

Your Medicare Rights and Protections



**This is the official government
booklet with important
information about the following:**

- ★ Your rights and protections in the Original Medicare Plan
- ★ Your rights and protections in a Medicare Advantage Plan or Medicare Cost Plan
- ★ Your rights and appeals in a Medicare drug plan
- ★ Where you can get help with your questions



Protect Your Medicare Number!

You should always keep your Medicare card and Medicare number as safe as you would any of your personal information. You also want to keep your plan membership card safe if you are in a [Medicare Advantage Plan](#) (like an HMO or PPO) or other Medicare health plan. This will help protect against someone using your information without your knowledge.

If you lose your Medicare card or it is stolen, you can order a replacement card by visiting www.socialsecurity.gov on the web. Or, you can call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

If you find out that someone is using your Social Security Number, you can call the following organizations:

- Federal Trade Commission's ID Theft hotline at 1-877-438-4338 to make a report. TTY users should call 1-866-653-4261.
- Social Security at 1-800-772-1213 to replace your Medicare card or to get a new Social Security Number. TTY users should call 1-800-325-0778.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

“Your Medicare Rights and Protections” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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The information in this booklet was correct when it was printed. Changes may occur after printing. To get the most up-to-date information and Medicare telephone numbers, visit www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

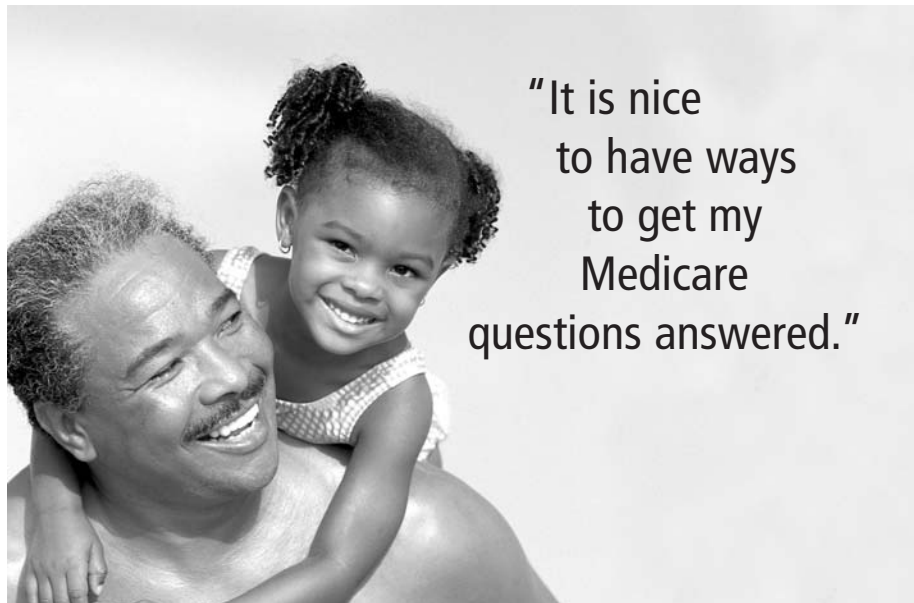
Welcome

How this booklet can help you

This booklet is about your Medicare rights and protections. As a person with Medicare, you have certain guaranteed rights and protections that include the following:

- Protect you when you get health care
- Make sure you get the health care services that the law says you can get
- Protect you against unethical practices
- Protect your privacy

Remember, you have rights whether you are in the [Original Medicare Plan](#), a [Medicare Advantage Plan](#) (like an HMO or PPO), [Medicare Cost Plan](#), or have a Medicare drug plan.



Section 1: Medicare Basics

What is Medicare?

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

What are my Medicare plan choices?

Depending on where you live, you may be able to get your health care in one of several ways. Your Medicare plan choices include the following:

- The [Original Medicare Plan](#). See below.
- [Medicare Advantage Plans](#) or other Medicare health plans. See page 4.
- Medicare drug plans. See page 5.

What is the Original Medicare Plan?

The Original Medicare Plan is a “fee-for-service” plan. You are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. You are in the Original Medicare Plan unless you choose to join a Medicare Health Plan. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care.

To help cover the costs the Original Medicare Plan doesn’t cover, you may want to get a [Medigap](#) (Medicare Supplement Insurance) [policy](#).

What is a Medigap (Medicare Supplement Insurance) policy?

A Medigap policy is health insurance designed to supplement the Original Medicare Plan coverage. It helps pay some of the health care costs or “gaps” that the Original Medicare Plan doesn’t cover (like copayments, coinsurance, and deductibles).

Medigap policies are sold by private insurance companies. Insurance companies can only sell you a “standardized” Medigap policy. Standardized Medigap policies are identified by letters (Medigap Plans A through L; except in Massachusetts, Minnesota, or Wisconsin). Medigap policies must follow Federal and state laws. These laws protect you.

For more information about Medigap policies, visit www.medicare.gov on the web and view the booklet “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.” Under “Search Tools,” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you are in the Original Medicare Plan, see pages 20–21 for information about your right to buy a Medigap policy.

Words in blue are defined on pages 43–46.

Section 1: Medicare Basics

What are Medicare Advantage Plans?

Medicare Advantage Plans (like an HMO or PPO) are health plan options that are approved by Medicare and run by private companies. They are part of the Medicare Program, and sometimes called “Part C.” If you join one of these plans, you generally get all your Medicare-covered health care through that plan. This coverage also may include prescription drug coverage. Medicare pays a set amount of money for your care every month to these private health plans, whether or not you use services. In most of these plans, generally there are extra benefits and lower [copayments](#) than in the Original Medicare Plan. However, you may also have to see doctors that belong to the plan or go to certain hospitals to get services.

Medicare Advantage Plans include the following:

- Medicare [Preferred Provider Organization \(PPO\) Plans](#)
- Medicare [Health Maintenance Organization \(HMO\) Plans](#)
- Medicare [Private Fee-for-Service \(PFFS\) Plans](#)
- Medicare [Special Needs Plans](#)
- [Medicare Medical Savings Account \(MSA\) Plans](#)

What are the other Medicare health plans?

There are some types of other Medicare health plans that aren't part of Medicare Advantage, but still provide your health care coverage as part of the Medicare Program. Medicare either pays a set amount of money for your care every month to these plans or reimburses the plan's reasonable cost for your care. They provide your Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) coverage, and some provide Part D (Medicare prescription drug coverage) as well.

Other Medicare health plans include the following:

- [Medicare Cost Plans](#)
- Demonstrations/Pilot Programs
- [PACE \(Programs of All-inclusive Care for the Elderly\)](#)

Note: You may be able to join a Medicare Advantage Plan or another Medicare health plan depending on your needs and your circumstances. In this booklet, the Original Medicare Plan, Medicare Advantage Plans, and other Medicare health plans are referred to as Medicare Health Plans.

Section 1: Medicare Basics

What is Medicare prescription drug coverage?

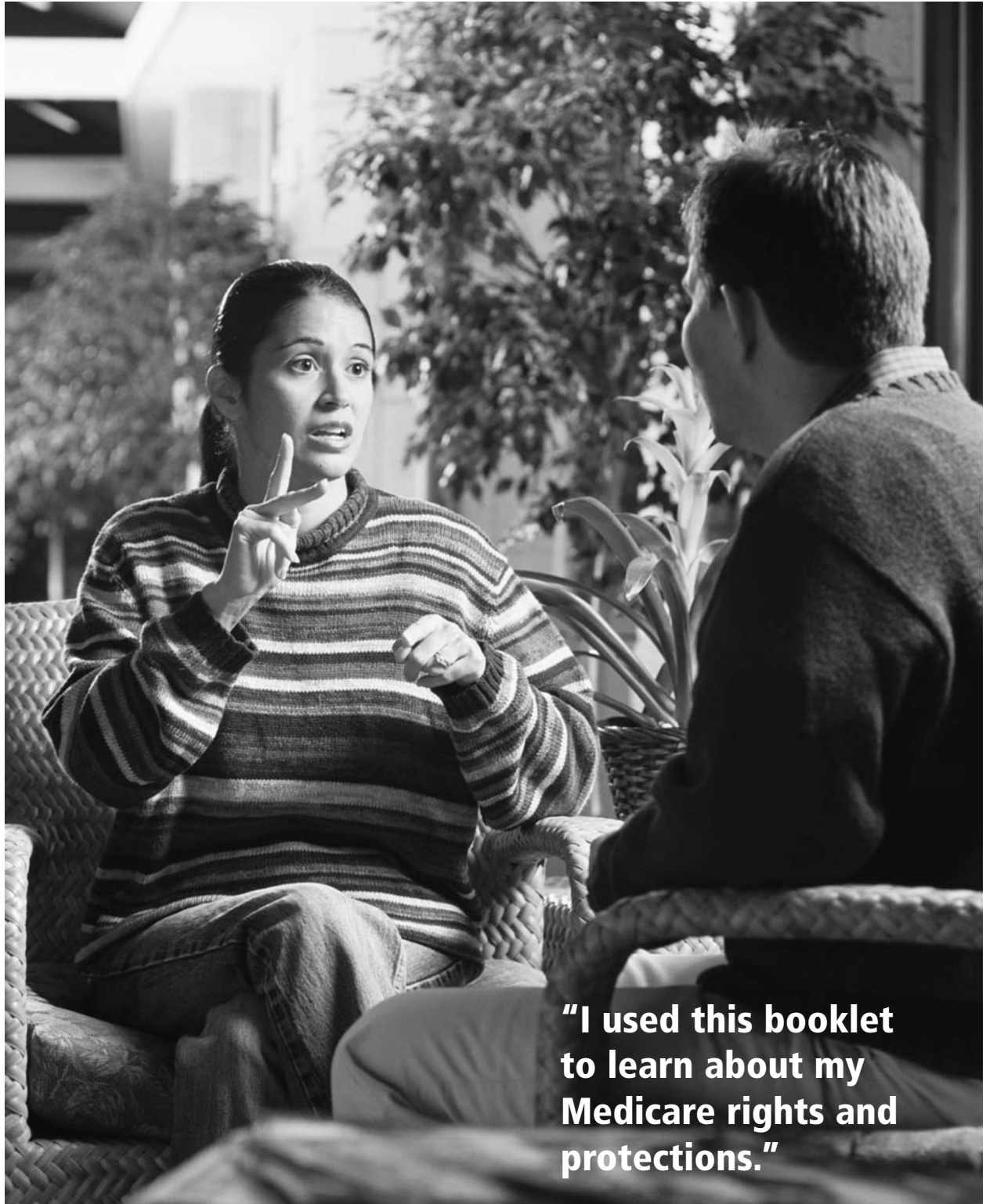
Medicare offers prescription drug coverage for everyone with Medicare. This is called “Part D.” This coverage may help lower prescription drug costs and help protect against higher costs in the future. It can give you greater access to drugs that you can use to prevent complications of diseases and stay well.

Medicare drug plans are run by insurance companies and other private companies approved by Medicare. If you join a Medicare drug plan, you usually pay a monthly premium. Joining Part D is optional. If you decide not to join a Medicare drug plan when you are first eligible, you may pay a late-enrollment penalty if you choose to join later. If you are told you have to pay a late-enrollment penalty, you have the right to ask for a review of this decision. See page 40 for more information.

There are two ways to get Medicare prescription drug coverage:

- 1. Join a Medicare Prescription Drug Plan.** These plans (sometimes called “PDPs”) add drug coverage to the [Original Medicare Plan](#), some [Medicare Cost Plans](#), some Medicare [Private Fee-for-Service \(PFFS\) Plans](#), and [Medicare Medical Savings Account \(MSA\) Plans](#).
- 2. Join a [Medicare Advantage Plan](#) (like an HMO or PPO) or another Medicare health plan that includes prescription drug coverage.** You get all of your Medicare coverage (Part A and Part B), including prescription drugs (Part D), through these plans.

Words in blue are defined on pages 43–46.



**"I used this booklet
to learn about my
Medicare rights and
protections."**

Section 2: Your Medicare Rights

If you have Medicare, you have certain guaranteed rights and protections. You have these rights whether you have the [Original Medicare Plan](#) (with or without a [Medigap policy](#)) or a [Medicare Advantage Plan](#). You have the right to

1. Be treated with dignity and respect at all times

2. Be protected from discrimination

Discrimination is against the law. Every company or agency that works with Medicare must obey the law. You can't be treated differently because of your race, color, national origin, disability, age, religion, and sex (under certain conditions).

Also, your rights to health information privacy are protected. If you think that you haven't been treated fairly for any of these reasons, call the Office for Civil Rights in your state. Call toll-free at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr on the web for more information.

3. Get information about Medicare that you can understand to help you make health care decisions

This information includes the following:

- What is covered
- What costs are paid
- How much you have to pay
- What to do if you want to file a complaint

4. Have your questions about the Medicare Program answered

You can call 1-800-MEDICARE (1-800-633-4227) to get your questions answered. Or, call your [State Health Insurance Assistance Program](#). See pages 41–42 for their telephone number. TTY users should call 1-877-486-2048. If you enrolled in a Medicare Advantage Plan, you can also call your plan.

Words in blue are defined on pages 43–46.

Section 2: Your Medicare Rights

5. Culturally competent services

You have the right to get health care services in a language you can understand and in a culturally sensitive way. For more information about getting health care services in languages other than English, call the Office for Civil Rights in your state or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr on the web for more information.

6. Get emergency care when and where you need it

A medical emergency is when you think your health is in serious danger—when every second counts. If you think your health is in danger because you have a bad injury, sudden illness, or an illness quickly getting much worse, call 911. You can get emergency care anywhere in the United States.

To learn about emergency care in the [Original Medicare Plan](#), call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you joined a [Medicare Advantage Plan](#), your plan materials describe how to get emergency care. You don't need to get permission from your primary care doctor before you get emergency care. Your primary care doctor is the doctor you see first for health problems. If you are admitted to the hospital, you, a family member, or your primary care doctor should contact your Medicare Advantage Plan as soon as possible so the plan can manage your care.

If you get emergency care, you will have to pay your regular share of the cost ([copayment](#)). Then, your plan will pay its share. If your plan doesn't pay its share for your emergency care, you have the right to [appeal](#).

7. Learn about all of your treatment choices in clear language that you can understand

You have the right to fully participate in all your health care decisions. If you can't fully participate, you can ask family members, friends, or anyone you trust to help you make a decision about what treatment is right for you. Medicare Advantage Plans can't have rules that stop your doctor from telling you what you need to know about your treatment choices.

Words in [blue](#) are defined on pages 43–46.

Section 2: Your Medicare Rights

8. File a complaint

You can file a complaint about payment, services you received, other concerns or problems you have in getting health care, and the quality of the health care you received.

Your Medicare Quality of Care Concerns

You have a right to file a complaint if you think you aren't getting quality services or you have quality of care issues. (This type of complaint is called a “[grievance](#)” if you are enrolled in a [Medicare Advantage Plan](#) or a Medicare drug plan.) If you are enrolled in the [Original Medicare Plan](#) or a Medicare Advantage Plan and you want to file a complaint about the quality of health care you have received, call your plan or call the [Quality Improvement Organization](#) in your state. See pages 41–42 for their telephone number.

Note: If you have End-Stage Renal Disease and have a complaint about your care, call the ESRD Network for your state. To get this telephone number, visit www.medicare.gov on the web. Under “Search Tools,” select “Find Helpful Phone Numbers and Websites.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

9. Know Your Medicare Appeal Rights

You have the right to [appeal](#) decisions relating to your claims for benefits. For more information on appeals, see Sections 3–5 on pages 11–40 or call the [State Health Insurance Assistance Program](#) (SHIP) in your state. See pages 41–42 for their telephone number.

Tip: If you need help filing an appeal, you can name a family member, friend, advocate, attorney, doctor, or someone else to act on your behalf. This process is called “Appointment of a Representative.” Medicare has a form that you and your representative fill out to complete this process.

This form is available by visiting www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf on the web (CMS Form Number 1696). You can also appoint a representative with a letter signed and dated by you and the person helping you. Your letter must include the same information that is requested on the Appointment of Representative form. The form or letter must be sent with your appeal request.

If you have questions about appointing a representative, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section 2: Your Medicare Rights

10. Have your health information that Medicare collects about you kept private

Medicare may collect information about you as part of its regular business, such as paying your health care bills and making sure you get quality health care. Medicare keeps the information it collects about you private. When Medicare asks for your health information, they must tell you the following:

- Why it is needed
- Whether it is required or optional
- What happens if you don't give the information
- How it will be used

If you want to know more about how Medicare uses your personal information, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your state may have additional privacy laws that protect your personal information. If you want to know about the laws in your state, call your [State Health Insurance Assistance Program](#). See pages 41–42 for their telephone number.

11. Know the health information privacy rights

You have privacy rights under a Federal law that protects your health information. Your health care provider or Medicare Health Plan must follow this law to protect your privacy rights. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a [complaint](#) if you think your rights are being denied or your health information isn't being protected. If you are enrolled in the [Original Medicare Plan](#), see the “Notice of Privacy Practices for the Original Medicare Plan” on pages 22–24. If you are enrolled in a [Medicare Advantage Plan](#) or a Medicare drug plan, your plan materials describe your privacy rights.

Words in blue are defined on pages 43–46.

Section 3: Your Rights and Protections in the Original Medicare Plan

In addition to the rights listed in Section 2, if you are in the [Original Medicare Plan](#), you have the following rights and protections:

1. Access to doctors, specialists (including women’s health specialists), and hospitals

You can see any doctor or specialist, or go to any Medicare-certified hospital that participates in Medicare.

2. Timely information on Medicare payment, and fair and efficient appeal processes

If you have the Original Medicare Plan, you can get certain information, notices and [appeal](#) rights that help you resolve issues when Medicare doesn’t pay for health care. See pages 12–18.

Advance Beneficiary Notices (ABNs)

If your doctor, health care provider, or supplier thinks that Medicare won’t pay for an item or service, they will give you a written notice called an “Advance Beneficiary Notice” (ABN). The ABN explains what items or services Medicare probably won’t pay for, the reasons why Medicare won’t pay, and gives you an estimate of costs. Using the ABN, you can make an informed choice about whether or not you want to get this item or service knowing that you or your other insurance may be responsible for payment.

When your doctor, health care provider, or supplier gives you an ABN, you have to decide if you want the items or services listed. In most cases, your options will be explained on the ABN. You must choose an option. You will have to sign and date the ABN to show you understand your options. If you get the item or service and Medicare later pays for it, you will be refunded any money you paid (except for applicable coinsurance or deductibles).

The following are the 4 types of ABNs:

- Advance Beneficiary Notice—General (ABN-G). See page 12.
- Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). See page 12.
- Home Health Advance Beneficiary Notice (HHABN). See page 12.
- Hospital-Issued Notice of Non-coverage (HINN). See pages 13.

Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Advance Beneficiary Notice—General (ABN–G)

The general ABN is used by doctors, durable medical equipment suppliers, and certain health care providers (for example, independent physical and occupational therapists, and outpatient hospitals).

Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

The SNFABN is used only for [skilled nursing facility care](#).

When you meet certain requirements, Medicare Part A pays up to 100 days of room, board, and covered services as part of skilled nursing care when you stay in a skilled nursing facility, or get skilled nursing care in a special area of a hospital called a “swing bed.”

When a facility that gives skilled nursing care believes Medicare may not continue to cover your stay, the facility will give you a SNFABN telling you when you will be responsible for payment. You don’t have to pay for services at that time, you pay only after a claim is filed and an official Medicare decision is made to deny payment.

However, you still continue to pay any other costs that you would normally have to pay while the claim is being processed. These costs include the daily [coinsurance](#) and the costs for services and supplies Medicare never pays for, such as telephone or television services. If you have questions about Medicare Part A services, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Home Health Advance Beneficiary Notice (HHABN)

The HHABN is used only by [home health agencies](#). The HHABN is given in most instances where your home health agency is either giving you [home health care](#) Medicare probably won’t pay for, or when your home health agency will reduce or end care for other reasons.

Words in [blue](#) are defined on pages 43–46.

Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Hospital Issued Notice of Non-coverage (HINN)

If you are getting **inpatient hospital care**, you may get a notice called a “Hospital Issued Notice of Non-coverage” (HINN) when the hospital thinks Medicare may not pay for your care. You may get one of these notices before you are admitted, at admission, or at any point during your hospital stay. This notice will tell you why the hospital thinks Medicare won’t pay and what you have to pay if you keep getting services. This notice doesn’t have options to check off like Advance Beneficiary Notices. You still need to sign and date this notice to show that you understand your options.

Services that Medicare Never Covers

Doctors, health care providers, and suppliers don’t have to give you an Advance Beneficiary Notice for services that Medicare never covers, such as the following:

- Routine physical exams*
- Dental services
- Hearing aids
- Routine eye exams
- Routine foot care

* Medicare Part B covers a one-time “Welcome to Medicare” physical exam within the first 6 months of having Medicare Part B. You may have to pay some costs for this physical exam.

Your doctor, health care provider, or supplier may still choose to give you an ABN for items or services that Medicare never covers.

Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Fast Appeals in Hospitals

When you are admitted as an inpatient to a hospital, you have the right to get all the hospital care that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your inpatient hospital stay is no longer medically necessary. This section explains what to do if you believe that you are being discharged too soon.

Information you should get during your hospital stay

As part of the pre-admission process (but not more than 7 days before admission) or within 2 days of admission as an inpatient, someone at the hospital must give you a notice called “An Important Message from Medicare About Your Rights” (the “IM”). If you don’t get this notice, ask for it. This notice explains the following:

- Your right to get all medically necessary hospital services
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them
- Your right to get services you need after you leave the hospital
- Your right to appeal a discharge decision and have your hospital services paid for during the appeal (except for any applicable [coinsurance](#) or deductibles)
- Your potential financial liability for continuing to stay in the hospital after your discharge date

You or your representative will be asked to sign the IM. If the hospital gives you the IM more than 2 days before your discharge day, it must give you a copy of your signed IM before you are discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to ask a [Quality Improvement Organization](#) (QIO) to review whether you are being discharged too soon. See pages 41–42 for their telephone number.

Words in [blue](#) are defined on pages 43–46.

Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Getting QIO review of your hospital discharge

You must quickly contact the QIO. The IM gives the name and telephone number of the QIO and tells you what you must do. Ask the QIO for a fast review no later than the day you are discharged from the hospital. If you meet this deadline, you may stay in the hospital after your discharge date without paying for it (except for applicable [coinsurance](#) or deductibles) while you wait to get the decision from the QIO.

What will happen during the QIO's review?

When the QIO gets your request, the QIO will notify the hospital that you have requested a fast review. Once the hospital gets this notice from the QIO, the hospital will give you a notice called the "Detailed Notice of Discharge" that includes the following information:

- Explains why your services are no longer reasonable and necessary or are no longer covered
- Describes the applicable Medicare coverage rule or policy, including information on how you can get a copy of the policy
- Explains how the applicable coverage rule applies to your specific situation

This detailed notice must be delivered to you or your appointed representative as soon as possible, but no later than noon of the day after the QIO notifies the hospital of your request for a fast review.

The QIO will look at your medical information provided by the hospital and will also ask for your or your appointed representative's opinion. The QIO will decide, within one day after getting the information it needs, if you are ready to be discharged on the date that has been set for you.

What happens if the QIO decides in your favor?

Medicare will continue to cover your [skilled nursing facility \(SNF\)](#), [home health agency \(HHA\)](#), [comprehensive outpatient rehabilitation facility \(CORF\)](#), [hospice](#), or hospital swing bed services for as long as medically necessary (except for applicable coinsurance or deductibles).

Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

What happens if the QIO agrees with the discharge?

You won't be responsible for paying the hospital charges (except for applicable [coinsurance](#) or deductibles) until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you miss the deadline for a fast review, you may still ask the QIO to review your case, but different rules apply. If you have any questions about fast appeals in hospitals, call the QIO at the telephone number listed on the notice the hospital gives you or see pages 41–42 for their telephone number. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Fast Appeals in Other Health Care Settings

If you are getting Medicare-covered services from a [skilled nursing facility \(SNF\)](#), [home health agency \(HHA\)](#), [comprehensive outpatient rehabilitation facility \(CORF\)](#), [hospice](#), or hospital swing bed, you have the right to a fast [appeal](#) if you think your Medicare-covered services are ending too soon. During a fast appeal, a QIO looks at your case and decides if your health care services need to continue.

Information you will get while getting your SNF, HHA, CORF, hospice, or hospital swing bed services

Your provider will give you a notice called the “Notice of Medicare Provider Non-Coverage” at least 2 days before covered services end. If you don't get this notice, ask for it. This notice contains the following information:

- The date that your covered services will end
- An explanation of your financial liability if you continue getting services
- Information on your right to a fast appeal, including your right to submit evidence to support your case
- Information on your right to get a detailed notice about why your covered services are ending

You or your representative will be asked to sign and date this notice.

Words in [blue](#) are defined on pages 43–46.

Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

Getting the QIO to review the decision to end coverage

As explained in the notice you get from your provider, you can ask the QIO to do an independent review of whether it is medically appropriate to end coverage for your SNF, HHA, CORF, hospice, or hospital swing bed services.

How soon do you have to ask for QIO review?

You must ask the QIO for a review no later than noon of the day before the date that your Medicare-covered services end. The notice you get from your provider will give the name and telephone number of your QIO and tells you what you must do.

What will happen during the QIO's review?

When the QIO gets your request, the QIO will notify the provider that you have requested a fast review. Once the provider gets this notice from the QIO, the provider will give you a notice called the "Detailed Explanation of Non-Coverage" that includes the following information:

- Why your services are no longer reasonable and necessary or are no longer covered
- The applicable Medicare coverage rule or policy, including information on how you can get a copy of the policy
- How the applicable coverage rule applies to your specific situation

This detailed notice must be sent to you by the end of the day the QIO notifies the provider of your request for a fast review.

What happens if the QIO decides in your favor?

Medicare will continue to cover your SNF, HHA, CORF, hospice, or hospital swing bed services for as long as medically necessary (except for applicable [coinsurance](#) or deductibles).

Section 3: Your Rights and Protections in the Original Medicare Plan

2. (continued)

What happens if the QIO agrees that your coverage should end?

You won't be responsible for paying for any SNF, HHA, CORF, hospice or hospital swing bed services provided before the termination date on the "Notice of Medicare Provider Non-Coverage." You may stop getting services on or before the date given on the "Notice of Medicare Provider Non-Coverage" and avoid any possible financial liability.

If you miss the deadline for requesting a fast appeal, you may still ask the QIO to review your case, but different rules apply. If you have questions about your rights regarding SNF, HHA, CORF, hospice, or hospital swing bed services, including appealing the QIO's decision, getting notices, or learning about rights after missing the filing deadline, call the QIO at the number listed on the notice the provider gives you or see pages 41–42 for their telephone number. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Billing Information

After you get care, if you aren't sure if Medicare was billed for the items or services that you got, write or call your doctor, health care provider, or supplier and ask for an itemized statement. This statement will list each Medicare item or service you got. You can also check your [Medicare Summary Notice](#) to see if Medicare was billed.

You have the right to insist your doctor, health care provider, or supplier bill Medicare if you get an item or service from them. Sometimes, this right is referred to as a "demand bill." For example, if you have been told your Medicare Part A [skilled nursing facility care](#) is coming to an end, you can ask that a claim be submitted so that Medicare makes a final decision on whether you still qualify for this care.

3. General Appeal Rights

After Medicare makes a decision on a claim, you have the right to a fair, efficient, and timely process for appealing health care payment decisions or initial determinations on items or services you received. You may appeal if

- a service or item you received isn't covered, and you think it should be, or
- a service or item is denied, and you think it should be paid.

Words in blue are defined on pages 43–46.

Section 3: Your Rights and Protections in the Original Medicare Plan

3. (continued)

The [Medicare Summary Notice](#) is mailed to you by the company that handles claims for Medicare. This notice indicates if your claim is approved or denied. If the claim is denied, the reason for the denial will be included on the notice. The notice will also include information about how to file an appeal. You can file an appeal if you disagree with Medicare's decision on payment or coverage for the items or services you received. If you appeal, ask your doctor, health care provider, or supplier for any information that might help your case. You should keep a copy of everything you send to Medicare as part of your appeal.

There are **5 levels** of appeal available to you. You should follow the order of the levels listed below and on page 20.

A. Redetermination by Medicare

The company that handles claims for Medicare will make the first decision on your [appeal](#). This is called a redetermination. You can request a redetermination by sending a written request to the company that sends your Medicare Summary Notice. You must file your request within 120 days from the date you get the initial determination. Details of how, where, and when to file are on the Medicare Summary Notice. You will get a decision on your appeal about 60 days after your appeal request is received.

B. Reconsideration by a Qualified Independent Contractor (QIC)

If you disagree with the redetermination decision, you can ask for a reconsideration. A contractor that didn't take part in the first decision makes the reconsideration decision. You must file your request in writing within 180 days from the date you get the Medicare Redetermination Notice. The Medicare Redetermination Notice will explain how to request a reconsideration. You can use the form sent with your Medicare Redetermination Notice to make your request.

In most cases, the QIC will issue a decision about 60 days after your appeal request is received. If the QIC can't issue a decision on time, you will get a letter that will ask you if you want to skip to the next level of appeal.

Section 3: Your Rights and Protections in the Original Medicare Plan

Levels of Appeal: (continued)

C. Hearing with an Administrative Law Judge (ALJ)

If you disagree with the QIC's decision, you can request a hearing with an ALJ. To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. You must file your request in writing within 60 days from the date you get the reconsideration notice from the QIC. The Medicare Reconsideration Notice will explain how to file a request for a hearing with an ALJ.

In most cases, the ALJ will issue a decision about 90 days after your appeal request is received. If the ALJ can't issue a decision on time, you will get a letter that will ask you if you want to skip to the next level of appeal.

In most cases, the ALJ will issue a decision in 90 days after getting your appeal request. If the ALJ can't issue a decision on time, you will get a letter that will ask you if you want to skip to the next level of appeal.

D. Review by the Medicare Appeals Council (MAC)

If you disagree with the ALJ's decision, you can request a review by the MAC. You must file your request in writing within 60 days from the date you get the ALJ's decision. The ALJ's decision letter will provide details about how to file a request for MAC review. The MAC has 90 days to make a decision after your request for review is received. If the MAC can't issue a decision on time, you can ask the MAC to skip to the next level of appeal.

E. Review by a Federal Court

If you disagree with the MAC's decision, you can request a review by a Federal court. To get a review by a Federal court, the amount of your case must meet a minimum dollar amount. You must make the request in writing within 60 days from the date you get the MAC's decision. The MAC's decision will explain how to file a request for a review by a Federal court.

4. Your rights to buy a Medigap policy

In some situations, you have the right to buy a **Medigap policy** outside of your **Medigap open enrollment period**. These rights are called "Medigap Protections." They are also called **guaranteed issue rights** because the law says that insurance companies must issue you a Medigap policy.

Words in blue are defined on pages 43–46.

Section 3: Your Rights and Protections in the Original Medicare Plan

4. (continued)

There are a few situations involving health coverage changes where you may have a guaranteed issue right to buy a Medigap policy. In the following situations, an insurance company

- must sell you a Medigap policy.
- must cover all your pre-existing conditions.
- can't charge you more for a Medigap policy because of past or present health problem.

To learn about the situations where you have a guaranteed issue right to buy a Medigap policy because you lost certain kinds of health coverage, you can do any of the following:

- Visit www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication," to view the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You can get more detailed Medigap information from the following resources:

- Visit www.medicare.gov on the web. Under "Search Tools," select "Compare Health Plans and Medigap Policies in Your Area."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. A customer service representative will help you.
- Call the [State Health Insurance Assistance Program](#) in your state. Ask if they have a Medigap rate comparison shopping guide for your state. See pages 41–42 for their telephone number.

If you think any of your Medigap rights have been violated, call your State Health Insurance Assistance Program.

Section 3: Your Rights and Protections in the Original Medicare Plan

Notice of Privacy Practices for the Original Medicare Plan

The Notice of Privacy Practices for the Original Medicare Plan describes how Medicare uses and gives out your personal health information and tells you your individual rights. The notice is below, and on pages 23–24.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, Medicare is required to protect the privacy of your personal medical information. Medicare is also required to give you this notice to tell you how Medicare may use and give out (“disclose”) your personal medical information held by Medicare.

Medicare must use and give out your personal medical information to provide information

- to you or someone who has the legal right to act for you (your personal representative),
- to the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- where required by law.

Medicare has the right to use and give out your personal medical information to pay for your health care and to operate the Medicare Program. Examples include the following:

- Medicare Carriers use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), or to prepare your Medicare Summary Notice.
- Medicare may use your personal medical information to make sure you and other Medicare beneficiaries get quality health care, to provide customer services to you, to resolve any complaints you have, or to contact you about research studies.

Section 3: Your Rights and Protections in the Original Medicare Plan

Notice of Privacy Practices for the Original Medicare Plan (continued)

Medicare may use or give out your personal medical information for the following purposes under limited circumstances

- to State and other Federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/State Medicaid programs),
- for public health activities (such as reporting disease outbreaks),
- for government health care oversight activities (such as fraud and abuse investigations),
- for judicial and administrative proceedings (such as in response to a court order),
- for law enforcement purposes (such as providing limited information to locate a missing person),
- for research studies, including surveys, that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- to avoid a serious and imminent threat to health or safety,
- to contact you about new or changed benefits under Medicare, and
- to create a collection of information that can no longer be traced back to you.

By law, Medicare must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that isn’t set out in this notice. You may take back (“revoke”) your written permission at any time, except if Medicare has already acted based on your permission.

By law, you have the right to

- see and get a copy of your personal medical information held by Medicare.
- have your personal medical information amended if you believe that it is wrong or if information is missing, and Medicare agrees. If Medicare disagrees, you may have a statement of your disagreement added to your personal medical information.

Section 3: Your Rights and Protections in the Original Medicare Plan

Notice of Privacy Practices for the Original Medicare Plan (continued)

- get a listing of those getting your personal medical information from Medicare. The listing won't cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for Medicare operations, or that was given out for law enforcement purposes.
- ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare Program. Please note that Medicare may not be able to agree to your request.
- get a separate paper copy of this notice.

Visit www.medicare.gov on the web for more information on

- exercising your rights set out in this notice.
- filing a complaint, if you believe the Original Medicare Plan has violated these privacy rights. Filing a complaint won't affect your benefits under Medicare.

You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. Ask to speak to a customer service representative about Medicare's privacy notice. TTY users should call 1-877-486-2048.

You may file a complaint with the Secretary of the Department of Health and Human Services. Visit www.hhs.gov/ocr/hipaa on the web or call the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

By law, Medicare is required to follow the terms in this privacy notice. Medicare has the right to change the way your personal medical information is used and given out. If Medicare makes any changes to the way your personal medical information is used and given out, you will get a new notice by mail within 60 days of the change.

The Notice of Privacy Practices listed above and on pages 22–23 became effective April 14, 2003.

Section 4: Your Rights and Protections in a Medicare Advantage Plan or Medicare Cost Plan

If you are in a [Medicare Advantage Plan](#) (like an HMO or PPO) or [Medicare Cost Plan](#), you have the following rights and protections. If you want to know more about your rights and protections, including rights and protections you may have in addition to those discussed in this booklet, read your plan's membership materials or call your plan.

Note about PACE (Programs of All-inclusive Care for the Elderly): To get a detailed list of your [PACE](#) rights and protections, visit www.cms.hhs.gov/pace/downloads/prtemp.pdf on the web. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Note about Medicare Cost Plans: If you have a Medicare Cost Plan and you want to [appeal](#) services that were provided outside the plan's network (without the plan's involvement), you will need to follow the [Original Medicare Plan](#) appeal process as described in Section 3.

1. Choice of health care providers

You may have the right to choose health care providers within the plan so you can get the health care you need.

2. Access to health care providers

If you have a complex or serious medical condition, you have the right to get a treatment plan from your doctor. This treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need.

Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.

3. Know how your doctors are paid

You have the right to know how your plan pays its doctors. When you ask your plan how it pays its doctors, the plan must tell you. Medicare doesn't allow a plan to pay doctors in a way that wouldn't let you get the care you need.

Words in [blue](#) are defined on pages 43–46.

Section 4: Your Rights and Protections in a Medicare Advantage Plan or Medicare Cost Plan

4. A fair, efficient, and timely appeals process

You have the right to a fair, efficient, and timely process to resolve differences with your plan. This process includes the initial decision made by the plan, an internal review, and an independent external review.

You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours if the following applies:

- It determines your life or health could be seriously harmed if the plan took the normal 14 days to respond.
- A doctor supports your request and indicates you could be harmed if the plan takes 14 days to respond.

If the plan denies what you asked for, the plan must tell you, in writing, why it won't provide or pay for a service, and how to appeal this decision. If you appeal the plan's decision, you may want to ask for a copy of your file containing medical and other information about your case. The plan may charge you for copying this information and sending it to you.

There are **5 levels** of appeal available to you. You should follow the order of the levels listed below and on page 27.

A. Appeal through your plan (called a “reconsideration”)

If you ask your plan to provide or pay for a service and your request is denied, you can request a reconsideration with your plan. You must request this appeal within 60 calendar days from the date of the organization determination (your plan's decision to pay for or provide a service). You or your representative must file a written standard request. Some plans will allow you to file a request by telephone. You, your appointed representative, or your doctor can call your plan or write to them for an expedited request. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be seriously jeopardized by waiting for a standard decision. Your plan's address is in your plan materials and will be in the notice containing any unfavorable organization determination decision. Once your plan gets your request for an appeal, the plan has 30 calendar days (for a standard service request), 60 calendar days (for a payment request), or 72 hours (for an expedited request) to notify you of its decision.

Section 4: Your Rights and Protections in a Medicare Advantage Plan or Medicare Cost Plan

Levels of Appeal: (continued)

B. Review by an Independent Review Entity (IRE)

If the plan again decides against you, your appeal is **automatically** sent to an IRE for review. The review will be expedited if the IRE determines that your life or health may be seriously jeopardized by waiting for a standard decision. The IRE has 30 calendar days (for a standard service request for coverage), 60 calendar days (for a payment request), or 72 hours (for expedited requests for coverage) to notify you of its decision.

C. Hearing with an Administrative Law Judge (ALJ)

If you disagree with the IRE's decision, you or your appointed representative can request a hearing with an ALJ. You must make the request in writing within 60 calendar days from the date of the notice of the IRE's decision. You must send your request to the location specified in the IRE's reconsideration notice. To get an ALJ hearing, the projected value of your denied coverage must meet the minimum dollar amount specified in the reconsideration notice (you may be able to combine claims to meet the minimum dollar amount). If the ALJ decides in your favor, the plan has the right to appeal this decision by asking for a review by the Medicare Appeals Council.

D. Review by the Medicare Appeals Council (MAC)

If you disagree with the ALJ's decision, you or your appointed representative can request a review by the MAC. You must make the request to the MAC in writing within 60 calendar days from the date of the notice of the ALJ's decision. You must send your request to the location specified in the ALJ's decision notice. The MAC doesn't review every case it gets. If they decide not to review your case, you or the plan may ask for a review by a Federal court.

E. Review by a Federal court

If you disagree with the MAC's decision, you or your appointed representative can request a review by a Federal court. You must make the request in writing, within 60 calendar days from the date of the notice of the MAC's decision. You must send your request to the location specified in the MAC's decision notice. To get a review by a Federal court, the projected value of your denied coverage must meet the minimum dollar amount stated in the MAC's decision.

Note: If you have drug coverage through a [Medicare Advantage Plan](#), see Section 5 for the appeal timeframes, which starts on page 35.

Section 4: Your Rights and Protections in a Medicare Advantage Plan or Medicare Cost Plan

5. Fast appeals in Hospitals

When you are admitted as an inpatient to a hospital, you have the right to get all the hospital care covered by the plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your inpatient hospital stay is no longer medically necessary. This section explains what to do if you believe that you are being discharged too soon.

Information you should get during your hospital stay

As part of the pre-admission process (but not more than 7 days before admission) or within 2 days of admission as an inpatient, someone at the hospital must give you a notice called “An Important Message from Medicare About Your Rights” (the “IM”). If you don’t get this notice, ask for it. This notice explains the following:

- Your right to get all medically-necessary hospital services paid for by the plan
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them
- Your right to get services you need after you leave the hospital
- Your right to appeal a discharge decision and have your hospital services paid for by the plan during the appeal (except for any applicable [copayments](#) or deductibles)
- Your potential financial liability for continuing to stay in the hospital after your discharge date

You or your representative will be asked to sign the IM. If the hospital gives you the IM more than 2 days before your discharge day, it must give you a copy of your signed IM before you are discharged.

Review of your hospital discharge by the Quality Improvement Organization (QIO)

You have the right to ask a QIO to review whether you are being discharged too soon. See pages 41–42 for their telephone number.

Section 4: Your Rights and Protections in a Medicare Advantage Plan or Medicare Cost Plan

5. (continued)

Getting QIO review of your hospital discharge

You must quickly contact the QIO. The IM gives the name and telephone number of the QIO and tells you what you must do. Ask the QIO for a fast review no later than the day you are discharged from the hospital. If you meet this deadline, you may stay in the hospital after your discharge date without paying for it (except for applicable [copayments](#) or deductibles) while you wait to get the decision from the QIO.

What will happen during the QIO's review?

When the QIO gets your request, the QIO will notify the plan and the hospital that you have requested a fast review. Once the plan and the hospital gets this notice from the QIO, the plan (or hospital) will give you a notice called the “Detailed Notice of Discharge” that includes the following:

- Explains why your services are no longer reasonable and necessary or are no longer covered
- Describes the applicable Medicare coverage rule or policy, including information on how you can get a copy of the policy
- Describes any applicable plan policy, contract provision or reason on which your discharge decision was based
- Explains how the applicable coverage rule applies to your specific situation

This detailed notice must be delivered to you or your appointed representative as soon as possible, but no later than noon of the day after the QIO notifies the plan and the hospital of your request for a fast review.

The QIO will look at your medical information provided by the plan and the hospital and will also ask for your or your appointed representative's opinion. The QIO will decide, within 1 day after getting the information it needs, if you are ready to be discharged on the date that has been set for you.

Section 4: Your Rights and Protections in a Medicare Advantage Plan or Medicare Cost Plan

5. (continued)

What happens if the QIO decides in your favor?

The plan will continue to cover your hospital stay for as long as it is medically necessary (except for applicable [copayments](#) or deductibles).

What happens if the QIO agrees with the discharge?

You won't be responsible for paying the hospital charges (except for applicable copayments or deductibles) until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you miss the deadline for asking the QIO for a fast review, you may appeal the discharge decision to your plan. If you have any questions about fast appeals in hospitals, call your [Medicare Advantage Plan](#) or [Medicare Cost Plan](#) (the telephone number is in the plan's benefit materials) or call the QIO at the telephone number listed on the notice the hospital gives you or see pages 41–42 for their telephone number. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

6. Fast Appeals in Other Health Care Settings

When you are a patient in a [skilled nursing facility \(SNF\)](#), with a [home health agency \(HHA\)](#), or in a [comprehensive outpatient rehabilitation facility \(CORF\)](#), you have the right to a fast [appeal](#) if you think that coverage for your services are ending too soon.

Section 4: Your Rights and Protections in a Medicare Advantage Plan or Medicare Cost Plan

6. (continued)

Information you will get while getting your SNF, HHA, or CORF services

Your provider will give you a notice called the “Notice of Medicare Non-Coverage” at least two days before covered services end. If you don’t get this notice, ask for it. This notice contains the following information:

- The date that your covered services will end
- An explanation of your financial liability if you continue getting services
- Information on your right to a fast appeal, including your right to submit evidence to support your case
- Information on your right to get a detailed notice about why your covered services are ending

You or your representative will be asked to sign and date this notice.

Getting the QIO to review the decision to end coverage

As explained in the notice you get from your provider, you can ask the QIO to do an independent review of whether it is medically appropriate to end coverage for your SNF, CORF, or HHA services.

How soon do you have to ask for QIO review?

You must ask the QIO for a review no later than noon of the day before the date that your Medicare covered services end. The notice you get from your provider will give the name and telephone number of your QIO and tells you what you must do.

Section 4: Your Rights and Protections in a Medicare Advantage Plan or Medicare Cost Plan

6. (continued)

What will happen during the QIO's review?

When the QIO gets your request, the QIO will notify the plan and the provider that you have requested a fast review. Once the plan gets this notice from the QIO, the plan will give you a notice called the “Detailed Explanation of Non-Coverage” that includes the following information:

- Why your services are no longer reasonable and necessary or are no longer covered
- The applicable Medicare coverage rule or policy, including information on how you can get a copy of the policy
- Any applicable plan policy, contract provision, or reason on which your discharge decision was based
- How the applicable coverage rule applies to your specific situation

The plan must send you this detailed notice by the end of the day on which the QIO notifies the plan of your request for a fast review.

The QIO will ask for your opinion about why you believe coverage for the services should continue. The QIO will also look at your medical records and the information provided by the plan. The QIO will make a decision by close of business the day after receiving the information it needs to make a decision.

What happens if the QIO decides in your favor?

The plan will continue to cover your SNF, HHA, or CORF services for as long as medically necessary (except for applicable [copayments](#) or deductibles).

Section 4: Your Rights and Protections in a Medicare Advantage Plan or Medicare Cost Plan

6. (continued)

What happens if the QIO agrees that your coverage should end?

You won't be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the "Notice of Medicare Non-Coverage" you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability.

If you miss the deadline for asking the QIO for a fast review, you may appeal the discharge decision to your plan. If you have questions about your rights regarding SNF, HHA, or CORF services, including appealing the QIO's decision, getting notices, or learning about your additional appeal rights after missing the filing deadline, call your health plan (their telephone number is in your plan materials), or call the QIO in your state (see pages 41–42). Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

7. File a grievance about other concerns or problems

You have a right to file a grievance if you have concerns or problems with your [Medicare Advantage Plan](#) or [Medicare Cost Plan](#). For example, if you believe your plan's hours of operation should be different, or there aren't enough specialists in the plan to meet your needs, you can file a grievance. Check your plan's membership materials or call your plan to find out how to file a grievance.

8. Call your Medicare Advantage Plan or Medicare Cost Plan

You should call your plan

- before you get a service or supply to find out if it will be covered. Your plan must tell you if you ask.
- to get information about skilled nursing facility coverage.
- if you have questions about home health care rights and protections.

9. Privacy of Personal Health Information

You have the right to have the privacy of your health information protected. For more information about your rights to privacy, look in your plan materials or call your plan.

Words in blue are defined on pages 43–46.



Section 5: Your Rights and Appeals in a Medicare Drug Plan

If your pharmacist or plan tells you that a drug you believe should be covered isn't covered, is covered at a higher cost than you think you are required to pay, or you have to meet a plan coverage rule (such as prior authorization) before you can get the drug you requested, you have the right to the following:

- Request a [coverage determination](#) from your plan, or
- Pay for the prescription, save your receipt, and request that the plan pay you back by requesting a coverage determination.

You, your doctor, or your appointed representative (see “Tip” below) can request a coverage determination.

Tip: Any person you appoint, such as a family member, friend, or your doctor, may help you request a coverage determination or an appeal. If you have questions about appointing a representative, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also get a copy of the “Appointment of Representative” form by visiting www.medicare.gov/basics/forms/default.asp on the web (CMS Form Number 1696).

You may file either a standard request or an expedited request for a coverage determination. Standard requests must be made in writing unless your plan accepts them by telephone (call your plan to find out if you can make a standard request by telephone). You can call or write your plan to file an expedited request. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be seriously jeopardized by waiting for a standard request. Once your plan has received the request, it has 72 hours (for a standard request for coverage or for a request to pay you back) or 24 hours (for an expedited request for coverage) to notify you of its decision.

Section 5: Your Rights and Appeals in a Medicare Drug Plan

Note: The plan will continue to cover your SNF, HHA, or CORF services for as long as medically necessary (except for applicable copayments or deductibles).

For some types of coverage determinations called “exceptions,” you will need a supporting statement from your doctor explaining why you need the drug you are requesting. You will need this statement for the following situations:

- You are requesting that the plan cover a drug that isn’t on its list of covered drugs (formulary)
- You want the plan to cover a non-preferred drug at the preferred drug price
- Your doctor believes that you can’t meet one of your plan’s coverage rules, such as a prior authorization, quantity limit, or dose limit

Check with your plan to find out if the supporting statement is required and if it must be made in writing. If a supporting statement is required, the plan’s decision-making time period begins once your plan gets the supporting statement.

If the plan decides against you, you can appeal the decision. There are **5 levels** of appeal available to you. You should follow the order of the levels listed on pages 37–38.

Note: When you join a Medicare drug plan, the plan will send you information about the plan’s appeal procedures. Read the information carefully and keep it where you can find it when you need it. Call your plan if you have questions.

Section 5: Your Rights and Appeals in a Medicare Drug Plan

Levels of Appeal:

1. Appeal through your plan (called a “redetermination”)

If you disagree with your plan’s coverage determination, you can file an appeal with the plan. The plan’s denial notice will explain how to file this appeal. Your plan materials also explain how to file this appeal. You must request this appeal within 60 calendar days from the date of the coverage determination.

Your or your appointed representative may file a standard redetermination request with the plan. Standard requests must be made in writing unless your plan accepts them by telephone (call your plan to find out if you can make a standard request by telephone). You, your appointed representative, or your doctor can file an expedited redetermination request with your plan. Expedited requests can be made by telephone or in writing. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be seriously jeopardized by waiting for a standard decision.

Once your plan gets your request for an appeal, the plan has 7 calendar days (for a standard request for coverage or for a request to pay you back) or 72 hours (for an expedited request for coverage) to notify you of its decision.

2. Review by an Independent Review Entity (IRE) (called a “reconsideration”)

If you disagree with the plan’s redetermination decision, you or your appointed representative can request a review by the IRE. You may make a standard or expedited reconsideration request. All requests must be made in writing within 60 calendar days from the date of the plan’s redetermination decision. The plan’s redetermination decision will explain how to request this appeal. Your request will be expedited if the IRE determines, or your doctor tells the IRE, that your life or health may be seriously jeopardized by waiting for a standard decision.

Once the plan gets the request for review, it has up to 7 days (for a standard request for coverage or for a request to pay you back) or 72 hours (for expedited requests for coverage) to notify you of its decision.

Section 5: Your Rights and Appeals in a Medicare Drug Plan

Levels of Appeal: (continued)

3. Hearing with an Administrative Law Judge (ALJ)

If you disagree with the IRE's decision, you or your appointed representative can request a hearing with an ALJ. You must make the request in writing within 60 calendar days from the date of the notice of the IRE's decision. You must send your request to the location specified in the IRE's reconsideration notice. To get an ALJ hearing, the projected value of your denied coverage must meet a minimum dollar amount (you may be able to combine claims to meet the minimum dollar amount). The IRE's decision will include this amount.

4. Review by the Medicare Appeals Council (MAC)

If you disagree with the ALJ's decision, you or your appointed representative can request a review by the MAC. You must make the request to the MAC in writing within 60 calendar days from the date of the notice of the ALJ's decision. You must send your request to the location specified in the ALJ's decision notice.

5. Review by a Federal court

If you disagree with the MAC's decision, you or your appointed representative can request a review by a Federal court. You must make the request in writing within 60 calendar days from the date of the notice of the MAC's decision. You must send your request to the location specified in the MAC's decision notice. To get a review by a Federal court, the projected value of your denied coverage must meet the minimum dollar amount stated in the MAC's decision.

Privacy of Personal Health Information

You have the right to have the privacy of your health and prescription drug information protected. For more information about your right to privacy, look in your plan materials or call your plan.

Section 5: Your Rights and Appeals in a Medicare Drug Plan

What if I have a complaint about my Medicare drug plan?

You have the right to file a complaint (called a “grievance”) with the plan. You must file your complaint within 60 calendar days of the date of the event that led to your complaint. Some examples of why you might file a complaint include the following:

- You believe your plan’s customer service hours of operation should be different
- You have to wait too long for your prescription
- The pharmacy is charging you more than you think you should have to pay. If you think you were charged too much for a prescription, call the company offering your plan to get the most up-to-date price. If the plan doesn’t take care of your complaint, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The company offering your plan is sending you materials that you didn’t ask to get and aren’t related to the drug plan
- The plan doesn’t give you a decision about a coverage determination (see page 35) or first-level appeal (see Appeal Level Number 1 on page 37) within the required timeframe
- The plan didn’t make a decision about a coverage determination or first-level appeal within the required timeframe and didn’t send your case to the IRS
- You disagree with the plan’s decision not to grant your request for an expedited coverage determination or first-level appeal
- The plan didn’t provide the required notices
- The plan’s notices don’t follow Medicare rules

Section 5: Your Rights and Appeals in a Medicare Drug Plan

What if I don't agree with Medicare's late-enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, you may have to pay a late-enrollment penalty unless you had prescription drug coverage that was at least as good as Medicare's ("creditable coverage"). You have the right to ask Medicare to look at, or reconsider, your late-enrollment penalty. This is called a "reconsideration."

Some examples of why you may request reconsideration of your late-enrollment penalty include the following:

- You don't think Medicare counted all of your previous creditable prescription drug coverage, or
- You didn't get a notice that clearly explained whether your previous drug coverage was creditable.

Your Medicare drug plan will give you a reconsideration request form when it sends you the letter telling you that you have to pay a late-enrollment penalty. Complete the request form. Mail the form to the address or fax it to the number listed on the form within 60 days from the date on the letter you got stating you had to pay a late-enrollment penalty.

You should also send any proof that supports your case, like information about previous creditable prescription drug coverage.

If you need more information about requesting reconsideration of your late-enrollment penalty, call your Medicare drug plan. You also may visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for help. TTY users should call Medicare at 1-877-486-2048.

Words in blue are defined on pages 43–46.

Section 6: For More Information

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the [Helpful Contacts](#) section of our web site. Thank you.

Section 6: For More Information

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the [Helpful Contacts](#) section of our web site. Thank you.

Section 7: Words to Know

Appeal—A special kind of complaint you make if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if you request a health care service, supply, or prescription that you think you should be able to get, or if you request payment for health care you already got, and Medicare or your plan denies the request. You can also appeal if you are already getting coverage and Medicare or the plan stops paying.

Coinsurance—An amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible. In a Medicare Prescription Drug Plan, the coinsurance will vary by plan and will depend on how much you have spent.

Comprehensive Outpatient Rehabilitation Facility—A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

Copayment—An amount you pay in some Medicare health and prescription drug plans, for each medical service, like a doctor's visit, or prescription. A copayment is usually a set amount. For example, you could pay \$10 or \$20 for a doctor's visit or prescription. Copayments are lower for people with Medicaid and people who qualify for extra help. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Coverage Determination—The first decision made by a Medicare drug plan (not the pharmacy) about the drug benefits you may be entitled to get, including decisions about the following:

- Whether to provide or pay for a drug
- An exception request you may have made
- The amount you have been asked to pay for a drug
- Whether you have satisfied a coverage rule for a requested drug

If the Medicare drug plan doesn't give you a prompt decision, and you can show that the delay would affect your health, the plan's failure to act is considered to be a coverage determination. If you disagree with the coverage determination, the next step is an appeal.

End-Stage Renal Disease (ESRD)—Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Section 7: Words to Know

Exception—A type of coverage determination. A formulary exception is a decision to cover a drug that's not on the formulary or a decision to waive a coverage rule. A tiering exception is a decision to charge you a lower amount for a drug that is on the non-preferred drug tier. Your doctor must send a supporting statement explaining the medical reason for the exception.

Grievance—A complaint about the way your Medicare Health Plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved towards you. A grievance isn't the way to deal with a complaint about a service, supply, or prescription that isn't covered (see Coverage Determination, Exception, and Appeal).

Guaranteed Issue Rights (also called "Medigap Protections")—Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy or place conditions on a Medigap policy, such as exclusions for pre-existing conditions, and can't charge you more for a Medigap policy because of past or present health problems.

Health Maintenance Organization Plan (Medicare)—A type of Medicare Advantage Plan (Part C) available in some areas of the country. Plans must cover all Part A and Part B health care. Many HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your costs may be lower than in the Original Medicare Plan.

Home Health Agency—An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.

Home Health Care—Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech language pathology services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services covered under Medicare Part A and Part B.

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. Hospice care is covered under Medicare Part A (Hospital Insurance).

Section 7: Words to Know

Inpatient Hospital Care—Health care that you get when you are admitted to a hospital.

Medicare Advantage Plan—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. Also called “Part C,” 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 are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and aren’t paid for under the Original Medicare Plan. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Cost Plans—A type of health plan. 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 the Original Medicare Plan (your Cost Plan pays for emergency services, or urgently needed services).

Medicare Medical Savings Account (MSA) Plans—MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare in the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Summary Notice—A notice you get after your doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medigap Policy—Medicare supplement insurance sold by private insurance companies to fill “gaps” in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan.

Medigap Open Enrollment Period—A one-time-only, 6 month period when Federal law allows you to buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B **and** you are age 65 or older. During this period, you can’t be denied a Medigap policy or charged more due to past or present health problems. Some states may have additional open enrollment rights under state law.

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

Section 7: Words to Know

PACE (Programs of All-inclusive Care for the Elderly)—A program that combines medical, social, and long-term care services to help frail people stay independent and living in their community as long as possible, while getting the high-quality care they need. PACE is available only in states that have chosen to offer it under Medicaid.

Preferred Provider Organization Plan (Medicare)—A type of Medicare Advantage Plan (Part C) available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost. Many Medicare Advantage Plans are PPOs.

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

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

Quality Improvement Organization—A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to people with Medicare.

Skilled Nursing Facility—A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitative services and other related health services.

Skilled Nursing Facility Care—This is a level of care that requires daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (such as help with activities of daily living, like bathing and dressing) can't qualify you for Medicare coverage in a skilled nursing facility if that's the only care you need. However, if you qualify for coverage based on your need for skilled nursing care or rehabilitation, Medicare will cover all of your care needs in the facility, including help with activities of daily living.

Special Needs Plan—A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

State Health Insurance Assistance Program—A State program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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