QMB BENEFITS GUIDE

The pamphlet IM-4 (QMB) provides general information regarding benefits covered under the QMB program. This guide is intended to supplement that information for use by the worker. This guide explains which services are covered by QMB only, which are covered by Medicaid only, and which are covered by both. If the **worker** is unable to determine if a specific service is covered by QMB, the **worker** may call the Division of Medical Services' Provider Relations Unit at 1-800-391-0938. **Do not give this number to claimants.**

Note the following differences between QMB and regular Medicaid.

QMB pays…	Medicaid pays…
Coinsurance and deductibles for **all** Medicare covered services.	Coinsurance and deductibles for Medicare covered services to Medicaid providers.
The full charge for a Medicare covered service only if the individual's deductible is not yet met.	The full charge for Medicaid services not covered by Medicare.
As the secondary payer only. Medicare is always billed first.	As the primary payer if no other coverage is available.

The following charts may be used to help explain benefits to the claimant and to determine what expenses to allow toward Medical Assistance spenddown for individuals who are currently receiving QMB benefits.

The first two charts show general Medicare services and the corresponding coinsurance and deductibles for 2002 for Part A and Part B. The charts show who is responsible for payment for each type of services. For the services listed, only those charges in the "Claimant Pays" column are allowable toward meeting Medical Assistance spenddown for a QMB recipient.

The second chart shows which types of providers are paid by Medicaid, which are paid by QMB, and which are paid by both. Some provider information on the listings is qualified by statements regarding specific services for which payment can be made. On this chart, allow toward MA spenddown for a QMB recipient expenses for services from providers paid by Medicaid only. (Do not count toward MA spenddown charges for those specific services identified as covered by QMB)

MEDICARE (PART A); HOSPITAL INSURANCE – COVERED SERVICES PER BENEFIT PERIOD (1)				
Services	Benefit	Medicare Pays**	QMB Pays**	Claimant Pays
HOSPITILIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days 61st to 90th day 91st to 150th day Beyond 150 days	All but $840 All but $210 a day All but $420 a day Nothing	$840 $210 a day $420 a day Nothing	-- -- -- All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge. (2)	First 20 days Additional 80 days Beyond	100% of approved amount All but $105 a day Nothing	-- $105 a day Nothing	-- Anything over approved amount All costs
HOME HEALTH CARE	Medically necessary skilled care, home health aide services, medical supplies, etc.	Full cost of services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment	Anything over approved amount
HOSPICE CARE Available to terminally ill	As long as doctor certifies need	All but limited costs for outpatient drugs and impatient respite care	--	Limited cost for outpatient drugs and impatient respite care
BLOOD	Blood	All but first 3 pints per calendar year	--	For first 3 pints***

*60 reserve days may be used only once; days used are not renewable.

**These figures are for 2003 and are subject to change each year.

***To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

(1)A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

(2)Medicare and most private insurance will not pay for custodial care in a nursing home.