MEDICARE Basics

A Guide for Families and Friends of People with Medicare

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Introduction

A guide for families and friends of people with Medicare

As your parents, grandparents, relatives, or friends face health care decisions, they may need your help. Medicare can be an important factor in many of those decisions. If you aren't familiar with Medicare and other resources that are available for the person you're caring for, or if you just want to brush up on what you already know, this booklet is for you.

"Medicare Basics" highlights several topics related to the health and care of a person with Medicare. For each of these topics, you'll find basic information about Medicare and suggestions on where to find more information. Words you see in blue are defined in the "Definitions" section.

"Medicare Basics" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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

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"My grandmother is having more and more health problems, and she needs my help. Where do I start?"

1

Getting Organized

This section has information to help you get organized. Even though it may seem difficult to know where to begin, there are several things you can do to make helping or caring for someone with Medicare easier.

Words in blue are defined on pages 47–50.

Gathering important information

Start by helping the person you're caring for gather this information so it's available when you need it:

- Social Security Number
- Medicare number (You can find this on his or her red, white, and blue Medicare card.)
- Medicare plan enrollment (See pages 13–14 for information on how to check his or her current coverage.)
- Other insurance plans and policy numbers, including long-term care insurance
- Contact information for health care providers, like doctors, nurses, hospitals, pharmacies, and medical suppliers
- List of current prescription drugs and dosages
- Current health conditions, symptoms, and treatments
- History of past health problems
- Allergies or food restrictions
- Emergency contacts, like close friends, family, neighbors, clergy, or housing manager
- Financial and legal information

Gathering important information (continued)

Next steps

For help keeping track of this information:

- Visit MyMedicare.gov to help the person you're caring for get personalized information about his or her Medicare benefits and services, like plan enrollment, claims, and more. See pages 42–43 for more information.

Planning for future health care decisions

Ask the person you're caring for to share information about his or her doctors, medicines, and medical history. Knowing this information will better enable you to help him or her plan for health care and prescription drug needs. It's also important to encourage the person to decide who should have the legal right to make medical and treatment decisions if he or she is unable.

Talk to the person you're caring for about what he or she wants and doesn't want you to do. He or she may want to choose and authorize someone to make decisions about his or her medical care. These decisions are generally called advance directives.

Note: Before Medicare will give personal health information to you, the person you're caring for has to let Medicare know in writing. If you plan on contacting Medicare, it would be a good idea for the person you're caring for to fill out a "Medicare Authorization to Disclose Personal Health Information" form. See page 45 for more information.

Planning for future health care decisions (continued)

In most cases, advance directives include these types of documents:

- A **health care proxy** (also called a durable power of attorney). This document names a specific person to make health care decisions for someone who isn't able to make decisions for him or herself.
- A **living will**. Living wills give directions about the kind of health care a person wants, and which medical treatments a person wants if his or her life were threatened, including things like:
  - Dialysis and breathing machines
  - Resuscitation if the person's breathing or heart stops
  - Tube feeding
- **After-death wishes**. These documents may include decisions like organ and tissue donation.

If the person you're caring for has advance directives, make sure you know where these documents are, and give copies to his or her doctors, nursing home, caregivers, and other health care providers, and anyone named in the advance directives.

Next steps

For more information on how to become authorized to make health care decisions on someone's behalf, you can do these:

- Contact your local office on aging, your state health department, or an attorney to learn more about advance directives. You can also visit eldercare.gov, or call 1-800-677-1116 to use the Eldercare Locator. The Eldercare Locator can help you find local resources and services that serve older adults.
- Get free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). See page 42 for more information about this program.

Managing health care

The person you're caring for may have health information in lots of places—at home or in doctor or hospital records. You may need to know certain information about his or her health care like the last time he or she had a certain medical procedure. It may seem overwhelming to remember all of these details, and trying to find the information when it's in lots of places can be hard.

You may be able to help him or her set up a Personal Health Record (PHR). A PHR is usually an electronic file or record of health information and recent services. With a PHR, a person can keep track of his or her health information, like the date of his or her last physical, major illnesses, operations, allergies, or list of medicines. This information can be stored in one place, and then shared with others, as needed.

The person whose information is contained in the PHR generally controls how the information is used and who can access it. If you help the person you're caring for set up a PHR, and he or she gives you access, you'll have all of their health information in one place.

Note: To view the person's Medicare claims, Medicare eligibility, and plan enrollment, visit MyMedicare.gov. If you create a PHR, you can enter the information from MyMedicare.gov into the PHR so it's easier to view in different ways. See page 46 for more information about MyMedicare.gov.

Next steps

For more information:

- Visit Medicare.gov/phr to learn more about PHRs, and get details on special PHR projects Medicare is sponsoring in certain states.
- Visit Medicare.gov/publications to view the "Personal Health Records" brochure.

Notes

Use this page to write down important information or questions.

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"How are my retired parents paying for their health care? What sort of coverage do they have?"

2

Understanding Medicare

This section has information that explains what Medicare is and how to get it. It also explains the different parts of Medicare and what each part covers.

Words in blue are defined on pages 47–50.

What's Medicare?

Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

What are the different parts of Medicare?

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
- Some preventive services

Medicare Part C (Medicare Advantage Plans)

- Includes all benefits and services covered under Part A and Part B
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- Run by Medicare-approved private insurance companies
- May include extra benefits and services for an extra cost

Medicare Part D (Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- Run by Medicare-approved private insurance companies
- May help lower your prescription drug costs and help protect against higher costs in the future

Other Medicare health plans

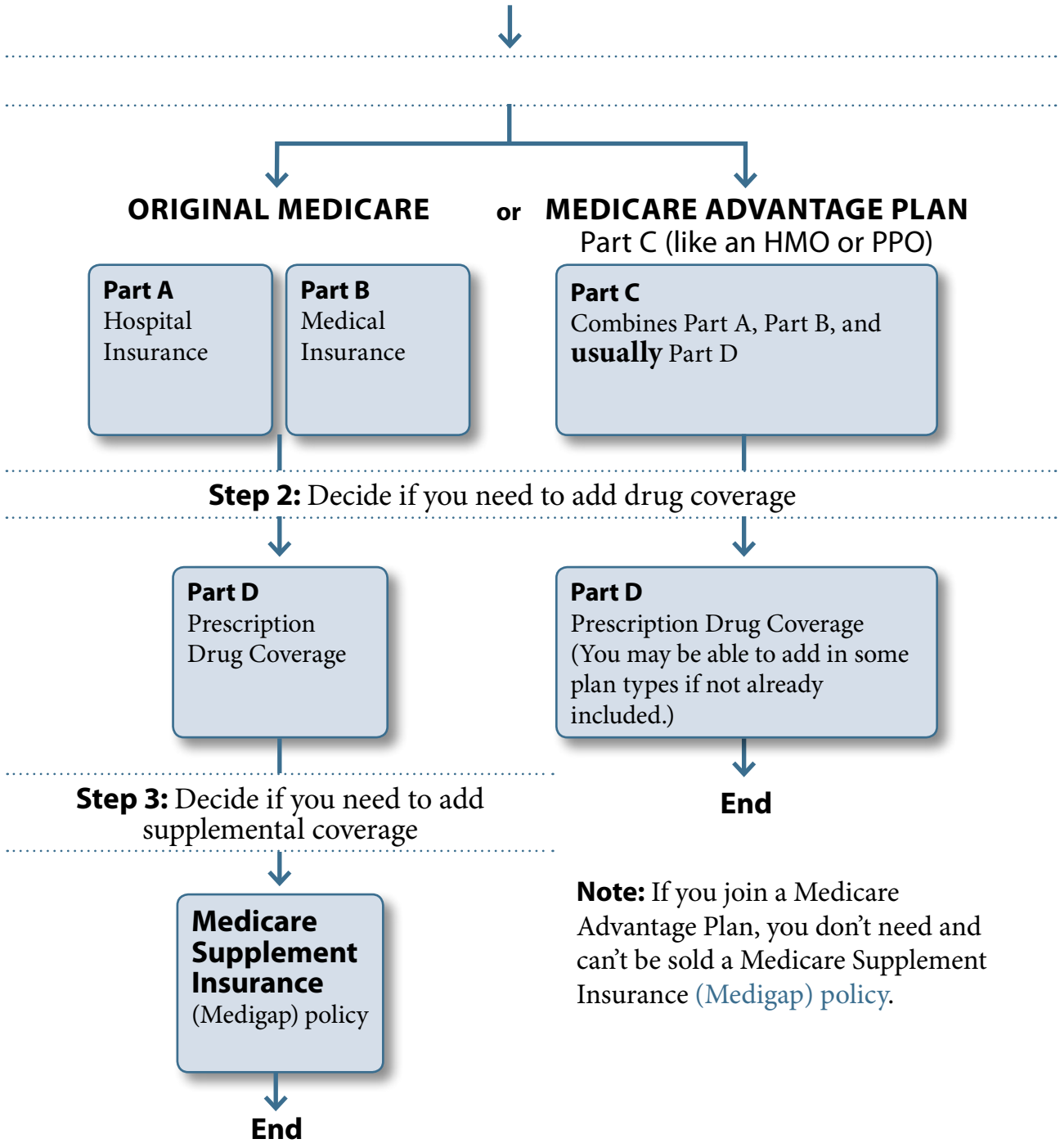
Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage Plans but are still part of Medicare. Some of these plans provide Part A and/or Part B coverage, and some also provide Medicare prescription drug coverage. These plans have some of the same rules as Medicare Advantage Plans. Some examples include Medicare Cost Plans, Demonstration or Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Note: Medicare models, demonstrations, and pilot programs, sometimes called "research studies," are special projects that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time for a specific group of people and/or are offered only in specific areas. Check with the model, demonstration, or pilot program for more information about how it works. To find out about current Medicare models, demonstrations, and pilot programs, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Extra Help paying for prescription drugs is available. People with Medicare who have limited income and resources may qualify for Extra Help to cover prescription drugs for little or no cost. If you think the person you're caring for may qualify for Extra Help, visit Socialsecurity.gov. or call 1-800-772-1213. TTY users should call 1-800-325-0778.

Your Medicare coverage choices at a glance

There are 2 main ways to get your Medicare coverage: Original Medicare or a Medicare Advantage Plan. Use these steps to help you decide which way to get your coverage.



Note: If you join a Medicare Advantage Plan, you don't need and can't be sold a Medicare Supplement Insurance (Medigap) policy.

Your Medicare coverage choices at a glance (continued)

Next steps

To learn more about the different parts of Medicare, what Medicare covers, and how much Medicare costs:

- Visit Medicare.gov.
- Visit Medicare.gov/publications to view:
  - "Medicare & You" handbook.
  - "Your Medicare Benefits"
  - "Your Guide to Medicare Prescription Drug Coverage."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Checking current coverage

If you don't know what kind of coverage the person you're caring for has, now is the time to find out. First, check if he or she currently has Medicare. If so, find out if he or she has Medicare Part A and/or Medicare Part B. This information is listed on his or her red, white, and blue Medicare card.

You'll also want to find out if the person you're caring for is in a Medicare plan like a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Prescription Drug Plan. If he or she has Original Medicare, check to see if he or she has a Medigap (Medicare Supplement Insurance) policy.

It's essential to find out if the person has other health coverage, like a health plan with a former employer, Veterans' benefits, Military benefits (TRICARE), Medicaid, or other insurance that can help pay for health care needs. If he or she has other health coverage, find out how that coverage will work with Medicare. For example, a person with Medicare Part A who's eligible for TRICARE must enroll in Part B or lose the TRICARE coverage.

Checking current coverage (continued)

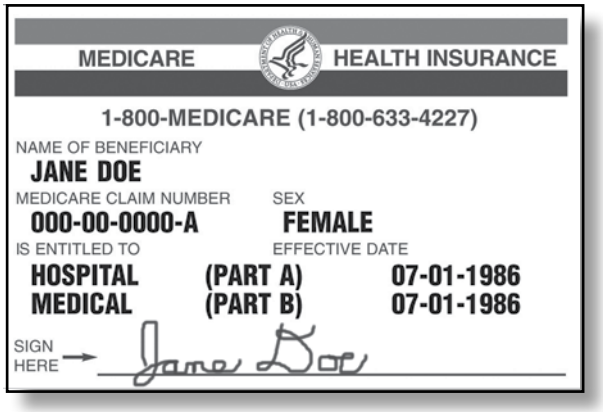
Once you know what Medicare coverage the person has, you'll need to make sure that the coverage is still meeting his or her needs, and understand when and how to make changes if it's not. See page 19 for more information.

If the person doesn't have Medicare, find out if he or she is eligible, what decisions he or she will need to make, and how to sign up. See page 15 for more information.

Next steps

To find out what kind of coverage the person you're caring for already has, or to find out how his or her coverage will work with Medicare, you can do any of these:

- Check the person's Medicare card. Also check all other insurance cards that he or she may have. You can call the phone number on the cards to get more information about the coverage.



- Visit MyMedicare.gov to help the person you're caring for get direct access to his or her Medicare eligibility information. You can see information about his or her Medicare health or prescription drug plan enrollment. See pages 42–43 for more information about MyMedicare.gov.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If the person you're caring for has employer or union coverage, call the employer's benefits administrator.

Checking current coverage (continued)

Next steps (continued)

- Call the U.S. Department of Veterans Affairs (VA) at 1-800-827-1000, or visit va.gov if the person gets Veterans' benefits. TTY users should call 1-800-829-4833.
- Call the company that handles TRICARE claims at 1-866-773-0404, or visit tricare.osd.mil if the person gets Military benefits. TTY users should call 1-866-773-0405.
- For information about Medicaid eligibility, call the State Medical Assistance (Medicaid) office. Call 1-800-MEDICARE and say "Medicaid" to get their phone number, or visit Medicare.gov/contacts.

Getting Medicare

Enrollment in Medicare Part A and B is automatic when a person:

- Turns 65 and is already getting Social Security or Railroad Retirement Board (RRB) benefits. A Medicare card will be mailed about 3 months before his or her 65th birthday.
- Is under 65 and disabled, he or she will automatically get Part A and B after getting disability benefits from Social Security or certain disability benefits from the RRB for 24 months. A Medicare card will be mailed about 3 months before the 25th month of disability.
- Has ALS (Amyotrophic Lateral Sclerosis also known as Lou Gehrig's disease). People with ALS automatically get Part A and Part B the month the disability benefits start.

Note: Part B is optional. Someone who doesn't want Part B must follow the instructions that come with the Medicare card, and send the card back. A person who keeps the card keeps Part B and will pay Part B premiums.

Getting Medicare (continued)

A person must sign up for Medicare Part A and/or Part B if he or she:

- Isn't getting Social Security or RRB benefits (for instance, because he or she is still working) and wants Part A or Part B. The person should contact Social Security 3 months before he or she turns 65. People who worked for a railroad should contact the RRB to sign up.
- Has End Stage Renal Disease (ESRD) (permanent kidney failure that requires dialysis or a kidney transplant). The person should visit the local Social Security office, or call Social Security at 1-800-772-1213 to sign up for Part A and Part B. TTY users should call 1-800-325-0778. For more information, visit Medicare.gov/publications to view the booklet, "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."
- Isn't eligible for premium-free Part A (see page 17) but wants to buy Part A. The person must also sign up for Part B, and should contact Social Security 3 months before he or she turns 65.

If someone doesn't automatically get Part B, or isn't eligible for premium-free Part A (see page 17), he or she can sign up for Part B and/or buy Part A during one of these times:

- **Initial Enrollment Period**—A person can sign up when first eligible for Part B. (For example, if the person is eligible for Part B when he or she turns 65, the Initial Enrollment Period is a 7-month period that begins 3 months before the month he or she turns 65, includes the month he or she turns 65, and ends 3 months after the month he or she turns 65.)
- **General Enrollment Period**—If a person didn't sign up for Part A and/or Part B when first eligible, he or she can sign up between January 1–March 31 each year. The coverage will begin on July 1, but he or she may have to pay a late enrollment penalty (a higher premium).

Getting Medicare (continued)

- **Special Enrollment Period**—A person may decide to wait to sign up for Part A and/or Part B because he or she is covered by a group health plan based on his or her own or a spouse's current employment (or if disabled, a family member's current employment). Someone in this situation can sign up for Part A and/or Part B at any time while he or she has group health plan coverage based on current employment or during the 8-month period that begins the month after the employment ends, or the group health plan coverage ends, whichever happens first. **Note:** This Special Enrollment Period doesn't apply to people with ESRD.
- **Special Enrollment Period for international volunteers**—A person who waited to sign up for Part A and/or Part B because he or she had health insurance while volunteering in a foreign country has a special opportunity to sign up.

Medicare Part A and Part B premiums

Most people don't have to pay a monthly premium for Part A because they or a spouse paid Medicare taxes while they were working. This is called "premium-free Part A." Most people do pay a premium each month for Part B.

Late enrollment penalties

A person who doesn't sign up for Part A when he or she is first eligible may have to pay a penalty equal to 10% of the Part A premium. The 10% premium penalty applies no matter how long someone delays Part A enrollment. The person will have to pay the premium penalty for twice the number of years he or she could have had Part A, but didn't sign up.

A person who doesn't sign up for Part B when he or she is first eligible may have to pay a late enrollment penalty. The monthly premium for Part B may go up 10% for each full 12-month period that the person could have had Part B, but didn't sign up for it. The person will have to pay the premium penalty for a long as he or she has Medicare.

Usually, there's no late enrollment penalty if someone signs up for Part A and/or Part B during a Special Enrollment Period.

Getting Medicare (continued)

When can a person with Medicare join a Medicare Advantage Plan (like an HMO or PPO) or a Medicare drug plan?

There are specific times when a person can sign up for a Medicare Advantage Plan or a Medicare drug plan:

- When a person first becomes eligible for Medicare or turns 65, during his or her Initial Enrollment Period.
- Between October 15–December 7 each year, with coverage beginning on January 1 of the following year.
- Under certain circumstances that qualify a person for a Special Enrollment Period (SEP), like:
  - Moving out of the plan's service area
  - Having both Medicare and Medicaid
  - Qualifying for Extra Help to pay for prescription drugs
  - Living in an institution (like a nursing home)

It may be possible to join, switch, or drop a Medicare Advantage Plan at other times, under certain circumstances. See page 19 for more information.

Making changes to Medicare coverage

If the person you're caring for already has Medicare, it's a good idea to make sure the current coverage is still meeting his or her health, financial, and coverage needs. A Medicare health or prescription drug plan can change how much it costs and what it covers each year. Each fall, there's an opportunity to change Medicare coverage options, so you should help the person review his or her current health and prescription drug coverage.

If he or she is satisfied with the current plan's cost and coverage for the coming year, do nothing. However, if the person wants to make a change, it can be done during certain times depending on the type of coverage.

Fall Open Enrollment Period
Between October 15–December 7 each year, a person with Medicare can join, switch, or drop a Medicare Advantage Plan (like an HMO or PPO) or a Medicare drug plan. The coverage will begin on January 1 of the following year.

Medicare Advantage Disenrollment Period
Between **January 1–February 14** each year, if someone is in a Medicare Advantage Plan, he or she can leave that plan and switch to Original Medicare. If the person switches to Original Medicare during this period, he or she will have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. The coverage will begin the first day of the month after the plan gets the enrollment form.

During this period, a person **can't** do any of these:

- Switch from Original Medicare to a Medicare Advantage Plan.
- Switch from one Medicare Advantage Plan to another.
- Switch from one Medicare Prescription Drug Plan to another.
- Join, switch, or drop a Medicare Medical Savings Account Plan.

Making changes to Medicare coverage (continued)

In most cases, a person must stay enrolled in a Medicare Advantage or Medicare Prescription Drug Plan for a whole calendar year. However, there are exceptions, like:

- Moving out of the plan's service area
- Having both Medicare and Medicaid
- Qualifying for Extra Help to pay for prescription drugs
- Living in an institution (like a nursing home)

Next steps

Before recommending any decisions, learn as much as you can about the types of coverage available to the person you're caring for. These resources are available if you need help deciding what to recommend:

- Visit Medicare.gov/publications to view the "Medicare & You" handbook.
- Visit Medicare.gov/publications to view the tip sheet "Understanding Medicare Part C & D Enrollment Periods."
- Call Social Security at 1-800-772-1213 for more information about Medicare eligibility and how to sign up for Part B. TTY users should call 1-800-325-0778. For information about Railroad Retirement Board (RRB) benefits, call your local RRB office or 1-877-772-5772.
- Visit Medicare.gov.
- Visit Medicare.gov/find-a-plan to learn more about Medicare Advantage Plans, Medicare drug plans, Medigap policies, and other Medicare health plans.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Get free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). See page 42 for more information about this program.

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"Dad is pretty healthy right now. What can I do to help him find the right doctors and services to stay healthy? Mom has needed a lot more care. How do I find the best care for her?"

Health Care Choices

Helping someone make health care choices can be difficult. This section explains the different types of care available through Medicare and gives you information to help you make informed recommendations for the person you're caring for.

Words in blue are defined on pages 47–50.

Medicare's preventive services

The best way for you and the person you're caring for to stay healthy is to live a healthy lifestyle. You can live a healthy lifestyle and prevent disease by exercising, eating well, keeping a healthy weight, and not smoking. Medicare can help you and the person you're caring for focus on preventive care.

Medicare pays for many preventive services to keep people with Medicare healthy. Preventive services can find health problems early, when treatment works best, and can help prevent certain diseases or illnesses. Preventive services may include exams, lab tests, and screenings. They may also include shots, counseling, and information to help people take care of their health.

Medicare helps pay for these preventive tests and services:

Shots	**Pneumococcal** **Flu** **Hepatitis B** (for people at medium to high risk)
Exams	**One-Time "Welcome to Medicare" preventive visit** (within the first 12 months of having Part B) **Yearly "Wellness" visit**
Screenings	**Abdominal aortic aneurysm** (for people at risk) **Alcohol misuse** (screening and counseling) **Bone mass measurement** **Breast cancer** (mammograms) **Cardiovascular disease** **Cervical and vaginal cancer** **Colorectal cancer** **Depression** **Diabetes** (for people at risk) **Glaucoma** (for people at high risk) **Hepatitis C** (for certain ages and people at high risk) **HIV** (for people at increased risk) **Pap test** **Prostate cancer** **Sexually transmitted infections** (screening and counseling)
Other Preventive Benefits	**Cardiovascular disease** (intensive behavioral therapy) **Diabetes self-management training** **Medical nutrition therapy** (for people with diabetes or renal disease) **Obesity** (intensive behavioral therapy)

Original Medicare covers 100% of the Medicare-approved amount for most preventive services. Additional conditions may apply.

Medicare's preventive services (continued)

Next steps

To learn more about Medicare's preventive services:

- Call 1-800-MEDICARE (1-800-633-4227) to find out what preventive services the person is able to get and when they are able to get them. TTY users should call 1-877-486-2048.
- Visit MyMedicare.gov to help the person you're caring for get direct access to his or her preventive health information. You can see a description of covered preventive services, the date he or she last had the service, and the next date he or she can get the service. See pages 42–43 for more information about MyMedicare.gov.
- Visit Medicare.gov/publications to view the booklet "Your Guide to Medicare's Preventive Services."

Finding a doctor, provider, or supplier

If you're helping someone you care for choose a doctor, provider, or supplier, it's important to know how he or she gets his or her Medicare coverage.

If the person has Original Medicare, he or she can go to any doctor, provider, or supplier that's enrolled in Medicare and is accepting new Medicare patients. Most doctors, providers, and suppliers accept assignment, but you should always check to make sure.

Note: Assignment can save a person with Medicare money because it is an agreement by a doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill for any more than the Medicare deductible and coinsurance.

Medicare Advantage and other Medicare health plans usually have different rules for how to get services. For example, a person who belongs to an HMO may have to go to certain doctors, providers, or suppliers that belong to the plan for the plan to pay. Also, he or she may need a referral to see a specialist.

Finding a doctor, provider, or supplier (continued)

No matter how the person you're caring for gets his or her Medicare coverage, it's a good idea to ask a doctor, provider, or supplier these questions:

- Are you accepting new Medicare patients?
- Do you accept the person's Medicare plan?
- Do you provide and track preventive services, like shots and screenings?
- Do you "e-prescribe" (prescribe medicine electronically)?
- What are your office hours?
- Which hospitals do you use?

Next steps

If you need help finding a doctor or provider for someone:

- Visit Medicare.gov/find-a-doctor or Medicare.gov/supplier to find doctors and suppliers who accept assignment. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call the plan or check his or her plan materials for more information if the person you're caring for is in a Medicare Advantage or other Medicare health plan.

Help with hospitalization

Much like choosing a doctor, provider, or supplier, choosing a hospital generally depends on how someone gets his or her Medicare coverage.

If the person you're caring for is able to plan ahead and has Original Medicare, he or she can choose among any hospital or facility that accepts people with Medicare.

If the person you're caring for is in a Medicare health plan, he or she may have to go to certain hospitals or facilities that belong to the plan for the plan to pay.

In an emergency, he or she should always go to the nearest hospital, even if it isn't on a plan's list.

Everyone with Medicare can get this inpatient hospital care:

- General nursing
- Semi-private room
- Doctor's services you get while you're in a hospital (if you have Part B).
- Meals and supplies

Original Medicare **doesn't** pay for these services:

- Private-duty nursing
- Private room (unless medically necessary)
- Television and phone

Note: Some Medicare Advantage and other Medicare health plans may cover these services. Check with your plan for more information.

While the person you're caring for is in a hospital or skilled nursing facility, the staff is planning for the day he or she goes home or to another facility. During his or her stay in a hospital, nursing home, or other health care setting, the staff will work with you to plan for his or her discharge. Ask to see the plan of care, talk about treatment options, and be aware of Medicare's discharge appeal rights. Most importantly, make sure the person's wishes are known. Medicare's discharge planning checklist can help. Visit Medicare.gov/publications to view "Your Discharge Planning Checklist."

Help with hospitalization (continued)

Next steps

If you need help finding a hospital for someone:

- Visit Medicare.gov/hospital to find and compare hospitals. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call the plan or check his or her plan materials for more information if the person you're caring for is in a Medicare health plan.

Home health care

The right kind of support can go a long way to help people continue to lead independent, productive lives at home. Together, you and the person you're caring for should start by checking with his or her doctor about what services are needed and who provides them.

Home health care under Original Medicare is short-term skilled care at home for the treatment of an illness or injury, often following a hospitalization. This includes skilled nursing care, physical therapy, occupational therapy, speech-language pathology, medical social work, and care by home health aides. Home health services may also include medical social services, or durable medical equipment (like wheelchairs, hospital beds, oxygen, and walkers) and medical supplies for use at home. Medicare doesn't pay for full-time personal care, homemaker services (shopping, cleaning, laundry), or home meal delivery.

Home health care (continued)

Medicare home health care benefits are available to patients if they meet all of these conditions:

1. The patient must be under the care of a doctor, and must be getting services under a plan of care established and reviewed regularly by a doctor.
2. The patient must need, and a doctor must certify that the patient needs, one or more of these:
   - Intermittent skilled nursing care.
   - Physical therapy.
   - Speech-language pathology services.
   - Continued occupational therapy.
3. The home health agency caring for the patient must be approved by Medicare (Medicare-certified).
4. The patient must be homebound, and a doctor must certify that he or she is homebound. To be homebound means:
   - Leaving home isn't recommended because of the patient's condition.
   - The condition keeps the patient from leaving home without help (like using a wheelchair or walker, needing special transportation, or getting help from another person).
   - Leaving home takes a considerable and taxing effort.

Note: A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, like attending religious services. A patient can still get home health care if he or she attends adult day care, but he or she would get the home care services in the home.

Medicare Advantage and other Medicare health plans may have additional rules for home health services. All Medicare health plans must cover at least the same home health services as Original Medicare.

Home health care (continued)

Next steps

If you need help finding a home health agency, or would like more information on Medicare home health care:

- Ask the doctor or the hospital discharge planner for their recommendations.
- Use a senior community referral service or agency. Visit Medicare.gov/contacts to find resources in the community.
- Visit Medicare.gov/hhcompare to find and compare home health agencies. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call the plan or check his or her plan materials for more information, if the person you're caring for is in a Medicare Advantage or other Medicare health plan.

Long-term care options

Serious and chronic illness or disability may create a need for long-term care. It's a decision you and the person you're caring for should discuss with the doctor, as well as other family members. Long-term care can be provided at home, in the community, in an assisted living facility, or in a nursing home. **Medicare and most health insurance plans, including Medigap (Medicare Supplement Insurance) policies don't pay for this type of care.**

Long-term care options (continued)

Medicare only covers certain skilled nursing facility care that's needed daily on a short-term basis (up to 100 days). Skilled nursing facility care is skilled care given when the person needs skilled nursing or rehabilitation staff to manage, observe, and evaluate his or her care on an inpatient basis. Examples of skilled care include changing sterile dressings and physical therapy. Care that can be given by non-professional staff isn't considered skilled care. Medicare only covers skilled nursing facility care after a 3-day qualifying hospital stay.

There are times when a person's needs extend beyond the short-term skilled nursing facility care covered by Medicare. You should explore all of the options that are available in the community. Often, community-based senior citizens' services offer companionship visits, help around the house, meal programs, caregiver respite, adult day care services, transportation, and more. These support services may be funded by state and county programs or offered by faith-based or volunteer groups. Community-based services across the country support independent living and are designed to promote the health, well-being, and independence of older adults. These services can also supplement the supportive activities of caregivers.

If other options available in the community aren't enough to provide the level of care that the person you're caring for needs, you may need to help him or her choose a nursing home. If he or she needs to move into a nursing home, follow these steps to find a nursing home that best meets his or her needs:

1. Find nursing homes in his or her area. Compare the quality of nursing homes you and the person are considering. Look at health inspection and fire safety inspection reports, nursing home staffing rates, quality measures, and other important information such as how many stars they received on their quality rating. One way to find and compare nursing homes is to use the Nursing Home Compare website by visiting Medicare.gov/nhcompare. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Long-term care options (continued)

2. Visit the nursing homes you and the person are interested in. For a nursing home checklist that can help you with your search, visit Medicare.gov/publications to view Medicare's "Guide to Choosing a Nursing Home."

Long-term care can be very expensive. There are many ways people can pay for long-term care. Most people who enter nursing homes begin by paying for their care out of their own pocket. Others may be able to get help from their state or use long-term care insurance. As they use up their resources over a period of time, they may eventually become eligible for Medicaid.

Medicaid is a state and federal program that will pay most nursing home costs for certain people with limited income and resources. Eligibility varies by state. Medicaid pays for care for about 7 out of every 10 nursing home residents. Medicaid will pay for nursing home care only when provided in a Medicaid-certified facility. For information about Medicaid eligibility, call your State Medical Assistance (Medicaid) office. Call 1-800-MEDICARE (1-800-633-4227) and say "Medicaid" to get their phone number, or visit Medicare.gov/contacts. TTY users should call 1-877-486-2048.

Long-term care options (continued)

Next steps

If you need help finding long-term care for someone, there are many resources available:

- Visit Medicare.gov/nhcompare.
- Visit longtermcare.gov to learn more about planning for long-term care, and download the "Long-Term Care Planning Kit."
- Contact the Aging and Disability Resource Center (ADRC). ADRCs assist people of all incomes and ages. Forty-three states have ADRCs. To find out if someone's area is served by an ADRC, visit adrc-tae.acl.gov.
- Contact your local Area Agency on Aging (AAA). To find the AAA in your area, call the Eldercare Locator at 1-800-677-1116 weekdays from 9:00 a.m. to 8:00 p.m. (EST), or visit eldercare.gov.
- For more information about help paying for nursing care and other health care costs, call your State Health Insurance Assistance Program (see page 42 for more information) or your Long-term Care Ombudsman. To find their phone numbers, visit Medicare.gov/contacts.
- For more information on Medicare coverage of skilled nursing facility care, visit Medicare.gov/publications to view the booklet "Medicare Coverage of Skilled Nursing Facility Care."
- If the person you're caring for is in a Medicare Advantage or other Medicare health plan, call the plan or check his or her plan materials for more information.

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"Alice asked for my help. She's in the hospital, and I'm trying to sort out her bills."

4

Help with Billing

You can protect the person you're caring for and Medicare by knowing his or her rights (including the right to appeal) and how to identify and report fraud. This section tells you how to read a "Medicare Summary Notice" (MSN) and what to do if you disagree with something on the MSN.

Words in blue are defined on pages 47 –50.

How to use a "Medicare Summary Notice"

If a person with Original Medicare gets a Medicare-covered service, he or she will get a "Medicare Summary Notice" (MSN) in the mail. MSNs are mailed every 3 months. If Medicare owes someone a refund, the MSN will be mailed as soon as the claim is processed. The MSN isn't a bill. The notice lists the services the person got and the amount he or she may be billed by a hospital, doctor, or other provider. These notices are sent by companies that handle bills for Medicare.

When the person you're caring for gets an MSN:

- Keep receipts and bills, and compare them to the MSN to be sure he or she got all the services, supplies, or equipment listed.
- If he or she has other coverage, check to see if it covers anything that Medicare didn't.
- If he or she paid a bill before getting the MSN, compare the MSN with the bill to make sure he or she paid the right amount for the services.

If a person with Medicare disagrees with the information on an MSN, he or she can file an appeal. Information on how to appeal is included on the notice.

How to use a "Medicare Summary Notice" (continued)

Next steps

For more information about the MSN:

- To help someone view his or her Medicare claims and order copies of his or her MSNs, visit MyMedicare.gov. See pages 42–43 for more information about MyMedicare.gov.
- Call 1-800-MEDICARE (1-800-633-4227) to order a copy of an MSN. TTY users should call 1-877-486-2048.
- If the person you're caring for needs to change his or her address on MSNs, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If he or she gets Railroad Retirement Board (RRB) benefits, call the local RRB office at 1-877-772-5772.
- For questions about a statement from a Medicare Advantage Plan, Medicare Prescription Drug Plan, or Medigap policy, call the benefits coordinator at the company or health plan that offers the plan. To locate phone numbers, look at the notice or bill from the plan.

Appeals

All people with Medicare have certain guaranteed rights. One of these is the right to get a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.

Information on how to file an appeal is on the "Medicare Summary Notice" (MSN) or in the health or drug plan materials.

Note: If the person you're caring for wants you to file an appeal on his or her behalf, he or she will need to complete an "Appointment of Representative" form. You can find this form by visiting cms.gov/cmsforms/downloads/cms1696.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Next steps

If the person you're caring for decides to file an appeal, you can help by:

- Asking doctor or provider for any information that may help the case.
- Calling State Health Insurance Assistance Program (SHIP) for help filing an appeal. See page 42 for more information.
- Visiting Medicare.gov/publications to view the booklet "Medicare Appeals."
- Calling 1-800-MEDICARE. Call the plan or check his or her plan materials if he or she is in a Medicare Advantage or other Medicare health plan.
- Visiting Medicare.gov/appeals for more information.

Reporting fraud

Most doctors, pharmacists, plans, and other health care providers who work with Medicare are honest. Unfortunately, there may be some who are dishonest. Medicare fraud happens when Medicare is billed for services or supplies that were never received. Medicare fraud costs Medicare a lot of money each year.

When the person you're caring for gets health care services, record the dates on a calendar and save the receipts he or she gets from providers. Use the calendar and receipts to check for mistakes on statements he or she gets. These include the "Medicare Summary Notice" (MSN) if he or she has Original Medicare, or similar statements that list the services he or she got or prescriptions he or she filled in a Medicare health or drug plan.

You can help the person you're caring for check his or her Original Medicare claims sooner by visiting MyMedicare.gov. Claims are generally available within 24 hours after processing. See pages 42–43 for more information about MyMedicare.gov.

Remember these tips to help prevent billing fraud:

- Ask questions! Everyone has the right to know information about his or her health care, including the items and services billed to Medicare.
- Educate yourself and the person you're caring for about Medicare. Know your rights, review MSNs and other statements. If necessary, ask your health care provider about items and services billed to Medicare.
- Be wary of providers who say that the item or service isn't usually covered, but they "know how to bill Medicare" so Medicare will pay.

Reporting fraud (continued)

Next steps

If you suspect billing fraud, you can do any of these:

- If you or the person you're caring for knows the provider, contact his or her office to be sure the bill is correct.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call 1-877-7SAFERX (1-877-772-3379) if the person you're caring for is in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.

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"Henry is doing better after his illness, but he may need some ongoing help. How do I find him the services he needs?"

5

How to Help–Next Steps

You can support the person you're caring for by becoming familiar with Medicare and other services. The resources in this booklet provide a starting point. Once you gather the information, the next step is to contact the people and organizations that can help. This section explains some of Medicare's resources, and tells you where to find more help.

Words in blue are defined on pages 47 –50.

Coping with illness

Facing a chronic health condition or surgery will raise questions and increase concerns for the person you're caring for. Having your support is important. Talk with this person about his or her condition and treatment and about what the doctor said during visits. Going over the facts may relieve some concerns and give a more realistic picture of the situation. Having you to talk to will be comforting and helpful as he or she makes health care decisions.

Helping someone cope with a serious health condition, especially over a long period of time, can be physically and emotionally draining.

If you're a caregiver, there are a few things you can do:

- Find someone you can talk to about your feelings. All of them are legitimate, even those that upset you.
- Set realistic goals. Balancing work, family, and time for yourself is difficult. Determine your priorities and turn to other people for help with some tasks.
- Carve out time for yourself, even if it's just an hour or two.

Note: If available, take advantage of respite care. Respite care is a service that provides temporary care. Respite care may mean help with a specific task or having health care providers care for the individual at home or in an extended care facility while you take time off. Medicare doesn't usually pay for respite care, except for when it is related to hospice care. However, other help may be available.

Coping with illness (continued)

Next steps

Sharing experiences with others can help you manage stress, locate resources, and reduce feelings of isolation. There may be resources in your community that can help. To locate a caregiver support group in your area:

- Check the newspaper or local library to find help that's available in your community.
- Contact your local Area Agency on Aging. Visit the Eldercare Locator at eldercare.gov, or call 1-800-677-1116 for your local Area Agency on Aging phone number.
- Check to see if help is available through your employee assistance program at work. You may be able to talk to a professional who's trained to provide counseling on caregiving issues.

State Health Insurance Assistance Programs (SHIPs)

The State Health Insurance Assistance Program (SHIP) provides free, personalized counseling and assistance about Medicare and insurance-related issues. The SHIP can help people with Medicare, or family and friends who have authorization to help someone with Medicare.

You can meet with a SHIP counselor face-to-face or over the phone for personal assistance. The counselors at your SHIP office can answer general questions about enrollment in Medicare plans, long-term care insurance, claims and billing problems, information and referrals on public benefit programs for those with limited income and resources, and other health insurance benefit information. When you have a Medicare concern, your SHIP is a good place to start for solutions.

To get the most up-to-date SHIP phone numbers, call 1-800-MEDICARE (1-800-633-4227) or visit Medicare.gov/contacts. TTY users should call 1-877-486-2048.

Medicare.gov and MyMedicare.gov

Visit Medicare.gov. It's an easy-to-use, comprehensive resource. Here are some of the things you or the person you're caring for can do on the website:

- Find out if he or she is eligible for Medicare and when he or she can enroll.
- See what Medicare covers, including preventive services.
- Get detailed information about the Medicare health and prescription drug plans in his or her area, including what they cost and what services they provide.
- Find doctors and suppliers who provide Medicare services or products.
- Get information about the quality of care provided by nursing homes, hospitals, home health agencies, Medicare plans, and dialysis facilities.
- Get Medicare appeals information and forms.
- Look up helpful phone numbers.
- View Medicare publications.

Medicare.gov and MyMedicare.gov (continued)

Medicare's secure online service for accessing your personal Medicare information, MyMedicare.gov, is available 24 hours a day, every day. You can help the person you're caring for register on the website. On MyMedicare.gov, you or the person can:

- Complete an "Initial Enrollment Questionnaire" so Medicare can process his or her bills correctly.
- Create and print an "On the Go" report that lists information you can share with providers.
- Track health care claims.
- Order a duplicate "Medicare Summary Notice" (MSN) or replacement Medicare card.
- Check Part B deductible status.
- View eligibility information.
- Track the preventive services he or she can get.
- Find information about his or her Medicare health or prescription drug plan, or search for a new one.
- Keep his or her Medicare information in one convenient place.
- Sign up to get the "Medicare & You" handbook electronically.

1-800-MEDICARE

Medicare is here for you 24 hours a day, every day. Call 1-800-MEDICARE (1-800-633-4227) to talk with a Medicare customer service representative. TTY users should call 1-877-486-2048.

You or the person you're caring for can call 1-800-MEDICARE to:

- Get answers to questions about what Medicare Part A and Part B cover.
- Get information about his or her claims.
- Ask for information about his or her Medicare health coverage choices including cost, benefits, quality, and more.
- Get information and ask questions about Medicare health and prescription drug plans in his or her area, including what they cost and what services they provide.
- Join a Medicare Prescription Drug Plan or Medicare Advantage Plan (like an HMO or PPO) when eligible.
- Get information about nursing homes, hospitals, home health agencies, and dialysis facilities in his or her area.
- Get information about Medicare appeal and patient rights.
- Ask for Medicare publications, including the "Medicare & You" handbook.
- Get helpful phone numbers.

Before you call, have the person's Medicare number from his or her red, white, and blue Medicare card available.

1-800-MEDICARE (continued)

Medicare can't give personal health information unless the person you're caring for gives verbal permission while you're on the phone or has submitted written authorization. It's a good idea to have the person you're caring for fill out an authorization form in advance. He or she can do this by:

- Filling out and submitting an e-Authorization Form online at Medicare.gov/Medicareonlineforms. If the person you're caring for is having difficulty completing the form online, he or she can call 1-800-MEDICARE and ask the customer service representative to help submit the form electronically while on the phone. Filling out the form online lets you immediately call and speak on behalf of the person you're caring for.
- Downloading and completing a PDF version of the standard authorization form at Medicare.gov/Medicareonlineforms. The person you're caring for can mail the completed, signed form to:

  Medicare BCC, Written Authorization Department
  PO Box 1270
  Lawrence, Kansas 66044

You can also have the person call 1-800-MEDICARE and ask the customer service representative to help fill out the standard authorization form over the phone. The customer service representative will mail the completed form to the person you're caring for to sign and return. Filling out the paper authorization form takes more time and you'll generally need to wait a few weeks before you're able to call and speak on his or her behalf.

If you need help resolving an issue on a Medicare claim for someone who has passed away, you must have the "Medicare Summary Notice" (MSN) before asking 1-800-MEDICARE questions about the claim. If you don't have an MSN, call 1-800-MEDICARE and ask for one. It will be sent to the address listed in Medicare's records. Medicare can't change the address on the person's record, but Social Security may be able to help you with changing the address. Call Social Security at 1-800-772-1213 for more information.

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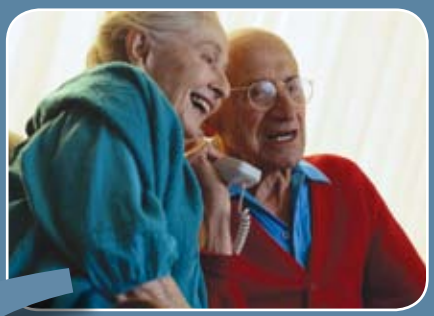

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Definitions

Advance directive
A written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a living will and a durable power of attorney for health care.

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%).

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

Durable power of attorney
A legal document that names someone else to make health care decisions for you. This is helpful if you become unable to make your own decisions.

Home health care
Health care services and supplies a doctor decides you may receive 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.

Hospice
A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver as well.

Living will
A written legal document, also called a "medical directive" or "advance directive." It shows what type of treatments you want or don't want in case you can't speak for yourself, like whether you want life support. Usually, this document only comes into effect if you're unconscious.

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 supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

Long-term care ombudsman
An independent advocate (supporter) for nursing home and assisted living facility residents who works to solve problems between residents and nursing homes or assisted living facilities. They may be able to provide information about home health agencies in their area.

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 Medicare 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, 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 Cost Plan

A type of Medicare health plan available in some areas. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under Original Medicare (your Cost Plan pays for emergency services or urgently needed services).

Medicare Medical Savings Account (MSA) Plan

MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare into the account. You can use the money in this account to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount so you generally will have to pay out-of-pocket before your coverage begins.

Medicare Prescription Drug Plan

Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medigap Policy
Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Original Medicare
Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

Power of attorney
A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent, or a durable power of attorney for health care.

Programs of All-inclusive Care for the Elderly (PACE)
A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically necessary care and services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.

Respite care
Temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.

Skilled nursing facility (SNF) care
Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility.

Notes

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You can't always plan ahead when you need health care, but when you can, take time to compare. Medicare collects information about the quality of care and services given by most Medicare plans and other health care providers. Visit Medicare.gov to compare the quality of care and services given by health and prescription drug plans, health care providers, and facilities nationwide.

If you have a question or complaint about the quality of care that the person you're caring for has received, call your Beneficiary Family Centered Care Quality Improvement Organization (BFCC-QIO). Call 1-800-MEDICARE (1-800-633-4227) or visit Medicare.gov to get the phone number. TTY users should call 1-877-486-2048.

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