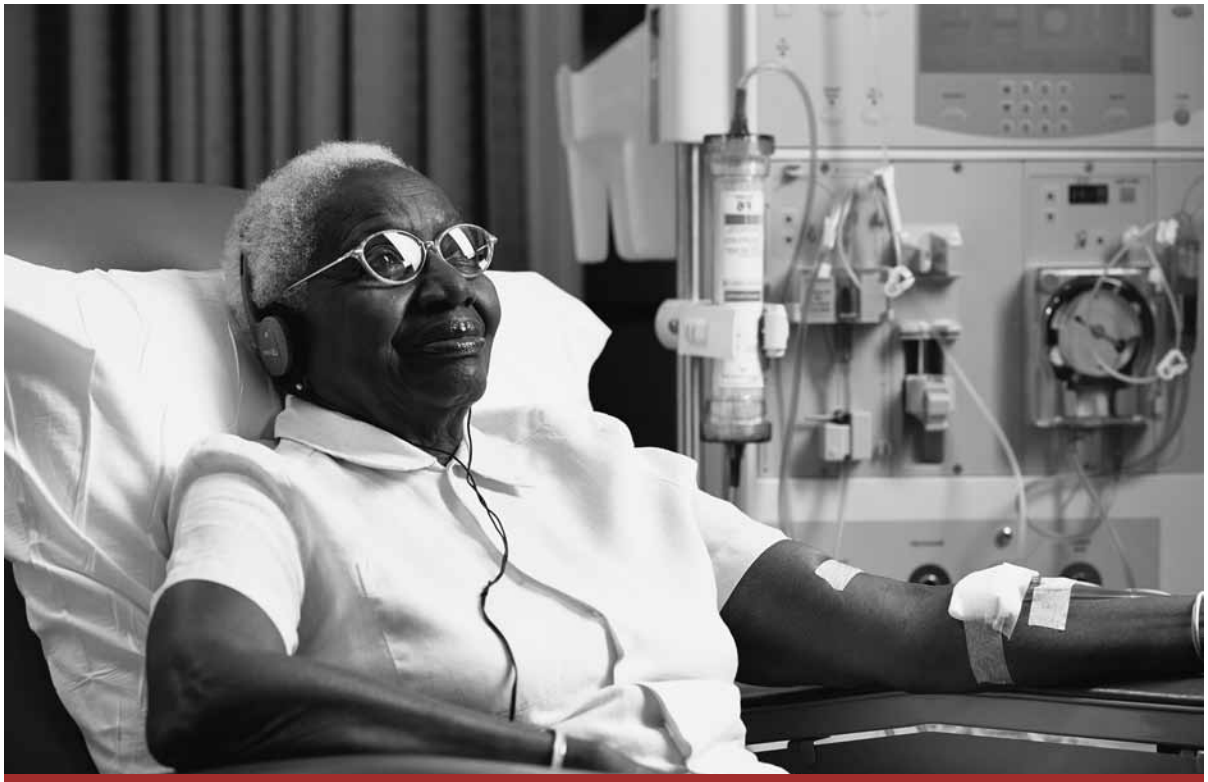
CENTERS FOR MEDICARE & MEDICAID SERVICES



Medicare Coverage of Kidney Dialysis & Kidney Transplant Services

This official government booklet explains:

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

The information in this booklet was correct when it was printed. Changes may occur after printing. Visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users should call 1-877-486-2048.

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

Table of Contents

Introduction

Learning that you have permanent kidney failure isn't easy. Even though you may feel sad, confused, or frustrated, you can still take control of your life. The fact that you're reading this booklet is a start.

This booklet explains how Medicare helps pay for kidney dialysis and kidney transplant services in Original Medicare. In most cases, you can't join a Medicare Advantage Plan (like an HMO or PPO) if you have End-Stage Renal Disease. See page 9. If you're in a Medicare Health Plan, your plan must give you at least the same coverage that Original Medicare gives, but your costs, rights, protections, and/or choices of where you get your care may be different. You may also be able to get extra benefits. You can read this booklet to understand what Medicare covers, but you'll need to read your plan materials or call your benefits administrator for more information about plan rules.

Talk with your health care team to learn more about permanent kidney failure and your treatment options. Your doctors, nurses, social workers, dieticians, and dialysis technicians make up your health care team. They are there to help you decide what's best for you based on your situation.

If you have questions about Medicare after reading this booklet, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section 1: Medicare Basics

What is Medicare?

Medicare is health insurance for:

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

What Medicare covers

Medicare Part A (Hospital Insurance) helps cover:

- Inpatient care in hospitals
- Inpatient care in skilled nursing facilities (not custodial or long-term care)
- Hospice care
- Home health care

Medicare Part B (Medical Insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Some preventive services

For more details about what Medicare covers, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What Medicare costs

Part A costs

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

Part B costs

Most people must pay a monthly premium for Part B. The standard Part B premium for 2012 is $99.90 per month, although it may be higher based on your income. Premium rates can change yearly. **You need Part B to get the full benefits available under Medicare for people with ESRD, and you must pay the premium to get Part B.** For more information about the Part B premium, visit www.socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Words in red are defined on pages 53–54.

Paying for Part B

When you sign up for Part B, the premium is usually taken out of your monthly Social Security or Railroad Retirement payment. If you don't get one of these payments, Medicare sends you a bill for your Part B premium every 3 months. You should get your Medicare premium bill by the 10th of the month. If you don't get your bill by the 10th, call Social Security.

Who's eligible?

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

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

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

If you qualify for Part A, you can also get Part B. As noted above, enrolling in Part B is your choice, but **you'll need both Part A and Part B to get the full benefits available under Medicare to cover certain dialysis and kidney transplant services.**

If you don't qualify for Medicare, you may be able to get help from your state to pay for your dialysis treatments. See pages 45–46.

Call Social Security at 1-800-772-1213 for more information about the required amount of time needed under Social Security, the Railroad Retirement Board, or as a government employee to be eligible for Medicare based on ESRD. TTY users should call 1-800-325-0778. You can also visit www.socialsecurity.gov.

Medicare plan choices

Medicare generally offers different choices for how you can get your health and prescription drug coverage, although the choices may be limited if you have ESRD. Your costs will vary depending on your coverage and the services you use.

If you have ESRD and you're new to Medicare, you'll most likely get your health care through Original Medicare. Original Medicare is managed by the Federal government. You can go to any doctor or supplier that's enrolled in and accepts Medicare and is accepting new Medicare patients, or to any participating hospital or other facility. You pay a set amount for your health care (deductible) before Medicare pays its share. Then, Medicare pays its share, and you pay your share (coinsurance or copayment) for covered services and supplies.

When you have Original Medicare, you can add prescription drug coverage by joining a Medicare Prescription Drug Plan (Part D). Private companies approved by Medicare run these plans. Different plans cover different drugs, but most medically-necessary drugs must be covered. See pages 37–39 for more information about Medicare Prescription Drug Plans.

You usually can't join a Medicare Advantage Plan (like an HMO or PPO) if you already have ESRD, and haven't had a kidney transplant. However, you may be able to join a Medicare Special Needs Plan, a type of Medicare Advantage Plan for people with certain chronic diseases, if one is available in your area for people with ESRD. These plans must provide all Part A and Part B health care and services, as well as Medicare prescription drug coverage. You also may be able to join a Medicare Advantage Plan if you're already getting your health benefits (for example, through an employer health plan) through the same organization that offers the Medicare Advantage Plan. While you're in a Medicare Advantage Plan, the plan will be the primary provider of your health care coverage. You must use your Medicare Advantage Plan ID card instead of your red, white, and blue Medicare card when you see your doctor or get other kinds of health care services.

Medicare plan choices (continued)

If you had ESRD, but have had a kidney transplant, and you still qualify for Medicare benefits based on your age or a disability, you can stay in Original Medicare, or join a Medicare Advantage Plan.

If you have ESRD and are enrolled in a Medicare Advantage Plan that stops being offered in your area, you have a one-time right to join another Medicare Advantage Plan if one is available in your area. You don't have to use your one-time right to join a new plan immediately. If you change directly to Original Medicare after your plan stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan at a later date as long as the plan you choose is accepting new members.

For more information about your Medicare plan choices, look at your "Medicare & You" handbook. You can visit www.medicare.gov/publications to view the handbook. You can also call 1-800-MEDICARE (1-800-633-4227) to get more information. TTY users should call 1-877-486-2048.

How to sign up for Medicare

If you're eligible for Medicare because of ESRD, you can enroll in Part A and Part B by visiting your local Social Security office or by calling Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

If you qualify for Part A, you'll also be offered Part B. As noted above, you need both parts to get all the Medicare benefits available for ESRD, and there's a premium for Part B. If you decide not to get Part B right away, you can only enroll January 1–March 31 each year. Your coverage will begin on July 1. Also, the cost of Part B will go up 10% for each 12-month period that you could have had Part B but didn't sign up for it. If you have employer or union group health plan coverage, see pages 13–15.

Note: If you're already enrolled in Medicare based on age or disability, and you're already paying a higher Part B premium because you didn't enroll in Part B when you were first eligible, the penalty will stop when you become entitled to Medicare based on ESRD. Call your local Social Security office to make an appointment to re-enroll in Medicare based on ESRD.

When Medicare coverage begins

When you enroll in Medicare based on ESRD and you're on dialysis, Medicare coverage usually starts the first day of the fourth month of your dialysis treatments. For example, if you start getting your dialysis treatments in July, your Medicare coverage would start on October 1.

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

If you're covered by an employer or union group health plan, for the first 30 months you're covered by Medicare, your employer or union group health plan will pay first on your health care bills, and Medicare will pay second. For more detailed information, see pages 13–15.

If you don't have employer group health plan coverage, there are other types of insurance and programs that may help to pay some of your health care costs. See pages 44–46.

Medicare coverage can start as early as the first month of dialysis if you meet all of the following conditions:

- You take part in a home dialysis training program offered by a Medicare-approved training facility to teach you how to give yourself dialysis treatments at home.
- Your doctor expects you to finish training and be able to do your own dialysis treatments.

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

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

When Medicare coverage begins (continued)

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

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

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

Note: This waiting period will start even if you haven't signed up for Medicare. For example, if you don't sign up until after you've met all the requirements, your coverage could begin up to 12 months before the month you apply.

When Medicare coverage ends

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

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

Your Medicare coverage will be extended if:

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

Important: Remember, you need both Part A and Part B to get the benefits available under Medicare for people with ESRD. If you don't pay your Part B premium or if you choose to cancel it, your Part B coverage will end.

How Medicare works with employer or union group health plan coverage

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

If your employer or union plan doesn't pay all costs for dialysis, you may have to pay some of the costs. You may be able to get help paying these costs. See pages 44–46.

Once you become eligible for Medicare because of permanent kidney failure (usually the fourth month of dialysis), there will still be a period of time, called a "coordination period," when your employer or union group health plan will continue to pay your health care bills. However, if your plan doesn't pay 100% of your health care bills, Medicare may pay some of the remaining costs. This is called "coordination of benefits," under which your plan "pays first" and Medicare "pays second." During this time, Medicare is called the secondary payer. This coordination period lasts for 30 months.

When the 30-month coordination period starts

The waiting period for eligibility will start even if you haven't signed up for Medicare. The same thing is true of the 30-month coordination period, which starts the first month you would be eligible to get Medicare because of permanent kidney failure (usually the fourth month of dialysis), **even if you haven't signed up for Medicare yet**. For example, if you start dialysis and are eligible for Medicare in June, the 30-month coordination period will start September 1, the fourth month of dialysis even if you don't have Medicare.

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

Important: If you have employer or union group health plan coverage, tell your health care provider that you have this coverage. This is very important to make sure that your services are billed correctly.

How Medicare works with employer or union group health plan coverage (continued)

When the 30-month coordination period ends

At the end of the 30-month coordination period, Medicare will pay first for all Medicare-covered services. Your employer or union group health plan coverage may still pay for services not covered by Medicare. Check with your plan's benefits administrator.

How the 30-month coordination period works if you enroll in Medicare more than once

There's a separate 30-month coordination period each time you enroll in Medicare based on permanent kidney failure. For example, if you get a kidney transplant that continues to work for 36 months, your Medicare coverage will end (unless you have Medicare because you're 65 or older or you have a certain disability). If after 36 months you enroll in Medicare again because you start dialysis or get another transplant, your Medicare coverage will start right away. There will be no 3-month waiting period before Medicare begins to pay. However, there will be a new 30-month coordination period if you have employer or union group health plan coverage.

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

No, but you should think carefully about this decision. If you get a kidney transplant, you'll need to take immunosuppressive drugs for the rest of your life, so it's important to know if they'll be covered. If you're entitled to Medicare only because of ESRD (you're not over 65 or disabled), Part B will **only** cover your immunosuppressive drugs (see pages 30–32) **if** you already had Part A at the time of the transplant, and the transplant surgery was performed at a Medicare-approved facility.

Note that Part B will only cover the immunosuppressive drugs after you're enrolled in Part B. There won't be any retroactive coverage.

Note: If you don't meet the conditions for Part B coverage of immunosuppressive drugs, you may be able to get coverage by joining a Medicare Prescription Drug Plan. See pages 37–39.

How Medicare works with employer or union group health plan coverage (continued)

If your group health plan coverage has a yearly deductible, copayment, or coinsurance, enrolling in Part A and Part B could help pay those costs during the coordination period.

If your group health plan coverage will pay for most or all of your health care costs (for example, if it doesn't have a yearly deductible), you may want to delay enrolling in Part A and Part B until the 30-month coordination period is over. If you delay enrollment, you won't have to pay the Part B premium for coverage you don't need yet. After the 30-month coordination period, you should enroll in Part A and Part B. Your Part B premium won't be higher because you delayed your enrollment. If your group health plan benefits are decreased or end during this period, you should enroll in Part A and Part B as soon as possible.

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

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

Medicare for children with ESRD

Medicare covers people of all ages who have ESRD. Your child can be covered if you or your spouse has worked the required amount of time under Social Security, the Railroad Board, or as a government employee. Your child can also be covered if you, your spouse, or the child gets Social Security or Railroad Retirement benefits. Medicare can help cover your child's medical costs if your child needs regular dialysis because his or her kidneys no longer work, or if he or she has had a kidney transplant.

Use the information in this booklet to help answer your questions, or visit www.medicare.gov/publications to view the brochure "Medicare for Children with End-Stage Renal Disease: Getting Started." You can also contact your local Social Security office, or call 1-800-772-1213. TTY users should call 1-800-325-0778.

Section 2: Kidney Dialysis

What is dialysis?

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

Dialysis treatment options

There are 2 types of dialysis treatment options:

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

You should work with your health care team to decide the type of dialysis you need based on your situation. The goal is to help you stay healthy and active.

Words in red are defined on pages 53–54.

Dialysis services and supplies covered by Medicare

Medicare covers the following dialysis services and pays part of their costs:

Service or supply	Covered by Medicare Part A	Covered by Medicare Part B
Inpatient dialysis treatments (if you're admitted to a hospital for special care)	✔	
Outpatient dialysis treatments (if you get treatments in any Medicare-approved dialysis facility)		✔
Outpatient doctors' services (see page 23)		✔
Self-dialysis training (includes instruction for you and the person helping you with your home dialysis treatments)		✔
Home dialysis equipment and supplies (like the machine, water treatment system, basic recliner, alcohol, wipes, sterile drapes, rubber gloves, and scissors) (see pages 22–23)		✔
Certain home support services (may include visits by trained hospital or dialysis facility workers to check on your home dialysis, to help in emergencies when needed, and to check your dialysis equipment and water supply) (see page 22)		✔
Most drugs for home dialysis (see page 20)		✔
Other services and supplies that are a part of dialysis (like laboratory tests)		✔

To find out what you pay for these services, see pages 21–23.

Home dialysis services and supplies NOT covered by Medicare

Medicare **doesn't** cover the following services or supplies:

Service or supply	Not covered
Paid dialysis aides to help you with home dialysis	✗
Any lost pay to you or the person who may be helping you during self-dialysis training	✗
A place to stay during your treatment	✗
Blood or packed red blood cells for home self-dialysis unless part of a doctors' service	✗

There are some types of insurance that may pay some of the health care costs that Medicare doesn't pay. See pages 43–46. For more information on Medicare prescription drug coverage, see pages 37–39.

Medicare payment system for dialysis services

A new payment system called the ESRD Prospective Payment System (PPS) went into effect on January 1, 2011. This payment system "bundles" or combines all of the Part B ESRD dialysis services and items that were previously grouped under the composite rate and those ESRD dialysis items or services that were previously billed separately. The composite rate is the former method that Medicare used to pay dialysis facilities for dialysis-related services.

What's included in the new payment system

The new payment system includes the following Part B covered services and items:

- Dialysis-related services, equipment, and supplies that were in the prior composite rate
- Injectable drugs and their oral forms and biologicals, including erythropoiesis stimulating agents used for ESRD dialysis treatment*
- Laboratory tests and other items and services provided for ESRD dialysis treatment
- Home dialysis training by a Medicare-certified home dialysis training facility (if you choose to get dialysis at home)

*Medications that are only available in oral form will continue to be covered under Medicare prescription drug coverage (Part D). Talk with your doctor or health care team about the use of any drugs, including over-the-counter products.

What YOU pay for dialysis services in a dialysis facility under the new payment system

If you have Original Medicare, you'll continue to pay 20% of the Medicare-approved amount for all covered dialysis related services. Medicare will pay the remaining 80%.

The amount (20%) for which you're responsible may vary under the new payment system. If you're in a Medicare Advantage Plan (like an HMO or PPO) or have a Medicare Supplement Insurance (Medigap) policy that covers all or part of your 20% coinsurance, then your costs may be different. Read your plan materials or call your benefits administrator to get your cost information. You must also continue to pay your monthly Part B and Part D (if applicable) premiums.

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

Medicare payment for children with ESRD

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

Training for self-dialysis at home

Training for self-dialysis at home is covered under Part B on an outpatient basis, but only in a facility certified for dialysis training. You may qualify for training if you think you would benefit from self-dialysis training for at-home treatments, and your doctor approves. Training sessions will occur at the same time you get dialysis treatment and are subject to a maximum number of sessions.

Doctors' self-dialysis training services

In Original Medicare, Medicare pays your kidney doctor a flat fee to supervise self-dialysis training. After you pay the Part B yearly deductible ($140 in 2012), Medicare pays 80% of the flat fee and you pay the remaining 20%.

Example: (What you pay may be different than what's shown.)
Let's say the flat fee for the doctor who's supervising the self-dialysis training is $500. After you pay the Part B yearly deductible, here are the costs:

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

Home dialysis

Your dialysis facility will be responsible for providing all of your home dialysis related items and services including equipment and supplies (either directly or under arrangement). Under the new payment system, home dialysis equipment and supplies provided directly from dialysis suppliers (formerly referred to as Method II) are no longer available. However, dialysis suppliers may provide equipment and supplies under arrangement with your dialysis facility. Medicare pays for home dialysis at the same rate as dialysis you get in a facility.

Monthly doctor visits for home dialysis

Medicare pays doctors (and certain non-doctors, such as physician assistants and nurse practitioners), on a monthly basis, to help people with Medicare who perform self-dialysis at home manage their care. This benefit includes a face-to-face visit between you and your doctor once a month. The face-to-face visit allows you and your doctor to discuss your care and the effectiveness of your dialysis, to check for complications, and to give you a chance to ask questions about your home dialysis treatment.

How long will Medicare pay for home dialysis equipment?

Part B will pay for home dialysis equipment as long as you need dialysis at home. If you no longer need home dialysis (for example, if you had a kidney transplant), Part B would stop paying.

Dialysis in a hospital

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

Inpatient doctors' services

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

Outpatient doctors' services

In Original Medicare, Medicare pays most kidney doctors a monthly amount. After you pay the Part B yearly deductible ($140 in 2012), Medicare pays 80% of the monthly amount. You pay the remaining 20% coinsurance.

In some cases, your doctor may be paid per day if you get services for less than 1 month.

Example: (What you pay may be different than what's shown.)
Let's say the monthly amount that Medicare pays your doctor for each dialysis patient is $125. After you pay the Part B yearly deductible, here are the costs:

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

Where to get dialysis treatments

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

At the dialysis facility, a nurse or trained technician may give you the treatment. At home, you can treat yourself or you can ask a family member or friend for help. If you decide to do home dialysis, you and your helper (if you have one) will get training.

If you have a problem with the care you're getting from your dialysis facility, you have the right to file a grievance (complaint) to resolve your problem. See page 42, "Filing a grievance (complaint)," for more information.

How to find a dialysis facility

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

You can also call your local ESRD Network (see pages 50–51) to find a dialysis facility that's close to you, or you can use "Dialysis Facility Compare" by visiting www.medicare.gov/dialysis.

"Dialysis Facility Compare"

"Dialysis Facility Compare" has important information about Medicare-certified dialysis facilities in your area and around the country. Visit www.medicare.gov/dialysis. You can find information such as addresses and phone numbers, how far certain facilities are from you, and what kind of dialysis services the facilities offer. You can also compare facilities by the services they offer and by certain quality of care information. Helpful Web sites, publications, and phone numbers are also available. You can discuss the information on this Web site with your health care team.

If you don't have a computer, your local library or senior center may be able to help you look at this information. You can also call 1-800-MEDICARE (1-800-633-4227), or contact your local State Health Insurance Assistance Program (see pages 50–51) to get help with comparing dialysis facilities. TTY users should call 1-877-486-2048.

Knowing how well your dialysis is working

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

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

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

Even if you feel fine, you should still check how well your dialysis is working.

For a short period of time, you may feel okay without adequate dialysis. However, over time, not getting adequate dialysis can make you feel weak and tired. It can lead to a higher risk of infection and prolonged bleeding. It can shorten your life.

Here are some steps you can take to get adequate dialysis:

- Go to all of your scheduled treatments and arrive on time.
- Stay for the full treatment time.
- Follow your diet and fluid restrictions.
- Follow the advice of your dialysis staff on taking care of yourself.
- Check your URR or Kt/V adequacy number every month.
- Talk to your doctor about which hemodialysis vascular access* is best for you.
- Learn how to take care of your vascular access.

To learn more about how well your dialysis is working, talk with your doctor or other health team members at your dialysis facility.

* Your vascular access is the entrance your doctor makes into your blood vessels. During dialysis, your blood is removed and returned through your vascular access.

Dialysis when you travel

You can still travel within the United States if you need dialysis. There are over 5,000 dialysis facilities around the country. Your facility can help you plan your treatment along the route of your trip before you travel. Your dialysis facility will help you by checking to see if the facilities on your route:

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

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

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

Transportation to dialysis facilities

Medicare covers ambulance services to and from your home to the nearest dialysis facility for treatment of ESRD **only** if other forms of transportation would be harmful to your health.

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

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

For more information about ambulance coverage, visit www.medicare.gov/publications to read or print the booklet "Medicare Coverage of Ambulance Services." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Visit www.medicare.gov/dialysis to get information about Medicare-certified dialysis facilities in your area.

Section 3: Kidney Transplants

What is a kidney transplant?

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

To be covered by Medicare, your kidney transplant must be done in a hospital that's approved by Medicare to do kidney transplants.

If you have a problem with the care that you're getting for your transplant, you have the right to file a grievance (complaint). See page 42, "Filing a grievance (complaint)," for more information.

Words in red are defined on pages 53–54.

Kidney transplant services covered by Medicare

Medicare covers the following transplant services and pays part of their costs:

Service or supply	Medicare Part A	Medicare Part B
Inpatient services in an approved hospital	✔	
Kidney registry fee	✔	
Laboratory and other tests needed to evaluate your medical condition*	✔	
Laboratory and other tests needed to evaluate the medical condition of potential kidney donors*	✔	
The costs of finding the proper kidney for your transplant surgery (if there's no kidney donor)	✔	
The full cost of care for your kidney donor (including care before surgery, the actual surgery, and care after surgery)	✔	
Any additional inpatient hospital care for your donor in case of problems due to the surgery	✔	
Doctors' services for kidney transplant surgery (including care before surgery, the actual surgery, and care after surgery)		✔
Doctors' services for your kidney donor during their hospital stay		✔
Immunosuppressive drugs (for a limited time after you leave the hospital following a transplant). See pages 31–32. See pages 37–39 for information about Medicare Prescription Drug Plans.		✔
Blood (whole or units of packed red blood cells, blood components, and the cost of processing and giving you blood). See pages 35–36.	✔	✔

Note: Buying or selling human organs is against the law. Therefore, Medicare doesn't pay for the kidneys used for transplant.

To find out what you pay for these services, see pages 33–34.

* These services are covered whether they are done by the Medicare-approved hospital where you will get your transplant, or by another hospital that participates in Medicare.

Transplant drugs (called immunosuppressive drugs)

What are immunosuppressive drugs?

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

Important: You must meet the conditions on page 14 for Medicare to cover your immunosuppressive drugs.

What if I stop taking my transplant drugs?

If you stop taking your transplant drugs, your body may reject your new kidney, and the kidney could stop working. If that happens, you may have to start dialysis again. Talk to your doctor before you stop taking your transplant drugs.

How long will Medicare pay for transplant drugs?

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

Medicare won't pay for any services or items, including immunosuppressive drugs, for patients who aren't entitled to Medicare.

Medicare will continue to pay for your immunosuppressive drugs **with no time limit** if you:

- Were already entitled to Medicare because of age or disability before you got ESRD
- Became entitled to Medicare because of age or disability after getting a transplant that was paid for by Medicare, or paid for by private insurance that paid primary to your Part A coverage, in a Medicare-certified facility

> If you're entitled to Medicare only because of permanent kidney failure, your Medicare coverage will end when your 36-month period is over.

Transplant drugs (called immunosuppressive drugs) (continued)

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

Transplant drugs can be very costly. If you're entitled to Medicare only because of permanent kidney failure, your immunosuppressive drugs are only covered for 36 months after the month of your transplant. If you're worried about paying for them after your Medicare coverage ends, talk to your doctor, nurse, or social worker. There may be other ways to help you pay for these drugs. See pages 43–46 to learn more about other health insurance options.

Special information about pancreas transplants

If you have ESRD and need a pancreas transplant, Medicare covers the transplant if one of the following applies:

- It's done at the same time you get a kidney transplant.
- It's done after a kidney transplant.

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

If you're entitled to Medicare only because of permanent kidney failure, and you have the pancreas transplant after the kidney transplant, Medicare will only pay for your immunosuppressive drug therapy for 36 months after the month of the kidney transplant. This is because your Medicare coverage will end 36 months after a successful kidney transplant if you only have Medicare due to permanent kidney failure.

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

What YOU pay for kidney transplant services

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

Do I have to pay for my kidney donor?

No. Medicare will pay the full cost of care for your kidney donor. You don't have to pay a deductible, coinsurance, or other costs for your donor's hospital stay.

Hospital services

If you have Original Medicare, in 2012 you pay:

- $1,156 deductible per benefit period
- $0 for the first 60 days of each benefit period
- $289 per day for days 61–90 each benefit period
- $578 per lifetime reserve day* after day 90 each benefit period (up to 60 days over your lifetime)
- All costs for each day after the lifetime reserve days

For Medicare-approved care in a skilled nursing facility, you pay:

- $0 for the first 20 days each benefit period
- Up to $144.50 per day for days 21–100 each benefit period
- All costs for each day after day 100 in the benefit period

To find out what you pay for other Part A and Part B services, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Doctors' services

In Original Medicare, you must pay the Part B yearly deductible ($140 in 2012). After you pay the deductible, Medicare pays 80% of the Medicare-approved amount. You must pay the remaining 20% coinsurance.

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

Clinical laboratory services

You pay nothing for Medicare-approved laboratory tests.

Section 4: How Medicare Pays for Blood

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

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

What YOU pay for blood

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

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

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

Words in red are defined on pages 53–54.

Having blood donated

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

Can I be charged for the blood that I have donated?

No. A hospital or skilled nursing facility can't charge you for any of the first 3 pints of blood you have already donated or will have donated.

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

Section 5: Medicare Prescription Drug Coverage

Medicare Part B covers immunosuppressive drugs after a covered transplant and most of the drugs you get for dialysis. See pages 30–32. However, it doesn't cover prescription drugs for other health conditions you may have, like high blood pressure or diabetes. Medicare offers prescription drug coverage to help you with the costs of your drugs not covered by Part B.

> Medicare prescription drug coverage won't cover drugs you can get under Part B—like immunosuppressive drug therapy under the conditions discussed on page 14. However, if you don't meet the conditions on page 14, you may be able to get coverage of your immunosuppressive drug therapy by joining a Medicare Prescription Drug Plan.

Medicare prescription drug coverage (Part D) is offered by private companies approved by Medicare. There are 2 types of Medicare plans that provide Medicare prescription drug coverage:

- Medicare Prescription Drug Plans that add coverage to Original Medicare or certain types of Medicare health plans.
- Medicare prescription drug coverage provided as part of Medicare Advantage Plans (like an HMO or PPO). Most people with ESRD can **only** get prescription drug coverage through a Medicare Advantage Plan if they already belong to a plan, or if they switch to a different plan offered by the same company.

What it costs

Most Medicare drug plans charge a monthly premium that varies by plan. Your premium may be higher based on your income. You pay the Part D premium in addition to the Part B premium. Some plans have no premium at all. Your costs will vary depending on which drugs you use and which drug plan you choose. Also, if you have limited income and resources, you may be able to get Extra Help paying for your Part D prescription drug costs. See page 38. Look at your "Medicare & You" handbook to get detailed information about prescription drug coverage costs.

Words in red are defined on pages 53–54.

Extra Help for those who need it most

Medicare provides Extra Help to pay prescription drug costs for people who meet specific income and resource limits. Resources include your savings and stocks, but not your home or car. If you qualify, you'll get help paying for your Medicare drug plan's monthly premium, yearly deductible, and prescription copayments or coinsurance.

To qualify for Extra Help, your yearly income must be below $16,755 ($22,695 for a married couple living together), and your resources may be up to $13,070 ($26,120 for a married couple living together). These amounts may change in 2013.

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

Note: Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa provide their residents help with Medicare drug costs. This help isn't the same as the Extra Help described here. Call your local Medical Assistance (Medicaid) office to learn more.

How do I apply for Extra Help?

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

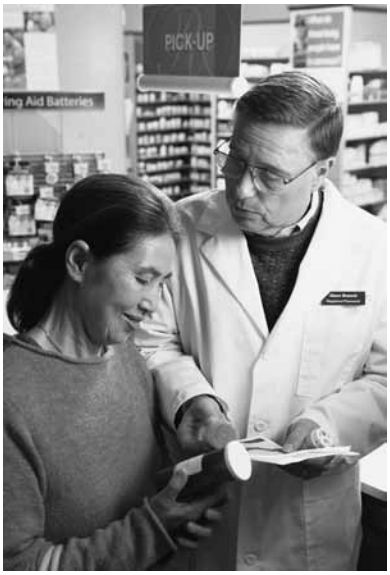
If you didn't automatically qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what to do next. Even if you don't qualify, you should still consider joining a Medicare Prescription Drug Plan.

If you apply and qualify for Extra Help, you can either join a plan on your own or let Medicare enroll you in a plan. Medicare will send you a letter letting you know what plan it will enroll you in and when your coverage begins. Check to see if the plan you're enrolled in covers the drugs you use and if you can go to the pharmacies you want. If not, you can change plans at any time.

When you can join

If you become entitled to Medicare based on ESRD, your first chance to join a Medicare drug plan will be during the 7-month period that begins 3 months before the month you're entitled to Medicare and ends 3 months after the first month you're entitled to Medicare.

Your prescription drug coverage will start the same time your Medicare coverage begins or the first month after you make your request, whichever is later. See page 11.



If you don't join when you're first eligible, you can join between October 15–December 7 each year. Your coverage will begin on January 1 of the following year. If you join after your initial enrollment period is over and there was a period of 63 continuous days or more during which you didn't have creditable prescription drug coverage (coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage), **you may have to pay a late enrollment penalty**. This amount increases the longer you go without creditable coverage. You will have to pay this penalty as long as you have Medicare prescription drug coverage. However, if you get Extra Help, you don't have to pay a late enrollment penalty.

For more information about Medicare prescription drug coverage, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also contact your local State Health Insurance Assistance Program. See pages 50–51.

Section 6: Appeals & Grievances

Your Medicare rights

If you have Medicare, you have certain guaranteed rights to help protect you. One of these is the right to a process for appealing decisions about health care payment or services. **Whether you have Original Medicare or a Medicare Advantage Plan (like an HMO or PPO), you have the right to appeal, and to file grievances.**

Appeals

An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare Health Plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies:

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

You can also appeal if Medicare or your plan stops providing or paying for all or part of an item or service you think you still need.

Appeal rights in Original Medicare

If you have Original Medicare, you can file an appeal if you aren't satisfied with a coverage or payment decision. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal. Please review your Medicare notices carefully and follow the instructions before filing an appeal.

Words in red are defined on pages 53–54.

Appeal rights in a Medicare health plan

If you're in a Medicare health plan, or a Medicare Prescription Drug Plan, you can file an appeal for any of the reasons listed on page 41. For more information on your appeal rights, see your plan's membership materials, contact your plan, or visit www.medicare.gov/publications to view the booklet, "Medicare Appeals." You may also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Filing a grievance (complaint)

A grievance is different from an appeal. A grievance is for problems you have with the way you get services. If you have a problem with your ESRD dialysis facility:

- Talk with your doctor, nurse, or facility administrator first to see if they can help you solve your problem. Most problems can be handled at your facility.
- File a grievance (a written complaint) with your facility if talking to your health care team doesn't solve the problem.

Every facility has a grievance policy for accepting and trying to work out your problems or concerns. If you don't know your facility's grievance policy, ask for a copy of it.

If you filed a grievance with your facility and you still feel that your problem has not been solved, you have the right to file a grievance with the ESRD Network in your area. See pages 50–51. Call the ESRD Network to find out how to file a grievance. You can also call your State Survey Agency to complain about your care. **Your calls and name will be kept private.** Visit www.medicare.gov/contacts to get the phone number to the State Survey Agency. You can also call 1-800-MEDICARE.

Section 7: Other Kinds of Health Insurance

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

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

Employee or retiree coverage from an employer or union

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

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

See pages 13–15 for an explanation of when your employer will pay first, and when Medicare will pay first with your employer providing supplemental coverage.

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

Words in red are defined on pages 53–54.

Medicare Supplement Insurance (Medigap) policies

A Medigap policy is health insurance sold by private insurance companies to help fill the "gaps" in Original Medicare coverage, like deductibles and coinsurance. Medigap policies help pay some of the health care costs that Original Medicare doesn't cover. Medigap insurance must follow Federal and state laws that protect you. All Medigap policies are clearly marked "Medicare Supplement Insurance."

Not all insurance companies will sell Medigap policies to people with Medicare under 65. If a company does sell Medigap policies voluntarily, or because state law requires it, these Medigap policies will probably cost you more than if you were 65 or older. Medigap rules vary from state to state. Call your State Health Insurance Assistance Program (see pages 50–51) for information about buying a Medigap policy if you're disabled or have ESRD. When you turn 65, you will be guaranteed an opportunity to buy a Medigap policy.

For detailed information about Medigap policies:

✓ Visit www.medicare.gov/publications to read or print a copy of "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

✓ Visit www.medicare.gov/medigap to get information about Medigap policies in your state. When you use this Web site, you'll get a personalized summary page with general information to help you compare plans. You can get detailed information about all the plans available in your area, or just the ones you're most interested in. This Web site has the following information:

- Which Medigap policies are sold in your state
- Comparing Medigap policies
- What each policy covers
- Your out-of-pocket costs

If you don't have a computer, your local library or senior center may be able to help you look at this information.

Medicaid

This is a joint Federal and state program that helps pay medical costs for some people with limited income and resources. Medicaid programs vary from state to state. Most health care costs are covered if you qualify for both Medicare and Medicaid and see providers who accept both.

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

- Medicare Part A.
- A monthly income of less than $1,277 for an individual or $1,723 for a couple in 2012. These income limits are slightly higher in Hawaii and Alaska. Income limits can change each year.
- Savings of $6,940 or less for an individual, or $10,410 or less for a couple. Savings include money in a checking or savings account, stocks, and bonds.

To get more information on these programs, visit www.medicare.gov. You can also call 1-800-MEDICARE (1-800-633-4227), and ask for information on "savings for people with Medicare." TTY users should call 1-877-486-2048.

Veterans' benefits

If you're a veteran, the U.S. Department of Veterans Affairs can help pay for ESRD treatment. For more information, call the U.S. Department of Veterans Affairs at 1-800-827-1000. TTY users should call 1-800-829-4833. If you or your spouse is active duty or retired from the military, call the Department of Defense at 1-800-538-9552 for more information. TTY users should call 1-866-363-2883.

Other ways to get help

In most states there are agencies and state kidney programs that help with some of the health care costs that Medicare doesn't pay. Call your State Health Insurance Assistance Program if you have questions about health insurance. See pages 50–51.

Section 8: Where to Get More Information

Talk with your health care team to learn more about kidney dialysis, transplants, and your situation.

Kidney organizations

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

American Association of Kidney Patients
3505 East Frontage Road, Suite 315
Tampa, Florida 33607
1-800-749-2257
www.aakp.org

American Kidney Fund
6110 Executive Boulevard, Suite 1010
Rockville, Maryland 20852
1-800-638-8299
www.kidneyfund.org

Dialysis Patient Citizens
900 7th Street, NW, Suite 670
Washington, DC 20001
1-866-877-4242
www.dialysispatients.org

National Kidney Foundation, Inc.
30 East 33rd Street
New York, New York 10016
1-800-622-9010
www.kidney.org

National Kidney and Urologic Diseases Information Clearinghouse
3 Information Way
Bethesda, Maryland 20892
1-800-891-5390
www.kidney.niddk.nih.gov

Words in red are defined on pages 53–54.

End-Stage Renal Disease (ESRD) Networks

You can call your local ESRD Network Organization (see pages 50–51) to get information about the following:

- Dialysis or kidney transplants
- How to get help from other kidney-related agencies
- Problems with your facility that aren't solved after talking to facility staff
- Location of dialysis facilities and transplant centers

Your ESRD Network makes sure that you're getting the best possible care and keeps your facility aware of important issues about kidney dialysis and transplants.

State Health Insurance Assistance Programs (SHIP)

Call your State Health Insurance Assistance Program (see pages 50–51) if you have questions about:

- Medigap policies
- Medicare health plan choices
- Filing an appeal
- Other general health insurance questions

State Survey Agency

The State Survey Agency inspects dialysis facilities and makes sure that Medicare standards are met. Your State Survey Agency can also help you if you have a complaint about your care. Visit www.medicare.gov/contacts to get the phone number of your State Survey Agency. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. **Your calls and name will be kept private.**

Other Medicare products for kidney patients

To read or print a copy of these booklets, visit www.medicare.gov/publications. You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

1. "Dialysis Facility Compare"
   This brochure gives you information about the Dialysis Facility Compare tool at www.medicare.gov/dialysis.
2. "Medicare's Coverage of Dialysis and Kidney Transplant Benefits: Getting Started"
   This brochure explains basic Medicare benefits for people with kidney disease.
3. "Medicare for Children with End-Stage Renal Disease"
   This brochure gives information about Medicare coverage for children with permanent kidney failure.

Important phone numbers

ESRD Networks and State Health Insurance Assistance Program phone numbers are on pages 50–51. At the time of printing, these phone numbers were correct. Phone numbers sometimes change. To get the most updated phone numbers, visit www.medicare.gov/contacts. You can also call 1-800-MEDICARE.

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit www.medicare.gov/contacts. Thank you.

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit www.medicare.gov/contacts. Thank you.

Important phone numbers

Phone number _____

Doctor _____

Social worker _____

Health insurance company _____

ESRD Network _____

State Survey Agency _____

Notes

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Section 9: Definitions

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

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

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

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

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

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

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're unhappy with the way a staff person at the plan has behaved towards you. However, if you have a complaint about a plan's refusal to cover a service, supply, or prescription, you file an appeal.

Medically necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

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

Medicare-approved amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare health plan—A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

Secondary payer—The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

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HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
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This booklet is available in Spanish. To get your copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Esta publicación está disponible en Español. Para obtener una copia, llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.