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 people with Medicare 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 people with Medicare make informed decisions about Medicare.

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

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.

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

**PART A**
(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
- Part B 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)
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
(Supplemental/Medigap)
(GHI, Medigap, or Medicaid)

Prescription Drug Coverage
(Part D or GHI)

Option 2

MEDICARE ADVANTAGE
(Part C)
Hospital Medical
Prescription Drug Coverage
D

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 for Medicare. 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 65th birthday or the 25th month of disability benefits.

Initial Enrollment Information (IEP)

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, your birthday month, and 3 months after your 65th birthday).

Avoid 10% Penalties

When you apply for Medicare, you can sign up for Parts A & B. You must pay a premium for Part B. 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.

Note: If the employer has fewer than 20 employees. You should sign up for Part A and Part B when you're first eligible. In this case, Medicare pays before your other 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.

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, 2019.

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

<table>
<thead>
<tr>
<th>Services</th>
<th>Benefits</th>
<th>Medicare pays</th>
<th>You pay</th>
</tr>
</thead>
</table>
| Hospitalization
Semi-private room, general nursing, miscellaneous services and supplies | First 60 days | All but $1,340 deductible | $1,340 deductible |
| | 61st to 90th day | All but $335 per day | $335 per day |
| | 91st to 150th day | All but $670 per day | $670 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 $167.50 per day | $167.50 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 (DME) | 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 |

Note: 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

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

# 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.  

**Medicare does not cover:**

- Long-term care
- Dentures or Dental care
- Hearing aids
- Eye Wear
- Eye examinations for glasses
- 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.

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**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 $422.00 or a lesser amount based on the length of time worked.

**Medicare Part B Premium if new to Medicare in 2018**

<table>
<thead>
<tr>
<th>If Yearly Income is:</th>
<th>Monthly Premium Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>File Individual Tax Return</td>
<td>File Joint Tax Return</td>
</tr>
<tr>
<td>$85,000 or below</td>
<td>$170,000 or below</td>
</tr>
<tr>
<td>$85,001-$107,000</td>
<td>$170,001-$214,000</td>
</tr>
<tr>
<td>$107,001-$160,000</td>
<td>$214,001-$320,000</td>
</tr>
<tr>
<td>$160,001-$214,000</td>
<td>$320,001-$428,000</td>
</tr>
<tr>
<td>Above $214,001</td>
<td>Above $428,001</td>
</tr>
</tbody>
</table>
### Who Pays First?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Primary Insurer</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have retiree insurance from your or your spouse’s former employment</td>
<td>Medicare pays first</td>
</tr>
<tr>
<td>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</td>
<td>Your group health plan pays first</td>
</tr>
<tr>
<td>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</td>
<td>Medicare pays first</td>
</tr>
<tr>
<td>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</td>
<td>Your group health plan pays first</td>
</tr>
<tr>
<td>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</td>
<td>Medicare pays first</td>
</tr>
<tr>
<td>You have Medicare because of your group health plan and have End-Stage Renal Disease (ESRD)</td>
<td>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</td>
</tr>
</tbody>
</table>

### 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 people with Medicare to enroll in Part A and Part B.
Medicare Supplement Insurance (Medigap)

- 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 all the cost of your health care to use out-of-network doctors or hospitals.

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 all the cost of your health care to use out-of-network doctors or hospitals.

- What is the cost?
  - 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 $1,340.00 in 2018. The MA Plan might change the cost sharing so the patient pays $395 per day for the first five days. If patients stay two days, they owe $790 instead of the Original Medicare deductible of $1,340. If patients stay five days, they owe $1,975 instead of the Original Medicare deductible of $1,340.
Two Programs can help you with Medicare costs if you have limited income and resources

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.*

Extra Help pays for prescription drugs (Part D)

If you qualify for **Extra Help** and enroll in a Medicare drug plan, you will get help paying 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.

**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)

**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.

**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 new coverage will begin the following month.
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 higher 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 $3,750.00 for covered drugs. In 2018, once you enter the coverage gap, you pay 35% of the plan’s cost for covered brand-name drugs and 44% of the plan’s cost for covered generic drugs until you reach the end of the coverage gap of $5,000.00.

You will automatically receive CATASTROPHIC COVERAGE once you get out of the donut hole. It assures you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.
# 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 **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](http://www.arkansas.insurance.gov).

## When can you apply?

<table>
<thead>
<tr>
<th>Age</th>
<th>Description</th>
</tr>
</thead>
</table>
| 65+ | **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 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.
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

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For more detailed information about Part B preventive & screening services, please visit Medicare.gov website or contact Medicare at 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 drug coverage

## 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](http://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

*A KEPRO team member can help you write your complaint.*
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.
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.
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](http://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
1200 West 3rd St.
Little Rock, Arkansas 72201
www.insurance.arkansas.gov

Call SHIIP Toll Free: 1-800-224-6330
insurance.shiip@arkansas.gov

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