to decide if a **Medicare Private Fee-for-Service Plan** is the right health plan choice for you. In addition to reading this booklet, you should also carefully read plan materials before you decide to join a Medicare Private Fee-for-Service Plan. Consider talking with someone who helps you make important decisions such as your spouse, children, trusted friend, or your physician before selecting a Medicare Advantage Plan.

Joining a Medicare Private Fee-for-Service Plan is optional. For information about other Medicare health plan options, look at your copy of the “Medicare & You” handbook. It’s mailed to all people with Medicare each fall. Or, visit www.medicare.gov on the web. You can also call 1-800-MEDICARE (1-800-633-4227), and ask a customer service representative about Medicare health plan options in your area. TTY users should call 1-877-486-2048.

Remember, if you join a Medicare Private Fee-for-Service Plan, you are still in the Medicare Program.

Things to consider as you make a decision about your health and prescription drug coverage:

- Each year you should review your health and prescription needs. If you decide another plan will better meet your needs, you can switch to a different plan during certain times.
- If you want to keep your current plan, you don’t need to do anything.

The Basics

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

Remember, words in red are defined on pages 20–22.

A **Medicare Private Fee-for-Service Plan** is a **Medicare Advantage Plan** offered by a private insurance company. In a Medicare 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 fee-for-service arrangement. Also, the insurance company, rather than the Medicare Program, decides how much you pay for the services you get.

Note: A Medicare Private Fee-for-Service Plan isn't the same as the **Original Medicare Plan** which is **offered by the Federal government**. It also isn't the same as a **Medigap** (Medicare Supplement Insurance) policy, Medicare SELECT, or Medicare Prescription Drug Plan.

Because insurance companies decide where they will do business, companies may only offer Medicare 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 available 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 Medicare Private Fee-for-Service Plans can decide whether to offer such a plan in a given area.

How do Medicare Private Fee-for-Service Plans work?

Generally, you get care in the United States from any Medicare-approved provider such as a doctor or hospital who, before treating you, agrees to accept the Medicare Private Fee-for-Service Plan's terms and conditions of payment. You must show your plan membership ID card every time you visit a health care provider. There is a telephone number or website on the card for the provider to find out about the plan's terms and conditions of payment. This gives your provider the right to choose whether to accept the plan's terms and conditions of payment. If you need emergency care, it is covered whether the provider accepts the plan's payment terms or not.

If you join a Medicare Private Fee-for-Service Plan, not all providers will accept the plan's payment terms or agree to treat you. Before you get any services, ask your doctor or hospital if they are willing to contact the plan for payment information and accept the plan's payment terms.

The Basics

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

If your provider agrees to the plan's terms and conditions of payment

The provider must follow the plan's terms and conditions for payment, and bill the plan for the services they provide for you. However, the provider can decide at every visit whether or not to accept the plan and agree to treat you.

If your provider doesn't agree to the plan's terms and conditions of payment

The provider shouldn't provide services to you except for emergencies, and you will need to find another provider that will accept the plan.

If the provider chooses to treat you, then they may not bill you. They must bill the plan for your covered health care services. You are only required to pay the **copayment** or **coinsurance** amount allowed by the plan for the type(s) of service you get at the time of the service. You may have to pay an additional amount if the plan allows providers to **balance bill** (see page 4).

Remember, words in **red** are defined on pages 20–22.

If you join a Medicare Private Fee-for-Service Plan

- you are still in the Medicare Program,
- you still get all of 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 Medicare Private Fee-for-Service Plan says aren't **medically necessary** (see example on page 8).

Note: If your Medicare Private Fee-for-Service Plan has a network of providers (providers under contract with the plan) for some or all categories of services, you can still see providers who aren't part of the plan's network. As long as providers accept the plan's payment terms you can get your services from them, but you may pay more. Ask your Medicare Private Fee-for-Service Plan about the health care providers you can see.

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

The chart on page 3 shows some of the differences between Medicare 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 "Compare Health Plans and Medigap Policies in Your Area" to see information that compares all of the Medicare plans in your area.

The Basics

	Medicare Private Fee-for-Service Plans	Original Medicare Plan
Premiums: Do I have to pay the monthly Part B premium to be in the plan?	Yes	Yes
Premiums: Will I have to pay an additional monthly premium to be in the plan?	Possibly, and there is no limit on the premium amount that Medicare 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. However, your cost-sharing may be different from the Original Medicare Plan . Call the insurance company offering the plan to find out.	No
Providers: Are there any limitations on which doctors or hospitals I can use for services covered under the plan?	<p>Possibly. Most Medicare Private Fee-For-Service Plans don't have a network of participating providers for you to get covered services. You must find doctors, hospitals, and other types of providers willing to accept the plan's payment terms. Before enrolling in a Medicare Private Fee-for-Service Plan, be sure you have found providers willing to accept the Medicare Private Fee-for-Service Plan's terms.</p> <p>There are a few Medicare Private Fee-for-Service Plans with a network of providers (providers who have a contract with the plan) for some or all categories of services. You can still see out-of-network providers willing to accept the plan's payment terms, but you may pay more.</p>	No
Cost Sharing: Does the plan let providers (such as doctors or hospitals) charge more than Medicare's deductibles, coinsurance, and copayments?	<p>Possibly. Plans may let providers charge you up to 15% above the plan's payment amount for services. Call the insurance company offering the plan to find out.</p> <p>Your cost-sharing may be higher if you see out-of-network providers in a Medicare Private Fee-for-Service Plan with an established network of providers for some or all categories of services.</p>	No for hospitals. Possibly for doctors. Doctors who don't accept assignment can bill up to 15% above Medicare's payment amount.
Supplemental Coverage: Can I get a Medigap (Medicare Supplement Insurance) policy to pay costs not covered by my plan?	No. 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 buy a Medigap policy from a private insurance company to cover gaps in the Original Medicare Plan coverage.

Costs

What are the costs in a Medicare Private Fee-for-Service Plan?

You pay

- the monthly Medicare Part B **premium** (\$93.50 in 2007*).
- any additional monthly premium the Medicare Private Fee-for-Service Plan charges above the Medicare Part B premium.
- any additional monthly premium the Medicare Private Fee-for-Service Plan charges for extra benefits.
- any plan **deductible**, **coinsurance**, or **copayment** amounts the Medicare 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. These amounts can be different than those under the **Original Medicare Plan**.

Remember, words in **red** are defined on pages 20–22.

Medicare Private Fee-for-Service Plans may let providers (such as doctors or hospitals) charge you up to 15% over the plan's payment amount for services. This 15% **balance billing** amount applies to providers who have a written contract with the Medicare Private Fee-for-Service Plan or who have met certain company conditions (they are **deemed** to have a contract).

Ask if your Medicare Private Fee-for-Service Plan allows providers to “balance bill.” This will affect how much you may pay. Even if balance billing is allowed, your provider may accept the plan's payment amount as payment in full.

Contact your **State Health Insurance Assistance Program (SHIP)** to find out if you qualify for help paying your premiums, deductibles, and/or coinsurance.

* Your Medicare Part B monthly premium will be higher if your annual income is more than \$80,000 (single), or more than \$160,000 (married and file a joint tax return). These amounts change each year. A few Medicare Advantage Plans may pay all or part of your Part B premium. You would still get all Part A and Part B-covered services. For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Costs

What are the costs in a Medicare Private Fee-for-Service Plan? (continued)

Example

Medicare Private Fee-for-Service Plan Costs

Mrs. Jones is thinking about joining a Medicare Private Fee-for-Service Plan. The Medicare Private Fee-for-Service Plan has a \$75 monthly premium, but covers additional benefits the Original Medicare Plan doesn't cover. To be in this plan, Mrs. Jones would have to pay the monthly Medicare Part B premium (\$93.50 in 2007) 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 \$93.50 and \$75 monthly premiums, and a total of \$30 for her three doctor visits (\$10 per visit); therefore, Mrs. Jones would pay \$198.50 ($\$93.50 + \$75 + \30) that month.

How do my out-of-pocket costs vary?

Each year, Medicare Private Fee-for-Service Plans establish the amounts they charge for premiums, deductibles, and services. The Medicare Private Fee-for-Service Plan (rather than the Medicare Program) decides how much you pay for the covered services you get. What you pay the plan may change only once a year on January 1.

Your costs depend on

- which Medicare Private Fee-for-Service Plan you choose,
- whether the plan charges an additional monthly premium,
- how much the plan charges for your services,
- 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 4.),
- how often and the type of health care you get,
- which extra benefits are covered by the plan, and
- whether you see out-of-network providers in a Medicare Private Fee-for-Service Plan with an established network of contracted providers.

Costs

How do my out-of-pocket costs vary? (continued)

Example

Mr. Stevens must have surgery. His hospital has a contract with his Medicare Private Fee-for-Service Plan. This **Medicare 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 Medicare 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 do I pay my bills (such as a doctor or hospital bill)?

If you get covered health care services from a provider, you are only required to pay the copayment or coinsurance amount allowed by the plan for the type(s) of service you get, at the time of the service. The provider will bill the plan for the remaining amount according to the plan’s payment terms.

If you get a bill for services, you can send the bill to the plan for the plan to pay its share of the cost to the provider. The plan will let you know if you must pay a share of the costs. (If you paid for the covered services, the plan will reimburse you for its share of the cost.)

Note: If you have any questions about whether the Medicare Private Fee-for-Service Plan will pay for a certain health care service, you can ask the plan for a written **advance coverage decision** before you get the service. The plan will let you know if it will pay for the service.

Covered Services

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

Medicare Private Fee-for-Service Plans must cover all **medically-necessary** services covered by **Medicare Part A** and **Part B**.

What is covered by Medicare Part A and Part B?

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals. Part A also helps cover skilled nursing facility, hospice, and home health care if you meet certain conditions.

Medicare Part B (Medical Insurance) helps cover medically-necessary services like doctors' services and outpatient care. Part B also helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse.

Although Medicare Private Fee-for-Service Plans must cover all of the medically-necessary services covered under Medicare Part A and Part B, the amounts you pay for these services may not be the same as in the **Original Medicare Plan**. In some cases they may be either higher or lower amounts.

Do Medicare Private Fee-for-Service Plans cover extra benefits?

Medicare Private Fee-for-Service Plans may have extra benefits the Original Medicare Plan doesn't cover, such as some vision, hearing, dental, and/or prescription drug coverage. However, you may have to pay more for these extra benefits. To find out what benefits are covered in a Medicare Private Fee-for-Service Plan, call the insurance company offering the plan you want and ask for this information. You can also visit www.medicare.gov on the web. Under "Search Tools," select "Compare Health Plans and Medigap Policies in Your Area."

How do I know if a service I need is medically necessary?

Medicare 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 Medicare Private Fee-for-Service Plan must cover the service. You can also ask the plan for a written **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 Medicare Private Fee-for-Service Plan.

Remember, words in **red** are defined on pages 20–22.

Covered Services

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

Medicare 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 **Medicare 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 16 and 17).

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 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 Medicare Private Fee-for-Service Plan won't pay for services I think I need?

If the Medicare 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 16 and 17).

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

To get more information about your Medicare-covered services, look at your "Medicare & You" handbook, or visit www.medicare.gov on the web. Under "Search Tools," select "Find Out What Medicare Covers."

Remember, words in **red** are defined on pages 20–22.

Adding Prescription Drug Coverage

What if the Medicare Private Fee-for-Service Plan offers prescription drug coverage?

A **Medicare Private Fee-for-Service Plan** may offer prescription drug coverage. If you want Medicare prescription drug coverage and it's offered by the plan, you must get your Medicare prescription drug coverage from that plan.

What if the Medicare Private Fee-for-Service Plan doesn't offer prescription drug coverage?

If a Medicare Private Fee-for-Service Plan doesn't offer prescription drug coverage, you can add this coverage. Generally, you can only add prescription drug coverage from November 15 – December 31 each year (with coverage starting January 1 of the following year) in one of the following ways:

- You can stay in your Medicare Private Fee-for-Service Plan and join a separate Medicare Prescription Drug Plan.
- You can switch to another **Medicare Advantage Plan** or other Medicare health plan in your area that offers Medicare prescription drug coverage during certain times (see page 10).
- You can switch to the **Original Medicare Plan**, and join a Medicare Prescription Drug Plan.

If you stay in your current plan that doesn't offer drug coverage, and you don't join a Medicare Prescription Drug Plan, you may have to pay a late enrollment penalty (higher **premium**) if you join a Medicare Prescription Drug Plan later.

If you have limited income and resources, you might qualify for extra help paying your Medicare prescription drug coverage costs. Call 1-800-MEDICARE (1-800-633-4227) or your **State Health Insurance Assistance Program** (see page 19) to get answers to your questions about extra help paying for your prescription drug costs. TTY users should call 1-877-486-2048.

For more information about your choices, you can contact your Medicare Private Fee-for-Service Plan insurance company. The telephone number will be in your plan member materials. You can also visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Joining, Switching, and Leaving Medicare Private Fee-for-Service Plans

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

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

- you live in the **service area** of the plan you want to join. The plan can give you more information about its service area. If you live in another state for part of the year, check to see if the plan will cover you there.

AND

- you have **Medicare Part A and Part B**.

AND

- you don't have **End-Stage Renal Disease** (permanent kidney failure requiring dialysis or a kidney transplant).

When can I join, switch, or leave a Medicare Private Fee-for-Service Plan?

You can join, switch, or leave a Medicare Private Fee-for-Service Plan

- when you first become eligible for Medicare (three months before you turn age 65 to three months after the month you turn age 65). If you get Medicare due to a disability, you can join during the three months before to three months after your 25th month of cash disability payments.
- from November 15–December 31 each year. Your coverage will begin on January 1 of the following year.
- from January 1–March 31 of each year. However, you can't add or change to a plan with prescription drug coverage during this time unless you already have Medicare prescription drug coverage.

In certain situations, you may be able to join, switch, or leave Medicare Private Fee-for-Service Plans at other times (like if you move, have both Medicare and **Medicaid**, or live in an institution).

You can't remain a member of a plan if you move out of the plan's service area. However, if you like your coverage, check with the insurance company to see if they offer a plan in your new area. Or you can choose to join another **Medicare Advantage Plan** if one is available in your new area.

Remember, words in **red** are defined on pages 20–22.

Joining, Switching, and Leaving Medicare Private Fee-for-Service Plans

How can I compare Medicare Private Fee-for-Service Plans or other Medicare plans available in my area?

To compare [Medicare Private Fee-for-Service Plans](#) or to find out what plans are available in your area, you can

- visit www.medicare.gov on the web. Under “Search Tools,” select “Compare Health Plans and Medigap Policies in Your Area.” 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). TTY users should call 1-877-486-2048.
- call the insurance company offering the Medicare 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 19).

After I choose a Medicare Private Fee-for-Service Plan, how do I join?

Once you choose a plan, you can join in several ways. You may be able to join a plan by completing a paper application, calling the plan, or enrolling online. Talk with the plan to find out how you can join. When you join a plan, you will have to provide the Medicare number and the date your Part A and/or Part B coverage started from your Medicare card.

You can also visit www.medicare.gov on the web. Under “Search Tools,” select “Compare Health Plans and Medigap Policies in Your Area.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You don’t need to meet with a plan representative in order to join.

Joining, Switching, and Leaving Medicare Private Fee-for-Service Plans

What happens after I join a plan?

Starting in the fall 2007, you will get a telephone call from the plan so that the plan can verify that you wanted to join. The plan representative will also make sure that you understand how a **Medicare Private Fee-for-Service Plan** works and answer any questions you may have about the plan. The plan will send you a letter with this information if it can't reach you by telephone.

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

Once you enroll in a Medicare Private Fee-for-Service Plan, you must show your plan ID card every time you visit a health care provider. You can't use your red, white, and blue Medicare card to get health care because the **Original Medicare Plan** won't pay for your health care while you are enrolled in the Medicare Private Fee-for-Service Plan. You should keep your Medicare card in a safe place in case you return to the Original Medicare Plan in the future.

Private Fee-for-Service Plans have different rules. For example, all plan providers, on a one-by-one basis, must be willing to accept the plan's coverage. This means you must check with each doctor or hospital to be sure they will accept the plan's payment.

Read plan materials carefully to find out about other rules that can affect where you get your care and what you pay, including the following:

- Does the plan have a network (certain providers you must use to pay the lowest cost)?
- What is your share of the costs for services and supplies?

Note: If you believe a Medicare plan has misled you, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Medigap (Medicare Supplement Insurance) Policy Information

Can I keep my **Medigap** policy if I join a Medicare 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 Medicare Private Fee-for-Service Plan. You may want to keep your Medigap policy until you are sure that you are happy with the Medicare Private Fee-for-Service Plan. If you are in a Medicare 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.

Remember, words in **red** are defined on pages 20–22.

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

At the end of the year, plans can decide to leave the Medicare Program. If your plan leaves the Medicare Program, the plan will send you a letter about your options. Generally, you will be automatically returned to the **Original Medicare Plan** if you don't choose to join another **Medicare Advantage Plan**. You will also have the right to buy a Medigap policy (see page 15). You should learn as much as you can about your choices before making a decision.

No matter what you choose, you are still in the Medicare Program and will get all Medicare-covered services. If your health plan covers prescription drugs and you want to keep getting prescription drug coverage, you need to join another plan that offers this coverage. If you decide to return to the Original Medicare Plan and want to continue to have drug coverage, you will have to join a Medicare Prescription Drug Plan. See page 15 to find out where you can get more information on Medigap policies and protections.

Note: In recent years, very few plans have left the Medicare Program.

Medigap (Medicare Supplement Insurance) Policy Information

What happens if my Medicare Private Fee-for-Service Plan coverage ends, and I have **End-Stage Renal Disease (ESRD)**?

Remember, words in red are defined on pages 20–22.

If you have ESRD and a Medicare **Private Fee-for-Service Plan** and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another **Medicare Advantage Plan**. You don't have to use your one-time right to join a new plan immediately. If you change directly to the **Original Medicare Plan** after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan later, as long as the plan you choose is accepting new members.

For more information about ESRD, visit www.medicare.gov on the web. Under “Search Tools,” select “Find a Medicare Publication” to view the booklet “Medicare Coverage of Kidney Dialysis and Kidney Transplant Services.”

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

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

- your Medicare Private Fee-for-Service Plan coverage ends (through no fault of your own), or
- you join a Medicare 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 Medicare 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.

Medigap (Medicare Supplement Insurance) Policy Information

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 Medicare Private Fee-for-Service Plan when you first became eligible for Medicare at age 65, and
- you leave the Medicare 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 Medicare 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

- visit www.medicare.gov on the web. Under “Search Tools,” select “Compare Health Plans and Medigap Policies in Your Area.”
- call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of the “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.” This guide gives information on buying a Medigap policy and information on your Medigap rights and protections.
- call your **State Health Insurance Assistance Program** (see page 19). This state program gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Appeal Rights

What can I do if my Medicare 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, you can file an appeal.

If you have Medicare, you have certain guaranteed rights. One of these is the right to a fair process to appeal decisions about health care payment of services. An appeal is a kind of complaint you make if

- your Medicare Private Fee-for-Service Plan refuses to pay for a service, item, or prescription drug that you got and think should be covered.
- your Medicare Private Fee-for-Service Plan has told you in advance that it won't cover a service, item, or prescription drug you think should be covered.
- you disagree with the amount that you have to pay for a service or item you got.

The appeal rights listed above apply to benefits generally covered by Medicare and extra plan benefits provided by your Medicare Private Fee-for-Service Plan.

If you decide to file an appeal, ask your doctor, health care provider, or supplier for any information that may help your case. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. If the plan or physician agrees, the plan must make a decision within 72 hours.

Appeal Rights

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

The Medicare 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.

Remember, words in red are defined on pages 20–22.

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 visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites." TTY users should call 1-877-486-2048.

In addition, you will have the right to a fast-track appeals process when you disagree with a decision that you no longer need services you are getting from a skilled nursing facility, home health agency, or a comprehensive outpatient rehabilitation facility. You can get a quick review whenever you are getting services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility. You will get 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.

For More Information

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

- visit www.medicare.gov on the web. Under “Search Tools,” select “Compare Health Plans and Medigap Policies in Your Area.” 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). TTY users should call 1-877-486-2048.
- call the insurance company offering the Medicare 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 19). This state program gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Remember, words in red are defined on pages 20–22.

Note: At the time of printing, the telephone numbers listed on page 19 were correct. Telephone numbers sometimes change. To get the most up-to-date telephone numbers, visit www.medicare.gov on the web. Select “Helpful Phone Numbers and Websites.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For More Information

State Health Insurance Assistance Program: For help with questions about appeals, buying other insurance, choosing a health plan, buying a **Medigap** policy, and Medicare rights and protections.

Alabama	(800) 243-5463	Nebraska	(800) 234-7119
Alaska	(800) 478-6065	Nevada	(800) 307-4444
Arizona	(800) 432-4040	New Hampshire	(866) 634-9412
Arkansas	(800) 224-6330	New Jersey	(800) 792-8820
California	(800) 434-0222	New Mexico	(800) 432-2080
Colorado	(888) 696-7213	New York	(800) 701-0501
Connecticut	(800) 994-9422	North Carolina	(800) 443-9354
Delaware	(800) 336-9500	North Dakota	(888) 575-6611
Florida.....	(800) 963-5337	Ohio	(800) 686-1578
Georgia	(800) 669-8387	Oklahoma	(800) 763-2828
Guam	(671) 735-7388	Oregon	(800) 722-4134
Hawaii	(888) 875-9229	Pennsylvania	(800) 783-7067
Idaho.....	(800) 247-4422	Puerto Rico	(877) 725-4300
Illinois.....	(800) 548-9034	Rhode Island	(401) 462-4444
Indiana	(800) 452-4800	South Carolina	(800) 868-9095
Iowa	(800) 351-4664	South Dakota	(800) 536-8197
Kansas	(800) 860-5260	Tennessee	(877) 801-0044
Kentucky.....	(877) 293-7447	Texas.....	(800) 252-9240
Louisiana.....	(800) 259-5301	Utah	(800) 541-7735
Maine	(877) 353-3771	Vermont	(800) 642-5119
Maryland.....	(800) 243-3425	Virgin Islands (St. Croix) ..	(340) 772-7368
Massachusetts	(800) 243-4636	(St. Thomas, St. John) ..	(340) 714-4354
Michigan.....	(800) 803-7174	Virginia.....	(800) 552-3402
Minnesota	(800) 333-2433	Washington.....	(800) 562-6900
Mississippi.....	(800) 948-3090	Washington, D.C.....	(202) 739-0668
Missouri	(800) 390-3330	West Virginia	(877) 987-4463
Montana	(800) 551-3191	Wisconsin	(800) 242-1060
		Wyoming	(800) 856-4398

Words to Know

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

Assignment—An agreement between a person with Medicare, a doctor or supplier, and Medicare. The person with Medicare agrees to let the doctor or supplier request direct payment from Medicare for covered Part B services, equipment, and supplies. Doctors or suppliers who agree to (or must by law) accept assignment from Medicare can't try to collect more than the Medicare deductible and coinsurance amounts from the person with Medicare, the person's other insurance (if any), or from anyone else.

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

Coinsurance—The percentage of the Medicare Private Fee-for-Service Plan amount that you may have to pay after you pay any plan deductibles. In a Medicare 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 and prescription drug 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 example, this could be \$10 or \$20 for a doctor's visit or prescription. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

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

Deemed—Providers are "deemed" when they know, before providing a service, that you are in a Medicare Private Fee-for-Service Plan; they have reasonable access to the plan's terms and conditions of payment; and the service is covered by the plan. 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.

Words to Know

Medicaid—A joint Federal and State program that helps with medical costs for some people with limited income and 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 needed for the diagnosis or 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 (Part C)—A type of Medicare plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called Part C, Medicare Advantage Plans are HMOs, PPOs, Private Fee-for-Service Plans, or Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under the Original Medicare Plan.

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. Medigap policies only work with the Original Medicare Plan.

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

Words to Know

Original Medicare Plan—The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). It is a fee-for-service health plan. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

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

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 any provider or practitioner providing Medicare-covered services. QIOs also hear certain appeals for people with Medicare.

Service Area—The area where a Medicare 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	6, 7, 8, 20
Appeal	8, 16–17
Assignment	3, 20
Balance Billing	4, 20
Coinsurance	2, 3, 4, 6, 20
Copayment	2, 3, 4, 6, 20
Deductible	3, 4, 5, 20
Deemed	4, 20
End-Stage Renal Disease	10, 14, 20
Medicaid	10, 13, 21
Medically Necessary	2, 7, 8, 16, 17, 21
Medicare Advantage Plan	1, 9, 10, 13, 14, 21
Medicare Part A (Hospital Insurance)	3, 7, 10, 21
Medicare Part B (Medical Insurance)	3, 4, 5, 7, 21
Medigap Policy	1, 2, 3, 7, 11, 13–15, 21
Original Medicare Plan	1–4, 7, 9, 22
Premium	3, 4, 5, 22
Prescription Drugs	1, 7, 9, 10, 13, 16
Quality Improvement Organization	17, 22
Rights	2, 15–17
Service Area	10, 22
State Health Insurance Assistance Program	9, 11, 15, 19, 22

**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 Pub. No. 10144
Revised May 2007

*My Health.
My Medicare.*



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.