Your Guide to Private Fee-for-Service Plans

A New Type of Medicare Health Plan

A Guide To:

- Understanding Private Fee-for-Service Plans
- Joining and Leaving Private Fee-for-Service Plans
- Other Important Information on Private Fee-for-Service Plans

HEALTH CARE FINANCING ADMINISTRATION
The Federal Medicare Agency

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Note: Terms in red are defined on pages 19 and 20.

Introduction

Congress passed a law in 1997 which made many changes in the Medicare program. This law includes a variety of new health plan options called Medicare + Choice. One of the new Medicare + Choice options is called a Private Fee-for-Service plan.

This pamphlet gives you some general information on Private Fee-for-Service plans. However, you will need more information than this pamphlet can give you to decide if a Private Fee-for-Service plan is the right choice for you. This pamphlet will help you to ask the right questions to get the information you need to make your choice.

Remember that if you join a Private Fee-for-Service plan, you are still in the Medicare program.

What are my Medicare health plan choices?

All of your current Medicare health plan choices are listed below.

These choices are available nationwide:

- The Original Medicare Plan
- The Original Medicare Plan with a Supplemental Insurance Policy (called a Medigap policy in this publication)

These choices may be available in your area:

- Medicare Managed Care Plans
- Private Fee-for-Service Plans*

*At the time this pamphlet was printed, no private insurance companies were offering Private Fee-for-Service plans to people with Medicare.

To find out if Private Fee-for-Service plans have become available in your area, call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) or look on the Internet at www.medicare.gov. Your local library or senior center may be able to help you get information using their computers.

Introduction

What is the Original Medicare Plan?

The Original Medicare Plan is a health insurance program offered by the federal government for:

- People 65 years of age and older.
- Some disabled people under 65 years of age.
- People with End-Stage Renal Disease.

It is available everywhere in the United States. It is the way most people get their Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) health care. You may go to any doctor, specialist, or hospital that accepts Medicare. You pay your share, Medicare pays its share. Some things are not covered, like prescription drugs.

What types of private insurance supplement the Original Medicare Plan?

There are many types of private health coverage that pay for some or all of the health care costs not covered by Medicare. All of these types are sometimes called "supplemental coverage." These include:

- Employee Coverage* (from an employer or union);
- Retiree Coverage* (from a former employer or union); and
- Medigap Insurance (from a private company or group).

What is a Medigap policy?

A Medigap policy is a type of health coverage offered by private insurance companies that pays for some or all of the health care costs not covered by the Original Medicare Plan. In most states, a Medigap policy must be one of ten standardized policies to help you compare them easily. Each policy has a different set of benefits. Two of the ten standardized policies may have a high deductible option. Insurance companies may offer a high deductible option on Plans F and J. If you choose this option, you must pay a $1500 deductible per year before the plan pays anything.

*If you drop your employer or union based group health coverage, you probably won't be able to get it back. Call your employer's or union's benefit administrator for more information.

Remember: Terms in red are defined on pages 19-20.

In some states, you may also be able to buy a "Medicare SELECT" policy. Medicare SELECT is a type of standardized Medigap insurance company. With a Medicare SELECT policy, you may need to use specific hospitals and doctors to get full insurance benefits (except in an emergency). This will not affect how Medicare pays its share. For this reason, Medicare SELECT policies generally have a lower premium.

What are Medicare managed care plans?

Medicare managed care plans are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B benefits. Some plans cover extra benefits, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

For more information:

Call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) and ask for a copy of the *Medicare & You* handbook for more information on the Original Medicare Plan and Medicare managed care plans or the *Guide to Health Insurance for People with Medicare* or *Medicare Supplemental Insurance (Medigap) Policies and Protections* for more information on Medigap.

Things to Think About

What things should I think about before I make any changes in my health plan?

Do you know the type of health care coverage you have now? If not, you should find out. Medicare may not be the only health care coverage you have or can get. You might be able to get health care coverage or help with health care costs that may give you more benefits or lower out-of-pocket costs than Medicare alone does.

If you or your spouse are retired or still work, you may have, or be able to get, employer or union health care coverage:

- Call the employer or union to find out if you have or can get health care coverage from your or your spouse's past or present employment.
- Ask your employer or union's benefit administrator how much their coverage costs, and how the benefits add to your Medicare health plan.

Caution: If you already have employer or union coverage, talk to your employer or union before you sign up for a different Medicare health plan. If you drop your employer or union coverage, you may not be able to get it back.

If you are a Veteran or a military retiree, you may have, or be able to get, medical benefits:

- If you are a Veteran, call the U.S. Department of Veteran Affairs at 1-800-827-1000. If you are retired from the military, you may also call the Department of Defense at 1-800-538-9552 for more information.

If you have a low income and limited assets, you may have, or be able to get, help paying your health care costs:

- To see if you qualify, call your State medical assistance office. Call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) to get the number of your State medical assistance office.

Private Fee-for-Service Plan Basics

What is a Private Fee-for-Service plan?

A Private Fee-for-Service plan is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan which is offered by the federal government. In a Private Fee-for-Service plan, Medicare pays a set amount of money every month to the private company to provide health care coverage to people with Medicare on a pay-per-visit arrangement.

Where are Private Fee-for-Service plans offered?

Because the company decides where it will do business, it may only offer Private Fee-for-Service plans in some parts of the country. The company can decide that a plan will be available to everyone with Medicare in a State, or be open only in certain counties. The company may also offer more than one plan in an area, with different benefits and costs. Each year, the insurance company offering a Private Fee-for-Service plan can decide to join or leave Medicare.

How do Private Fee-for-Service plans work?

- In Private Fee-for-Service plans, you may go to any doctor or hospital you want.
- You can get services outside your service area.
- Although the amount you pay for these services may not be the same as the Original Medicare Plan, you get all services covered under Medicare Part A and Part B.
- You may have extra benefits the Original Medicare Plan doesn't cover, like outpatient prescription drugs. However, you may have to pay more for these extra benefits. To find out what benefits are covered in a Private Fee-for-Service plan, call the insurance company offering the plan and ask for this information. You can also look at Medicare Compare on the Internet at www.medicare.gov.
- Private Fee-for-Service plans can charge you a premium amount above the Medicare Part B premium.
- Private Fee-for-Service plans can charge deductible and coinsurance amounts that are different than those under the Original Medicare Plan.

Remember: Terms in red are defined on pages 19-20.

- Private Fee-for-Service plans can charge a premium for extra benefits like prescription drugs.
- Private Fee-for-Service plans may let providers (such as doctors or hospitals) charge you 15% over the plan's payment amount for services. This 15% balance billing amount applies to providers who have a written contract with the Private Fee-for-Service plan or who the company has decided to think of as having a contract (deemed) because they have met certain conditions.

  If the provider doesn't have a contract with the Private Fee-for-Service plan or is not deemed to have a contract with the plan, the provider cannot charge you more than the plan's cost sharing amount.

  Because this could affect how much you will pay for services, find out if your Private Fee-for-Service plan allows balance billing and what other costs you may have. Even if balance billing is allowed, your provider may be willing to accept the plan's payment amount as payment in full.

Note: If you go to any provider and tell them you have a Private Fee-for-Service plan, and the provider agrees to give you care, they have a contract with the Private Fee-for-Service plan.

Example ▶

Mr. Stevens must go to the hospital for bypass surgery. The hospital he is going to has a contract with Mr. Stevens' Private Fee-for-Service plan. This Private Fee-for-Service plan lets contracting providers "balance bill" (charge you 15% over the plan's payment amount) for services. Mr. Stevens has a 20% coinsurance amount he must pay for all inpatient hospital services he gets. The Private Fee-for-Service plan's payment amount for Mr. Stevens' hospital services is $15,000. Mr. Stevens must pay $3,000 (the 20% coinsurance amount). The hospital also charges Mr. Stevens 15% over the $15,000 plan payment amount. This amount is $2,250. Mr. Stevens owes a total of $5,250 ($3,000 + $2,250) to the hospital for his services.

Note: The insurance company, rather than the Medicare program, decides how much you pay for the services you get.

Remember: Terms in red are defined on pages 19-20.

Private Fee-for-Service Plan Basics

How are Private Fee-for-Service plans different from the Original Medicare Plan and Medicare managed care plans?

The following chart shows some of the differences between Private Fee-for-Service plans, the Original Medicare Plan, and Medicare managed care plans. For more information, you can also look on the Internet at www.medicare.gov. Click on Medicare Compare to see information that compares all of the Medicare plans in your area.

	Private Fee-for-Service plans	Original Medicare Plan	Medicare managed care plans
Premiums: Will I have to pay more than the monthly Part B premium to be in the plan?	Possibly, and there is no limit on the premium amount that Private Fee-for-Service plans can charge. Call the insurance company offering the plan to find out.	No.	Possibly, but there is a limit on the premium amount that Medicare managed care plans can charge. Call the plan to find out.
Benefits: Does the plan cover more benefits than Medicare Part A and Part B?	Possibly for an additional premium. Call the insurance company offering the plan to find out.	No.	Usually yes. Benefits are either free or cost an additional premium. Call the plan to find out.
Providers: Do I have to get services from specific doctors and hospitals for the plan to cover them?	No.	No.	Generally, yes.
Cost sharing: Does the plan let providers (such as doctors or hospitals) charge me more than Medicare's deductibles, coinsurance, and copayments?	Possibly. Plans may let providers charge you 15% above the plan's payment amount for services. Call the insurance company offering the plan to find out.	No for hospitals. Possibly. Doctors who do not accept assignment can bill up to 15% above Medicare's payment amount. Call 1-800-MEDICARE (1-800-633-4227) to find out more about assignment.	No.
Medigap: Do I also need a Medigap policy if I join this plan?	You do not need a Medigap policy if you join this plan. In fact, it is illegal for someone to sell you a Medigap policy if you are in this plan.	You may need a Medigap policy to cover services the Original Medicare Plan doesn't cover.	You do not need a Medigap policy if you join this plan. In fact, it is illegal for someone to sell you a Medigap policy if you are in this plan.

Private Fee-for-Service Plan Costs

What is the cost of a Private Fee-for-Service plan?

You pay:

- The monthly Medicare Part B premium ($45.50 in 1999); and
- Any additional monthly premium the Private Fee-for-Service plan charges above the Medicare Part B premium; and
- Any additional monthly premium the Private Fee-for-Service plan charges for extra benefits; and
- Any plan deductible, coinsurance, or copayment amounts that the Private Fee-for-Service plan charges. For example, the plan may charge a set amount (copayment), like $5 or $10 every time you see a doctor.

Example ▶

Mrs. Jones is thinking about joining a Private Fee-for-Service plan. The Private Fee-for-Service plan has a $75.00 monthly premium, but covers additional benefits not covered by Medicare. To be in this plan, Mrs. Jones would have to pay the monthly Medicare Part B premium ($45.50 in 1999) and the additional monthly premium ($75.00) the plan charges. This plan also charges $5 for every doctor visit. If Mrs. Jones goes to her doctor three times in one month, she would have to pay the $45.50 and $75.00 monthly premiums, and a total of $15 for her three doctor visits ($5 per visit). Therefore, Mrs. Jones would pay $45.50 to Medicare, $75.00 to her Private Fee-for-Service plan, and $15.00 to her doctor for that month. Her total costs for that month would be $135.50 ($45.50+$75.00+$15.00).

Important ▶

The Private Fee-for-Service plan may allow providers such as doctors or hospitals to charge you more than the deductible, coinsurance, or copayment amounts that the Private Fee-for-Service plan charges. This means that your costs may be higher when you visit your doctor or a hospital. It is important to find out if providers (including hospitals) can charge you more before you join the plan. If the plan lets your provider charge you more, find out from your provider if they are going to charge you more for services.

Example ▶

Mr. Johnson joined a Private Fee-for-Service plan that lets providers charge more for services than the Private Fee-for-Service plan charges. Mr. Johnson's Private Fee-for-Service plan charges a $5 copayment for doctor visits. However, when Mr. Johnson goes to his doctor, the doctor charges a $15 copayment. Because Mr. Johnson's Private Fee-for-Service plan lets his doctor charge more for services, Mr. Johnson must pay the $15.

How do my out-of-pocket costs vary?

Private Fee-for-Service plans will differ in the amount they charge for premiums, deductibles, and services. The Private Fee-for-Service plan (rather than Medicare) decides how much you pay for the covered services you get.

Your costs depend on:

- Which Private Fee-for-Service plan you choose.
- Whether the plan charges an additional monthly premium.
- How much the plan charges per visit.
- Whether the plan lets doctors, hospitals, and other providers bill you more than the plan pays (up to a limit) for services. (If this is allowed, you must pay the difference.) (See page 6.)
- How often and the type of health care you get.
- Which extra benefits are covered by the plan.

How will I have to pay provider (such as a doctor or hospital) bills?

If the Private Fee-for-Service plan pays the doctor or hospital directly, you will not have to pay the doctor or hospital bill. However, other plans may make you pay all of the doctor's or hospital's bill, and pay you back the plan's share later. Before joining any Private Fee-for-Service plan, you should ask the plan or check the plan brochure to find out how you will have to pay bills.

Who can join a Private Fee-for-Service plan?

You can join a Private Fee-for-Service plan if:

- You have both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). If you are not sure if you have Part A and B, look on your red, white, and blue Medicare card. You can also call your local Social Security office, or call Social Security at 1-800-772-1213.
- You do not have End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant, sometimes called ESRD).
- You live in the service area of the plan. You will need to check with the insurance company to see if you can stay in the plan if you move out of the plan's service area. If you must leave the plan, you will then be covered under the Original Medicare Plan. Or, you can choose to join another Medicare health plan (like a Medicare managed care plan) if one is available in your new area.

If you join a Private Fee-for-Service plan:

- You are still in the Medicare program.
- You must continue to pay the monthly Part B premium of $45.50 (in 1999).
- You will keep all of your rights and protections under the Original Medicare Plan except that you will not be protected against having to pay for services you got that the Private Fee-for-Service plan says are not medically necessary (see example on page 14).
- You still get all your regular Medicare covered services.

To get more information about your Medicare rights and protections, and covered services, call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of the brochure *Medicare Patient Rights* and the *Medicare & You* handbook.

Remember: Terms in red are defined on pages 19-20.

How do I join a Private Fee-for-Service plan?

At the present time, you may be able to join any Private Fee-for-Service plan that is available in your area at any time.* If you want to join:

1. Call the plan and ask for an enrollment form.
2. Fill out the form and mail it to the plan.
3. You will get a letter from the plan telling you when your coverage begins. The plan cannot refuse to enroll you if you are eligible.

How do I leave a Private Fee-for-Service plan?

At the present time, you may leave a plan at any time for any reason. Write a letter to the plan or the Social Security Administration and tell them you want to leave.

When you leave the plan, you can join another Medicare health plan (if the plan is accepting new members) or return to the Original Medicare Plan. In most cases, your new coverage starts the month after you leave your current plan. In some cases, you may have the right to buy a Medigap policy (see pages 16 and 17).

Starting in 2002, health plan enrollment rules will change. You may only be able to leave the plan at certain times. Call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) for more information. (See page 18 to find out what plans, if any, are available in your area.)

*At the time this pamphlet was printed, no private insurance companies were offering Private Fee-for-Service plans to people with Medicare.

Example ▶

Mr. Smith wants to leave his Private Fee-for-Service plan and go back to the Original Medicare Plan. He sends a signed letter to his plan on October 3, 2000 telling the plan he wants to leave. Mr. Smith gets a letter from his plan telling him that his coverage ends after October 31, 2000. Mr. Smith does not join any other Medicare health plan. His Original Medicare Plan coverage starts on November 1, 2000. Mr. Smith must continue to get services through his Private Fee-for-Service plan from October 3, 2000 to October 31, 2000. On November 1, 2000, Mr. Smith must get services through the Original Medicare Plan.

Remember, if you leave your Private Fee-for-Service plan and do not join another one, you will return to the Original Medicare Plan (as long as you continue to pay your Part B premium).

Note: Private Fee-for-Service plans can leave the Medicare program at the end of the calendar year. (See page 16 to find out what you can do if your Private Fee-for-Service plan leaves the Medicare program.)

Private Fee-for-Service Plan Covered Services

What services must Private Fee-for-Service plans cover?

Private Fee-for-Service plans must cover:

- all of the services covered under Medicare Part A and Part B; and
- all services that Medicare considers medically necessary.

They may cover extra benefits, like outpatient prescription drugs, but you may have to pay more for these extra benefits.

How do I know if a service I need will be medically necessary?

Private Fee-for-Service plans must use Medicare's coverage rules to decide what services are medically necessary. This means that if a service is medically necessary under Medicare, then the Private Fee-for-Service plan must cover the service. You can also ask the plan for an advance coverage decision to make sure the service is medically necessary and will be covered. If you ask for an advance coverage decision, you have the right to get a decision from the Private Fee-for-Service plan.

Do Private Fee-for-Service plans cover services that Medicare does not consider medically necessary?

Private Fee-for-Service plans may not cover the costs of services that are not medically necessary under Medicare. If you need a service that the Private Fee-for-Service plan decides is not medically necessary:

- you may have to pay all the costs of the service; and
- you have the right to appeal the decision (see page 15).

Example ▶

Mrs. Jenkins had a broken arm that healed correctly. Her doctor decided to send her to physical therapy to strengthen her arm instead of showing her simple exercises she could do at home. She gets physical therapy every day for five days. The total cost of the therapy is $250. After Mrs. Jenkins has stopped going to therapy, she finds out that the plan looked at her claim and decided her therapy was not medically necessary because her arm healed correctly. Therefore, the plan decided not to pay for her physical therapy services. Mrs. Jenkins must pay the $250 herself. She has the right to appeal this decision if she wants.

What can I do if the Private Fee-for-Service plan will not pay for services I think I need?

If the Private Fee-for-Service plan will not pay for a service you think you need,

- you will have to pay all of the costs if you did not ask for an advance coverage decision.
- you can appeal the decision (see page 15).

If you are interested in joining a Private Fee-for-Service plan, ask the plan or check the plan brochure to see how they handle medically necessary services and advance coverage decisions.

What can I do if my Private Fee-for-Service plan will not pay for a service I think is medically necessary?

If your plan will not pay for or does not allow a service that you think should be covered (including medically necessary services), you can file an appeal.

How do I question or appeal a Private Fee-for-Service plan coverage decision?

You have the right to appeal any decision about your Medicare covered services. This is true whether you are in the Original Medicare Plan or a Private Fee-for-Service plan. In addition, you have the right to appeal any decision about your Private Fee-for-Service plan extra benefits.

If you are in a Private Fee-for-Service plan, you can file an appeal if your plan will not pay for, does not allow, stops, or limits a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. They must answer you within 72 hours.

The Private Fee-for-Service plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization in your area. A Peer Review Organization is a group of doctors and health professionals which monitors and reviews your complaints about the quality of care. You will be able to stay in the hospital at no charge while they review your case. The hospital cannot force you to leave before the Peer Review Organization reaches a decision. Call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) to get the phone number for the Peer Review Organization in your area or look on the Internet at www.medicare.gov.

Can I keep my Medigap policy if I join a Private Fee-for-Service plan?

If you join a Private Fee-for-Service plan, you may keep your Medigap policy (but you can't use it unless you return to the Original Medicare Plan). You may want to keep your Medigap policy until you are sure that you are happy with the Private Fee-for-Service plan. If you are in a Private Fee-for-Service plan, or if you are covered by Medicaid, you do not need a Medigap policy. Generally, it is not legal for anyone to sell you one in these cases.

What happens if my Private Fee-for-Service plan coverage ends?

If your Private Fee-for-Service plan coverage ends or stops providing care in your area, you can join another Medicare health plan, if one is available or you can return to the Original Medicare Plan. Generally, if you return to the Orignial Medicare Plan, you may also have the right to buy a Medigap policy. (See page 17 to find out where you can get more information on Medigap policies and protections.)

What happens if my Private Fee-for-Service plan coverage ends and I am under age 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD)?

Depending on where you live in the country, you may have the same protections as those over age 65 if your Private Fee-for-Service plan coverage ends. There is no Federal law that requires insurance companies to sell Medigap plans to people under age 65.

Do I have any Medigap protections if I drop my Medigap policy when I join a Private Fee-for-Service plan?

If you drop your Medigap policy when you join a Private Fee-for-Service plan, you may have the right to get another Medigap policy later if:

- Your Private Fee-for-Service plan coverage ends (through no fault of your own), or
- You join a Private Fee-for-Service plan for the first time (and have not been in another Medicare managed care plan), and within one year of joining, you leave the Private Fee-for-Service plan. If you were new to Medicare when you joined the plan, you may be able to choose any Medigap policy you want. If you already had a Medigap policy before you joined the plan, you may be able to get the same policy back.

Are there any other times I have a right to buy a Medigap policy?

You have the right to buy any Medigap policy sold in your State if:

- You joined a Private Fee-for-Service plan when you first became eligible for Medicare at age 65; and
- You leave the Private Fee-for-Service plan within one year after joining.

You must apply for the Medigap policy no later than 63 calendar days after your Private Fee-for-Service plan coverage ends.

Where can I get more information about Medigap policies and protections?

Call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) and ask for:

- a copy of *Medicare Supplemental Insurance (Medigap) Policies and Protections*.
- a copy of the *Guide to Health Insurance for People with Medicare*. This guide gives information on buying a Medigap policy and other kinds of health insurance, including information on your Medigap rights and protections.
- the phone number for your State Health Insurance Assistance Program. Volunteer counselors can help you understand your choices and protections.

You can also look on the Internet at www.medicare.gov.

For More Information

Where can I get more information about Private Fee-for-Service plans?

For more information about Private Fee-for-Service plans or to find out what plans are available in your area, you can:

- Look at Medicare health plan comparison information on the Internet at www.medicare.gov. Click on Medicare Compare. If you don't have a computer, your local library or senior center may be able to help you access the Medicare website.

- Call 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) and ask for:
  - information on Private Fee-for-Service plans available in your area.
  - the phone number for your State Health Insurance Assistance Program.
  - the *Worksheet for Comparing Medicare Health Plans* to help you compare differences between available plans.

- Call the insurance company offering the Private Fee-for-Service plan you are interested in to answer any questions you have about the plan. The health plan administrator will be able to send you information about the plan and explain all the benefits the plan offers.

Definitions of Important Terms

Advance Coverage Decision: A decision that your Private Fee-for-Service plan makes on whether it will pay for a particular service.

Balance Billing: When Private Fee-for-Service plan providers (such as doctors or hospitals) charge 15% more than the plan's payment amount for services.

Coinsurance: The percent of the Private Fee-for-Service plan amount that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Copayment: The amount that you pay for each medical service you get, like a doctor visit.

Deductible: The amount you must pay for health care, before the Private Fee-for-Service plan begins to pay.

End-Stage Renal Disease (ESRD): Permanent kidney failure that is treated with regular dialysis or a kidney transplant.

Medicaid: A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from State to State, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary: Services or supplies that:

- are proper and needed for the diagnosis, or treatment of your medical condition;
- are used for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the local medical community; and
- are not mainly for the convenience of you or your doctor.

Medicare + Choice: A new Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Medicare Managed Care Plan: A group of doctors, hospitals, and other health care providers who have agreed to give health care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. Managed care plans include Health Maintenance Organizations (HMO), HMOs with a Point of Service Option (POS), Provider Sponsored Organizations (PSO), and Preferred Provider Organizations (PPO).

Medicare Part A (Hospital Insurance): Medicare hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

Medicare Part B (Medical Insurance): Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.

Medigap: Medicare supplemental insurance policies that are sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. In all states except Minnesota, Massachusetts, and Wisconsin, your state decides which of the 10 standardized policies can be sold in your state. Medigap policies only work with the Original Medicare Plan.

Original Medicare Plan: A pay-per-visit health care plan that allows you to go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Peer Review Organization (PRO): Groups of practicing doctors and other health care experts paid by the Federal Government to monitor and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service plans, and ambulatory surgical centers.

Premium: Your monthly payment for health care coverage to Medicare, an insurance company, or a health care plan.

Private Fee-for-Service Plan: A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you get. You may pay more for Medicare covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Service Area: The area where a Private Fee-for-Service plan accepts members.

State Health Insurance Assistance Program: A State organization that receives money from the Federal Government to give free health insurance counseling and assistance to Medicare beneficiaries.

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U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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