2017 MEDICARE
Basic Toolkit

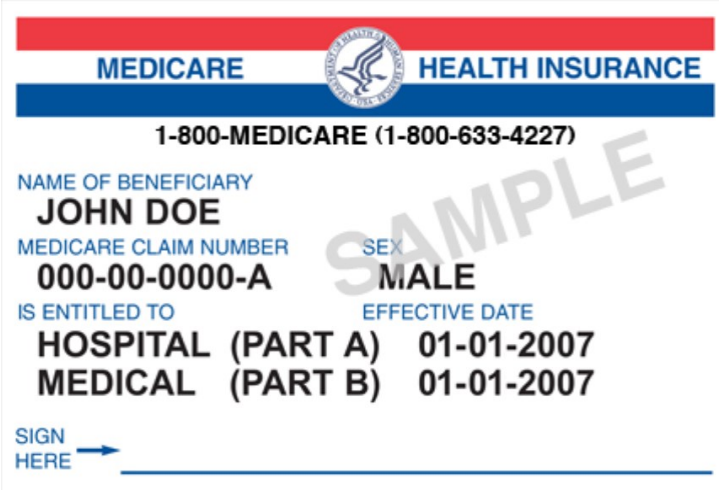
Medicare can be complicated, but we have the answers.

Provided by Arkansas SHIIP, a program funded by the federal government to educate and empower Arkansans to make informed decisions about their healthcare benefits.

SHIIP counselors provide free, confidential, objective health insurance information and one-on-one counseling for Medicare beneficiaries and their families or caregivers.

If you are eligible for Medicare, you are eligible for SHIIP counseling.

SHIIP counselors are not connected with any insurance company, are not licensed to sell insurance, and do not provide legal advice. They will not make decisions for you, but will help you make your own healthcare decisions in your best interest.



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Our job is to help Medicare beneficiaries make informed decisions about Medicare.

Call SHIIP for Medicare help – 1-800-224-6330

ARKANSAS SHIIP
Senior Health Insurance Information Program

What is Medicare?

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

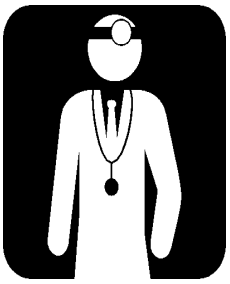
Medicare has Four Parts – A, B, C and D.

PART A

H

(Hospital Insurance)
Helps pay for:
- Inpatient hospital stay
- Skilled nursing or rehabilitation facility care
- Hospice care
- Home health care

PART B



(Medical Insurance)
Helps pay for:
- Services from doctors and other healthcare providers
- Outpatient surgery and tests
- Home health care
- Durable medical equipment (DME) such as wheelchairs, walkers, diabetic test strips, lancets and meters
- Some preventive services. (see page 15)

PART C MEDICARE ADVANTAGE

Replaces Medicare A & B
- Buy from a private insurance company
- Possible vision, dental or hearing coverage
- May pay premium in addition to Part B
- May require a network of providers

PART D

Helps cover cost of prescription drugs
- Managed by Medicare approved private insurance companies
- See page **11** for more information

Guard your Medicare number from fraudsters and identity thieves.

Do not carry your Medicare Card and do not give your number to anyone who contacts you by phone, email or in person, unless you have given them permission

Medicare will never contact you for your Medicare number or other personal information. **See pages 17& 19 for more about Medicare fraud, waste and abuse.**

If your card is damaged, lost or stolen, contact the S. S. Administration for a replacement at **www.ssa.gov** or call **1-800-772-1213.**

What are my Medicare coverage choices?

You can receive your Medicare benefits through either Original Medicare (Part A and Part B) or a Medicare Advantage plan. If you choose Original Medicare, you can also purchase: (1) Secondary or supplemental insurance such as Medigap or a Group Health Insurance plan (GHI), and/or (2) Prescription drug coverage (Part D or GHI).

Option 1

ORIGINAL MEDICARE
(Part A and Part B)

+

Secondary Insurance (Supplimental/Medigap)

+

Prescription Drug Coverage

OR

Option 2

MEDICARE ADVANTAGE
(Part C)

Hospital
Medical
Prescription Drug Coverage

Where can I get my questions answered?

Get general or claims-specific Medicare information, find a doctor or hospital, request documents in a different format, and make changes to your Medicare coverage. If you need help in a language other than English or Spanish, say "Agent" to talk to a customer service representative.

1-800-MEDICARE (**1-800-633-4227**)

TTY number: **1-877-486-2048**

Website: **www.medicare.gov**

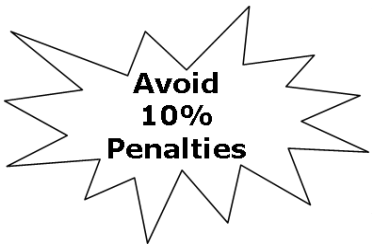
How and When do I enroll in Medicare?

If you're close to 65, and not getting Social Security or Railroad Retirement Board (RRB) benefits, you will have to sign up. Contact Social Security 3 months before you turn 65.

Medicare enrollment is automatic **only** if you are already receiving Social Security or a RRB benefits check. A red white and Blue Medicare card will be sent to you 3 months before your 65 birthday or the 25th month of disability benefits.

General Enrollment Information

When you are first eligible for Medicare, you have a 7-month **Initial Enrollment Period** to sign up for Part A and/or Part B (3 months before to 3 months after your 65th birthday).



When you apply for Medicare, you can sign up for Parts A & B. You must pay a premium for Part B, However, you can turn it down. If you decide to enroll in Part B later on, you may have to pay a **monthly late enrollment penalty for as long as you have Part B coverage** and could have a gap in your health coverage.

Your premium will go up 10% for each 12-month period you were eligible for Part B, but did not sign up for it, unless you qualify for a special enrollment period due to a life changing event:

- You or your spouse still work and are covered under a group health plan, or
- You are receiving Social Security disability benefits and are covered under a group health plan.
- Qualify for Medicare Savings Program (MSP)

If you did not sign up for Part A (if you have to buy it) and/or Part B (for which you must pay a premium) during your **Initial Enrollment Period**, you can sign up **between January 1 and March 31** each year. **Your coverage will not start until July 1 of that year.**

Medicare health and drug plans can make changes each year in cost, covered services, and which providers and pharmacies are in their networks. Plans can also change their provider networks throughout the year.

You do not need to sign up for Medicare each year. You should review your coverage and make changes during the **Open Enrollment Period (October 15 – December 7).**

New coverage will begin on January 1, 2018.

Shop and compare plans every year.

Use the Medicare Plan finder at **www.medicare.gov** or

Call SHIIP for help – 1-800-224-6330.

NO WAITING! APPLY ONLINE

Social Security Administration Website – **www.ssa.gov/medicare**

OR

Call Social Security at 1-800-772-1213 (TTY at 1-800-325-0778)

Medicare Internet Resources

www.medicare.gov

- Compare Drug Plans (Part D)
- Compare Medicare Advantage Plans (Part C)
- Compare Hospitals
- Compare Nursing Homes
- Compare Home Health Agencies
- Order a replacement Medicare card

www.mymedicare.gov

- Create an account
- Manage personal Medicare information via a secure website:
- Review eligibility, entitlement and plan information
- Track preventive services
- Keep a prescription drug list
- Complete Authorization Forms

Part A Hospital insurance covered services and costs

Services	Benefits	Medicare pays	You pay
Hospitalization Semi-private room, general nursing, miscellaneous services and supplies	First 60 days	All but $1,316 deductible	$1,316 deductible
	61st to 90th day	All but $329 per day	$329 per day
	91st to 150th day	All but $658 per day	$658 per day
	Beyond 150 days	Nothing	All charges
POST-HOSPITAL Skilled Nursing Facility (SNF) Care after a 3-night inpatient hospital stay	First 20 days	100% of approved	Nothing if approved
	21st to 100th day	All but $164.50 per day	$164.50 per day
	Beyond 100 days	Nothing	All costs
Home Health Care following a 3-night inpatient hospital or SNF stay	Part-time care as long as you meet guidelines	100% of approved; 80% of approved amount for durable medical equipment	Nothing for services if approved; 20% of approved amount for DME
Hospice Care Full scope of pain relief and support services for the terminally ill	As long as doctor certifies need	All but limited costs for drugs & inpatient respite care	Limited cost sharing
Blood	Blood	After first 3 pints	First 3 pints

A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 consecutive days.

Part B Medical covered services and your cost

Services	Medicare pays	You pay
Medical Expense Physician services and medical supplies in and out of the hospital	80% of approved amount (after $183 deductible)	20% of approved amount (after $183 deductible)
Clinical Laboratory diagnostic tests	100% of approved	Nothing if approved
Home Health Care Medically necessary skilled care, home health aide services, medical supplies, etc. after a 3-day inpatient hospital stay Requires a prescription	100% of approved	Nothing if approved
Outpatient Hospital Treatment Unlimited if medically necessary	80% of approved	20% of approved amount (after $183 deductible)
Durable Medical Equipment Prescribed by a doctor for use in home	80% of approved amount (after $183 deductible)	20% of approved amount (after $183 deductible)
Blood	80% of approved amount (after $183 deductible) and after the first 3 pints	20% of approved amount (after $183 deductible) and after payment of the first 3 pints

What is NOT covered by Part A and Part B?

Medicare does not cover everything. If you need certain services that are not covered under Medicare Part A or Part B, you will have to pay for them yourself unless:

You have other coverage (Medicaid or private insurance) to cover the costs, or you are in a Medicare Advantage plan that covers these services.

Medicare and most health insurance plans do not pay for long-term care (non-medical care for people who have a chronic illness or disability. This includes non-skilled personal care assistance such as help with activities of daily living such as dressing, bathing, and using the bathroom).

Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and/or copayments. **X** **Medicare does not cover:X**

- **X** Long-term care
- **X** Dentures or Dental care
- **X** Hearing aids
- **X** Eye Wear
- **X** Eye examinations for glasses
- **X** Cosmetic surgery

Common terms – What do they mean?

Beneficiary: someone who has healthcare insurance through Medicare or Medicaid

Copayment (copay): a fixed amount you pay for a covered healthcare service after you have paid your deductible

Deductible: the amount you must pay for covered healthcare services before your insurance plan starts to pay (For example: with a $2,000 deductible, you pay the first $2,000 of covered services yourself.)

Durable Medical Equipment (DME): reusable medical equipment like wheelchairs, walkers, crutches, hospital beds, home oxygen equipment, diabetic testing meters and supplies

Health Insurance Marketplace: a comparison-shopping area that allows people to buy private health insurance that best meets their needs.

Medicare assignment: an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and copay.

Minimum essential coverage: coverage that you must have to meet the individual responsibility requirement under the health care law.

Prior authorization: You and/or your prescriber must contact the drug plan before you can fill certain prescriptions.

Medicare Premiums

Medicare Part A Premium

If you or your spouse worked at least 10 years and paid payroll taxes, there is no monthly premium for Part A. However, there is a 10% penalty for late enrollment.

For those who did not work long enough to get Medicare Part A for free, the monthly ***premium is $413.00*** *or a lesser amount based on the length of time worked.*

Medicare Part B Premium if new to Medicare in 2017

If Yearly Income is:		Monthly Premium Payment
File Individual Tax Return	**File Joint Tax Return**	
$85,000 or below	$170,000 or below	$134.00 per month
$85,001-$107,000	$170,001-$214,000	$187.50 per month
$107,001-$160,000	$214,001-$320,000	$267.90 per month
$160,001-$214,000	$320,001-$428,000	$348.30 per month
Above $214,001	Above $428,001	$428.60 per month

How does my other insurance work with Medicare?

When you have other insurance (Ex: employer group health coverage) and Medicare, there are rules that decide whether Medicare or your other insurance pays first.

Who Pays First?	
If you have retiree insurance from your or your spouse's former employment	Medicare pays first
If you are 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees	Your group health plan pays first
If you are 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has less than 20 employees	Medicare pays first
If you are under 65 and disabled, have group health plan coverage based on your or your spouse's current employment, and the employer has 100 or more employees	Your group health plan pays first
If you are under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has less than 100 employees	Medicare pays first
If you have Medicare because of your group health plan and have End-Stage Renal Disease (ESRD)	Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Then Medicare will pay first after this 30-month period

Facts to Remember

- ⇒ The insurance that pays first (primary payer) pays up to the limits of its coverage
- ⇒ The insurance that pays second (secondary payer) only pays if there are costs the primary insurer did not cover
- ⇒ The secondary payer might not pay all of the uncovered costs (expenses not covered by Medicare are not covered by secondary insurances)
- ⇒ Medicare might pay second if you are in an accident or have a workers' compensation case in which other insurance covers your injury and pays first. In these situations, you or your lawyer should contact Medicare as soon as possible
- ⇒ Tricare for Life (TFL) requires the Medicare Beneficiary to enroll in Part A and Part B

Medicare Advantage (MA) Part C

What is it?

- A Medicare Health Plan or Medicare Replacement Plan sold by a private insurance company with Medicare approval
- Replaces original Medicare Part A and Part B (no need for Medigap)
- May offer added benefits such as vision, dental, hearing or transportation. Be sure to get specific coverage details in writing.
- Most plans require use of certain doctors and hospitals (a provider network). You will have to pay more or even all the cost of your health care to use out-of-network doctors or hospitals.

What is the cost?

- You still must pay Medicare Part B premiums ($109/$134 in 2017).
- You may have to pay an additional premium to the MA company (The premium varies by plan).
- Usually pay per-visit copayments for medical services instead of Original Medicare's 20% copayment

What does it pay?

- MA plans must cover the same benefits as Original Medicare, but the coverage and costs (deductibles and copays) vary.
- Some plans include drug coverage (Part D); vision, hearing and/or dental coverage; home delivered meal after surgery, and gym membership.

What is the advantage?

Plans may include **additional benefits.** Many of the dental and hearing benefits are preventive, which means they pay for teeth cleaning or hearing exams, but not for dentures or hearing aids. **Ask questions about what the policy will pay and get a list of benefits in writing. Request a Summary of Benefits for the plan.** **Cost sharing** may be less expensive for some. For example, Original Medicare hospital coverage requires a deductible of $1,316.00 in 2017. An MA Plan might change the cost sharing so the patient pays $295 per day for the first five days. If patients stay two days, they owe $590 instead of the Original Medicare deductible of $1,316. If patients stay five days, they owe $1,475 instead of the Original Medicare deductible of $1,316.

Two programs can help you with Medicare costs if you have limited income and resources

1 Medicare Savings Programs pay Medicare Premiums

There are 4 types of Medicare Savings benefits:

1. **AR Seniors -** helps pay for Part A and/or Part B premiums, deductibles, coinsurance, copayments, and full Medicaid benefits (must be 65 or older).
2. **Qualified Medicare Beneficiary (QMB) Program** – helps pay for Part A and/or Part B premiums, deductibles, coinsurance, copayments, copays for managed care, and a Medicaid card.
3. **Specified Low-Income Medicare Beneficiary** (SMB) Program – helps pay Part B premiums and the Part B late enrollment penalty.
4. **Qualifying Individual (QI-1) Program** – helps pay Part B premiums and late enrollment penalty.

These programs are different in every state and each has different income and asset levels to qualify.

2 Extra Help pays for prescription drugs (Part D)

If you qualify for **Extra Help** and join a Medicare drug plan, you will get help to pay your Medicare drug plan's monthly premium, yearly deductible, coinsurance, and copayments.

With **Extra Help**, there will be no coverage gap (donut hole) and no late enrollment penalty. You can also switch drug plans at any time.

Medicare will mail you a **PURPLE LETTER** if you are qualified for **Extra Help**. Keep the letter for your records. You will not need to apply.

You automatically qualify for **Extra Help** if you have Medicare and meet any of these conditions:

- ✓ You have full Medicaid coverage
- ✓ You get help from a Medicare Savings Program
- ✓ You get Supplemental Security Income (SSI) benefits

Income and asset levels can change every year.

Call SHIIP – 1-800-224-6330

Medicare Drug Coverage (Part D)

Do you need Part D?

Yes, unless you have ***"creditable coverage,"*** – prescription drug coverage through a current or former employer, union, or the Veterans Administration as good as Medicare Part D.

Remember, there is a penalty for late enrollment. In most cases, you have to pay this penalty for as long as you have a Medicare drug plan, even if you switch plans.

Things to consider:

Total Annual Cost— amount you pay yearly

Monthly premium— amount you pay each month in addition to your Part B premium.

Deductible— amount you pay for your drugs before your insurance begins to pay.

Copayment (Coinsurance)— amount you pay for your drugs after the deductible.

Choose coverage through a Medicare drug plan or a Medicare Advantage Plan.

If you have a MA plan that includes prescription drug coverage and you join a Medicare Prescription Drug Plan, you will be dis-enrolled from your MA plan and returned to Original Medicare.

Plan Restrictions:

Quantity Limit — number of pills or amount of medication covered over a certain period of time.

Step Therapy— plans may require you to first try a less expensive drug to treat your medical condition before they will cover a more expensive drug for that condition.

Prior Authorization— an approval from your insurance plan before you can fill your prescription.

The Plan's Formulary – (see next page 12)

When can you enroll or switch a Medicare drug plan?

- When you first become eligible for Medicare during your Initial Enrollment Period
- During Open Enrollment, between October 15 and December 7 each year (your coverage will begin on January 1 of the following year)
- At any time if you qualify for Extra Help (see page 10).

Special Enrollment Periods apply – when you move out of your plan's service area, lose other creditable coverage, live in an institution (Ex: a nursing home), have Medicaid, qualify for Extra Help or the Medicare Savings Program. You can switch to a new Medicare drug plan simply by enrolling in another drug plan. Your

What is a Formulary?

A FORMULARY is a list of drugs covered by a Medicare prescription drug plan. ***Each plan has its own formulary and the formulary can change from year to year.***

Shop and compare plans every year. Drug costs (premiums, deductibles and formularies) change every year. Contact the plan to find out its current formulary or visit the plan's website. Your plan should notify you if there are any formulary changes.

Use the **Medicare Plan Finder** at **Medicare.gov/find-a-plan**

OR

Call 1-800-MEDICARE (1-800-633-4227)
TTY users should call 1-877-486-2048

OR

Call SHIIP for help 1-800-224-6330

Many Medicare drug plans place drugs into different "tiers" or "levels" with different costs. Generally, the higher the tier, the higher the cost. HOWEVER, if your doctor thinks you need a drug in a high tier instead of a similar drug in a lower tier, he/she can ask your plan for an exception to get a lower copayment for that drug.

Each month that you fill a prescription, your drug plan will mail you an **Explanation of Benefits (EOB) notice.** This will give you a summary of your prescription drug claims and your costs. Review your notice and check it for mistakes. Contact your plan if you have questions or find mistakes.

Medicare Coverage Gap (Donut Hole)

Most Medicare drug plans have a coverage gap, the "donut hole". Your drug costs may not be high enough for you to be affected. The gap begins after you and your drug plan together have spent $3,700.00 for covered drugs. In 2017, once you enter the coverage gap, you pay 40% of the plan's cost for covered brand-name drugs and 51% of the plan's cost for covered generic drugs until you reach the end of the coverage gap of $4,950.00.

You will automatically receive ***CATASTROPHIC COVERAGE*** once you get out of the donut hole. This means that you will only have to pay a coinsurance amount or copayment for covered drugs for the rest of the year.

Medicare Annual Open Enrollment
OCT. 15 – DEC. 7

Medicare Supplement Insurance (Medigap)

What is it?

- Secondary health insurance that **only** pays after Original Medicare A and B
- Only pays the 20% for care and services **NOT** covered by Medicare Part A and Part B
- Sold by private insurance companies
- Not allowed with Medicare Advantage (Part C)

A guide to all companies approved to sell health insurance in Arkansas called **Bridging the Gap** is available from SHIIP or on SHIIP's website – **www.arkansas.insurance.gov.**

When can you apply?

APPLY ANYTIME. Unlike Medicare Drug and Advantage Plans, there is no specific time of year to buy a Medicare Supplement Policy.

age 65 or older

Medigap for Medicare recipients age 65 or older

The **Medigap Open Enrollment Period** is a 6-month period when an insurance company must issue a policy regardless of medical history, health status, or prior claims. The Medigap Open Enrollment Period begins on your first day of Medicare Part B enrollment at age 65 or older. Enrolling in Part B starts the Medigap Open Enrollment Period.

under age 65

Medigap for Medicare recipients under age 65

Younger Medicare beneficiaries may be denied a policy based on their prior medical history. There is no assurance that those under age 65 will be issued a Medigap Policy.

NOTE

Retiree insurance may pay 20% after Medicare, like Medigap does. Check with your Human Resources Department before enrolling in a Medigap Plan. Other retiree benefits – such as life, dental, hearing or vision insurance may be affected.

Medicare and the Health Insurance Marketplace

The Health Insurance Marketplace provides a way for people who do not have health insurance through a job or a federal program to get health coverage. **The Marketplace does not offer Medicare health plans, Medicare drug plans (Part D), or Supplement Insurance (Medigap) policies. Medicare is not part of the Marketplace.**

Is Medicare coverage "minimum essential coverage"?
As long as you have Medicare Part A coverage (or coverage from a Medicare Advantage Plan), you have minimum essential coverage and you do not have to get any additional coverage. If you only have Medicare Part B, you are not considered to have minimum essential coverage. ***This means you may have to pay a fee for not having minimum essential coverage when you file your federal income tax return.***

Can I get a Marketplace plan instead of Medicare, or can I get a Marketplace plan in addition to Medicare?
Generally, no. It is against the law for someone who knows you have Medicare to sell you a Marketplace plan because that would duplicate your coverage. HOWEVER, if you are employed and your employer offers employer-based coverage through the Marketplace, you may be eligible for this type of coverage.

What if I become eligible for Medicare after I join a Marketplace plan?
If you have a Marketplace plan, you can keep it until your Medicare coverage starts. Then, you can terminate the Marketplace plan without penalty. Visit **HealthCare.gov** to find out how to terminate your Marketplace plan.

Note: If you've been getting premium tax credits or other savings on a Marketplace plan, your eligibility for these savings will end once your Medicare Part A coverage starts.

To learn more about how Medicare works with the Marketplace, visit HealthCare.gov and Medicare.gov.

Part B Preventive & Screening Services

- Abdominal aortic aneurysm screening
- Alcohol misuse screenings & counseling
- Bone mass measurements
- Cardiovascular disease screenings
- Cardiovascular disease (behavioral therapy, one-time visit)
- Cervical & vaginal cancer screening
- Depression screenings
- Diabetes screenings
- Diabetes self-management training
- Glaucoma tests
- Lung cancer screening
- Hepatitis C screening test
- HIV screening
- Lung cancer screening

- Mammograms (screening)
- Nutrition therapy services
- Obesity screenings and counseling
- One-time “Welcome to Medicare” preventive visit
- Prostate cancer screenings
- Sexually transmitted infections screening & counseling
- Tobacco use cessation counseling
- Yearly "Wellness" visit

Shots:

- Flu shots
- Hepatitis B shots
- Pneumonia shots

For more detailed information about Part B preventive & screening services, Please visit Medicare.gov website.

1-800-633-4227

Medicare Rights and Protections

What are my Medicare rights?

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Your personal and health information kept confidential
- Have questions about Medicare answered
- Have access to doctors, other healthcare providers, specialists, hospitals, and get emergency care when needed.
- Get information from Medicare, healthcare providers, and Medicare contractors about your treatment choices in clear language, in a format you understand, and to participate in treatment decisions
- Request a review (appeal) of certain decisions about healthcare payments, coverage of services, or prescription drug coverage
- File complaints (or grievances), including complaints about the quality of your care
- Get a decision about a healthcare payment, coverage of services, or prescription

Who protects my Medicare rights?

KEPRO is the Medicare Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Arkansas.

If you are not satisfied with the quality of care you receive, you can:
Call the KEPRO Medicare Beneficiary Helpline – 844-430-950 toll free OR download a quality of care complaint form (in English or Spanish) at:
www.keproqio.com/bene/qualityofcarecomp.aspx

Send complaint forms to KEPRO by:

Fax: 844-878-7921

Email: beneficiary.complaints@hcqis.org

Mail: Rock Run Center, Suite 100
5700 Lombardo Center Drive
Seven Hills, OH 44131
Attention: Beneficiary Complaints

Examples of Poor Quality Care:

- Your condition was misdiagnosed
- You got the wrong medication or an overdose of medication
- Your surgery or diagnostic testing was unnecessary
- You had a change in your condition that was not treated
- You did not get complete discharge instructions from the hospital

What is an Advanced Beneficiary Notice of Noncoverage (ABN)?

To protect you from unexpected bills, Medicare requires healthcare providers to give you in a written notice if they think Medicare will not pay for an item or service. It will give you the cost of the item or service so you can decide whether to pay for it or not.

How do I file an Appeal?

You can appeal a denied item or service if you think Medicare should pay but did not or if you think Medicare did not pay the right amount.
Review your Medicare Summary Notice (MSN) that shows the item or service you are appealing and follow the directions on the MSN to appeal within 120 days of the date you receive the MSN in the mail. You should receive a decision from the Medicare Administrative Contractor (MAC) within 60 days after they receive your request. If Medicare will cover the item(s) or service(s), it will be listed on your next MSN.

What if I think my services are ending too soon or I am denied admission to the hospital?

You can ask for a **fast appeal** – an immediate review by the BFCC-QIO.For more information, visit **Medicare.gov/appeals** or

Call SHIIP – 1-800-224-6330.

Protect yourself from identity theft

Identity theft happens when someone uses your personal information (your name and your Social Security, Medicare, credit card, or bank account numbers) without your consent to commit fraud or other crimes.

Guard your cards and protect your Medicare and Social Security numbers. Only give your Medicare number and personal information to doctors, other healthcare providers, Medicare-approved plans; your insurance company; and trusted people in the community who work with Medicare such as SHIIP or Social Security.

Call 1-800-MEDICARE (1-800-633-4227) to find out if a provider is approved by Medicare. TTY users should call 1-877-486-2048.

If you suspect identity theft, call your local police department and the Federal Trade Commission's **ID Theft Hotline at 1-877-438-4338.**

TTY users should call 1-866-653-4261.

Visit **ftc.gov/idtheft** to learn more about identity theft.

Medicare plans must follow certain rules for marketing and enrollment. They cannot ask you for credit card or banking information over the phone or via email, unless you are already a member of that plan. They cannot enroll you into a plan by phone unless you call them and ask to enroll, or you have given them permission to contact you.

Call 1-800-MEDICARE (1-800-633-4227) to report any plans that: ask for your personal information over the phone or email, call to enroll you in a plan, or use false information to mislead you .

Any Questions?

Why do I need Medicare supplement insurance?

Original Medicare does not pay all medical expenses. Medicare supplement policy, also known as Medigap insurance, fills most of the Medicare coverage gaps.

Does Medicare cover care in a nursing home?

Medicare does not cover long-term care in a nursing home. However, you may be covered for short stays. You must meet certain pre-entrance requirements in order to qualify for benefits. If you are eligible, Medicare will pay for skilled care for the first 20 days and a certain amount each day for days 21 through 100.

After 100 days per benefit period, Medicare pays nothing.

Does Medicare cover home health care?

Yes, but only if your doctor orders part-time skilled care and you are homebound. If you meet these requirements, Medicare pays 100% of the cost of home health care.

Will Medicare pay for outpatient prescriptions, hearing aids, dentures, eyeglasses, etc.?

Original Medicare (Part A and Part B) covers very little prescription medication. Medicare Part D, the prescription drug benefit, is available through stand-alone plans or through most Medicare Advantage plans.

Original Medicare does not cover hearing aids, dental procedures or routine eye exams. Medicare Advantage plans may provide some coverage for these extra benefits.

Does Medicare cover diabetic supplies?

Yes, Medicare covers test strips, lancets, the machine used to test blood sugar levels, batteries and calibration solution for the machine. Medicare also covers outpatient self-management education and diabetic shoes.

Does Medicare pay for physical therapy?

Yes, Medicare Part B pays 80% of the approved amount for outpatient physical therapy up to a maximum. Medicare Part A may also cover physical therapy during inpatient stays.

Can my doctor insist that I pay for care up front before Medicare pays?

Yes, but only if your doctor does not accept assignment. If your doctor participates with Medicare, he or she can collect the deductible and copayment. If your doctor does not accept assignment, he or she cannot charge you more than the Medicare approved amount.

Find a doctor or healthcare provider who accepts Medicare Assignment

For a list of providers in your area, go to the **Medicare.gov Physician Compare website** at: **https://www.medicare.gov/physiciancompare/search.html.**

Enter your zip code in the "Location" box and the type of healthcare professional you are looking for in the "What are you searching for?" box (for example, primary care physician, nurse practitioner) and click on "search". In the box on the right of the screen labeled "Medicare assignment," click on the circle that says "Show only those accepting the Medicare-approved amount."

No Internet access? **Contact the potential Healthcare provider's office to ensure they accept Medicare assignment.**

Medicare Fraud, Waste & Abuse

Medicare fraud occurs when healthcare services are deliberately misrepresented, resulting in unnecessary cost to the program, improper payments to providers, or overpayments. Examples are billing for services that were never provided or billing for a service at a higher rate. ***Medicare abuse*** occurs when providers supply services or products that are medically unnecessary or do not meet professional standards.

What Does it Cost and Who Pays?

The estimated cost of healthcare fraud is over $13 billion annually for Medicare alone. ***Healthcare fraud*** affects every taxpayer, but it is not just a matter of dollars and cents. Poor care can affect a patient's functional level and extend his/her need for services. Loss of money to fraud and abuse means that less money is available for necessary services and programs to assist caregivers.

Check your **Medicare Summary Notice** quarterly to detect and report potential fraud and abuse. Sign up for **www.mymedicare.gov** to check claims regularly.

The **Arkansas Senior Medicare Patrol (SMP)**
can help with suspected Medicare fraud.
Call 1-866-726-2916.

Allen Kerr, Commissioner

Dan Honey, Deputy Commissioner

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