



Medicare Coverage of Kidney Dialysis & Kidney Transplant Services



This official government booklet tells you:

- The basics of Medicare
- How Medicare helps pay for kidney dialysis and kidney transplants
- Where to get help

The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227), to get the most current information. TTY users can call 1-877-486-2048.

“Medicare Coverage of Kidney Dialysis & Kidney Transplant Services” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.



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Introduction

This booklet explains what Medicare covers and how Medicare helps pay for kidney dialysis and kidney transplant services in [Original Medicare](#).

People with End-Stage Renal Disease can choose either Original Medicare or a Medicare Advantage Plan when deciding how to get Medicare coverage.

Turn to page 7 for more information.

If you're in a Medicare Advantage Plan (or another [Medicare health plan](#)), your plan must give you at least the same coverage that Original Medicare gives. But, your costs, rights, protections, and/or choices of where you get your care may

be different. You may also be able to get some extra benefits. Read your plan materials or call your benefits administrator for more information.

Talk with your health care team to learn more about permanent kidney failure and your treatment options.

Your doctors, nurses, social workers, dieticians, and dialysis technicians make up your health care team. Your health care team can help you decide what's best for you based on your situation. If you have questions about Medicare or need more information, visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.



SECTION

1 Medicare basics

What's Medicare?

Medicare is health insurance for:

- People 65 and older
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

What does Medicare cover?

Medicare Part A (Hospital Insurance) helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- [Home health care](#)

Medicare Part B (Medical Insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits)

For more details about what Medicare covers, visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Words in [blue](#) are defined on pages 49–51.

Getting Medicare with ESRD

You can get Medicare no matter how old you are, if your kidneys no longer work, you need regular dialysis or have had a kidney transplant, and one of these applies to you:

- You've worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee
- You're already getting or are eligible for Social Security or RRB benefits
- You're the spouse or dependent child of a person who meets either of the requirements above

You must also file an application and meet any waiting periods that apply.

If you qualify for Medicare Part A, you can also get Medicare Part B. Most people must pay a monthly **premium** for Part B. Turn to page 33. Signing up for Part B is your choice, but you'll need both Part A and Part B to get the full benefits available under Medicare to cover certain dialysis and kidney transplant services.

If you don't qualify for Medicare, you may be able to get help from your state to pay for your dialysis treatments. Turn to page 43.

Call Social Security at 1-800-772-1213 for more information about the required amount of time needed under Social Security, the RRB, or as a government employee to be eligible for Medicare based on ESRD. You can also visit [ssa.gov](https://www.ssa.gov). TTY users can call 1-800-325-0778.

Getting Medicare with ESRD (continued)

If your child has ESRD

Your child can be covered if you or your spouse has worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee. Your child can also be covered if you, your spouse, or your child gets Social Security or RRB benefits, or is eligible to get those benefits.

Medicare can help cover your child's medical costs if your child needs regular dialysis because their kidneys no longer work, or if they had a kidney transplant.

Visit [Medicare.gov/basics/children-and-end-stage-renal-disease](https://www.medicare.gov/basics/children-and-end-stage-renal-disease) for more information. To sign your child up for Medicare, or to get more information about eligibility, call or visit your local Social Security office. You can call Social Security at 1-800-772-1213 to make an appointment. TTY users can call 1-800-325-0778.

Medicare plan choices

You can get your coverage through [Original Medicare](#), or, you can join a [Medicare Advantage Plan](#).

If you have ESRD & choose Original Medicare

You can go to any doctor or [supplier](#) that's enrolled in and accepts Medicare and is accepting new patients, or to any participating hospital or other facility.

You pay a set amount for your health care ([deductible](#)) before Medicare starts paying. Then, Medicare pays its share, and you pay your share ([coinsurance](#) or [copayment](#)) for covered services and supplies.

When you have Original Medicare, you can add [Medicare drug coverage](#) by joining a Medicare drug plan. Different plans cover different drugs, but plans must cover most [medically necessary](#) drugs. Turn to page 29 for more information.

Medicare plan choices (continued)

If you have ESRD & choose a Medicare Advantage Plan

Medicare Advantage Plans are a type of [Medicare health plan](#) offered by a private company that contracts with Medicare to give all of your Part A and Part B benefits. Most Medicare Advantage Plans also offer drug coverage. Medicare Advantage Plans must cover all of the services that [Original Medicare](#) covers. Some plans may offer extra benefits that Original Medicare doesn't cover, like vision, hearing and dental services. Out-of-pocket costs vary in each plan.

Once you have Medicare Part A and Part B, you can join a Medicare Advantage Plan. Visit [Medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan](https://www.Medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan) to learn more.

Important: In many cases, you can only use health care providers who are in the plan's network and service area. Before you join, check with your providers and the plan you're considering to make sure the providers you currently see (like your dialysis facility or kidney doctor), or want to see in the future (like a transplant specialist), are in the plan's network. If you're already in a Medicare Advantage Plan, check with your providers to make sure they'll still be part of the plan's network next year. To learn more about a specific Medicare Advantage Plan, contact the plan, or visit [Medicare.gov/plan-compare](https://www.Medicare.gov/plan-compare).

If you join a Medicare Advantage Plan during Open Enrollment, or within the first 3 months you have Medicare Part A and Part B, you're eligible to make changes. You can switch back to Original Medicare or change to a different Medicare Advantage Plan (depending on which coverage works best for you) during the Medicare Advantage Open Enrollment Period (January 1–March 31).

To learn more about Medicare Advantage Plans, visit [Medicare.gov/types-of-medicare-health-plans/medicare-advantage-plans](https://www.Medicare.gov/types-of-medicare-health-plans/medicare-advantage-plans).

For more information about your Medicare plan choices, look at your “Medicare & You” handbook or visit [Medicare.gov](https://www.Medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227) to get more information. TTY users can call 1-877-486-2048.

How to sign up for Medicare

If you're eligible for Medicare because of ESRD, you can sign up for Medicare by visiting your local Social Security office or calling Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Once you have Medicare, you'll need to choose how you get your coverage. Turn to pages 7–8. For more information on your coverage options, visit [Medicare.gov](https://www.Medicare.gov).

Note: If you already have Medicare based on age or disability, and you're already paying a higher Part B [premium](#) because you didn't sign up for Part B when you were first eligible, the [penalty](#) will stop when you become eligible for Medicare based on ESRD. Call your local Social Security office to make an appointment to sign up for Medicare based on ESRD.

When Medicare coverage begins

Eligibility for Medicare coverage based on ESRD works differently than other types of Medicare eligibility. If you're eligible for Medicare based on ESRD and don't sign up right away, your coverage could start up to 12 months before the month you apply.

Example: If you become eligible for Medicare based on ESRD in February, but don't sign up for Medicare until November, your Medicare coverage will backdate to February (this is called retroactive coverage).

For more information, visit [Medicare.gov](https://www.Medicare.gov) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you're on dialysis

When you sign up for Medicare based on ESRD **and you're on dialysis**, Medicare coverage usually starts on the first day of the fourth month of your dialysis treatments. For example, if you start dialysis on July 1, your coverage will begin on October 1.

July	August	September	October
First month of dialysis.	Second month of dialysis.	Third month of dialysis.	Fourth month of dialysis. Medicare coverage begins.

When Medicare coverage begins (continued)

Medicare coverage can begin as early as the first month of a regular course of dialysis treatments if you meet both of these conditions:

- You participate in a home dialysis training program offered by a Medicare-certified training facility during the first 3 months of your regular course of dialysis
- Your doctor expects you to finish training and be able to do your own dialysis treatments

Important: Medicare won't cover surgery or other services needed to prepare for dialysis (like surgery for blood access (fistula)) before Medicare coverage begins. However, if you complete home dialysis training, your Medicare coverage will start the month you begin regular dialysis, and these services could be covered.

If you're already getting Medicare due to age or disability, Medicare will cover physician-ordered fistula placement or other preparatory services before dialysis begins.

If you're getting a kidney transplant

Medicare coverage can begin the month you're admitted to a Medicare-certified hospital for a kidney transplant (or for health care services that you need before your transplant) if your transplant takes place in that same month or within the next 2 months.

Example: Mr. Green will be admitted to the hospital on March 11 for his kidney transplant. His Medicare coverage will begin in March. If his transplant is delayed until April or May, his Medicare coverage will still begin in March.

If your transplant is delayed more than 2 months after you're admitted to the hospital (for the transplant or for health care services you need before your transplant), Medicare coverage can begin 2 months before your transplant.

Example: Mrs. Perkins was admitted to the hospital on May 25 for some tests she needed before her kidney transplant. She was supposed to get her transplant on June 15. However, her transplant was delayed until September 17. Therefore, Mrs. Perkins' Medicare coverage will start in July—2 months before the month of her transplant.

When Medicare coverage ends

If you're eligible for Medicare only because of permanent kidney failure, your Medicare coverage will end:

- 12 months after the month you stop dialysis treatments
- 36 months after the month you have a kidney transplant

Your Medicare coverage will resume if:

- You start dialysis again, or you get a kidney transplant within 12 months after the month you stopped getting dialysis
- You start dialysis or get another kidney transplant within 36 months after the month you get a kidney transplant

How Medicare works with employer or union group health plan coverage

If you're eligible for Medicare only because of permanent kidney failure, your coverage usually can't start until the fourth month of dialysis (also known as a "waiting period"). This means if you have coverage through an employer or union group health plan, that plan will be the only payer for your first 3 months of dialysis (unless you have other coverage).

If your employer or union plan doesn't pay all costs for dialysis, you may have to pay some of the costs. You may be able to get help paying these costs. Turn to pages 41–43.

Once you become eligible for Medicare because of permanent kidney failure (usually the fourth month of dialysis), there will still be a period of time, called a "coordination period," when your employer or union group health plan will continue to pay your health care bills.

If your plan doesn't pay 100% of your health care bills, Medicare may pay some of the remaining costs. This is called "coordination of benefits," under which your plan "pays first" and Medicare "pays second." During this time, Medicare is called the secondary payer (the insurance policy, plan, or program that pays second on a claim for medical care). This coordination period lasts for 30 months.

The 30-month coordination period

The 30-month coordination period starts the first month you would be eligible to get Medicare because of permanent kidney failure (usually the fourth month of dialysis), **even if you haven't signed up for Medicare yet.**

Example: If you start dialysis and are eligible for Medicare in June, the 30-month coordination period will start September 1, the fourth month of dialysis, even if you don't have Medicare.

If you participate in home dialysis training or get a kidney transplant during the 3-month waiting period, the 30-month coordination period will start earlier. During this 30-month period, Medicare will be the secondary payer.

Important: If you have employer or union group health plan coverage, tell your health care provider that you have this coverage. This is very important to make sure that your services are billed correctly. At the end of the 30-month coordination period, Medicare will pay first for all Medicare-covered services. Your employer or union group health plan coverage may still pay for services not covered by Medicare. Check with your plan's benefits administrator.

There's a separate 30-month coordination period each time you sign up for Medicare based on permanent kidney failure. For example, if you get a kidney transplant that continues to work for 36 months, your Medicare coverage will end (unless you have Medicare based on your age or disability).

If after 36 months you sign up for Medicare again because you start dialysis or get another transplant, your Medicare coverage will start right away. There will be no 3-month waiting period before Medicare begins to pay. However, there will be a new 30-month coordination period if you have employer or union group health plan coverage.

Do I have to get Medicare if I already have an employer or union group health plan?

No, but think carefully about this decision. If you get a kidney transplant, you'll need to take immunosuppressive drugs for the rest of your life, so it's important to know if they'll be covered. Medicare Part B only covers immunosuppressive drugs in specific circumstances (turn to pages 25–27).

Note: If you don't meet the conditions for Part B coverage of immunosuppressive drugs, you may be able to get coverage by joining a Medicare drug plan. Turn to pages 29–32.

If your group health plan coverage has a yearly **deductible**, **copayment**, or **coinsurance**, signing up for Medicare Part A and Part B could help pay those costs during the coordination period. If your group health plan coverage will pay for most or all of your health care costs (like, if it doesn't have a yearly deductible), you may want to delay signing up for Part A and Part B until the 30-month coordination period is over.

If you delay enrollment, you won't have to pay the Part B **premium** for coverage you don't need yet. After the 30-month coordination period, you should sign up for Part A and Part B. **Your Part B premium won't be higher because you delayed your enrollment in this situation.** If your group health plan benefits are decreased or end during the coordination period, you should sign up for Part A and Part B as soon as possible.

For more information about how employer or union group health plan coverage works with Medicare:

- Get a copy of your plan's benefits booklet.
- Call your benefits administrator, and ask how the plan pays when you have Medicare.

SECTION

2

Kidney dialysis

What's dialysis?

Dialysis is a treatment that cleans your blood when your kidneys don't work. It gets rid of harmful waste, extra salt, and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments may help you feel better and live longer, but they aren't a cure for permanent kidney failure.

Dialysis treatment options

There are 2 types of dialysis treatment options:

1. Hemodialysis uses a special filter (called a dialyzer) to clean your blood. The filter connects to a machine. During treatment, your blood flows through tubes into the dialyzer to clean out wastes and extra fluids. Then, the newly-cleaned blood flows through another set of tubes back into your body.
2. Peritoneal dialysis uses a special solution (called dialysate) that flows through a tube into your abdomen. After a few hours, the dialysate takes wastes from your blood and can be drained from your abdomen. After draining the used dialysate, your abdomen is filled with fresh dialysate, and the cleaning process begins again.

You should work with your health care team to decide which type of dialysis you need based on your situation.

Words in blue
are defined on
pages 49–51.

Dialysis services & supplies covered by Medicare

Service or supply	Medicare Part A	Medicare Part B
Inpatient dialysis treatments (if you're admitted to a hospital for special care).	✓	
Outpatient dialysis treatments & doctors' services (in a Medicare-certified dialysis facility or your home). Turn to pages 17–20.		✓
Home dialysis training (includes instruction for you and the person helping you with your home dialysis treatments).		✓
Home dialysis equipment and supplies (like the machine, water treatment system, basic recliner, alcohol, wipes, sterile drapes, rubber gloves, and scissors). Turn to pages 19–20.		✓
Certain home support services (may include visits by trained hospital or dialysis facility workers to check on your home dialysis, to help in emergencies when needed, and to check your dialysis equipment and water supply). Turn to pages 19–20.		✓
Most drugs for outpatient or home dialysis. Turn to page 29.		✓
Other services and supplies that are part of dialysis (like laboratory tests).		✓

To find out what you pay for these services, turn to pages 33–38.

Dialysis services & supplies NOT covered by Medicare

Medicare doesn't cover these services or supplies:

- Paid dialysis aides to help you with home dialysis
- Any lost pay to you or the person who may be helping you during home dialysis training
- A place to stay during your treatment
- Blood or packed red blood cells for home dialysis unless part of a doctor's service

There are some types of coverage that may pay some of the health care costs that Medicare doesn't pay. Turn to pages 41–43. For more information on [Medicare drug coverage](#), turn to pages 29–32.

Dialysis facilities

Dialysis can be done at home or in a Medicare-certified dialysis facility. For Medicare to pay for your treatments, the facility must be Medicare-certified to give dialysis (even if the facility already gives other Medicare-covered health care services).

At the dialysis facility, a nurse or trained technician may give you the treatment. At home, you can treat yourself or ask a family member or friend for help.

Medicare uses many different quality measures to evaluate dialysis facilities each year. These quality measures show how often dialysis facilities use best practices when caring for you. Medicare gives each dialysis facility a score based on its evaluation of these quality measures. Dialysis facilities are required to display that score in an area that's easy for you to find, and in a format and language you understand.

Dialysis facilities (continued)

How to find a facility

In most cases, you'll get your dialysis treatments at the facility where your kidney doctor works. You have the right to choose to get your treatments from another facility at any time, but this could mean changing doctors.

You can visit [Medicare.gov/care-compare](https://www.medicare.gov/care-compare) to find a dialysis facility that's close to you, or call your local ESRD Network (turn to page 46).

The Medicare Care Compare site has detailed information about Medicare-certified dialysis facilities (also known as dialysis centers). You can compare dialysis facilities based on their star ratings, as well as the services and quality of care they give. It also has other resources for patients and family members who want to learn more about chronic kidney disease and dialysis.

Find and compare this information about dialysis facilities:

- Addresses
- Phone numbers
- Maps and directions
- Types of dialysis services the facilities offer
- Quality of patient care information
- Patient experience of care survey results

If you don't have a smart phone or computer, your local library or senior center may be able to help you look up this information. You can also contact your local State Health Insurance Assistance Program (SHIP) (turn to page 47), or call 1-800-MEDICARE (1-800-633-4227) to get help comparing dialysis facilities. TTY users can call 1-877-486-2048.

If you have a problem finding a dialysis facility that's willing to take you as a patient, you have the right to file a complaint (grievance). Turn to pages 39–40 for more information.

Transportation to dialysis facilities

Original Medicare only covers ambulance services to and from your home to the nearest dialysis facility, if other forms of transportation could endanger your health.

For non-emergency, scheduled, repetitive ambulance services, the ambulance **supplier** must get a written order from your doctor before you get the ambulance service. The doctor's written order must certify that ambulance transportation is **medically necessary** and must be dated no earlier than 60 days before you get the ambulance service.

If you're in a **Medicare Advantage Plan**, the plan may cover some non-ambulance transportation to dialysis facilities and doctors. Read your plan materials, or call the plan for more information.

For more information about ambulance coverage, visit [Medicare.gov/coverage/ambulance-services](https://www.Medicare.gov/coverage/ambulance-services). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you need help with non-ambulance transportation, talk to the social worker at your dialysis facility to find out your options.

Dialysis in a hospital

If you're admitted to a hospital and get dialysis, Medicare Part A will cover your treatments as part of the cost of your covered inpatient hospital stay. Turn to page 35 for information about inpatient and outpatient costs for dialysis.

Home dialysis

Medicare Part B covers training for home dialysis, but only by a facility certified for dialysis training. You may qualify for training if you think you'll benefit from home dialysis treatments, and your doctor approves. Training sessions occur at the same time you get dialysis treatment and are limited to a maximum number of sessions.

Your dialysis facility is responsible for providing all of your home dialysis related items and services, including equipment and supplies, that are medically necessary and reasonable.

Your dialysis facility must give you these items and services directly, or through an arrangement with another provider.

Medicare makes a single payment per dialysis treatment to the dialysis facility for all dialysis-related services, including equipment and supplies. Dialysis facilities pay third-party **suppliers** from this single payment amount.

Home dialysis (continued)

Monthly doctor visits for home dialysis

You may be able to get a monthly visit from your health care provider (or certain non-doctors, like physician assistants and nurse practitioners) to help you manage your care.

This benefit includes a face-to-face visit between you and your health care provider once a month. You can also choose to get some of your monthly visits via telehealth. These visits allow you and your doctor to review your lab work, discuss your care and the effectiveness of your dialysis, check for complications, and give you a chance to ask questions about your home dialysis treatment. To learn more about telehealth, visit [Medicare.gov/coverage/telehealth](https://www.medicare.gov/coverage/telehealth).

Dialysis when you travel

You can still travel within the U.S. if you need dialysis. There are about 6,000 dialysis facilities around the country. Your facility can help you plan your treatment along the route of your trip before you travel.

While you're traveling, you may need to pay your [copayment](#) when you get your dialysis. Check with the social worker at your dialysis facility to learn more.

Your dialysis facility will help you by checking to see if the facilities on your route:

- Are Medicare-certified to give dialysis
- Have the space and time to give care when you need it
- Have enough information about you to give you the right treatment

In general, Medicare will only pay for hospital or medical care that you get in the U.S.

Note: If you get your dialysis services from a [Medicare Advantage Plan](#), your plan may be able to help you arrange to get dialysis while you travel. Contact your plan for more information.

Knowing how well your dialysis is working

With the right type and amount of dialysis, you'll probably feel better and less tired, have a better appetite, less nausea, have fewer hospital stays, and live longer.

You can tell how well the dialysis is working with blood tests that keep track of your URR or Kt/V (pronounced "kay tee over vee") number. These numbers tell your doctor or nurse how well dialysis is removing wastes from your body. Your doctor or nurse usually keeps track of one or both of these numbers, depending on which test your dialysis facility uses.

A URR of 65% and a Kt/V of 1.2 are the minimum numbers for adequate dialysis. Your health care provider or dialysis center may set a higher dialysis goal for your health and to make you feel better. Talk to your health care provider about your number.

Even if you feel fine, you should still check how well your dialysis is working. For a short period of time, you may feel okay without adequate dialysis. However, over time, not getting adequate dialysis can make you feel weak and tired, which can lead to a higher risk of infection, prolonged bleeding, and shorten your life.

Knowing how well your dialysis is working (continued)

Here are some steps you can take to make adequate dialysis more likely:

- Go to all of your scheduled treatments and arrive on time.
- Stay for the full treatment time.
- Follow your diet and fluid restrictions.
- Follow the advice of your dialysis staff on taking care of yourself.
- Check your URR or Kt/V adequacy number each month.
- Talk to your doctor about which hemodialysis vascular access is best for you. (Your vascular access uses your blood vessels and is created by a surgeon to use for cleaning your blood during dialysis.) During dialysis, your blood is removed and returned through your vascular access.
- Learn how to take care of your vascular access.

To learn more about how well your dialysis is working, talk with your doctor or other health team members at your dialysis facility. If you have a problem with the care that you're getting for your kidney disease, you have the right to file a complaint. Details about "Filing a complaint (grievance)" are on pages 39–40.

SECTION

Kidney transplants

3

What's a kidney transplant?

A kidney transplant is a type of surgery that puts someone else's healthy kidney into your body. This donated kidney does the work that your own kidneys no longer do. You may get a kidney from someone who has recently died, or from someone who's still living, like a family member. The blood and tissue of the person who gives you the kidney must be tested to see how well they match yours so that your body won't reject the new kidney.

Medicare will cover your kidney transplant only if it's done in a hospital that's Medicare-certified to do kidney transplants.

If you have a problem with the care that you're getting for your transplant or with getting a referral for a transplant work-up, you have the right to file a complaint (grievance). Details about "Filing a complaint (grievance)" are on pages 39–40.

Words in blue
are defined on
pages 49–51.

Kidney transplant services covered by Medicare

Service or supply	Medicare Part A	Medicare Part B
Inpatient services in a Medicare-certified hospital.	✓	
Kidney registry fee.	✓	
Laboratory and other tests to evaluate your medical condition and the condition of potential kidney donors.*	✓	
The costs of finding the proper kidney for your transplant surgery (if there's no kidney donor).	✓	
The full cost of care for your kidney donor (including care before, during, and after the surgery).	✓	
Any additional inpatient hospital care for your donor in case of problems due to the surgery.	✓	
Doctors' services for kidney transplant surgery (including care before, during, and after the surgery).		✓
Doctors' services for your kidney donor during their hospital stay.		✓
Transplant drugs (also called immunosuppressive drugs) for a limited time after you leave the hospital, following a transplant. Turn to pages 25–27.		✓
Blood (whole or units of packed red blood cells, blood components, and the cost of processing and giving you blood). Turn to page 38.	✓	✓

To find out what you pay for these services, turn to pages 36–38.

*Medicare covers these services whether they're done by the Medicare-certified hospital where you'll get your transplant, or by another hospital that participates in Medicare.

ESRD & pancreas transplants

If you have End-Stage Renal Disease (ESRD) and need a pancreas transplant, Medicare covers the transplant if it's done at the same time you get a kidney transplant or it's done after a kidney transplant.

Note: In some rare cases, Medicare may cover a pancreas transplant, even if you don't need a kidney transplant.

If you're entitled to Medicare only because of permanent kidney failure, and you have a pancreas transplant after a kidney transplant, Medicare will only pay for your immunosuppressive drug therapy for 36 months after the month of the kidney transplant and your Medicare coverage will end. However, you may be eligible for a Part B benefit that helps continue to pay for your immunosuppressive drugs beyond 36 months. Turn to page 26.

If you were already eligible for Medicare because of age or disability before you got ESRD, or if you became eligible for Medicare because of age or disability after getting a transplant, Medicare will continue to pay for your transplant drugs with no time limit.

Transplant drugs (also called immunosuppressive drugs)

What are transplant drugs?

Transplant drugs are immunosuppressive drugs used to reduce the risk of your body rejecting your new kidney after your transplant. You'll need to take these drugs for the rest of your life.

If you're only eligible for Medicare because of ESRD (you aren't 65 or older or have a disability), Medicare Part B will only cover your transplant drugs if both of these conditions are met:

- You already had Medicare Part A at the time of your transplant.
- You had transplant surgery at a Medicare-certified facility.

Part B will only cover your transplant drugs after you have Part B. There won't be any retroactive coverage (turn to page 9 for more information on retroactive coverage).

Transplant drugs (also called immunosuppressive drugs) (continued)

What if I stop taking my transplant drugs?

If you stop taking your transplant drugs, your body may reject your new kidney, and the kidney could stop working. Talk to your doctor before you stop taking your transplant drugs.

How long will Medicare pay for transplant drugs?

If you're eligible for Medicare only because of permanent kidney failure, **your Medicare coverage will end 36 months after the month of the transplant.**

However, Medicare will continue to pay for your transplant drugs beyond 36 months if you're eligible for the Part B immunosuppressive drug benefit.

Medicare will pay **without a time limit if one of these conditions applies:**

- You were already eligible for Medicare because of age or disability before you got ESRD.
- You became eligible for Medicare because of age or disability after getting a transplant (in a Medicare-certified facility) that Medicare paid for, or you had private insurance that paid before your Medicare Part A coverage.

What's the immunosuppressive drug benefit?

Medicare offers a benefit that helps you pay for your immunosuppressive drugs beyond 36 months, **if you don't have or expect to get certain types of other health coverage** (like a group health plan, TRICARE, or Medicaid that covers immunosuppressive drugs). **This benefit only covers your immunosuppressive drugs and no other items or services. It isn't a substitute for full health coverage.** You can sign up at any time as long as you had Medicare because of ESRD at the time of your kidney transplant. To sign up, call Social Security at 1-877-465-0355. This is a special phone number just for this benefit. TTY users can call 1-800-325-0788.

Transplant drugs (also called immunosuppressive drugs) (continued)

If you sign up for this benefit, you'll pay a monthly premium and an annual deductible:

- The monthly premium for this benefit is \$97.10 in 2023. (You may pay a higher premium based on your income.)
- The annual deductible is \$226 in 2023. Once you've met the deductible, you'll pay 20% of the Medicare-approved amount for your immunosuppressive drugs.

You may be able to get help paying for this benefit from programs offered through your state. Find out how to apply at [Medicaid.gov/about-us/beneficiary-resources/index.html](https://www.Medicaid.gov/about-us/beneficiary-resources/index.html).

Visit [Medicare.gov/basics/end-stage-renal-disease](https://www.Medicare.gov/basics/end-stage-renal-disease) to learn more about this benefit.

What if I can't pay for the transplant drugs?

If you don't qualify for the new Part B drug benefit and you're worried about paying for your transplant drugs after your Medicare coverage ends, talk to your doctor, nurse, or social worker. There may be other ways to help you pay for these drugs. Turn to pages 41–43 to learn more about other health coverage options.

SECTION

Medicare drug coverage (Part D)

4

What Medicare covers

Medicare Part B covers transplant drugs after a covered transplant (turn to pages 25–26) and most of the drugs you get for dialysis (turn to page 16). However, Part B doesn't cover drugs for other health conditions you may have, like high blood pressure. Medicare Part D offers drug coverage to help you with the costs of your drugs that Part B doesn't cover.

Medicare drug coverage won't cover drugs you can get under Part B, like immunosuppressive drug therapy under the conditions discussed on pages 33–34. However, if you don't meet the conditions on pages 33–34, you may be able to get coverage of your immunosuppressive drug therapy by joining a Medicare drug plan.

Private companies approved by Medicare offer drug coverage. There are 2 ways to get Medicare drug coverage:

1. Medicare drug plans that add coverage to **Original Medicare** or certain types of **Medicare health plans**.
2. **Medicare Advantage Plans** with drug coverage. Once you have Medicare Part A and Part B, you can join a Medicare Advantage Plan. Visit [Medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan](https://www.Medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan) to learn more.

Note: If you join a Medicare Advantage Plan with drug coverage, you'll get your drug coverage through your plan, and you can't join a separate Medicare drug plan.

Words in blue are defined on pages 49–51.

What Medicare covers (continued)

Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B [premium](#). If you're in a Medicare Advantage Plan with drug coverage, the monthly premium may include an amount for drug coverage. Your costs will vary depending on which drugs you use and which drug plan you choose.

Extra Help

Extra Help is a program that helps people with limited income and resources pay Medicare drug costs.

You can get Extra Help paying drug costs if you meet specific income and resource limits. Resources include things like your savings and stocks, but not your home or car. If you qualify, you'll get help paying for your Medicare drug plan's monthly premium, yearly [deductible](#), and prescription [copayments](#) or [coinsurance](#).

To qualify for Extra Help, your yearly income in 2022 must be below \$20,385 (\$27,465 for a married couple), and your resources must be below \$15,510 (\$30,950 for a married couple). These amounts may change in 2023.

If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, your income limits are higher. Resources don't include your home, one car, household items, burial plot, up to \$1,500 for burial expenses (per person), or life insurance policies.

Note: If you live in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, you may be able to get help with your drug coverage costs. This help isn't the same as the Extra Help described here. Visit [Medicare.gov/talk-to-someone](https://www.Medicare.gov/talk-to-someone) to get the contact information for your Medicaid office.

Extra Help (continued)

How can I apply?

Some people with Medicare automatically qualify for Extra Help and will get a letter from Medicare. Others will need to apply.

If you don't get a letter stating that you automatically qualify, visit secure.ssa.gov/i1020/start or call Social Security at 1-800-772-1213 to apply. TTY users can call 1-800-325-0778. After you apply, you'll get a letter in the mail letting you know if you qualify and what to do next. Even if you don't qualify for Extra Help, you may want to consider joining a Medicare drug plan.

If you qualify for Extra Help, and don't join a Medicare drug plan, Medicare will enroll you in a plan. You can "opt out" of being automatically enrolled. Medicare will send you a letter letting you know what plan it will enroll you in and when your coverage begins. Check to see if the plan you're being enrolled in covers the drugs you use, and if you can go to the pharmacies you want. If not, you can change plans.

When can I join?

If you become eligible for Medicare based on ESRD, your first chance to join a Medicare drug plan will be during the 7-month period that begins 3 months before the month you're eligible for Medicare and ends 3 months after the first month you're eligible for Medicare (called your Initial Enrollment Period).

Your Medicare drug coverage will start the same time your Medicare coverage starts. If you join a Medicare drug plan after your Medicare coverage starts, it will be effective the first day of the month after you join. Turn to pages 9–10.

If you don't join when you're first eligible, or during a Special Enrollment Period, you can join between October 15–December 7 each year. Your coverage will begin on January 1 of the next year. If you join after your Initial Enrollment Period is over, and there was a period of 63 continuous days or more during which you didn't have Part D or [creditable prescription drug coverage](#), you may have to pay a late enrollment [penalty](#) (which is added to your monthly [premium](#)).

When can I join? (continued)

This amount increases the longer you go without Part D or creditable coverage.

You'll have to pay this [penalty](#) as long as you have [Medicare drug coverage](#).

However, if you get Extra Help, you don't have to pay a late enrollment penalty.

Visit [Medicare.gov/drug-coverage-part-d](https://www.Medicare.gov/drug-coverage-part-d) for more information about Medicare drug coverage. You can also contact your local State Health Insurance Assistance Program (SHIP). Turn to page 47.

SECTION

Costs & payments

5

What Medicare costs

Medicare Part A (Hospital Insurance) costs

Most people don't pay a monthly **premium** for Part A because they (or a spouse) paid Medicare taxes while they were working.

Medicare Part B (Medical Insurance) costs

Most people must pay a monthly premium for Part B. The standard Part B premium for 2023 is \$164.90 per month, although it may be higher based on your income. Premium rates can change yearly.

You need Part B to get the full benefits, including regular dialysis, available for people with End-Stage Renal Disease (ESRD), and you must pay the premium to get Part B. For more information about the Part B premium, visit [ssa.gov](https://www.ssa.gov), or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Words in **blue**
are defined on
pages 49–51.

Paying for dialysis services

Medicare pays your dialysis facility to give you these Part B-covered dialysis services and items:

- Direct nursing services including: registered nurses, licensed practical nurses, technicians, social workers, and dietitians
- All equipment and supplies used for renal dialysis in the facility, or in your home, that are reasonable and [medically necessary](#)
- Injectable, intravenous (IV), and certain oral drugs that treat or manage conditions associated with ESRD (like anemia) or are used in the treatment of ESRD*
- Laboratory tests
- Home dialysis training by a Medicare-certified home dialysis training facility (if you choose to get dialysis at home)
- Other items and services, like heart monitoring during your dialysis treatments, oxygen given (if needed) during your dialysis treatments (if you're in a dialysis facility), monitoring of your access site, and certain nutritional services

Your dialysis facility must give you these items and services directly, or through an arrangement with another provider.

*[Medicare drug coverage](#) covers certain medications that are only available in an oral form. Talk with your doctor or health care team about the use of any drugs, including over-the-counter products.

Important note for people taking Calcimimetics (Sensipar® or Parsabiv™):

Medicare Part B covers calcimimetic medications under the ESRD payment system. Calcimimetic medications include the intravenous medication, Parsabiv, and the oral medication, Sensipar. Generic versions of Sensipar are available.

Your dialysis facility is responsible for giving you these medications. They can give them to you at their facility, or through a pharmacy they work with. You'll have a 20% [copayment](#) for these medications. If you're in a [Medicare Advantage Plan](#), your costs may be different.

You'll need to work with your dialysis facility and your doctor to find out where you'll get these medications, and how much you'll pay.

Paying for dialysis services (continued)

What will I pay for dialysis services in a dialysis facility?

If you have [Original Medicare](#), after you pay the Part B yearly deductible, you'll continue to pay a 20% [coinsurance](#) of the [Medicare-approved amount](#) for all covered dialysis-related services. Medicare will pay the remaining 80%.

The dollar amount of your coinsurance may vary. If you're in a [Medicare Advantage Plan](#) or have a Medicare Supplement Insurance (Medigap) policy (turn to page 42) that covers all or part of your 20% coinsurance, then your costs may be different. Read your plan materials or call your benefits administrator to get your cost information. You must also continue to pay your monthly Medicare Part B and Medicare drug coverage [premiums](#) (if applicable).

Note: Your 20% coinsurance covers all of the services and items listed on page 16. Since the bundled payment system includes these services and items, you **can't** be billed separately for them. You also don't need to get the drugs that are included in the bundle from your Medicare drug plan (if you have one).

What will I pay for dialysis in a hospital?

If you're admitted to a hospital and get dialysis, Part A will cover your treatments as part of the cost of your covered inpatient hospital stay.

- **Inpatient doctors' services**

In Original Medicare, your kidney doctor bills separately for the Medicare-covered ESRD services you get as an inpatient. In this case, your kidney doctor's monthly payment will be based on the number of days you stay in the hospital.

- **Outpatient doctors' services**

Original Medicare pays most kidney doctors a monthly amount. After you pay the Part B yearly [deductible](#) (\$226 in 2023) Medicare pays 80% of the monthly amount. You pay the remaining 20% coinsurance. In some cases, your doctor may be paid per day if you get services for less than one month.

Example: Let's say the monthly amount that Medicare pays your doctor for each dialysis patient is \$125. After you pay the Part B yearly deductible, here are the costs:

- Medicare pays 80% of the \$125 (or \$100).
- You pay the remaining 20% coinsurance (or \$25).

Remember, what you pay may be different than what's shown in this example.

What will I pay for home dialysis training services?

Original Medicare pays your kidney doctor a fee to supervise home dialysis training. After you pay the Part B yearly deductible (\$226 in 2023) Medicare pays 80% of the fee and you pay the remaining 20%.

Example: Let's say the fee for the kidney doctor who's supervising your home dialysis training is \$500. After you pay the Part B yearly deductible, here are the costs:

- Medicare pays 80% of the \$500 (or \$400).
- You pay the remaining 20% coinsurance (or \$100).

Remember, what you pay may be different than what's shown in this example.

What will I pay for my child who has ESRD?

If you have a child under 18 who has Medicare because of ESRD, the payment rules are the same as described above. However, the rates paid to dialysis facilities are adjusted based on the child's age and the type of dialysis they get. These adjustments allow for the special care needs of children. Your 20% coinsurance will be based on these special rates.

Visit [Medicare.gov/basics/children-and-end-stage-renal-disease](https://www.medicare.gov/basics/children-and-end-stage-renal-disease) for more information on Medicare coverage for children with ESRD.

What Medicare pays for transplant services

The amounts listed in this section are for transplant services that Original Medicare covers. If you're in a [Medicare Advantage Plan](#), your costs may be different. Read your plan materials, or call your plan to get information about your costs.

Paying for transplant services

What do I have to pay for my kidney donor?

Medicare will pay the full cost of care for your kidney donor. You don't have to pay a deductible, coinsurance, or other costs for your donor's hospital stay. Also, your kidney donor doesn't have to pay a deductible, coinsurance, or any other costs for their hospital stay.

Paying for transplant services (continued)

What do I have to pay for hospital services?

If you have [Original Medicare](#), in 2023, you pay:

- \$1,600 [deductible](#) per [benefit period](#)
- Days 1–60: \$0 [coinsurance](#) for each benefit period
- Days 61–90: \$400 coinsurance per day of each benefit period
- *Days 91 and beyond: \$800 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime)
- *Beyond lifetime reserve days: all costs

For Medicare-approved care in a [skilled nursing facility](#), you pay:

- Days 1–20: \$0 for each benefit period
- Days 21–100: \$200 coinsurance per day of each benefit period
- Days 101 and beyond: all costs

To find out what you'll pay for other Medicare Part A and Medicare Part B services, visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

*Lifetime reserve days are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that you can use during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

What do I have to pay for doctors' services?

In Original Medicare, you pay the Medicare Part B yearly deductible (\$226 in 2023). After you pay the deductible, Medicare pays 80% of the [Medicare-approved amount](#). You pay the remaining 20% coinsurance.

Important: There's a limit on the amount your doctor can charge you, even if your doctor doesn't accept [assignment](#). If your doctor doesn't accept assignment, you only have to pay the part of the bill that's up to 15% over the Medicare-approved amount.

What do I have to pay for clinical laboratory services?

You pay nothing for Medicare-approved laboratory tests.

What Medicare pays for blood services

In most cases, Medicare Part A and Medicare Part B help pay for:

- Whole blood units or packed red blood cells
- Blood components
- The cost of processing and giving you blood

Paying for blood services

Under both Part A and Part B, in most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital for the first 3 units of whole blood or equivalent units of packed red blood cells that you get in a calendar year (while you're staying in a hospital or [skilled nursing facility](#)), or replace the blood.

You pay a [copayment](#) for additional units of blood you get as an outpatient (after the first 3), and the Part B [deductible](#) applies.

Note: Once you've paid for or replaced the required units of blood, you don't have to do so again under either Part A or Part B for the remainder of the calendar year.

Having blood donated

You can replace the blood by donating it yourself or getting another person or organization to donate the blood for you. The blood that's donated doesn't have to match your blood type. If you decide to donate the blood yourself, check with your doctor first.

You can't be charged for blood that you've already donated. A hospital or skilled nursing facility can't charge you for any of the first 3 pints of blood you've already donated or will donate in the future.

Medicare doesn't pay for blood as part of home dialysis unless it's part of a doctor's service or is needed to prime the dialysis equipment.

SECTION

Filing a complaint (grievance) about dialysis or kidney transplant care

6

End-Stage Renal Disease (ESRD) Networks and State Survey Agencies work together to help you with complaints (grievances) about your dialysis or kidney transplant care.

ESRD Networks

ESRD Networks (or “Networks”) monitor and improve the quality of care given to people with ESRD, and can help you with complaints about your dialysis facility or transplant center. Call 1-800-MEDICARE (1-800-633-4227) to get the ESRD Network phone number for your state. TTY users can call 1-877-486-2048.

If you have a complaint about your care:

- You can complain directly to your facility, but you don’t have to.
- You can file it directly with your Network instead of with your facility.
- Your facility or Network must investigate it, work on your behalf to try to solve it, and help you understand your rights.
- Your Network can still investigate a complaint and represent you, even if you wish to remain anonymous.
- Your facility can’t take any action against you for filing a complaint.

Words in blue
are defined on
pages 49–51.

ESRD Networks (continued)

Examples of complaints you may contact your ESRD Network for include:

- The facility staff doesn't treat you with respect.
- The facility staff won't let you eat during dialysis, and you're always hungry.
- Your dialysis shifts conflict with your work hours, and the facility won't let you change your shift.
- You've made complaints to your facility, and they weren't resolved.

State Survey Agencies

State Survey Agencies also deal with complaints about Medicare and Medicaid participating dialysis facilities and transplant centers (as well as hospitals and other health care settings). Examples of complaints you may contact your State Survey Agency for include:

- Claims of abuse
- Mistakes in giving out or prescribing drugs
- Poor quality of care
- Unsafe conditions (like water damage or electrical or fire safety concerns)

Note: For questions about a specific service you got, look at your “Medicare Summary Notice” (MSN) if you have [Original Medicare](#), or similar statements from your plan if you're in a [Medicare Advantage Plan](#). Your MSN is a notice you get after the doctor, other health care provider, or [supplier](#) files a claim for Part A or Part B services in Original Medicare. It shows all the services or supplies that your providers and suppliers billed to Medicare during a 3-month period, what Medicare paid, and the maximum amount you may owe the provider.

You'll get your MSN in the mail every 3 months. You can also create a secure online Medicare account and sign up for electronic MSNs at [Medicare.gov](#). If you disagree with a coverage or payment decision made by Medicare, your [Medicare health plan](#), or your [Medicare drug plan](#), you can file an appeal.

SECTION

Other kinds of health coverage



There are other kinds of health coverage that may help pay for the services you need to treat permanent kidney failure. They include:

- Employee or retiree coverage from an employer or union
- Medicare Supplement Insurance (Medigap)
- Medicaid
- Veteran Administration benefits

Employee or retiree coverage from an employer or union

If you have coverage from a health plan based on your or your spouse's past or current employment, call your benefits administrator to find out what coverage they might offer for your permanent kidney failure. If you're eligible for coverage under the group health plan, but haven't yet signed up for it, call the benefits administrator to find out if you can still enroll.

Generally, employer plans have better rates than those you can get if you buy a policy directly from an insurance company. Also, employers may pay part of the cost of the coverage.

Turn to pages 11–12 for an explanation of when your employer will pay first, and when Medicare will pay first with your employer providing supplemental coverage.

If you lose your employer or union coverage, you may be able to continue your coverage temporarily through COBRA. This federal law allows you to temporarily keep your employer or union health coverage after your employment ends or after you lose coverage as a dependent of a covered employee. Talk to your benefits administrator for more information.

Words in blue are defined on pages 49–51.

Medicare Supplement Insurance (Medigap)

Medigap is health insurance sold by private insurance companies to help fill the “gaps” in [Original Medicare](#). Medigap policies help pay some of the health care costs that Original Medicare doesn’t cover, like your [deductible](#) or [coinsurance](#). Medigap must follow federal and state laws that protect you. All Medigap policies are clearly marked “Medicare Supplement Insurance” and give standardized benefits, no matter which insurance company sells them.

Not all insurance companies will sell Medigap policies to people under 65 who have Medicare. If a company does sell Medigap policies voluntarily, or because state law requires it, these Medigap policies will probably cost you more than if you were 65 or older.

Medigap rules vary from state to state. Call your State Health Insurance Assistance Program (SHIP) (turn to page 47) for information about buying a Medigap policy if you have End-Stage Renal Disease (ESRD). When you turn 65, you’ll be guaranteed an opportunity to buy a Medigap policy.

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about Medigap and to compare policies sold in your state.

Medicaid

Medicaid is a joint federal and state program that helps pay medical costs for some people who meet financial eligibility requirements. Medicaid programs vary from state to state. Most health care costs are covered if you qualify for both Medicare and Medicaid and see providers who accept both.

States also have Medicare Savings Programs that pay some or all of Medicare’s [premiums](#), and may also pay Medicare deductibles and coinsurance for certain people who have Medicare and a limited income. To qualify for these programs, generally you must have:

- Medicare Part A.
- A monthly income of less than \$1,549 for an individual or \$2,080 for a couple in 2022. These income limits are slightly higher in Hawaii and Alaska. Income limits can change each year.
- Savings of \$8,400 or less for an individual, or \$12,600 or less for a couple in 2022. Savings include money in a checking or savings account, stocks, and bonds.

Visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get more information on these programs. TTY users can call 1-877-486-2048.

Veterans' benefits

If you're a veteran, the U.S. Department of Veterans Affairs can help pay for End-Stage Renal Disease (ESRD) treatment. For more information, visit va.gov or call the U.S. Department of Veterans Affairs at 1-800-827-1000. TTY users can call 1-800-829-4833.

Other ways to get help

In most states, there are agencies and programs that help with some of the health care costs that Medicare doesn't pay. Call your State Health Insurance Assistance Program (SHIP) if you have questions about health coverage. Turn to page 47.

SECTION

8

Where to get more information

There are many resources available to help you learn more about kidney dialysis, transplants, and your situation. In addition to talking with your health care team, you can also connect with other people who have End-Stage Renal Disease (ESRD) through a national kidney organization. Find more information on [Medicare.gov](https://www.Medicare.gov), or reach out to your local ESRD Network, State Health Insurance Assistance Program (SHIP), or State Survey Agency.

Kidney organizations

There are special organizations that can give you more information about kidney dialysis and kidney transplants. Some of these organizations have members who are on dialysis, or have had kidney transplants, and can give you support.

American Association of Kidney Patients

14440 Bruce B. Downs Blvd.

Tampa, Florida 33613

1-800-749-2257

[aakp.org](https://www.aakp.org)

American Kidney Fund

11921 Rockville Pike, Suite 300

Rockville, Maryland 20852

1-800-638-8299

[kidneyfund.org](https://www.kidneyfund.org)

Words in blue
are defined on
pages 49–51.

Kidney organizations (continued)

Dialysis Patient Citizens

1001 Connecticut Ave, NW, Suite 1230
Washington DC, 20036
1-866-877-4242
dialysispatients.org

National Kidney Foundation

30 East 33rd Street
New York, New York 10016
1-800-622-9010
kidney.org

National Institute of Diabetes and Digestive and Kidney Diseases

9000 Rockville Pike
Bethesda, Maryland 20892
1-800-860-8747
niddk.nih.gov

End-Stage Renal Disease (ESRD) Networks

Call your local ESRD Network Organization to get information about:

- Dialysis treatments
- Kidney transplants
- How to get help from other kidney-related agencies
- Problems with your facility
- Location of dialysis facilities and transplant centers

Your ESRD Network makes sure that you're getting the best possible care and keeps your facility aware of important issues about kidney dialysis and transplants. To get the ESRD Network phone number for your state, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

State Health Insurance Assistance Programs (SHIPs)

SHIPs are state programs that give free local health insurance counseling to people with Medicare. Call your SHIP if you have questions about:

- Medigap policies
- [Medicare health plan](#) choices
- Filing an appeal
- Other general health insurance questions

Visit shiphelp.org to get the phone number for your SHIP, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

State Survey Agencies

The State Survey Agency inspects Medicare and Medicaid participating dialysis facilities and makes sure that Medicare standards are met. Your State Survey Agency can also help you if you have a complaint about your care. Call 1-800-MEDICARE to get the phone number for your State Survey Agency. **Your calls and name will be kept private.**

Notes

SECTION

9

Definitions

Assignment—An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period—The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

Creditable prescription drug coverage—Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your Medicare Advantage Plan, your Medicare drug plan, or your other insurance begins to pay.

Home health care—Health care services and supplies a doctor decides you may get in your home under a plan of care established by your doctor. Medicare only covers home health care on a limited basis as ordered by your doctor.

Long-term care—Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living like dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term services and supports at any age. Medicare and most health insurance plans don't pay for long-term care.

Medically necessary—Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare drug coverage (Part D)—Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Original Medicare—Original Medicare is a fee-for-service health plan that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Penalty—An amount added to your monthly premium for Part B or a Medicare drug plan (Part D) if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

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

Skilled nursing facility (SNF)—A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Supplier—Generally, any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

Notes

CMS Accessible Communications

The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format, you can:

1. Call us:

For Medicare: 1-800-MEDICARE (1-800-633-4227)

TTY: 1-877-486-2048

2. Send us a fax: 1-844-530-3676

3. Send us a letter:

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop S1-13-25
Baltimore, MD 21244-1850
Attn: Customer Accessibility Resource Staff

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State Medical Assistance (Medicaid) office.

Nondiscrimination Notice

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You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, state or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health & Human Services, Office for Civil Rights:

1. Online:

hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

2. By phone:

Call 1-800-368-1019. TTY user can call 1-800-537-7697.

3. In writing: Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Room 509E, HHH Building
Washington, D.C. 20201

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Blvd.
Baltimore, Maryland 21244-1850

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

¿ Necesita usted una copia en español?
Llame GRATIS al 1-800-MEDICARE (1-800-633-4227).

