

SECTION 4

Medicare Advantage Plans & other options

What are Medicare Advantage Plans?

A [Medicare Advantage Plan](#) (like an HMO or PPO) 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 your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare. In most cases, you’ll need to use health care providers who participate in the plan’s network. Some plans offer out-of-network coverage. Remember, in most cases, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Keep your 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/find-a-plan](#).

Medicare Advantage Plans cover all Medicare Part A and Part B services

In all types of [Medicare Advantage Plans](#), you're always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the 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.

Some Medicare Advantage Plans offer coverage for things that aren't covered by Original Medicare, like vision, hearing, dental, and other health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to your Part B [premium](#), you might have to pay a monthly premium for the Medicare Advantage Plan.

Organization determinations

You (or a provider acting on your behalf) can request to see if an item or service will be covered by the plan in advance. Sometimes you must do this for the service to be covered. This is called an "organization determination." If your plan denies coverage, the plan must tell you in writing.

You don't have to pay more than the plan's usual cost-sharing for a service or supply if a network provider didn't get an organization determination and either of these is true:

- The provider gave you or referred you for services or supplies that you reasonably thought would be covered.
- The provider referred you to an out-of-network provider for plan-covered services.

Contact your plan for more information.

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.

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 else should I know about Medicare Advantage Plans?

- You have Medicare rights and protections, including the right to appeal. See pages 89–94.
- You must follow plan rules. It's important to check with the plan for information about your rights and responsibilities.
- 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.
- 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.
- Plans may offer supplemental benefits, like fitness or wellness benefits.
- Medicare Advantage Plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and [skilled nursing facility care](#).
- Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you'll pay nothing for covered services. Each plan can have a different limit, and the limit can change each year. You should consider this when choosing a plan.

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 59.
- **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 (like MSA plans) or choose not to offer drug coverage (like some PFFS plans), you can join a separate Medicare Prescription Drug Plan. **If you're in a Medicare Advantage HMO or PPO, and you join a separate Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.**

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're a U.S. citizen, U.S. national, or lawfully present in the U.S.
- You don't have End-Stage Renal Disease (ESRD), except as explained on page 59.

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. If you lose coverage for yourself, you may also lose coverage for your spouse and dependents. 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. **Remember, if you lose your employer or union coverage, you may not be able to get it back.**

A Medicare Advantage Plan with drug coverage is an option if you're interested in enrolling in Part D but can't afford a separate [premium](#) for prescription drug coverage. See page 83.

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'll probably want to drop your Medigap policy. **If you drop your Medigap policy, 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'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.

For more information, visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

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](#)).
- 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.
- 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 an extra premium for them.
- The plan’s yearly limit on your out-of-pocket costs for all medical services. Once you reach this limit, you’ll pay nothing for 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/find-a-plan](https://www.medicare.gov/find-a-plan).

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 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?**

In most cases, 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.

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?

- PPO plans aren't the same as Original Medicare or Medigap.
- Medicare PPO plans usually offer more benefits than Original Medicare, but you may have to pay extra for these benefits.
- 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?

- PFFS plans aren't the same as Original Medicare or Medigap.
- The plan decides how much you pay for services.
- 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)**Can I get my health care from any doctor, other health care provider, or hospital?**

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).

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?

- A plan must limit membership to these groups: 1) people who live in certain [institutions](#) (like nursing homes) or who require nursing care at home, or 2) people who are eligible for both Medicare and Medicaid, or 3) people who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease, HIV/AIDS, chronic heart failure, or dementia). Plans may further limit membership.
- Your plan will coordinate the services and providers you need to help you stay healthy and follow doctors' or other health care providers' orders.
- Visit [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan) to see if there are SNPs available in your area.
- 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 58 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.

New!

Can I make changes to my coverage after December 7?

Starting in 2019, 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 disenroll from your Medicare Advantage Plan and return to Original Medicare. If you choose to do so, you’ll be able to join a Medicare Prescription Drug Plan.
- 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 drug coverage) within the first 3 months you have Medicare.

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.

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 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. Some examples are:

- You move out of your plan's [service area](#).
- You have (or lose) Medicaid.
- You qualify for (or lose) [Extra Help](#). See pages 84–85.
- You live in an [institution](#) (like a nursing home).

5-star Special Enrollment Period

You can switch to a Medicare Advantage Plan or Medicare Cost Plan (see page 74) that has **5 stars for its overall star rating** from December 8, 2018–November 30, 2019. You can only use this Special Enrollment Period once during this timeframe. The overall star ratings are available at [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan). See pages 105–106 for more information.

Important!

You may lose your prescription drug coverage if you move from a Medicare Advantage Plan that has drug coverage to a 5-star Medicare Advantage Plan that doesn't. You'll have to wait until your next enrollment opportunity to get drug coverage, and you may have to pay a Part D late enrollment penalty. See pages 84–85.

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.

For more information on joining, dropping, and switching plans, visit [Medicare.gov](https://www.medicare.gov) or call 1-800-MEDICARE.

Are there other types of Medicare health plans and projects?

Some types of [Medicare health plans](#) that provide health coverage aren't [Medicare Advantage Plans](#) but are still part of Medicare. 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 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 different 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/find-a-plan](https://www.medicare.gov/find-a-plan). 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 provides coverage for many services, including prescription drugs, doctor or other health care practitioner visits, transportation, home care, hospital visits, and even nursing home stays whenever 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/find-a-plan](https://www.medicare.gov/find-a-plan), 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. To learn more about the current Medicare models, demonstrations, and pilot projects, visit [innovation.cms.gov](https://www.innovation.cms.gov). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.