Medicare Advantage Plans

Basics of Medicare Advantage

One in four people enrolled in Medicare today are covered under Medicare Advantage rather than Original Medicare. Medicare Advantage plans are health plans offered by private companies that contract with Medicare to provide Medicare benefits. There are many different types of Medicare Advantage plans. The most common types are Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Private fee-for-service (PFFS) plans. To enroll in a Medicare Advantage plan, you must have both Medicare Part A and Part B, and pay the premiums as applicable. To make an informed decision, and to be able to decide which plans best meet your health needs and financial constraints, you need to first understand how these health plans work and how they differ.

There are different types of Medicare Advantage plans. Medicare Advantage plans provide all benefits covered under Medicare Part A and Part B, but can do so with different cost-sharing than Original Medicare. Medicare Advantage plans have an annual out-of-pocket limit on cost-sharing for benefits covered under Parts A and B of Medicare. They may also provide additional benefits, such as vision and dental care. Medicare Advantage plans are also not allowed to charge you more than Original Medicare for certain services, including dialysis and chemotherapy. Medicare Advantage plans may charge a premium, in addition to the Part B monthly premium. In addition to variations in premiums, Medicare Advantage plans vary in benefits, cost-sharing requirements, and provider networks.

Medicare Advantage Plan Options

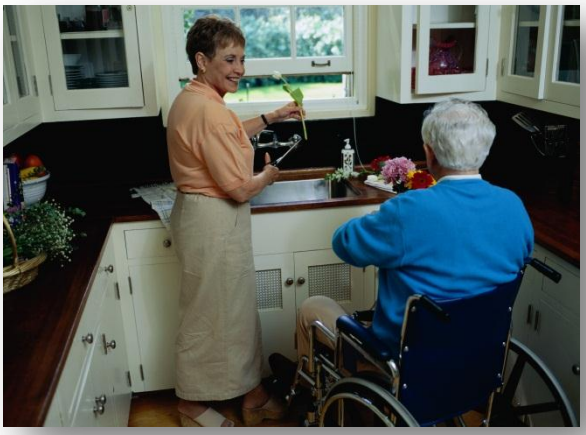
Health Maintenance Organizations (HMOs)

In Medicare HMOs, you can generally only use doctors, hospitals, and other providers in the HMO's network, unless it is an emergency or urgent situation. A network is a group of providers that contract with a plan to provide services for its members. Usually, if you see a doctor outside of the plan’s network you will have to pay for the full cost of your care.

If you join a Medicare HMO, you often need to choose a primary care physician. You may need to get permission or a referral from your primary care doctor before you can see a specialist.

If you are in a Medicare HMO and want Medicare drug coverage, you must get your drug coverage from the same HMO that provides your health coverage.

Preferred Provider Organizations (PPOs)



HMOs and PPOs differ in two key ways:

- PPOs typically will cover part of the cost of your care if you see a doctor out of the network, but you'll likely have to pay more than when you see in-network doctors.
- Medicare PPOs allow you to see a specialist without referral from your primary care physician.

As with HMOs, if you want Medicare drug coverage and you are in a PPO, you must receive your drug coverage from the same plan that provides your health coverage.

Regional PPOs became available under Medicare in 2006. These plans are similar to local PPOs, but serve a larger geographic area (either a single state or multi-state area) and must offer the same premiums, benefits, and cost-sharing requirements to all beneficiaries in the region. As with local PPOs, individuals who sign up for a regional PPO will typically pay more if they go to providers outside of the network.

Private Fee-for-Service (PFFS) Plans

Private fee-for-service plans are another type of Medicare Advantage plan. In a PFFS plan, the providers you use must accept the plan's terms and conditions. If you are considering enrolling in a PFFS plan, make sure your doctors and hospitals are willing to accept the PFFS plan's payments for services before you enroll.

In addition, some PFFS plans have networks. If your plan has a network, you will usually pay more if you see providers who are not in the plan's network. Be sure you understand a plan's benefits and cost sharing requirements before you enroll.

PFFS plans are not required to offer drug coverage, but most do. If you want Medicare drug coverage and you are in a PFFS plan that does not provide drug coverage, you can join a stand-alone prescription drug plan.

Medicare Medical Savings Accounts (MSAs)

Medicare Medical Savings Accounts (MSAs) are another type of Medicare Advantage plan. Here is how Medicare MSAs work:

- The plan makes an annual deposit on behalf of each beneficiary into a bank of the plan's choice. The money in the account will not be taxed as long as the beneficiary uses it for qualified medical expenses. Beneficiaries may not contribute their own funds to the account.
- A beneficiary enrolled in this type of plan must meet a high annual deductible (no more than $10,600 in 2012) before the plan will begin to pay for health care expenses. After the deductible is met, the plan is responsible for the full cost of all services covered under Medicare Part A or B.
- Beneficiaries can use the money in the MSA towards either meeting the deductible or to pay for health care services not covered by Medicare. At the end of the year, if any amount in the MSA account is unspent, it can be rolled over to cover the beneficiary's costs incurred in the following year. Beneficiaries enrolled in MSAs are still required to pay the Part B monthly premium; however, there is no additional monthly premium for these plans.
- MSAs do not cover Part D prescription drugs. Beneficiaries with an MSA should enroll in a stand-alone prescription drug plan (PDP) if they want Part D drug coverage.

For additional information about Medicare Advantage plans, call 1-800-MEDICARE, or get information about Medicare options in your area on the Medicare Options Compare website at www.medicare.gov/find-a-plan/questions/home.aspx.

Medicare Special Needs Plans (SNPs)

If you meet the qualifications of a Special Needs Plan (SNP) in your area, you have the option to enroll in it instead of having Original fee-for-service Medicare. SNPs are a type of Medicare Advantage plan that were created to improve the management of care for Medicare beneficiaries who are either dually eligible for Medicare and Medicaid, require an institutional level of care, or have certain chronic conditions. Like other Medicare Advantage plans, SNPs have contracts with Medicare and are run by private companies. All SNPs include Part D coverage. The Medicare program pays the plans fixed monthly amounts. If you have full or partial coverage from Medicaid in addition to Medicare, you have a continuous special enrollment period. This means that you can enroll and disenroll from any plan at any time during the year. Also, if you have a chronic health condition that a SNP in your area treats, you have a special enrollment period to join that SNP.

Medicare Advantage and Prescription Drugs

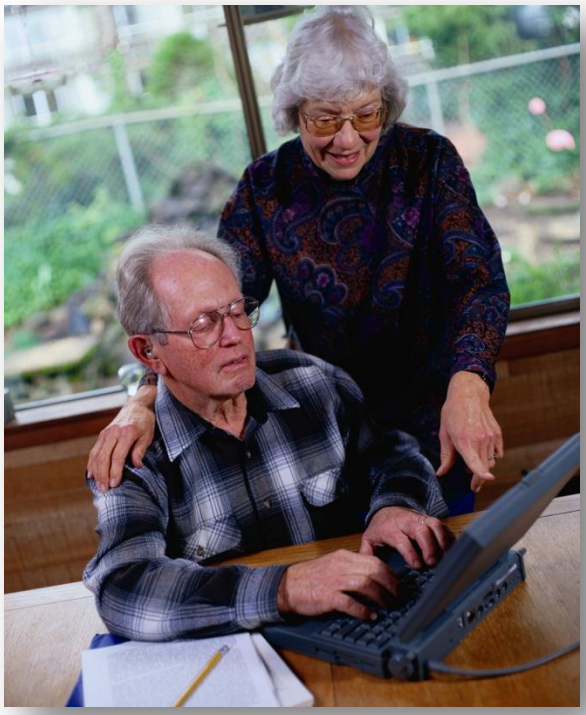
All companies offering Medicare Advantage plans must offer prescription drug coverage in at least one of their plans. About 80 percent of Medicare Advantage plans include drug coverage. Medicare Advantage plans with drug coverage may vary in their premiums, deductibles, formularies and cost-sharing, depending on the type of Medicare Advantage plan you select. In most cases, if you want to join a Medicare Advantage plan, you will need to get your Medicare prescription drug coverage through that plan. See the Medicare and Prescription Drug section for more information.

Choosing a Medicare Advantage Plan

Each January, plans change their coverage and costs. During the Fall Open Enrollment Period, you should find out how your current plan will change in January and review your coverage choices. You can keep your coverage through your Medicare private plan if the plan continues operating in your area from year to year. If you think you may want to change, the next step is to find out which plans are offered where you live. While Original Medicare is available in all parts of the U.S., certain types of private plans may not be. In some areas of the U.S., people with Medicare have a limited choice of private plans, while in other areas, there are many Medicare private plans to choose from.

For a list of plans in your area and a copy of the Medicare handbook, *Medicare & You*, call Medicare at 1-800-MEDICARE or visit Medicare's website at www.medicare.gov. For free help in understanding differences among Medicare plans, you can call your State Health Insurance Assistance Program (SHIP). Contact information for your state's SHIP is found in the Medicare handbook and in this guide under Additional Resources.

You should consider these important factors before signing up for a plan:



- **Accessibility of doctors and hospitals.** Can you continue to see the doctors you know and trust if you join a certain plan? Your doctor or specialist might be in one plan's network, but not in another plan's network.
- **Extra benefits.** The additional benefits offered by Medicare private plans vary widely and may change every year.
- **Prescription Drugs.** Remember that you must typically get your Part D prescription drug benefits through the same private health plan that offers your health benefits. Make sure that the prescription drug plan covers the drugs you need and that you understand any limits that may apply. Also, make sure the plan includes the pharmacies you use in its network.
- **Cost.** You might want to consider the following questions: How much are the monthly premiums and copayments associated with different health care services? Is there a deductible? How do the costs for various services differ from Original Medicare? Keep in mind that costs generally change each calendar year.
- **Quality ratings.** Not all Medicare private plans are the same. The Centers for Medicare and Medicaid Services (CMS) post quality ratings of Medicare Advantage plans that may be a useful tool. Find your plan's star rating from Medicare and try to talk to plan members about their experiences. To find your plan's star rating, visit Medicare's website at www.medicare.gov/find-a-plan.

Know your rights

No matter which plan you choose – Original Medicare, a Medicare HMO, or another Medicare private plan – understand your rights as a patient and a consumer. If you believe you have been unfairly denied any benefits covered by Medicare or your Medicare Advantage plan, you have the right to appeal. You should send a copy of the denial notice to the company that issued the denial and, if possible, a letter from your doctor explaining your need for the denied service and a letter requesting a review.

Enrolling in a Medicare Advantage Plan

There are a number of ways that you can sign up for a Medicare Advantage plan:

- **Mail in or fax a paper application.** Contact the company offering the plan you select and request that they send you an application. Once you fill out the application, mail or fax it back to the company.
- **Call the plan, or visit the plan's website.** You can enroll in a plan by calling the company and speaking with a representative, or by filling out your application online.
- **Call 1-800-MEDICARE, or visit Medicare's website.** You are also able to enroll in most plans at www.medicare.gov through Medicare's online enrollment center. Plan participation in Medicare's enrollment center is voluntary, so not all plans offer this option.

To enroll in a plan, you will have to provide your Medicare number and the date that your Part A and/or Part B coverage started. This information is on your Medicare card.

If you are already in a Medicare Advantage plan and are switching to a new one, you do not need to disenroll from your old plan. Simply enroll in the new plan. Your coverage in the old plan will automatically end when your new coverage begins.

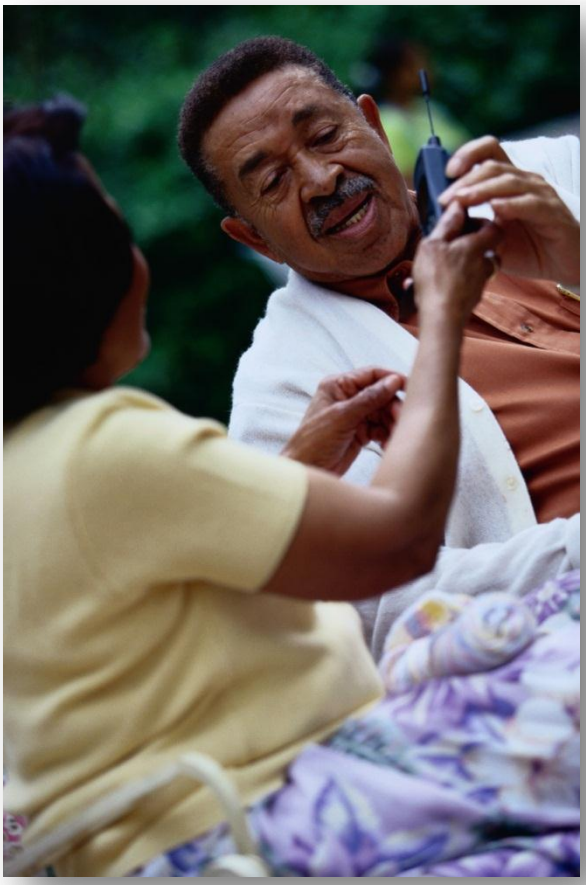
Medicare Advantage plans are not allowed to call you and enroll you in a plan. If a plan calls you, **do not** give your personal or financial information over the phone. Call 1-800-MEDICARE to report any plans that call you and request personal information.

Once your enrollment is processed, the company offering the plan will send you an acknowledgement letter confirming your enrollment. This letter serves as your proof of insurance until your membership card arrives.

Switching Medicare Advantage Plans

Fall Open Enrollment is from October 15 to December 7 each year. During this period, you can join a Medicare Advantage plan. You can also switch Medicare Advantage plans, and add, drop, or switch Medicare prescription drugs plans at this time. You can enroll in a Part D plan during this time even if you did not enroll during your Initial Enrollment Period.

In most cases, you will not be allowed to make a change outside of this designated time period. However, if you do need to make a change outside of the Fall Open Enrollment period, you can switch to a Medicare Advantage plan or a Part D plan that has the highest overall plan performance rating of 5 stars at any time during the year. You can find star ratings for plans in your area by going to www.medicare.gov/find-a-plan.



Changes you make during Fall Open Enrollment will take effect on January 1 of the following year. If you decide to switch your Medicare Advantage plan, you can simply enroll in the Medicare Advantage plan of your choice. Your old Medicare Advantage plan will automatically end when your new plan begins.

There is another period from January 1 through February 14 each year called the Medicare Advantage Disenrollment Period. During this time, you can drop your Medicare Advantage plan and return to Original Medicare. If you would like to begin receiving or continue to receive Medicare drug coverage, you can also usually enroll in a stand-alone drug plan during this period. Changes made during this period will take place on the first of the month after the change is made.

There are certain situations in which you might qualify for a Special Enrollment Period. A Special Enrollment Period is a time outside of the standard enrollment periods when you can add, drop or change your plan. A few examples of Special Enrollment Periods include (1) if you move outside the plan's service area, (2) if you enter, reside in or leave a skilled nursing facility, nursing home, or (3) if you receive Medicaid or Extra Help.