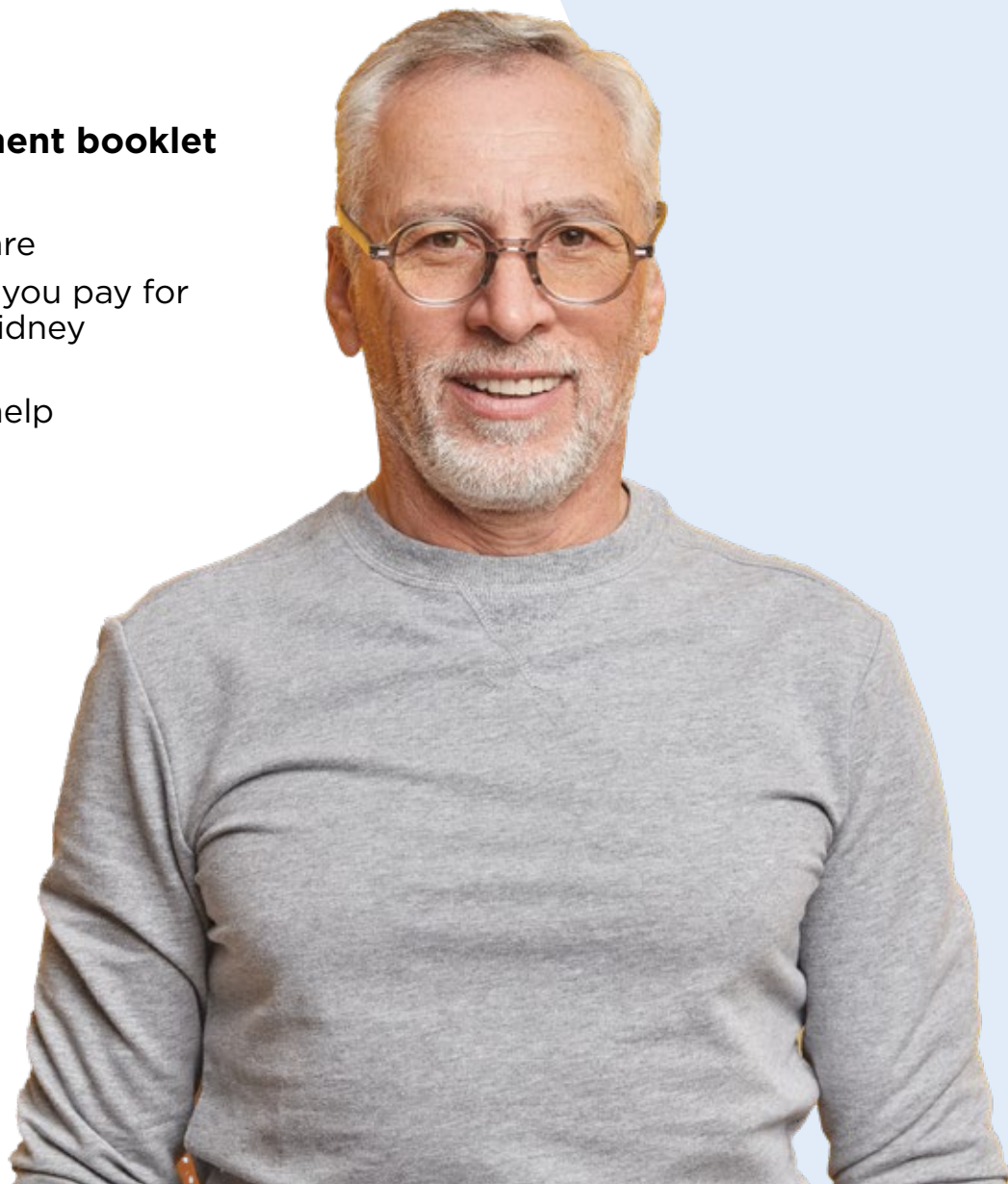


Medicare Coverage of Kidney Dialysis & Kidney Transplant Services

**This official government booklet
tells you:**

- The basics of Medicare
- How Medicare helps you pay for kidney dialysis and kidney transplants
- Where you can get help

Medicare.gov



Medicare

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Section 1

Medicare basics

What's Medicare?

Medicare is federal health insurance for:

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

Note: Go to pages 39–41 for definitions of **blue** words

What does Medicare cover?

Part A – Hospital Insurance

Helps cover:

- Inpatient care in hospitals
- **Skilled nursing facility care**
- Hospice care
- **Home health care**

Part B – Medical Insurance

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many **preventive services** (like screenings, shots or vaccines, and yearly “Wellness” visits)

Part D – Drug Coverage

Helps cover the cost of prescription drugs (including many recommended shots or vaccines). Part D also helps you with drug costs that Part B doesn’t cover.

Plans that offer **Medicare drug coverage (Part D)** are run by private insurance companies that follow rules set by Medicare. Different plans cover different drugs, but plans must cover a wide range of **medically necessary** drugs that people with Medicare take.

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

Medicare plan choices

There are 2 main ways to get Medicare: you can choose between **Original Medicare** or join a **Medicare Advantage Plan**.

If you have ESRD and choose Original Medicare

You can go to any doctor or **supplier** that accepts Medicare (and new patients), or any participating hospital or other facility.

You pay a set amount for your health care (**deductible**) before Medicare starts paying. 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 Medicare drug coverage (Part D) by joining a Medicare drug plan. Go to page 23.

If you have ESRD & choose a Medicare Advantage Plan

Medicare Advantage Plans are a type of **Medicare health plan** offered by a private insurance company that contracts with Medicare to give all of your Part A and Part B benefits. Most Medicare Advantage Plans also offer Part D drug coverage. Medicare Advantage Plans must cover all of the services that **Original Medicare** covers. Some plans may offer extra benefits that Original Medicare doesn't cover, like vision, hearing, and dental services. Out-of-pocket costs vary in each plan.

Once you have Medicare Part A and Part B, you can join a Medicare Advantage Plan. Visit [Medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan](https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan) to learn more.

Important: In many cases, you can only use health care providers who are in the Medicare Advantage Plan's network and service area. Before you join, check with your providers and the plan you're considering to make sure the providers you currently go to (like your dialysis facility or kidney doctor), or want to visit in the future (like a transplant specialist), are in the plan's network. If you're already in a Medicare Advantage Plan, check with your providers to make sure they'll still be part of the plan's network next year. To learn more about a specific Medicare Advantage Plan, contact the plan, or visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

If you join a Medicare Advantage Plan within the first 3 months and you have both Medicare Part A and Part B, you can use the Medicare Advantage Open Enrollment Period (January 1–March 31) to change to a different Medicare Advantage Plan or switch back to Original Medicare. If you join a Medicare Advantage Plan during the Open Enrollment Period (October 15–December 7), you can also use the Medicare Advantage Open Enrollment Period to change to a different Medicare Advantage Plan or switch back to Original Medicare (depending on which coverage works best for you).

To learn more about types of Medicare Advantage Plans, visit [Medicare.gov/health-drug-plans/health-plans/your-coverage-options/compare](https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/compare).

For more information about your Medicare plan choices, look at your most recent "Medicare & You" handbook or visit [Medicare.gov](https://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227) to get more information. TTY users can call 1-877-486-2048.

Getting Medicare with ESRD

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 one of these applies to you:

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

You must also file an application with the Social Security Administration and meet any waiting periods that apply.

Note: If you qualify for Medicare Part A, you can also get Medicare Part B. Most people must pay a monthly **premium** for Part B. Go to page 29. Signing up for 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. Go to page 36.

Visit [SSA.gov](https://www.ssa.gov) for more information about the required amount of time needed under Social Security, the RRB, or as a government employee to be eligible for Medicare based on ESRD.

If your child has ESRD

Your child can be covered if you or your spouse have worked the required amount of time under Social Security, the RRB, or as a government employee. Your child can also be covered if you, your spouse, or your child gets Social Security or RRB benefits, or is eligible to get those benefits.

Medicare can help cover your child's medical costs if your child needs regular dialysis because their kidneys no longer work, or if they had a kidney transplant.

Visit [Medicare.gov/basics/children-and-end-stage-renal-disease](https://www.Medicare.gov/basics/children-and-end-stage-renal-disease) for more information. To sign your child up for Medicare, or to get more information about eligibility, visit your local Social Security office.

How to sign up for Medicare

If you’re eligible for Medicare because of ESRD, you can visit your local Social Security office to sign up.

Once you have Medicare, you’ll need to choose how you get your coverage. Go to pages 2–4. For more information on your coverage options, visit [Medicare.gov](#).

Note: If you already have Medicare because of age or disability, and you’re currently paying a Part B late enrollment [penalty](#), you’ll need to sign up again for Medicare (because of ESRD) to stop paying the penalty. Visit your local Social Security office to make an appointment to re-enroll in Medicare based on ESRD.

When Medicare coverage begins

Eligibility for Medicare coverage because of ESRD works differently than other types of Medicare eligibility. If you’re eligible for Medicare because of ESRD and don’t sign up right away, your coverage could be retroactive up to 12 months before the month you apply, but no earlier than the date you first became eligible. Retroactive coverage means you may be covered for some costs that occurred in the past.

Example: If you become eligible for Medicare based on ESRD in February, but don’t sign up for Medicare until November, your Medicare coverage will backdate to February.

For more information, visit [Medicare.gov/basics/end-stage-renal-disease](#) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you’re on dialysis

When you sign up for Medicare because of ESRD **and you’re on dialysis**, Medicare coverage usually starts on the first day of the fourth month of your continuous dialysis treatments (called a “waiting period”). For example, if you start dialysis on July 1, your coverage will begin 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.

For some, Medicare coverage can begin as early as the first month of a regular course of dialysis treatments if you meet both of these conditions:

- You participate in a home dialysis training program that a Medicare-certified training facility offers during the first 3 months of your regular course of dialysis.
- Your doctor expects you to finish training and be able to do your own dialysis treatments.

Important: Medicare won't cover surgery or other services needed to prepare for dialysis (like surgery for 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 Medicare could cover these services.

If you're already getting Medicare because of age or disability, Medicare will cover physician-ordered fistula placement or other preparatory services before dialysis begins.

If you're getting a kidney transplant

Medicare coverage can begin the month you're admitted to a Medicare-certified 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 next 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, after his hospital admission, his Medicare coverage will still begin in March.

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), Medicare coverage can begin 2 months before your transplant.

When Medicare coverage ends

If you're eligible for Medicare only because of ESRD 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 resume 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.

Note: Medicare offers a benefit that helps pay for immunosuppressive drugs beyond 36 months after your kidney transplant (when Medicare coverage generally ends), if you don't have certain types of health coverage. This benefit only covers immunosuppressive drugs and no other items or services. It isn't a substitute for full health coverage. Visit [Medicare.gov/basics/end-stage-renal-disease](https://www.medicare.gov/basics/end-stage-renal-disease) to learn more.

How Medicare works with employer or union group health plan coverage

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

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. Go to page 36.

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.

If your plan doesn't pay 100% of your health care bills, Medicare may pay some of the remaining costs during a coordination period. 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 (the insurance policy, plan, or program that pays second on a claim for medical care). This coordination period lasts for 30 months.

The 30-month coordination period

The 30-month coordination period 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.**

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 participate in home 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 right away. This is very important to make sure that your services are billed correctly. 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 Medicare doesn't cover. Check with your plan's benefits administrator for more information.

There's a separate 30-month coordination period each time you sign up for 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 based on your age or disability).

If after 36 months you sign up for 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 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. Medicare Part B only covers immunosuppressive drugs in specific circumstances. Go to page 21.

Note: If you don't meet the conditions for Part B coverage of immunosuppressive drugs, you may be able to get Part D drug coverage. Go to pages 22–24 to learn more.

If your group health plan coverage has a yearly **deductible**, **copayment**, or **coinsurance**, signing up for Medicare 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 (like if it doesn't have a yearly deductible), you may choose to delay signing up for Part A and Part B until the 30-month coordination period is over.

If you delay enrollment in Medicare, 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 sign up for Part A and Part B. **Your Part B premium won't be higher because you delayed your enrollment while you have employer or union group health plan coverage based on your or your spouse's current employment.** If your group health plan benefits are decreased or end during the coordination period, you should sign up for 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.



Section 2

Kidney dialysis

What's 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. Dialysis also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments may help you feel better and live longer, but they aren't a cure for permanent kidney failure.

Note: Go to pages 39–41 for definitions of **blue** words

Dialysis treatment options

There are 2 primary types of dialysis treatment options:

- **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 dialyzer to clean out wastes and extra fluids. Then, the newly-cleaned blood flows through another set of tubes back into your body. Hemodialysis treatment can happen at a dialysis facility or at home.
- **Peritoneal dialysis** uses a special solution (called dialysate) that flows through a tube into your abdomen. After a few hours, the dialysate takes 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 which type of dialysis you need based on your situation.

Dialysis services & supplies Medicare covers

Service or supply	Medicare Part A	Medicare Part B
Inpatient dialysis treatments (if you're admitted to a hospital for special care).	✓	
Outpatient dialysis treatments and doctors' services (in a Medicare-certified dialysis facility or your home). Go to pages 14–17.		✓
Home 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). Go to pages 16–17.		✓
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). Go to pages 16–17.		✓
Most drugs for outpatient or home dialysis. Go to page 23.		✓
Other services and supplies that are part of dialysis (like laboratory tests).		✓

To find out what you pay for these services, go to pages 25–30.

Dialysis services & supplies NOT covered by Medicare

Medicare doesn't cover these services or supplies:

- Paid dialysis aides that help you with home dialysis, unless it's part of a bundled payment for your dialysis.
- Any lost pay to you or the person who may be helping you during home dialysis training
- A place to stay during your treatment
- Blood or packed red blood cells for home dialysis, unless part of a doctor's service

There are some types of coverage that may pay some of the health care costs that Medicare doesn't pay. For more information on [Medicare drug coverage \(Part D\)](#), go to pages 22–24.

Dialysis facilities

Dialysis can be done at home or in a Medicare-certified dialysis facility (also known as a dialysis center). For Medicare to pay for your treatments, the facility must be Medicare-certified to give dialysis, even if the facility already gives other health care services that Medicare covers.

At the dialysis facility, a nurse or trained technician may give you the treatment. At home, you can treat yourself or ask a family member or friend for help with your treatment.

Medicare evaluates dialysis facilities each year using different quality measures. These quality measures show how often dialysis facilities use best practices when caring for you. Medicare gives each dialysis facility a score based on its evaluation of these quality measures. Dialysis facilities are required to display that score in an area that's easy for you to find, and in a format and language you understand.

How to find a facility

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

You can visit [Medicare.gov/care-compare](https://www.medicare.gov/care-compare) to find a dialysis facility that's close to you, or call your local ESRD Network. Go to page 35.

[Medicare.gov/care-compare](https://www.medicare.gov/care-compare) has detailed information about Medicare-certified dialysis facilities. You can compare dialysis facilities based on their star ratings, as well as the services and quality of care they give. It also has other resources for patients and family members who want to learn more about chronic kidney disease and dialysis.

When you visit [Medicare.gov/care-compare](https://www.medicare.gov/care-compare), you can find and compare this information about dialysis facilities:

- Addresses
- Phone numbers
- Maps and directions
- Types of dialysis services offered
- Quality of patient care
- Patient experience of care survey results

If you don't have a smart phone or computer, your local library or senior center may be able to help you look up information on dialysis facilities. You can also contact your local State Health Insurance Assistance Program (SHIP) (page 38), or call 1-800-MEDICARE (1-800-633-4227) to get help comparing dialysis facilities. TTY users can call 1-877-486-2048.

If you have a problem finding a dialysis facility that's willing to take you as a patient, you have the right to file a complaint (grievance). Go to pages 31-33.

Transportation to dialysis facilities

Original Medicare only covers ambulance services to and from your home to the nearest dialysis facility, when other forms of transportation could endanger 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 the date must be 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 facilities and doctors. Read your plan materials, or call the plan for more information.

For more information about ambulance coverage, visit [Medicare.gov/coverage/ambulance-services](https://www.medicare.gov/coverage/ambulance-services). You can also call 1-800-MEDICARE (1-800-633-4227).

If you need help with non-ambulance transportation, talk to the social worker at your dialysis facility to find out your options.

Dialysis in a hospital

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

Go to page 28.

Home dialysis

Medicare Part B covers home dialysis training for you or your caregiver, but only by a facility certified for dialysis training. You may qualify for training if you think you'll benefit from home dialysis treatments, and your doctor approves. Training sessions occur at the same time you get dialysis treatment and are limited to a maximum number of sessions.

Your dialysis facility is responsible for giving you all of your home dialysis related items and services, including equipment and supplies, that are **medically necessary** and reasonable.

Your dialysis facility must give you these items and services directly, or through an arrangement with another provider.

Medicare makes a single payment per dialysis treatment to the dialysis facility for all dialysis-related services, including equipment and supplies. Dialysis facilities pay third-party **suppliers** from this single payment amount.

Monthly doctor visits for home dialysis

You may be able to get a monthly visit from your doctor (or certain other health care providers, like physician assistants and nurse practitioners) to help you manage your care.

This benefit includes an in-person visit between you and your health care provider once a month. You can also choose to get some of your monthly visits via telehealth. These visits allow you and your doctor to review your lab work, discuss your care and the effectiveness of your dialysis, check for complications, and give you a chance to ask questions about your home dialysis treatment. To learn more about telehealth, visit [Medicare.gov/coverage/telehealth](https://www.medicare.gov/coverage/telehealth).

Dialysis when you travel

You can still travel within the U.S. if you need dialysis. There are about 6,000 dialysis facilities around the country. Your facility can help you plan your treatment along the route of your trip before you travel.

While you're traveling, you may need to pay your **copayment** when you get your dialysis. Check with the social worker at your home dialysis facility to learn more.

Your dialysis facility will help you by checking if the facilities on your route:

- Are Medicare-certified 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 U.S.

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

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, 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.

The minimum numbers for adequate dialysis differ based on the type of dialysis (hemodialysis or peritoneal dialysis) treatment you're getting. 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, you may feel okay without adequate dialysis. However, over time, not getting adequate dialysis can make you feel weak and tired, which can lead to a higher risk of infection and prolonged bleeding, and shorten your life.

Here are some steps you can take to help make dialysis work better:

- Arrive on time to all of your scheduled treatments.
- 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 each month.
- Before you start dialysis, talk to your doctor about which type of dialysis is best for you. If you're starting hemodialysis, talk to your doctor about which type of hemodialysis vascular access is best for you. Your vascular access uses your blood vessels and is created by a surgeon to use for cleaning your blood during dialysis.
- Learn how to care for 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. If you have a problem with the care that you're getting for your kidney disease, you have the right to file a complaint. Go to pages 31–33.



Section 3

Kidney transplants

What's a kidney transplant?

A kidney transplant is a type of surgery that puts someone else's healthy kidney into your body. This donated kidney does the work that your own kidneys no longer do. You may get a kidney from someone who recently died, or from someone who's still living, like an eligible family member. The blood of the possible kidney donor must be tested to make sure that it's compatible with your body so that your body won't reject the new kidney.

Original Medicare will cover your kidney transplant only if it's done in a hospital that's Medicare-certified to do kidney transplants. If you're in a **Medicare Advantage Plan**, you might be able to use hospitals outside the plan's network and service area. Check with your plan to find out which hospital you can use.

If you have a problem with the care that you're getting for your transplant or with getting a referral for a transplant work-up, you have the right to file a complaint. Go to pages 31–33.

Note: Go to pages 39–41 for definitions of **blue** words

Kidney transplant services covered by Medicare

Service or supply	Medicare Part A	Medicare Part B
Inpatient services in a Medicare-certified hospital.	✓	
Kidney registry fee.	✓	
Laboratory and other tests to evaluate your medical condition and the condition of potential kidney donors. Medicare covers these services at Medicare-certified hospitals where you'll get your transplant, or another hospital that participates in Medicare.	✓	
The costs of finding the proper kidney for your transplant surgery (if there's no kidney donor).	✓	
The cost of some care for your kidney donor.	✓	
Any extra inpatient hospital care your donor needs if they experience problems after donation.	✓	✓
Doctors' services for kidney transplant surgery (including care before, during, and after the surgery).		✓
Doctors' services for your kidney donor during their hospital stay.		✓
Transplant drugs (also called immunosuppressive drugs) for a limited time after you leave the hospital, following a transplant. Go to pages 20–21.		✓
Blood (whole or units of packed red blood cells, blood components, and the cost of processing and giving you blood). Go to page 30.	✓	✓

To find out what you pay for these services, go to pages 25–30.

ESRD & pancreas transplants

If you have ESRD and need a pancreas transplant, Medicare covers the transplant if it's done at the same time you get a kidney transplant or 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 have Medicare only because of permanent kidney failure, and you have a pancreas transplant after a kidney transplant, Medicare will only pay for your immunosuppressive drugs for 36 months after the month of the kidney transplant and your Medicare coverage will end after then. However, you may be eligible for a Part B benefit that helps continue to pay for your immunosuppressive drugs beyond 36 months. Go to page 21 to learn more.

If you were already eligible for 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 transplant drugs with no time limit.

Transplant drugs (also called immunosuppressive drugs)

What are transplant drugs?

Transplant drugs are immunosuppressive 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.

If you're only eligible for Medicare because of ESRD (you aren't 65 or older or have a disability), Medicare Part B will only cover your transplant drugs if both of these conditions are met:

- You already had Medicare Part A at the time of your transplant.
- You had transplant surgery at a Medicare-certified facility.

Part B will only cover your transplant drugs after you have Part B. There won't be any retroactive coverage (page 5).

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. Talk to your doctor before you stop taking your transplant drugs.

How long will Medicare pay for transplant drugs?

If you're eligible for Medicare only because of ESRD, **your Medicare coverage will end 36 months after the month of the transplant.**

However, if you're eligible for the Part B immunosuppressive drug benefit, Medicare will continue to pay for your transplant drugs beyond 36 months. Medicare will pay **without a time limit if one of these conditions applies:**

- You were already eligible for Medicare because of age or disability before you got ESRD.
- You became eligible for Medicare because of age or disability after getting a transplant that Medicare paid for (in a Medicare-certified facility), or you had private insurance that paid for your health care before your Medicare Part A coverage.

What's the immunosuppressive drug benefit?

Medicare offers a benefit that helps you pay for your immunosuppressive drugs beyond 36 months, **if you don't have or expect to get certain types of other health coverage** (like a group health plan, TRICARE, or Medicaid that covers immunosuppressive drugs). This **benefit only covers your immunosuppressive drugs and no other items or services. It isn't a substitute for full health coverage.** You can sign up for coverage of your immunosuppressive drugs at any time as long as you had Medicare because of ESRD at the time of your kidney transplant.

If you sign up for this benefit, you'll pay a monthly **premium** and a yearly **deductible**:

- The monthly premium for this benefit is \$121.60 in 2026. (You may pay a higher premium based on your income.)
- The yearly deductible is \$283 in 2026. Once you've met the deductible, you'll pay 20% of the **Medicare-approved amount** for your immunosuppressive drugs.

You may be able to get help paying for this benefit from programs offered through your state. To find out how to apply, contact your State Medicaid office at [Medicaid.gov/about-us/beneficiary-resources/index.html](https://www.Medicaid.gov/about-us/beneficiary-resources/index.html).

Visit [Medicare.gov/basics/end-stage-renal-disease](https://www.Medicare.gov/basics/end-stage-renal-disease) to learn more about the Part B immunosuppressive drug benefit.

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

If you don't qualify for the Part B immunosuppressive drug benefit and you're worried about paying for your transplant drugs 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. Go to page 36.



Section 4

Medicare drug coverage (Part D)

What Medicare covers

Medicare Part B covers transplant drugs after a covered transplant (go to pages 20–21) and most of the drugs you get for dialysis. However, Part B doesn't cover drugs for other health conditions you may have, like high blood pressure. [Medicare drug coverage \(Part D\)](#) offers drug coverage to help you with the costs of your drugs that Part B doesn't cover.

Note: Go to pages 39–41 for definitions of [blue](#) words

Medicare drug coverage won't cover drugs you can get under Part B, like immunosuppressive drugs under the conditions discussed on pages 20–21. However, if you don't meet the conditions on pages 20–21, you may be able to get coverage of your immunosuppressive drugs by joining a **Medicare Part D drug plan**.

Private companies approved by Medicare offer Part D drug coverage. There are 2 ways to get Medicare drug coverage (Part D):

- Medicare drug plans that add coverage to **Original Medicare** or certain types of **Medicare health plans**.
- **Medicare Advantage Plans** with drug coverage. You must have Medicare Part A and Part B to join a Medicare Advantage Plan. To learn more, visit [Medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan](https://www.Medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan).

Note: If you join a Medicare Advantage Plan with drug coverage, you'll get your drug coverage through your plan, and you can't join a separate Medicare drug plan.

Most drug plans charge a monthly **premium** that varies by plan. You pay this and the Part B premium. If you're in a Medicare Advantage Plan with drug coverage, the monthly premium may include an amount for drug coverage. Your costs will vary depending on which drugs you use and which drug plan you choose.

When can I join Medicare drug coverage (Part D)?

If you become eligible for Medicare because of ESRD, your first chance to join Medicare drug coverage (Part D) will be during the 7-month period that begins 3 months before the month you're eligible for Medicare and ends 3 months after the month you're eligible (called your Initial Enrollment Period).

Your Medicare drug coverage will start the same time your Medicare Part A and/or Part B coverage starts. If you join a Medicare drug plan after your Medicare Part A and/or Part B coverage starts, it will be effective the first day of the month after you join.

If you don't join when you're first eligible, or during a Special Enrollment Period, you can join during Open Enrollment (October 15–December 7 each year). Your coverage will begin on January 1 of the next 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 Part D or other **creditable prescription drug coverage**, you may have to pay a late enrollment **penalty** (which is added to your monthly premium).

This amount increases the longer you go without Part D or creditable coverage. You'll have to pay this penalty as long as you have Medicare drug coverage. However, if you get Extra Help, you don't have to pay a late enrollment penalty.

Visit [Medicare.gov/drug-coverage-part-d](https://www.Medicare.gov/drug-coverage-part-d) for more information about Medicare drug coverage. You can also visit [shiphelp.org](https://www.shiphelp.org) to contact your local State Health Insurance Assistance Program (SHIP) for free personalized health insurance counseling.

Extra Help

Extra Help is a program that helps people with limited income and resources pay Medicare Part D drug costs. If you qualify, you'll get help paying for your Medicare drug plan's monthly **premium**, yearly **deductible**, and prescription **copayments** or **coinsurance**.

In general, to qualify for Extra Help, your yearly income in 2025 must be below \$23,475 (\$31,725 for a married couple), and your resources must be below \$17,600 (\$35,130 for a married couple). These amounts may change in 2026.

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 include things like your savings and stocks (but not home), one car, household items, burial plot, up to \$1,500 for burial expenses (per person), and life insurance policies.

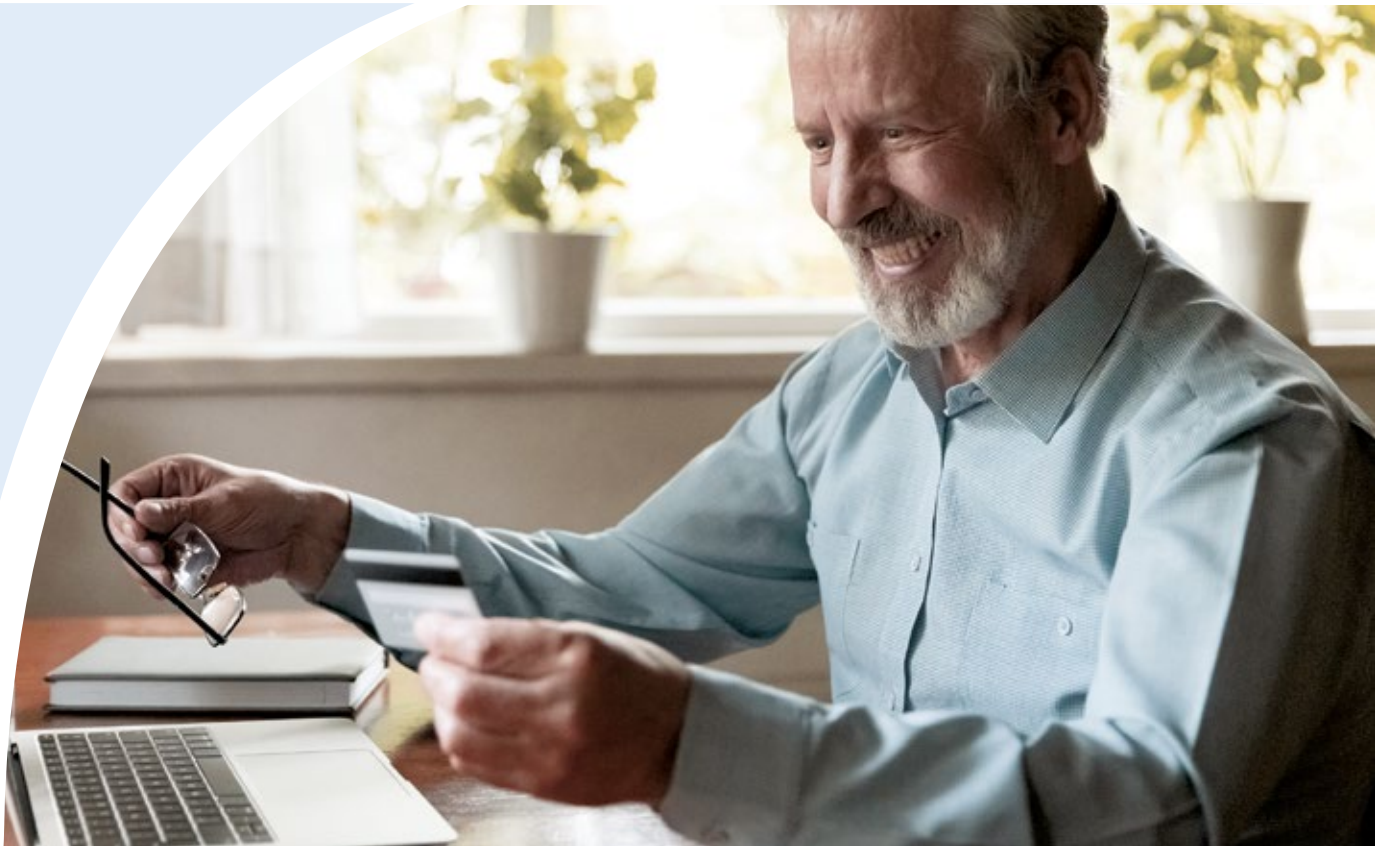
Note: If you live in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, you're not eligible for the same Extra Help described here. Visit [Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu](https://www.Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu) to get the contact information for your Medicaid office for more information about these programs.

How can I apply?

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

If you don't get a letter stating that you automatically qualify, visit [SSA.gov/extrahelp](https://www.SSA.gov/extrahelp) to apply. After you apply, you'll get a letter in the mail letting you know if you qualify and what to do next. Even if you don't qualify for Extra Help, you might consider joining a Medicare drug plan if you don't have other creditable drug coverage.

If you qualify for Extra Help, and don't join a Medicare drug plan, Medicare will automatically enroll you in a plan. You can "opt out" of being automatically enrolled. Medicare will send you a letter letting you know what plan it will enroll you in and when your coverage begins. Check if the plan you're being enrolled in covers the drugs you use, and if you can go to the pharmacies you want. If not, you can change plans. People who qualify for Extra Help can join, switch, or drop a Medicare drug plan once a month.



Section 5

Costs & payments

What does Medicare cost?

Medicare Part A (Hospital Insurance) costs

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

Medicare Part B (Medical Insurance) costs

Most people must pay a monthly **premium** for Part B. The standard Part B premium for 2025 is \$185 per month, although it may be higher based on your income. Premium rates can change yearly.

You need Part B to get full ESRD benefits, including regular dialysis, and you must pay the Part B premium. For more information about the Part B premium, visit [SSA.gov](https://www.ssa.gov).

Note: Go to pages 39–41 for definitions of **blue** words

Note: If you choose to join a [Medicare Advantage Plan](#), you may have different or additional costs based on your plan. For more information on costs, contact your plan for specific costs information.

What does Medicare pay for dialysis services?

Medicare pays your dialysis facility to give you these Part B-covered dialysis services and items:

- Direct nursing services including: registered nurses, licensed practical nurses, technicians, social workers, and dietitians
- All equipment and supplies used for kidney dialysis in the facility, or in your home, that are reasonable and medically necessary
- Injectable, intravenous (IV), and certain oral drugs that treat or manage conditions associated with ESRD (like anemia) or are used in the treatment of ESRD
- Laboratory tests
- Home dialysis training by a Medicare-certified home dialysis training facility (if you choose to get dialysis at home)
- Other items and services, like heart monitoring during your dialysis treatments, oxygen given (if needed) during your dialysis treatments (if you're in a dialysis facility), monitoring of your access site, and certain nutritional services

Your dialysis facility must give you these items and services directly, or through an arrangement with another provider.

Important note for people taking calcimimetics or phosphate binders:

Medicare Part B covers oral medications under the ESRD payment system, which includes oral calcimimetics and phosphate binders. Calcimimetic medications include the intravenous medication Parsabiv, and the oral medication Sensipar. Generic versions of Sensipar are available. Phosphate binders include all commercially available oral phosphate binders, including generics.

In addition to the calcimimetics and phosphate binders, the ESRD payment system includes payment for new and innovative drugs and biological products, including KORSUVA™ (difelikefalin) injection for the treatment of pruritis (itching) and VAFSEO® (Vadadustat) tablets, for oral use, for the treatment of anemia.

Your dialysis facility is responsible for giving you these medications. They can give them to you at their facility, or through a pharmacy they work with. You'll have a 20% [coinsurance](#) for these medications. If you're in a [Medicare Advantage Plan](#), your costs and coverage for you and your living donors will be (or are) different and plan-specific.

You'll need to work with your dialysis facility and your doctor to find out where you'll get these medications, and how much you'll pay. Talk with your doctor or health care team about the use of any drugs, including over-the-counter products.

What will I pay for dialysis services in a dialysis facility?

If you have **Original Medicare**, after you pay the Part B yearly **deductible**, you'll continue to pay a 20% coinsurance of the **Medicare-approved amount** for all covered dialysis-related services. Medicare will pay the remaining 80%.

The dollar amount of your coinsurance may vary. If you're in a Medicare Advantage Plan or have a Medicare Supplement Insurance (Medigap) policy (page 30) 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 Medicare Part B and Medicare Part D drug coverage **premiums** (if applicable).

Note: Your 20% coinsurance covers all of the services and items listed on page 12. Since the bundled payment system includes these services and items, 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 Part D plan (if you have one).

What will I pay for dialysis in a hospital?

If you're admitted to a hospital and get dialysis, Part A will cover your treatments as part of the cost 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**

Original Medicare pays most kidney doctors a monthly amount. In some cases, your doctor may be paid per day if you get services for less than one month.

After you pay the Part B yearly **deductible** (\$283 in 2026). Medicare pays 80% of the monthly amount. You pay the remaining 20% **coinsurance**.

Example: 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).

Remember, what you pay may be different than what's shown in this example.

What will I pay for home dialysis training services?

Original Medicare pays your kidney doctor a fee to supervise home dialysis training. After you pay the Part B yearly deductible (\$283 in 2026), Medicare pays 80% of the fee and you pay the remaining 20%.

Example: Let's say the fee for the kidney doctor who's supervising your home 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).

Remember, what you pay may be different than what's shown in this example.

What will I pay for my child who has ESRD?

If you have a child under 18 who has Medicare because of ESRD, the payment rules are the same as described above. However, the rates paid to dialysis facilities are increased by 30% and adjusted based on the child's age and the type of dialysis they get. These adjustments allow for the special care needs of children. Your 20% coinsurance will be based on these special rates.

Visit [Medicare.gov/basics/children-and-end-stage-renal-disease](https://www.medicare.gov/basics/children-and-end-stage-renal-disease) for more information on Medicare coverage for children with ESRD.

What Medicare pays for transplant services

The amounts listed in this section are for transplant services that **Original Medicare** covers. 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.

What do I have to pay for my kidney donor?

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. Also, your kidney donor doesn't have to pay a deductible, coinsurance, or any other costs for their hospital stay.

What do I have to pay for hospital services?

If you have Original Medicare, in 2026, you pay:

- \$1,736 deductible per benefit period
- Days 1–60: \$0 coinsurance for each [benefit period](#)
- Days 61–90: \$434 coinsurance per day of each benefit period
- Days 91 and beyond: \$868 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime)
- Beyond lifetime reserve days: all costs

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 you can use during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

For Medicare-approved care in a [skilled nursing facility](#), you pay:

- Days 1–20: \$0 for each benefit period
- Days 21–100: \$217 coinsurance per day of each benefit period
- Days 101 and beyond: You pay all costs

To find out what you’ll pay for other Medicare Part A and Medicare Part B services, visit [Medicare.gov/basics/costs](https://www.medicare.gov/basics/costs), or call 1-800-MEDICARE (1-800-633-4227).

TTY users can call 1-877-486-2048.

What do I have to pay for doctors’ services?

In Original Medicare, you pay the Medicare Part B yearly deductible (\$283). After you pay the deductible, Medicare pays 80% of the [Medicare-approved amount](#). You 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’s up to 15% over the [Medicare-approved amount](#).

What do I have to pay for clinical laboratory services?

You pay nothing for Medicare-approved laboratory tests. These services are included in the amount you pay for your dialysis treatment.

What Medicare pays for blood services

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

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

What do I pay for blood services?

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.

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've 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.

Donating blood

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.

You can't be charged for blood that you've already donated. A hospital or skilled nursing facility can't charge you for any of the first 3 pints of blood you've already donated or will donate in the future.

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



Section 6

Filing a complaint

End-Stage Renal Disease (ESRD) Networks and State Survey Agencies work together to help you with complaints (grievances) about your dialysis or kidney transplant care.

ESRD Networks

ESRD Networks (or “Networks”) monitor and improve the quality of care given to people with ESRD and can help you with complaints about your dialysis facility or transplant center. Call 1-800-MEDICARE (1-800-633-4227) to get the ESRD Network phone number for your state. TTY users can call 1-877-486-2048.

Note: Go to pages 39–41 for definitions of **blue** words

Call your local ESRD Network to get information about:

- Dialysis treatments
- Kidney transplants
- How to get help from other kidney-related agencies
- Problems with your facility
- Location of dialysis facilities and transplant centers

If you have a complaint about your care:

- You can complain directly to your facility or file it directly with your Network.
- Your facility or Network must investigate it, work on your behalf to try to solve it, and help you understand your rights. Your Network can still represent you, even if you wish to remain anonymous.
- Your facility can't take any action against you for filing a complaint.

Examples of complaints you may contact your ESRD Network for include:

- The facility staff doesn't treat you with respect.
- The facility staff won't let you eat during dialysis, and you're always hungry.
- Your dialysis shifts conflict with your work hours, and the facility won't let you change your shift.
- You've made complaints to your facility, and they weren't resolved.

State Survey Agencies

State Survey Agencies inspect Medicare and Medicaid participating 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. Call 1-800-MEDICARE to get the phone number for your State Survey Agency. **Your calls and name will be kept private.**

Examples of complaints you may contact your State Survey Agency for include:

- Claims of abuse
- Mistakes in giving out or prescribing drugs
- Poor quality of care
- Unsafe conditions (like water damage, or electrical or fire safety concerns)

Note: For questions about a specific service you got, look at your “Medicare Summary Notice” (MSN) if you have [Original Medicare](#) (or similar claim or explanation of benefit statements from your plan if you’re in a [Medicare Advantage Plan](#)). Your MSN is a notice you get after the doctor, other health care provider, or [supplier](#) files a claim for Part A or Part B services in Original Medicare. It shows:

- All the services or supplies that your providers and suppliers billed to Medicare during a 4-month period
- What Medicare paid
- The maximum amount you may owe the provider

You’ll get your MSN in the mail every 6 months, or you can create a secure online Medicare account and sign up for electronic MSNs at [Medicare.gov](#). You’ll get an email every month when MSNs are available in your Medicare account, instead of waiting for a paper copy. If you disagree with a coverage or payment decision made by Medicare, your [Medicare health plan](#), or your [Medicare drug plan](#), you can file an appeal. Visit [Medicare.gov/claims-appeals/how-do-i-file-an-appeal](#).



Section 7

Other health coverage

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

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

Note: Go to pages 39–41 for definitions of **blue** words

Employee or retiree coverage from an employer or union

If you have coverage from a health plan based on your or your spouse's past or current employment, call your benefits administrator to find out what coverage they might offer for ESRD. 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 those you can get if you buy a policy directly from an insurance company. Also, employers may pay part of the cost for the coverage.

Go to pages 7–9 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. COBRA is a federal law that lets you 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.

Medicare Supplement Insurance (Medigap)

Medigap is health insurance sold by private insurance companies to help fill the “gaps” in **Original Medicare**. Medigap policies help pay some of the health care costs that Original Medicare doesn't cover, like your **deductible** or **coinsurance**. Medigap must follow federal and state laws that protect you. All Medigap policies are clearly marked “Medicare Supplement Insurance” and give standardized benefits, no matter which insurance company sells them.

Not all insurance companies will sell Medigap policies to people under 65 who have Medicare. If a company does sell Medigap policies voluntarily, or because state law requires it, these Medigap policies may cost you more than if you were 65 or older.

Medigap rules vary from state to state. Call your State Health Insurance Assistance Program (SHIP) for information about buying a Medigap policy if you have ESRD. When you turn 65, you'll be guaranteed an opportunity to buy a Medigap policy.

Visit [Medicare.gov/health-drug-plans/medigap](https://www.medicare.gov/health-drug-plans/medigap) to learn more about Medigap and to compare policies sold in your state.

Medicaid

Medicaid 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 go to providers who accept both. For more information, call your contact your State Medical Assistance (Medicaid) office [Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu](https://www.Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu).

Medicare Savings Programs

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 find out if you qualify for one of these programs, visit [Medicare.gov/medicare-savings-programs](https://www.Medicare.gov/medicare-savings-programs).

Veterans Administration benefits

If you're a veteran, the U.S. Department of Veterans Affairs can help pay for ESRD treatment. For more information, visit [VA.gov](https://www.VA.gov) or call the U.S. Department of Veterans Affairs at 1-800-827-1000. TTY users can call 1-800-829-4833.

Other ways to get help

In most states, there are agencies and programs that help with some of the health care costs that Medicare doesn't pay. Call your State Health Insurance Assistance Program (SHIP) if you have questions about health coverage. Visit [shiphelp.org](https://www.shiphelp.org).

Visit [Medicare.gov/basics/costs/help](https://www.Medicare.gov/basics/costs/help), or call 1-800-MEDICARE (1-800-633-4227) to learn more about getting help with Medicare costs. TTY users can call 1-877-486-2048.



Section 8

More information

There are many resources available to help you learn more about kidney dialysis, transplants, and your situation. In addition to talking with your health care team, you can also connect with other people who have ESRD through national kidney organizations. Find more information on Medicare.gov, or reach out to your local ESRD Network, State Health Insurance Assistance Program (SHIP), or State Survey Agency.

Note: Go to pages 39–41 for definitions of **blue** words

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 can offer you support.

American Association of Kidney Patients

14440 Bruce B. Downs Blvd.

Tampa, Florida 33613

1-800-749-2257

aakp.org

American Kidney Fund

11921 Rockville Pike, Suite 300

Rockville, Maryland 20852

1-800-638-8299

kidneyfund.org

Dialysis Patient Citizens

1001 Connecticut Ave, NW, Suite 1230

Washington DC, 20036

1-866-877-4242

dialysispatients.org

National Institute of Diabetes and Digestive and Kidney Diseases

9000 Rockville Pike

Bethesda, Maryland 20892

1-800-860-8747

niddk.nih.gov

National Kidney Foundation

30 East 33rd Street

New York, New York 10016

1-800-622-9010

kidney.org

State Health Insurance Assistance Programs (SHIPs)

SHIPs are state programs that give free local health insurance counseling to people with Medicare. Call your SHIP if you have questions about:

- Medigap policies
- [Medicare health plan](#) choices
- Filing an appeal
- Other general health insurance questions

Visit shiphelp.org to get the phone number for your SHIP, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.



Section 9

Definitions

Assignment—The payment amount that Original Medicare sets for a covered service or item. Medicare pays its share and you pay your share of that amount.

Benefit period—The way that Original Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a skilled nursing facility) 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's no limit to the number of benefit periods.

Coinsurance—An amount you may be required to pay as your share of the cost for benefits 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 benefits after you pay any deductibles. A copayment is a fixed amount, like \$30.

Creditable prescription drug coverage—Prescription drug coverage that's expected to pay, on average, at least as much as Medicare drug coverage. This could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, VA, or individual health insurance coverage.

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

Home health care—a wide range of health care services that can be given in your home for an illness or injury.

Medically necessary—Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Most Medicare services aren't paid for by Original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage

Medicare-approved amount—The payment amount that Original Medicare sets for a covered service or item. Medicare pays its share and you pay your share of that amount.

Medicare health plan—Plans offered by private companies that contract with Medicare to provide Part A, Part B, and in many cases, Part D benefits. Includes Medicare Advantage Plans and certain other types of coverage (like Medicare Cost Plans, PACE programs, and demonstration/pilot programs).

Medicare drug coverage (Part D)—Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Original Medicare—A Fee-for-Service health insurance program that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). You typically pay a portion of the costs for covered services as you get them. Under Original Medicare, you don't have coverage through a Medicare Advantage Plan or another type of Medicare health plan.

Penalty—An amount added to your monthly premium for Part B or a Medicare drug plan (Part D) if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

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

Preventive services—Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Skilled nursing facility (SNF)—Skilled nursing care and therapy service provided on a daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a physical therapist or a registered nurse.

Supplier—Any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, state or local Medicaid office, or Marketplace Qualified Health Plans. There are 3 ways to file a complaint with the U.S. Department of Health & Human Services, Office for Civil Rights:

1. Online:

[HHS.gov/civil-rights/filing-a-complaint/complaint-process/index.html](https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html)

2. By phone:

Call 1-800-368-1019.

TTY users can call 1-800-537-7697.

3. In writing: Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Accessible Communications

Medicare provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. Call us:

For Medicare: 1-800-MEDICARE (1-800-633-4227)

TTY: 1-877-486-2048

For Marketplace: 1-800-318-2596

TTY: 1-855-889-4325

2. Email us: altformatrequest@cms.hhs.gov

3. Send us a fax: 1-844-530-3676

4. Send us a letter:

Centers for Medicare & Medicaid Services

Offices of Hearings and Inquiries (OHI)

7500 Security Boulevard, Mail Stop DO-01-20

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff (CARS)

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State Medical Assistance (Medicaid) office.

Notes

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