CENTERS for MEDICARE & MEDICAID SERVICES

# Medicare & Home Health Care

**This official government booklet tells you:**

- Who's eligible
- What services are covered
- How to find and compare home health agencies
- Your Medicare rights

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 can call 1-877-486-2048.

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

**CMS Accessible Communications**

Medicare 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
   For Marketplace: 1-800-318-2596
   TTY: 1-855-889-4325

2. **Email us:** altformatrequest@cms.hhs.gov

3. **Send us a fax:** 1-844-530-3676

4. **Send us a letter:**

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop DO-01-20
Baltimore, MD 21244-1850
Attn: Customer Accessibility Resource Staff (CARS)

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 or local Medicaid office.

The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

This product was produced at U.S. taxpayer expense.

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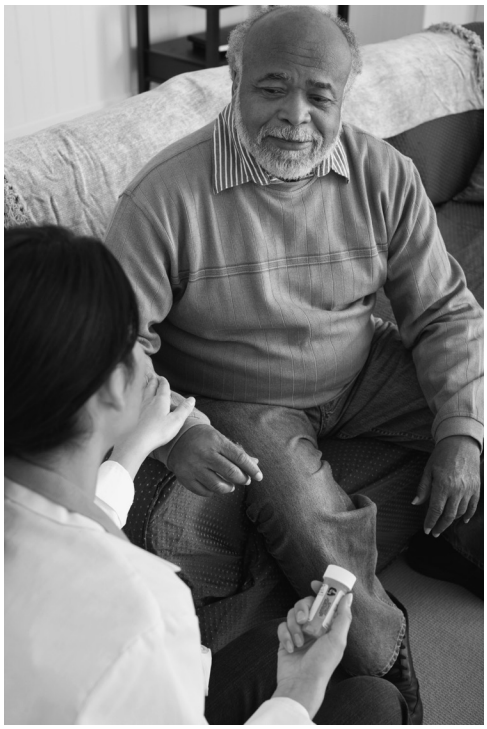

## Home health care

Many health care treatments that were once offered only in a hospital or a doctor's office can now be done in your home. Home health care is usually less expensive, more convenient, and can be just as effective as care you get in a hospital or skilled nursing facility. In general, the goal of home health care is to provide treatment for an illness or injury. Where possible, home health care helps you get better, regain your independence, and become more self-sufficient. Home health care may also help to maintain your current condition or level of function, or to slow decline.

Medicare pays for you to get health care services in your home if you meet certain eligibility criteria and the services are considered reasonable and necessary for the treatment of your illness or injury.

This booklet describes the home health care services that Medicare covers, and how to get those benefits through Medicare. If you get your Medicare benefits through a Medicare health plan (not Original Medicare) check your plan's membership materials, and contact the plan for details about your Medicare-covered home health benefits.

Words in red are defined on pages 27–28.

# Section 1: Medicare Coverage of Home Health Care

## Who's eligible

If you have Medicare, you can use your home health benefits if:

- You're under the care of a doctor or allowed practitioner (including a nurse practitioner (NP), a clinical nurse specialist (CNS), and physician assistant (PA)), and you're getting services as part of a care plan that your doctor or allowed practitioner established and reviews regularly.
- Your doctor or allowed practitioner certifies that you need one or more of these:
  - Intermittent skilled nursing care (other than drawing blood)
  - Physical therapy
  - Speech-language pathology services
  - Continued occupational therapy

  See pages 8–9 for more details on these services
- The home health agency caring for you is Medicare-certified.
- Your doctor or allowed practitioner certifies that you're homebound. To be homebound means:
  - You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury, or leaving your home isn't recommended because of your condition.
  - You're normally unable to leave your home, but if you do it requires a major effort.

  You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like an occasional trip to the barber, a walk around the block, or

attendance at a family reunion, funeral, graduation, or other infrequent or unique event. You can still get home health care if you attend adult day care or religious services.

- Your doctor or allowed practitioner documents that they've had a face-to-face encounter with you (like an appointment with your primary care doctor) within required timeframes and that the encounter was related to the reason you need home health care.

If you need more than "intermittent" skilled nursing care, you don't qualify for home health services. Medicare defines "intermittent" as skilled nursing care that's needed:

- Fewer than 7 days each week.
- Daily for less than 8 hours each day for up to 21 days. Medicare may extend the three week limit in exceptional circumstances.

If you're expected to need full-time skilled nursing care over an extended period, you won't usually qualify for home health benefits.

## How Medicare pays for home health care

Medicare pays your Medicare-certified home health agency one payment for the covered services you get during a 30-day period of care. You can have more than one 30-day period of care. Payment for each 30-day period is based on your condition and care needs.

Getting treatment from a home health agency that's Medicare-certified can reduce your out-of-pocket costs. A Medicare-certified home health agency agrees to:

- Be paid by Medicare
- Accept only the amount Medicare approves for their services

Medicare's home health benefit only pays for services you get from the home health agency. Other medical services and equipment are generally still covered as part of your other Medicare benefits.

Look in your "Medicare & You" handbook for information on how these services are covered under Medicare. To view or print this booklet, visit Medicare.gov/publications. You can also call 1-800-MEDICARE (1-800-633-4227) if you have questions about your Medicare benefits. TTY users can call 1-877-486-2048.

## What's covered

If you're eligible for home health care (see page 5), Medicare covers these services if they're reasonable and necessary for the treatment of your illness or injury. Medicare covers skilled nursing and therapy services when your doctor or allowed practitioner determines that the care you need requires the specialized judgment, knowledge, and skills of a nurse or therapist.

- **Skilled nursing care:** Medicare covers skilled nursing care when the services you need:
    - Require the skills of a nurse.
    - Are reasonable and necessary for the treatment of your illness or injury.

- Are provided on a part-time or intermittent basis (Medicare won't cover a visit if you're only having blood drawn). "Part-time or intermittent" means you may be able to get home health aide and skilled nursing services (combined) any number of days per week as long as the services are provided:
  - Fewer than 8 hours each day.
  - 28 or fewer hours each week (or up to 35 hours a week in some limited situations).

You can get skilled nursing services from a registered nurse or a licensed practical nurse. If you get services from a licensed practical nurse, a registered nurse will supervise your care. Home health nurses provide direct care and teach you and your caregivers about your care. They also manage, observe, and evaluate your care. Examples of skilled nursing care include: giving IV drugs, certain injections, or tube feedings; changing dressings; and teaching about prescription drugs or diabetes care. Any service that you could get safely and effectively from a non-medical person (including yourself) without the supervision of a nurse **isn't** skilled nursing care.

- **Physical therapy, occupational therapy, and speech-language pathology services:** Your therapy services are considered reasonable and necessary in the home setting if:
  - They're a specific, safe, and effective treatment for your condition
  - They're complex enough that you can only get them safely and effectively from a qualified therapist (or under the supervision of a qualified therapist)
  - Your condition requires one of these:
    - Therapy to restore or improve functions affected by your illness or injury
    - A skilled therapist or therapist assistant to safely and effectively perform therapy to help you maintain your current condition or prevent your condition from getting worse
  - The amount, frequency, and duration of the services are reasonable

- **Home health aide services:** Medicare will pay for part-time or intermittent home health aide services (like personal care), if you need them to maintain your health or treat your illness or injury. However, Medicare doesn't cover home health aide services unless you're also getting skilled care. Skilled care includes:
  - Skilled nursing care
  - Physical therapy
  - Speech-language pathology services
  - Continuing occupational therapy, if you no longer need any of the above
- **Medical social services:** Medicare covers these services when a doctor or allowed practitioner orders them to help you with social and emotional concerns that may interfere with your treatment or how quickly you recover. This might include counseling or help finding resources in your community. However, Medicare doesn't cover medical social services unless you're also getting skilled care as mentioned above.
- **Medical supplies:** Medicare covers supplies (like wound dressings) when your doctor or allowed practitioner orders them as part of your care.

Medicare pays for durable medical equipment separately from your home health care. The equipment must meet certain criteria and your doctor or allowed practitioner must order it. Medicare usually pays 80% of the Medicare-approved amount for certain medical equipment, like a wheelchair or walker. If your home health agency doesn't supply durable medical equipment directly, the home health agency staff will usually arrange for a supplier to bring you the items.

**Note:** Before your home health care begins, the home health agency should tell you how much of your bill Medicare will pay. The agency should also tell you if Medicare doesn't cover any of the items or services they give you, and how much you'll have to pay for them. They should explain it to you both verbally and in writing.

The home health agency must perform an initial assessment of all your care needs and must communicate those needs to the doctor or allowed

Words in red are defined on pages 27–28.

practitioner responsible for your plan of care. After that, the home health agency must routinely assess your needs. The home health agency is responsible for meeting all of your medical, nursing, rehabilitative, social, and discharge planning needs, as noted in your home health plan of care.

## What isn't covered

Medicare doesn't pay for:

- 24-hour-a-day care at home
- Meals delivered to your home
- Services, like shopping, cleaning, and laundry
- Custodial or personal care like bathing, dressing, and using the bathroom (when this is the only care you need)

Talk to your doctor (or allowed practitioner) or the home health agency if you have questions about whether certain services are covered. You can also call 1-800-MEDICARE.

**Note:** If you have a Medicare Supplement Insurance (Medigap) policy or other health coverage, be sure to tell your health care provider so your bills get paid correctly.

## What you pay

You may have to pay for:

- Services and supplies that Medicare never pays for, like routine foot care.
- Services and supplies that Medicare usually pays for, but won't pay for in this instance, when you've agreed to pay for them. The home health agency must give you a notice called the "Advance Beneficiary Notice of Noncoverage" (ABN) in these situations. See the next page for more information.
- 20% of the Medicare-approved amount for Medicare-covered medical equipment, like wheelchairs, walkers, and oxygen equipment.

Words in red are defined on pages 27–28.

## "Advance Beneficiary Notice of Noncoverage" (ABN)

The home health agency must give you a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN) before giving you a home health service or supply that Medicare probably won't cover for any of these reasons:

- The care isn't medically reasonable and necessary
- The care is only nonskilled personal care, like help with bathing or dressing
- You aren't homebound
- You don't need skilled care on an intermittent basis

When you get an ABN, the notice should describe the service and/or supply, and explain why Medicare probably won't pay. The ABN gives clear directions for getting an official decision from Medicare about payment for home health services and supplies and for filing an appeal if Medicare won't pay.

In general, to get an official decision on payment, you should:

- Keep getting the home health services and/or supplies if you think you need them. The home health agency must tell you how much they'll cost. Talk to your doctor or allowed practitioner and family about this decision.
- Understand you may have to pay the home health agency for these services and/or supplies.
- Ask the home health agency to send your claim to Medicare so that Medicare will make a decision about payment. You have the right to have the home health agency bill Medicare for your care.

If Original Medicare pays for your care, you'll get back all of your payments, except for any applicable coinsurance or deductibles, including any coinsurance payments you made for durable medical equipment.

The home health agency must also give you a "Home Health Change of Care Notice" (HHCCN) before they reduce or stop

Words in red are defined on pages 27–28.

providing any home health services or supplies that end up changing your plan of care.

Examples:

- The home health agency makes a business decision to reduce or stop giving you some or all of your home health services or supplies.
- Your doctor or allowed practitioner has changed or hasn't renewed your orders.

## Your right to a fast appeal

When all of your covered home health services are ending, you may have the right to a fast appeal if you think these services are ending too soon. During a fast appeal, an independent reviewer called a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) looks at your case and decides if you need your home health services to continue.

Your home health agency should give you a written notice called the "Notice of Medicare Non-Coverage" (NOMNC) at least 2 days before they end your services. If they don't give you a notice, ask for it. Read the notice carefully. It contains important information about:

- The date all your covered services will end
- How to ask for a fast appeal
- Your right to get a detailed notice about why your services are ending
- Any other information Medicare requires

If you ask for a fast appeal, the BFCC-QIO will ask why you think coverage of your home health services should continue. The BFCC-QIO will also look at your medical information and talk to your doctor or allowed practitioner. You should expect a response from the BFCC-QIO, generally no later than 3 days after the effective date of the NOMNC.

Words in red are defined on pages 27–28.

**If the BFCC-QIO decides your home health services should continue,** Medicare may continue to cover your home health care services, except for any applicable coinsurance or deductibles.

**If the BFCC-QIO decides that your coverage should end,** you'll have to pay for any services you got after the date on the NOMNC that says when your covered services should end. Your home health agency must give you an ABN with a cost estimate for these services.

You may choose to stop getting services on or before the date given on the NOMNC to avoid paying for any further services. If you don't ask for a fast appeal and want to continue getting services after the date listed on the NOMNC, your home health agency must give you an ABN to let you know what you must pay.

For more information on your right to a fast appeal and other Medicare appeal rights, look at your "Medicare & You" handbook or visit Medicare.gov/appeals. You can also call 1-800-MEDICARE.

# Section 2: Choosing a Home Health Agency

## Finding a Medicare-certified home health agency

If your doctor or allowed practitioner decides you need home health care, you may choose an agency from the participating Medicare-certified home health agencies that serve your area. Home health agencies are certified to make sure they meet certain federal health and safety requirements. Medicare.gov's Home Health Compare website can help you find a home health provider (Medicare.gov/care-compare/?providerType=HomeHealth).

You have a say in which agency you use, and your doctor (or allowed practitioner), hospital discharge planner, or other referring agency should honor your choice. However, your choices may be limited by agency availability, or by your insurance coverage. If you have a Medicare Advantage Plan or other Medicare health plan, it may require that you get home health services from agencies they contract with. Call your plan for more information.

Words in red are defined on pages 27–28.

## Home Health Agency Checklist

Use this checklist when choosing a home health agency.

Name of the home health agency: _____

| Question | Yes | No | Comments |
|---|---|---|---|
| 1. Is it Medicare-certified? | | | |
| 2. Is it Medicaid-certified (if you have both Medicare and Medicaid)? | | | |
| 3. Does it offer the specific health care services I need, like skilled nursing services or physical therapy? | | | |
| 4. Does it meet my special needs, like language or cultural preferences? | | | |
| 5. Does it offer the personal care services I need, like help bathing, dressing, and using the bathroom? | | | |
| 6. Does it offer the support services I need, or can help me arrange for additional services, like a meal delivery service, that I may need? (**Note:** These types of services aren't generally covered by Medicare). | | | |
| 7. Can the staff give the type and hours of care my doctor or allowed practitioner ordered and can they start when I need them? | | | |
| 8. Is this agency recommended by my hospital discharge planner, doctor (or allowed practitioner), or social worker? | | | |
| 9. Is staff available at night and on weekends for emergencies? | | | |
| 10. Has the agency explained what my insurance will cover and what I must pay out-of-pocket? | | | |
| 11. Does the agency have letters from satisfied patients, family members, and doctors/ practitioners that testify to the home health agency providing good care? | | | |

## Special rules for home health care

In general, most Medicare-certified home health agencies will accept all people with Medicare. An agency doesn't have to accept you if it determines that it can't meet your medical needs. An agency shouldn't refuse to take you because of your condition, unless the agency would also refuse to take other people with the same condition.

Medicare will only pay for you to get care from one home health agency at a time. You may decide to end your relationship with one agency and choose another at any time. Contact your doctor or allowed practitioner to get a referral to a new agency. You should tell both the agency you're leaving and the new agency you choose that you're changing home health agencies.

## Find out more about home health agencies

Your State Survey Agency, which inspects and certifies home health agencies for Medicare, can give you information about home health agencies. Ask them for the state survey report on any home health agency of interest to you. Visit medicare.gov/talk-to-someone to get your State Survey Agency's phone number. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

In some cases, your local long-term care ombudsman may have information on the home health agencies in your area. Visit ltcombudsman.org, eldercare.acl.gov, or call the eldercare locator at 1-800-677-1116.

To find out more about home health agencies, you can:

- Ask your doctor (or other allowed practitioner), hospital discharge planner, or social worker
- Ask friends or family about their home health care experiences
- Use a senior community referral service, or other community agencies that help you with your health care

# Section 3: Getting Home Health Care

You need a doctor or allowed practitioner's order to start and continue home health care. Usually, once you've been referred for home health services, staff from the home health agency will come to your home to talk to you about your needs and ask you some questions about your health. The home health agency will also talk to your doctor about your care and keep your doctor updated about your progress.

## Your plan of care

Your home health agency will work with you and your doctor or allowed practitioner to develop your plan of care. A plan of care lists what kind of services and care you should get for your health condition, including any services provided over the phone or a video monitor. You have the right to be involved in any decisions about your plan of care. Your plan of care includes:

- What services you need and how they will be provided
- Which health care professionals should give these services
- How often you'll need the services
- The visit schedule
- The medical equipment you need
- What results your doctor expects from your treatment

Your home health agency must give you all of the home care listed in your plan of care, including services and medical supplies. The agency may do this through its own staff or through an arrangement with another agency. The agency could also hire nurses, therapists, home health aides, and medical social workers to meet your needs.

## Your plan of care (continued)

Your doctor and home health team will review your plan of care as often as necessary, but at least once every 60 days. If your health condition changes, the home health team should tell your doctor right away. Your home heath team will:

- Review your plan of care and work with your doctor to make any necessary changes.
- Tell you about any changes in your plan of care. If you have a question about your care, or if you feel your needs aren't being met, talk to both your doctor and the home health team.
- Teach you (and family or friends who are helping you) to continue any care you may need, including wound care, therapy, and disease management. You should learn to recognize problems like infection or shortness of breath, and know what to do or whom to contact if they happen.

## Your rights when you get home health care

In general, as a person with Medicare getting home health care from a Medicare-certified home health agency, you have the right to:

- Get a written notice of your rights before your care starts
- Have your home and property treated with respect
- Be told, in advance, what care you'll be getting and when your plan of care is going to change
- Participate in your care planning and treatment
- Get written information about your privacy rights and your appeal rights
- Have your personal information kept private
- Get written and verbal information about how much Medicare is expected to pay and how much you'll have to pay for services
- Make complaints about your care and have the home health agency follow up on them
- Know the phone number of the home health hotline in your state where you can call with complaints or questions about your care

Visit Medicare.gov to learn more about your rights and protections. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

## Where to file a complaint about the quality of your home health care

If you have a complaint about the quality of care you're getting from a home health agency, you should call either of these organizations:

- Your state home health hotline. Your home health agency should give you this number when you start getting home health services.
- The Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in your state. You can call 1-800-MEDICARE to get the phone number for your BFCC-QIO.

## Home Health Care Checklist

This checklist can help you (and family or friends who are helping you) monitor your home health care. Use this checklist to help make sure that you're getting good quality care.

| When I get my home health care | Yes | No | Comments |
|---|---|---|---|
| 1. The staff is polite and treats me and my family with respect. | | | |
| 2. The staff explains my plan of care to me and my family, lets us participate in creating the plan, and lets us know ahead of time of any changes. | | | |
| 3. The staff is properly trained and licensed to perform the type of health care I need. | | | |
| 4. The agency explains what to do if I have a problem with the staff or the care I'm getting. | | | |
| 5. The agency responds quickly to my requests. | | | |
| 6. The staff checks my physical and emotional condition at each visit. | | | |
| 7. The staff responds quickly to changes in my health or behavior. | | | |
| 8. The staff checks my home and suggests changes to meet my special needs and to ensure my safety. | | | |
| 9. The staff has told me what to do if I have an emergency. | | | |
| 10. The agency and its staff protect my privacy. | | | |

# Section 4: Getting the Help You Need

## Help with questions about home health coverage

If you have questions about your Medicare home health care benefits or coverage and you have Original Medicare, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you get your Medicare benefits through a Medicare Advantage Plan (Part C) or other Medicare health plan, call your plan.

You may also call the State Health Insurance Assistance Program (SHIP). SHIP counselors answer questions about Medicare's home health benefits and what Medicare, Medicaid, and other types of insurance pay for. To get the phone number for your SHIP, visit shiphelp.org or call 1-800-MEDICARE.

Words in red are defined on pages 27–28.

## What you need to know about fraud

In general, most home health agencies are honest and use correct billing information. Unfortunately, there may be some who commit fraud. Fraud wastes Medicare dollars and takes away money that could be used to pay claims. You play an important role in the fight to prevent Medicare fraud, waste, and abuse.

Look for these signs of fraud:

- Home health visits that your doctor ordered, but you didn't get.
- Visits by home health staff that you didn't request and don't need.
- Bills for services and equipment you never got.
- Fake signatures (yours or your doctor's) on medical forms or equipment orders.
- Pressure to accept items and services that you don't need or Medicare doesn't cover.
- Items listed on your "Medicare Summary Notice" (MSN) that you don't think you got or used.
- Home health services your doctor or allowed practitioner didn't order. The doctor or allowed practitioner who approves home health services for you should know you, and should be involved in your care. If your plan of care changes, make sure your doctor was involved in making those changes.
- A home health agency that offers you free goods or services in exchange for your Medicare Number. Treat your Medicare card like a credit card or cash. Never give your Medicare or Medicaid number to people who tell you a service is free, and they need your number for their records.

The best way to protect your home health benefit is to know what Medicare covers and what your doctor or allowed practitioner has planned for you. If you don't understand something in your plan of care, ask questions.

Words in red are defined on pages 27–28.

## Reporting fraud

If you suspect fraud, you can:

- Contact your home health agency to be sure the bill is correct.
- Contact the Office of Inspector General:
  **Phone:** 1-800-HHS-TIPS (1-800-447-8477)
  **Fax:** 1-800-223-8164 (no more than 45 pages)
  **Online:** http://oig.hhs.gov
  **Mail:** Office of the Inspector General
  ATTN: OIG HOTLINE OPERATIONS
  P.O. Box 23489
  Washington, DC 20026

  Please note that it's current Hotline policy not to respond directly to written communications.
- Call 1-800-MEDICARE

**Important:** If you're reporting a possible case of Medicare fraud, provide as much identifying information as possible. Include the person or company's name, address, and phone number. Details should include the basics of who, what, when, where, why, and how.

## Fraud Notes

**Contact Name:** _____

**Company Name:** _____

**Address:** _____

**Phone Number:** _____

**Details: (who, what, when, where, why and how)**

_____

_____

_____

_____

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# Definitions

**Appeal**—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare drug plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment for a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

**Durable medical equipment**—Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

**Medicaid**—A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medicare Advantage Plan (Part C)**—A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare

even though you're still in the plan. Medicare Advantage Plans include:

- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Most Medicare services aren't paid for by Original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage.

**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 companies and provide Part D and other benefits in addition to Part A and Part B benefits.

**Medigap policy**—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

**Medicare Summary Notice (MSN)**—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 explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

**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).

**State Health Insurance Assistance Program (SHIP)**—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

## 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 and 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 users can call 1-800-537-7697.

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

   **Office for Civil Rights**

   **U.S. Department of Health and Human Services**

   **200 Independence Avenue, SW**

   **Room 509F, HHH Building**

   **Washington, D.C. 20201**

## Additional Notes

**U.S. DEPARTMENT OF**
**HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**
7500 Security Blvd.
Baltimore, MD 21244-1850

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Esta publicación está disponible en Español. Para obtener una copia gratis, visite Medicare.gov o llame al 1-800MEDICARE (18006334227). Los usuarios de TTY pueden llamar al 18774862048.