SECTION 4

Medicare Advantage Plans & other options

What are Medicare Advantage Plans?

A Medicare Advantage Plan is another way to get your Medicare coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by Medicare-approved private companies that must follow rules set by Medicare. If you join a Medicare Advantage Plan, you'll still have Medicare but you'll get most of your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare. Most plans include Medicare prescription drug coverage (Part D). In most cases, you'll need to use health care providers who participate in the plan's network. However, many plans offer out-of-network coverage, but sometimes at a higher cost. Remember, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Keep your red, white, and blue Medicare card in a safe place because you'll need it if you ever switch back to Original Medicare.

What are the different types of Medicare Advantage Plans?

- **Health Maintenance Organization (HMO) plans**: See page 61.
- **Preferred Provider Organization (PPO) plans**: See page 62.
- **Private Fee-for-Service (PFFS) plans**: See page 63.
- **Special Needs Plans (SNPs)**: See page 64.
- **HMO Point-of-Service (HMOPOS) plans**: These are HMO plans that may allow you to get some services out-of-network for a higher copayment or coinsurance.
- **Medical Savings Account (MSA) Plans**: These plans combine a high-deductible health plan with a bank account that the plan selects. The plan deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year. MSA Plans don't offer Medicare drug coverage. If you want drug coverage, you have to join a Medicare Prescription Drug Plan. For more information on MSA Plans, visit Medicare.gov. To find out if an MSA Plan is available in your area, visit **Medicare.gov/plan-compare**.

Medicare Advantage Plans cover almost all Medicare Part A and Part B benefits

In all types of Medicare Advantage Plans, you're always covered for emergency and urgent care. Medicare Advantage Plans must cover almost all of the medically necessary services that Original Medicare covers. However, if you're in a Medicare Advantage Plan, Original Medicare will still cover the cost for hospice care, some new Medicare benefits, and some costs for clinical research studies.

Important!

Plans can offer extra benefits

Most Medicare Advantage Plans offer coverage for things that aren't covered by Original Medicare, like vision, hearing, dental, and wellness programs (like gym memberships). Plans can also cover more extra benefits than they have in the past, including services like transportation to doctor visits, over-the-counter drugs, adult day-care services, and other health-related services that promote your health and wellness. Plans can also tailor their benefit packages to offer these new benefits to certain chronically ill enrollees. These packages will provide benefits customized to treat those conditions. Check with the plan to see what benefits are offered and if you qualify.

Medicare Advantage Plans must follow Medicare's rules

Medicare pays a fixed amount for your coverage each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to doctors, facilities, or suppliers that belong to the plan's network for non-emergency or non-urgent care). These rules can change each year. The plan must notify you about any changes before the start of the next enrollment year. **Remember, you have the option each year to keep your current plan, choose a different plan, or switch to Original Medicare.** See page 65. Providers can join or leave a plan's provider network anytime during the year. Your plan can also change the providers in the network anytime during the year. If this happens, you may need to choose a new provider. You generally can't change plans during the year if this happens.

Even though the network of providers may change during the year, the plan must still provide access to qualified doctors and specialists. Your plan will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving your plan so you have time to choose a new provider. Your plan will also help you choose a new provider to continue managing your health care needs.

In most cases, you don't need a referral to see a specialist if you have Original Medicare. See page 51.

Important!

Read the information you get from your plan

If you're in a Medicare Advantage Plan, review the "Annual Notice of Change" (ANOC) and "Evidence of Coverage" (EOC) from your plan each year:

- **The ANOC:** Includes any changes in coverage, costs, service area, and more that will be effective starting in January. Your plan will send you a printed copy by September 30.
- **The EOC:** Gives you details about what the plan covers, how much you pay, and more. Your plan will send you a notice (or printed copy) by October 15, which will include information on how to access the EOC electronically or request a printed copy.

If you don't get these important documents, contact your plan.

What should I know about Medicare Advantage Plans?

Who can join?

You must meet these conditions to join a Medicare Advantage Plan:

- You have Part A and Part B.
- You live in the plan's service area.
- You don't have End-Stage Renal Disease (ESRD), except as explained on page 58.

Joining and leaving

- You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease (ESRD), for which there are special rules. See page 58.
- **You can only join or leave a Medicare Advantage Plan at certain times during the year.** See pages 65–66.
- Each year, Medicare Advantage Plans can choose to leave Medicare or make changes to the services they cover and what you pay. If the plan decides to stop participating in Medicare, you'll have to join another Medicare Advantage Plan or return to Original Medicare. See page 90.
- Medicare Advantage Plans must follow certain rules when giving you information about how to join their plan. See page 98 for more information about these rules and how to protect your personal information.

Prescription drug coverage

You usually get prescription drug coverage (Part D) through the Medicare Advantage Plan. In certain types of plans that can't offer drug coverage (MSA plans) or choose not to offer drug coverage (certain PFFS plans), you can join a separate Medicare Prescription Drug Plan. **If you're in a Medicare Advantage HMO, HMOPOS, or PPO, and you join a stand-alone Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.**

What if I have other coverage?
Talk to your employer, union, or other benefits administrator about their rules before you join a Medicare Advantage Plan. In some cases, joining a Medicare Advantage Plan might cause you to lose your employer or union coverage for yourself, your spouse, and dependents and you may not be able to get it back. In other cases, if you join a Medicare Advantage Plan, you may still be able to use your employer or union coverage along with the Medicare Advantage Plan you join. Your employer or union may also offer a Medicare Advantage retiree health plan that they sponsor.

What if I have a Medicare Supplement Insurance (Medigap) policy?
You can't enroll in (and don't need) a Medicare Supplement Insurance (Medigap) policy while you're in a Medicare Advantage Plan. You can't use it to pay for any expenses (copayments, deductibles, and premiums) you have under a Medicare Advantage Plan.

If you already have a Medigap policy and join a Medicare Advantage Plan, you can drop your Medigap policy. **Keep in mind that if you drop your Medigap policy to join a Medicare Advantage Plan, you may not be able to get it back.** **See page 72.**

What if I have End-Stage Renal Disease (ESRD)?
If you have End-Stage Renal Disease (ESRD), you can only join a Medicare Advantage Plan in certain situations:

- If you're already in a Medicare Advantage Plan when you develop ESRD, you can stay in your plan or you may be able to join another Medicare Advantage Plan offered by the same company.
- If you're in a Medicare Advantage Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan.
- If you have an employer or union health plan or other health coverage through a company that offers one or more Medicare Advantage Plan(s), you may be able to join one of that company's Medicare Advantage Plans.
- If you're medically determined to no longer have ESRD (for example you've had a successful kidney transplant), you may be able to join a Medicare Advantage Plan.
- You may be able to join a Medicare Special Needs Plan (SNP) that covers people with ESRD if one is available in your area.

Starting in 2021, people with ESRD will be able to join Medicare Advantage Plans without these restrictions.

Note: If you have ESRD and Original Medicare, you may join a Medicare Prescription Drug Plan.

What do I pay?
Your out-of-pocket costs in a Medicare Advantage Plan depend on:

- Whether the plan charges a monthly premium. You pay this in addition to the Part B premium.
- Whether the plan pays any of your monthly Medicare premiums. Some Medicare Advantage Plans will help pay all or part of your Part B premium. This benefit is sometimes called a "Medicare Part B premium reduction."
- Whether the plan has a yearly deductible or any additional deductibles for certain services.
- How much you pay for each visit or service (copayments or coinsurance). Medicare Advantage Plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care.
- The type of health care services you need and how often you get them.
- Whether you get services from a network provider or a provider that doesn't contract with the plan. If you go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan's network for non-emergency or non-urgent care services, your services may not be covered, or your costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs.
- Whether you go to a doctor or supplier who accepts assignment (if you're in a Preferred Provider Organization, Private Fee-for-Service Plan, or Medical Savings Account Plan and you go out-of-network). See page 53 for more information about assignment.
- Whether the plan offers extra benefits (in addition to Original Medicare benefits) and if you need to pay extra to get them.
- The plan's yearly limit on your out-of-pocket costs for all Part A and Part B medical services. Once you reach this limit, you'll pay nothing for Part A- and Part B-covered services.
- Whether you have Medicaid or get help from your state.

To learn more about your costs in specific Medicare Advantage Plans, visit **Medicare.gov/plan-compare**.

How do I know what's covered?
You can get a decision from your plan in advance to see if a service, drug, or supply is covered. You can also find out how much you'll have to pay. **This is called an "organization determination."** Sometimes you have to do this as prior authorization for the service, drug, or supply to be covered.

You, your representative, or your doctor can request an organization determination. You also have the option to ask for a fast decision, based on your health needs. If your plan denies coverage, the plan must tell you in writing, and you have the right to an appeal. See pages 89–92.

If a plan provider refers you for a service or to a provider outside the network, but doesn't get an organization determination in advance, **this is called "plan directed care."** In most cases you won't have to pay more than the plan's usual cost sharing. Check with your plan for more information about this protection.

Types of Medicare Advantage Plans

HMO

Health Maintenance Organization (HMO) plan

Can I get my health care from any doctor, other health care provider, or hospital?
No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some HMO plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option.

Are prescription drugs covered?
In most cases, yes. If you want Medicare drug coverage, you must join an HMO plan that offers prescription drug coverage.

Do I need to choose a primary care doctor?
In most cases, yes.

Do I have to get a referral to see a specialist?
In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

What else do I need to know about this type of plan?

- If your doctor or other health care provider leaves the plan's network, your plan will notify you. You may choose another doctor in the plan's network.
- If you get health care outside the plan's network, you may have to pay the full cost.
- It's important that you follow the plan's rules, like getting prior approval for a certain service when needed.
- If you need more information than what's listed on this page, check with the plan.

PPO

Preferred Provider Organization (PPO) plan

Can I get my health care from any doctor, other health care provider, or hospital?
Yes. PPO plans have network doctors, other health care providers, and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost. You're always covered for emergency and urgent care.

Are prescription drugs covered?
In most cases, yes. If you want Medicare drug coverage, you must join a PPO plan that offers prescription drug coverage.

Do I need to choose a primary care doctor?
No.

Do I have to get a referral to see a specialist?
In most cases, no.

What else do I need to know about this type of plan?

- Because certain providers are "preferred" (as the name suggests), you can save money by using them.
- If you need more information than what's listed on this page, check with the plan.

PFFS

Private Fee-for-Service (PFFS) plan

Can I get my health care from any doctor, other health care provider, or hospital?
You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. If you join a PFFS plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but you may pay more.

Are prescription drugs covered?
Sometimes. If your PFFS plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan to get coverage.

Do I need to choose a primary care doctor?
No.

Do I have to get a referral to see a specialist?
No.

What else do I need to know about this type of plan?

- The plan decides how much you pay for services. The plan will tell you about your cost sharing in the "Annual Notice of Change" (ANOC) and "Evidence of Coverage" (EOC) documents that it sends each year.
- Some PFFS plans contract with a network of providers who agree to always treat you, even if you've never seen them before.
- Out-of-network doctors, hospitals, and other providers may decide not to treat you, even if you've seen them before.
- For each service you get, make sure to show your plan member card before you get treated.
- In a medical emergency, doctors, hospitals, and other providers must treat you.
- If you need more information than what's listed on this page, check with the plan.

SNP

Special Needs Plan (SNP)

A Special Needs Plan (SNP) provides benefits and services to people with specific diseases, certain health care needs, or limited incomes. SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.

Can I get my health care from any doctor, other health care provider, or hospital?
Some SNPs cover services out-of-network and some don't. Check with the plan to see if they cover services out-of-network, and if so, how it affects your costs.

Are prescription drugs covered?
Yes. All SNP plans must provide Medicare prescription drug coverage.

Do I need to choose a primary care doctor?
Generally, yes.

Do I have to get a referral to see a specialist?
In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

What else do I need to know about this type of plan?

- These groups are eligible to enroll in a SNP:
  1. People who live in certain institutions (like nursing homes) or who require nursing care at home (also called an Institutional SNP or I-SNP).
  2. People who are eligible for both Medicare and Medicaid (also called a Dual Eligible SNP or D-SNP).
  3. People who have specific severe or disabling chronic conditions (like diabetes, End-Stage Renal Disease, HIV/AIDS, chronic heart failure, or dementia) (also called a Chronic condition SNP or C-SNP). Plans may further limit membership.
- A SNP provides benefits targeted to its members' special needs, including care coordination services.
- Visit Medicare.gov/plan-compare to see if there are SNPs available in your area. For information on what a specific SNP covers, check directly with the plan.
- If you need more information than what's listed on this page, check with the plan.

When can I join, switch, or drop a Medicare Advantage Plan?

- When you first become eligible for Medicare, you can sign up during your Initial Enrollment Period. See page 17.
- If you have Part A coverage and you get Part B for the first time during the General Enrollment Period, you can also join a Medicare Advantage Plan at that time. Your coverage may not start until July 1. See page 18.
- Between October 15–December 7, anyone with Medicare can join, switch, or drop a Medicare Advantage Plan. Your coverage will begin on January 1, as long as the plan gets your request by December 7.

If you drop a Medigap policy to join a Medicare Advantage Plan, you might not be able to get it back. Rules vary by state and your situation. See page 72 for more information.

Always review the materials your plan sends you (like the "Annual Notice of Change" and "Evidence of Coverage"), and make sure your plan will still meet your needs for the following year. You can also visit the Medicare Plan Finder at **Medicare.gov/plan-compare** to compare your current plan with other available options.

Can I make changes to my coverage after December 7?

Between January 1–March 31 each year, you can make these changes during the **Medicare Advantage Open Enrollment Period**:

- If you're in a Medicare Advantage Plan (with or without drug coverage), you can switch to another Medicare Advantage Plan (with or without drug coverage).
- You can drop your Medicare Advantage Plan and return to Original Medicare. You'll also be able to join a Medicare Prescription Drug Plan.

During this period, you **can't**:

- Switch from Original Medicare to a Medicare Advantage Plan.
- Join a Medicare Prescription Drug Plan if you're in Original Medicare.
- Switch from one Medicare Prescription Drug Plan to another if you're in Original Medicare.

You can only make one change during this period, and any changes you make will be effective the first of the month after the plan gets your request. If you're returning to Original Medicare and joining a drug plan, you don't need to contact your Medicare Advantage Plan to disenroll. The disenrollment will happen automatically when you join the drug plan.

Note: If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without a drug plan) within the first 3 months you have Medicare.

Important!

Thinking about joining a Medicare Advantage Plan between October 15–December 7, but aren't sure? The Medicare Advantage Open Enrollment Period (January 1–March 31) gives you an opportunity to switch back to Original Medicare or change to a different Medicare Advantage Plan depending on which coverage works better for you.

Special Enrollment Periods

In most cases, you must stay enrolled for the calendar year starting the date your coverage begins. However, in certain situations, you may be able to join, switch, or drop a Medicare Advantage Plan during a Special Enrollment Period when certain events happen in your life. Check with your plan for more information.

How do I switch?

Follow these steps if you're already in a Medicare Advantage Plan and want to switch:

- **To switch to a new Medicare Advantage Plan,** simply join the plan you choose during one of the enrollment periods explained on page 65. You'll be disenrolled automatically from your old plan when your new plan's coverage begins.
- **To switch to Original Medicare,** contact your current plan, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. If you don't have drug coverage, you should consider joining a Medicare Prescription Drug Plan to avoid paying a penalty if you decide to join later. You may also want to consider joining a Medicare Supplement Insurance (Medigap) policy if you're eligible. See page 69 for more information about buying a Medigap policy.

To join or switch Medicare Advantage Plans, visit **Medicare.gov/plan-compare** or call 1-800-MEDICARE.

For more details about Medicare Advantage Plans, visit **Medicare.gov/publications** to view the booklet "Understanding Medicare Advantage Plans."

Are there other types of Medicare health plans and projects?

Yes, some of these plans provide Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, while others provide only Part B coverage. In addition, some also provide Part D prescription drug coverage. These plans have some of the same rules as Medicare Advantage Plans. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details.

Medicare Cost Plans

Medicare Cost Plans are a type of Medicare health plan available in certain, limited areas of the country. Here's what you should know about Medicare Cost Plans:

- You can join even if you only have Part B.
- If you have Part A and Part B and go to a non-network provider, the services are covered under Original Medicare. You'll pay the Part A and Part B coinsurance and deductibles.
- You can join anytime the Cost Plan is accepting new members.
- You can leave anytime and return to Original Medicare.
- You can either get your Medicare prescription drug coverage from the Cost Plan (if offered) or you can join a Medicare Prescription Drug Plan. Even if the Cost Plan offers prescription drug coverage, you can choose to get drug coverage from a separate Medicare drug plan.

  Note: You can add or drop Medicare prescription drug coverage only at certain times. See pages 74–75.

For more information about Medicare Cost Plans, visit the Medicare Plan Finder at **Medicare.gov/plan-compare**. Your State Health Insurance Assistance Program (SHIP) can also give you more information. See pages 109–112 for the phone number.

Programs of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community. To qualify for PACE, you must meet these conditions:

- You're 55 or older.
- You live in the service area of a PACE organization.
- You're certified by your state as needing a nursing home-level of care.
- At the time you join, you're able to live safely in the community with the help of PACE services.

PACE covers all Medicare- and Medicaid-covered care and services, and other services that the PACE team of health care professionals decides are necessary to improve and maintain your health. This includes prescription drugs, as well as any other medically necessary care, like doctor or health care provider visits, transportation, home care, hospital visits, and even nursing home stays when necessary.

If you have Medicaid, you won't have to pay a monthly premium for the long-term care portion of the PACE benefit. If you have Medicare but not Medicaid, you'll be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE, there's never a deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.

Visit **Medicare.gov/plan-compare** to see if there's a PACE organization that serves your community.

Medicare Innovation Projects

Medicare develops innovative models, demonstrations, and pilot projects to test and measure the effect of potential changes in Medicare. These projects help to find new ways to improve health care quality and reduce costs. Usually, they operate only a limited time for a specific group of people and/or are offered only in specific areas. Examples of current models, demonstrations, and pilot projects include innovations in primary care, care related to specific procedures (like hip and knee replacements), cancer care, and care for people with End-Stage Renal Disease (ESRD). To learn more about the current Medicare models, demonstrations, and pilot projects, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.