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AGENCY

PAUL BARRETT

of the Modern Medicare Agency's Guide to Understanding Medicare Advantage Plans

Hey there! Figuring out how to get your Medicare coverage is a big decision, and I’m here to make it as simple as possible for you. When you sign up for Medicare, you’ve got two main paths to choose from. Let’s break it down in plain English

Original Medicare

Think of this as the classic option. It includes Part A (hospital coverage) and Part B (medical coverage). Medicare pays a portion of your bills, but you’ll have to cover some of the costs, like coinsurance and deductibles. If you want prescription drug coverage, you can add a separate Part D plan.

Medicare Advantage (Part C)

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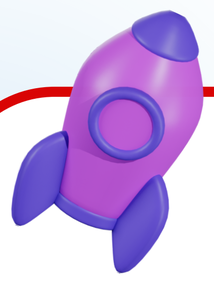
This is like an all-in-one bundle from private insurance companies. It combines Part A, Part B, and usually Part D into one plan. These plans often throw in extra perks like dental, vision, or gym memberships—things Original Medicare doesn't cover.

This is the traditional route, and it works like this:



ORIGINAL MEDICARE

What it Covers: Includes Part A (Hospital Insurance) and Part B (Medical Insurance).

Prescription Drugs: Not included, but you can add a separate Part D plan to cover medications.

Flexibility : You can see any doctor or visit any hospital in the U.S. that accepts Medicare—no network restrictions!

Extra Protection: You can buy supplemental insurance, like a Medigap plan, to help cover out-of-pocket costs (like the 20% coinsurance Medicare doesn't pay). Or, you might have coverage through a current or former employer, union, or even Medicaid.

WHAT'S THE DIFFERENCE ?

The option you choose affects how much you'll pay, what benefits you get, and which doctors you can see. That's why it's so important to pick what works best for you.

Think of Original Medicare as a flexible option with fewer bells and whistles but more add-on choices to customize your coverage.

Medicare Advantage (Part C)

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This option is offered by private insurance companies and bundles everything into one plan:

- **What it Covers:** Includes Part A, Part B, and usually Part D (prescription drugs) all in one.
- **Networks:** Most plans have a network of doctors and hospitals, so you'll need to check if your favorite providers are included.
- **Plan Rules:** Some plans require prior approval for certain drugs or services, which can limit flexibility.
- **Costs:** Out-of-pocket costs and premiums may vary. Be sure to compare carefully, as costs can differ from Original Medicare or Medigap plans.
- **Extra Perks:** Many plans offer additional benefits like vision, dental, hearing, or fitness programs—extras you won't find with Original Medicare.

Medicare Advantage is great if you prefer all-in-one coverage and are comfortable working within a network for your care.

Which One is Right for You?

The choice comes down to what's most important to you—flexibility, simplicity, or extra benefits. At The Modern Medicare Agency, I'm here to guide you through these options and help you find the plan that fits your needs, your lifestyle, and your budget. Let's make Medicare easy together!

At a Glance

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Original Medicare vs. Medicare Advantage Plans

When it comes to choosing between Original Medicare and Medicare Advantage, here's what you need to know—explained like we're having a chat over coffee:

DOCTOR & HOSPITAL CHOICE

Original Medicare: Freedom is the name of the game! You can visit any doctor or hospital in the U.S. that accepts Medicare. No need for referrals to see specialists.

Medicare Advantage: You're working with a network here. Most plans require you to use doctors in the plan's network for non-emergency care. Some plans let you go out of the network, but it may cost more. Also, referrals are often needed for specialists

COSTS

ORIGINAL MEDICARE:

- For most Part B services, you'll pay 20% of the Medicare-approved amount after meeting your deductible (that's coinsurance).
- You'll have separate premiums for Part B and Part D (if you want drug coverage).
- No yearly limit on out-of-pocket costs unless you add Medigap or other supplemental coverage to help protect you.

At a Glance

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Medicare Advantage:

- Costs vary depending on the plan, with premiums sometimes as low as $0. Many plans include Part D drug coverage.
- The big bonus? Medicare Advantage plans do have a yearly cap on out-of-pocket costs. Once you hit that limit, you're covered 100% for the rest of the year.

COSTS

NEED EXTRA COVERAGE?

- **Original Medicare:** You can buy a Medigap policy to help with out-of-pocket expenses, like coinsurance. Or, you might use coverage from an employer, retiree plan, or Medicaid.
- **Medicare Advantage:** Medigap isn't an option here, but most plans already bundle in extra benefits like dental, vision, or fitness perks.

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Original Medicare vs. Medicare Advantage Plan (Continued)

COVERAGE

Original Medicare: Covers most medically necessary services like hospital stays and doctor visits. However, it doesn't include routine physicals, dental care, or vision exams. Plus, there's no need to get prior approval (prior authorization) for services—if Medicare covers it, you're good to go. For drug coverage, you'll need to join a separate Part D plan

Medicare Advantage: These plans must cover all the same medically necessary services as Original Medicare but can use their own criteria to determine what's considered "medically necessary." You might need prior approval for certain treatments or supplies. The good news? Most plans bundle in drug coverage and may offer extras like vision, dental, or fitness benefits that Original Medicare doesn't.

What Is a Medicare Advantage Plan

A Medicare Advantage plan, also known as Part C, is an all-in-one alternative to Original Medicare. These plans are offered by private insurance companies approved by Medicare. They cover everything Original Medicare does—like hospital and doctor visits—but often include extras such as prescription drug coverage, dental, vision, hearing, and even fitness programs. Medicare Advantage plans typically work through provider networks (like HMOs or PPOs), so you might need to stick to their doctors and hospitals for the best rates
Let's face it—Medicare can be a maze of rules and jargon. But here's the exciting part about Medicare Advantage: these plans must cover everything Original Medicare does, but they have the freedom to define "medically necessary" their way. Sure, you might need prior approval for some treatments, but the perks can make it all worthwhile. Think bundled drug coverage, dental, vision, and even fitness benefits! It's like upgrading your basic cable to a premium package—extras included, all in one plan. Now, that's something worth talking about!

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WHAT DO MEDICARE ADVANTAGE PLANS COVER?

How Do Medicare Advantage Plans Work?

Here’s the scoop: Medicare Advantage Plans are offered by private companies approved by Medicare. Medicare pays these companies a fixed amount each month to manage your coverage. Each plan can have its own rules—like whether you need referrals for specialists or if you must use doctors and hospitals in the plan’s network for non-emergency care. These rules, along with costs, can change yearly. Plans will send you an Annual Notice of Change by late September, so you’re ready for Open Enrollment (October 15–December 7).

Medicare Advantage Plans include almost all the benefits of Original Medicare (Parts A and B), and they often go a step further. While Original Medicare still helps with hospice care, some clinical trial costs, and certain benefits the plan doesn’t cover, Medicare Advantage Plans can offer extras like gym memberships, routine vision exams, hearing aids, and dental cleanings.

A major perk? These plans have a yearly limit on what you’ll pay out of pocket for Part A and Part B services. Once you hit that limit, your covered services are fully paid for—giving you financial peace of mind.

Medicare Advantage and part D

Medicare Advantage Plans often include Part D prescription drug coverage as part of their all-in-one package, and this can come with some major benefits. Since Medicare reimburses Medicare Advantage plans at higher rates than standalone Part D plans, these plans can often offer more competitive drug coverage. That means you may find lower costs on your prescriptions, better access to certain drugs, and more generous formularies.

Additionally, bundling Part D with your Advantage Plan simplifies your coverage. Everything—your medical, hospital, and drug coverage—is managed under one plan, potentially saving you both money and hassle. This combination of convenience, cost savings, and robust drug benefits makes Medicare Advantage a popular choice for those who want an all-inclusive option.

What Are My Costs?

Medicare Advantage Plans set their own costs for premiums, deductibles, and the services, items, and drugs they cover. The plan decides how much you'll pay, but these costs can only change once a year, on January 1. While you're in a Medicare Advantage Plan, you'll still need to pay your Part B premium, which most people pay monthly at the standard rate.

The good news? Many Medicare Advantage Plans offer low or even $0 premiums and competitive out-of-pocket costs, making them a budget-friendly option for many beneficiaries

How to Calculate Your Costs in a Medicare Advantage Plan

When figuring out your out-of-pocket costs in a Medicare Advantage Plan, keep these key factors in mind

Medicaid or State Assistance

If you qualify for Medicaid or a Medicare Savings Program, they may help cover some costs

Out-of-Pocket Maximum

Medicare Advantage Plans set a yearly cap on your expenses, which can vary for in-network and out-of-network services. Once you hit this limit, you won't pay for covered services for the rest of the year.

Your Healthcare Needs

Think about the type of services you'll need and how often you'll use them.

Network Providers

Using doctors and suppliers in your plan's network usually saves you money.

Doctor Participation

If your doctor or supplier accepts assignment (agrees to Medicare-approved rates), it can impact your costs. This is especially important for certain plan types like PPOs or Private Fee-for-Service Plans.

Extra Benefits

Does your plan offer perks like dental, vision, or hearing? Check if there's an added cost.

Understanding these details will help you budget and choose the right plan for your needs!

Breaking It Down

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What These Terms Mean for You

Let’s make these terms simple and easy to understand:

Deductible: This is the amount you pay out of pocket for your healthcare or prescriptions before your plan starts to help with costs. Think of it as your "starting line" each year.

Coinsurance: After you’ve met your deductible, coinsurance is your share of the cost. It’s a percentage, like 20%, of the bill for a doctor’s visit or service.

Copayment (Copay): This is a flat fee you pay for a service, like $30 for a doctor’s visit, regardless of the total cost.

Maximum Out-of-Pocket Limit: This is the most you’ll have to pay in a year for services covered by your plan. Once you hit this limit, the plan covers everything for the rest of the year.

Think of these as puzzle pieces that help you budget for your healthcare!

Important Tip

Stay Informed About Your Plan

When you’re in a Medicare Advantage Plan, it’s important to keep track of updates each year. Look out for these two key notices from your plan

- **Annual Notice of Change (ANOC):** This outlines any changes in your coverage, costs, network, or service area for the coming year. Plan to mail this by **September 30** so you can review it before Open Enrollment.

- **Evidence of Coverage (EOC):** This gives detailed information about your plan, including what’s covered and how much you’ll pay. Plans send this by **October 15**, and you can request a printed or electronic copy.

Reviewing these notices ensures there are no surprises in your coverage!

Prior authorization and organization determinations You or your provider can get a decision, either spoken or in writing, from your plan in advance to find out if it covers a service, item, or drug. This decision is called “prior authorization.” If your plan doesn’t approve the request for prior authorization, you may have to pay the full cost of the service, item, or drug. You, your representative, or your doctor can ask for an “organization determination” which tells you whether a service, item, or drug will be covered, or how much you’ll have to pay. A representative is someone you can appoint to help you. Your representative can be a family member, friend, advocate, attorney, financial advisor, doctor, or someone else who will act on your behalf. Based on your health needs, you, your representative, or your doctor can ask for a fast decision on your organization's determination. If your plan denies coverage, they must tell you in writing. You have the right to appeal.

Who Can Join a Medicare Advantage Plan?

To enroll in a Medicare Advantage Plan, here's what you need:

- You must already have both **Part A (Hospital Insurance)** and **Part B (Medical Insurance).**
- You need to live within the plan's **service area** (the specific region the plan covers).
- You must be a **U.S. citizen** or lawfully present in the United States.

If you're worried about pre-existing conditions, don't be—Medicare Advantage Plans accept everyone, no matter your health history. Unlike other types of insurance, you won't be denied coverage or charged higher premiums because of a pre-existing condition. You can join during the appropriate enrollment periods, and your plan will provide coverage for all Medicare-approved services just like anyone else

Medicare Advantage & other coverage

If you have other coverage, like from an employer or union, it's important to check their rules before joining a Medicare Advantage Plan. In some cases, joining Medicare Advantage could cause you to lose your employer or union benefits for yourself, your spouse, and any dependents—and you may not be able to get it back.

In other situations, you may be able to use your employer or union coverage alongside your Medicare Advantage Plan. Some employers even offer their own Medicare Advantage plans for retirees. Remember, you can only be in one Medicare Advantage Plan at a time

When Can You Join, Switch, or Drop a Medicare Advantage Plan?

Making changes to your Medicare Advantage Plan isn't something you can do anytime, but there are specific windows where you have options. Let me break it down for you

OPEN ENROLLMENT PERIOD

From October 15 to December 7 each year, anyone with Medicare can join, switch, or drop a Medicare Advantage Plan. If you make changes during this time, your new coverage starts on January 1.

JOIN US

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Medicare Advantage Open Enrollment Period

This runs from **January 1 to March 31** each year and is only for people who are already in a Medicare Advantage Plan. During this time, you can:

- Switch to another Medicare Advantage Plan (with or without drug coverage).
- Drop your Medicare Advantage Plan and go back to Original Medicare, with the option to add a standalone Part D drug plan.

Important Notes:

- If you're on Original Medicare during this period, you can't switch to a Medicare Advantage Plan or make changes to your drug plan.
- You can only make one change during this period, and it will take effect the first day of the following month

Initial Enrollment Period

- 3 months before the month you turn 65.
- The month of your birthday.
- 3 months after your birthday month.

Your First Chance to Join Medicare Advantage

When you first become eligible for Medicare, you have a special 7-month Initial Enrollment Period to sign up for a Medicare Advantage Plan if you have both Part A and Part B. This period includes:

Here's how it works

- If you sign up in the first 3 months, your coverage usually starts on the first day of your birthday month (or the month before if your birthday is on the 1st).
- Sign up in your birthday month, and coverage starts the next month.
- Sign up in the last 3 months, and coverage begins the month after you enroll.

Besides your Initial **Enrollment Period,** you can join or switch a Medicare Advantage Plan during these times:

Medicare Advantage plans come in several types to fit different needs. Here's a quick rundown:

1. **Annual Enrollment Period (AEP):** October 15 – December 7. You can join, switch, or drop a Medicare Advantage Plan. Changes take effect on January 1.
2. **Medicare Advantage Open Enrollment Period:** January 1 – March 31. If you're already in a Medicare Advantage Plan, you can switch to another plan or return to Original Medicare. This is limited to one change.
3. **Special Enrollment Periods (SEPs):** These occur if you experience certain life events, such as moving out of your plan's service area, losing employer coverage, or qualifying for Medicaid.

Health Maintenance

Organization (HMO) Plans: A Simple Breakdown

HMO plans are a popular type of Medicare Advantage plan. They focus on coordinating your care by using a network of doctors, hospitals, and providers that contract with the plan. Here's what you need to know:

1. **Health Maintenance Organization (HMO):** You must use doctors and hospitals in the plan's network, except for emergencies. Referrals are typically needed for specialists.
2. **Preferred Provider Organization (PPO):** Offers more flexibility; you can see out-of-network providers at a higher cost and usually don't need referrals.
3. **Special Needs Plans (SNPs):** Tailored for people with specific conditions or financial needs, like chronic illnesses or dual Medicare and Medicaid eligibility.
4. **Private Fee-for-Service (PFFS):** Allows you to see any provider that accepts the plan's terms, though fewer providers may participate.
5. **Medical Savings Account (MSA):** Combines a high-deductible health plan with a bank account funded by Medicare to help pay for healthcare expenses.

- **In-Network Care:** You'll generally need to stick to the plan's network for your care unless it's an emergency, urgent care while traveling, or temporary dialysis. If you go outside the network without authorization, you'll likely pay the full cost.
- **Referrals Required:** Most HMO plans require a referral from your primary care doctor before seeing a specialist, which ensures your care is well-coordinated.
- **Out-of-Network Options:** Some HMOs offer a "Point-of-Service" (HMOPOS) option, allowing out-of-network care for certain services, but at a higher cost.
- **Prescription Drugs:** Most HMO plans include Medicare Part D drug coverage. However, if you enroll in an HMO without drug coverage, you can't join a separate Part D plan.

HMO plans are ideal for people who prefer streamlined, coordinated care and don't mind staying within a specific network

Preferred Provider Organization (PPO) Plans

WHAT YOU NEED TO KNOW

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PPO plans are a flexible type of Medicare Advantage plan with a network of doctors, hospitals, and other healthcare providers. Here’s the scoop:

Flexibility with Providers: While PPO plans have a network, you can see out-of-network providers for covered services—usually at a higher cost. Just make sure the provider agrees to treat you and hasn’t opted out of Medicare. Emergency and urgent care are always covered, whether in or out of the network.

Coverage Confirmation: Before getting care from an out-of-network provider, it’s a good idea to request an "organization determination" from your plan to confirm coverage and ensure services are necessary.

Prescription Drugs: Most PPO plans include Medicare Part D drug coverage. However, if your PPO doesn’t include drug coverage, you can’t enroll in a separate drug plan.

PPO plans are great if you want more provider options and are willing to pay a bit extra for the flexibility.

Private Fee-for-Service (PFFS) Plans

A Flexible Medicare Advantage Option

PFFS Plans are a unique type of Medicare Advantage plan offered by private insurance companies. Here's how they work:

- **Flexible Provider Options:** You can see any Medicare-approved doctor, hospital, or provider who agrees to the plan’s payment terms and conditions. If the plan has a network, you can use network providers or go out-of-network if the provider accepts the plan’s terms.
- **Costs and Billing:** PFFS plans set their own payment rates for care. Some may allow "balance billing," meaning providers can charge up to 15% more than Medicare pays, and you’ll be responsible for that amount, along with any copayments or coinsurance.
- **Prescription Drug Coverage:** Some PFFS plans include drug coverage. If yours doesn’t, you can join a separate Medicare Part D plan.

PFFS Plans can offer flexibility, but it’s important to check if your preferred providers accept the plan's terms

Special Needs Plans (SNPs) Tailored Coverage for Unique Needs

Special Needs Plans (SNPs) are Medicare Advantage plans designed specifically for people with certain health needs, chronic conditions, or those who qualify for both Medicare and Medicaid. These plans provide focused care, including tailored benefits, specialized provider networks, and drug formularies to better serve their members.

These plans offer care coordination to help members navigate their healthcare more easily

Special Needs Plans (SNPs): Personalized Care for Those Who Need It Most

Types of SNPs

Chronic Condition SNPs (C-SNPs)

For individuals with severe or disabling chronic conditions like diabetes, heart failure, dementia, or HIV/AIDS.

Dual Eligible SNPs (D-SNPs)

For those eligible for both Medicare and Medicaid

Institutional SNPs (I-SNPs)

For people who live in nursing homes or require nursing-level care at home.

I**nstitutional Special Needs Plans (I-SNPs)** are designed for individuals who live in or require the level of care typically provided by specialized facilities. These plans cater to people who

- Live in facilities such as nursing homes, skilled nursing facilities, rehabilitation hospitals, or long-term care hospitals.
- Reside in similar settings offering long-term healthcare services.
- Need a comparable level of care, even if they live in the community.

I-SNPs focus on providing highly coordinated care tailored to the unique needs of residents in these environments.

Dual Eligible SNPs (D-SNPs)

Coordinating Care for Medicare and Medicaid

If you qualify for both Medicare and Medicaid, a Dual Eligible Special Needs Plan (D-SNP) could be a perfect fit. These plans work with your state's Medicaid program to coordinate your Medicare and Medicaid benefits, helping you get the most from both programs.

D-SNPs can be PPO, HMO, or HMO-POS plans. They provide the same Medicare Part A and Part B coverage as other Medicare Advantage Plans, but they often include extra services tailored to your specific needs, like longer hospital stays for severe conditions.

Provider Networks and Care Coordination

HMO D-SNPs: You'll generally need to use in-network doctors and hospitals, except for emergencies, urgent care, or dialysis outside the area. A primary care doctor is often required.

PPO D-SNPs: You can see any qualified provider, but out-of-network services typically cost more.

These plans often include specialists and care coordinators focused on managing conditions common to their members. For example, someone in a D-SNP for diabetes may have a coordinator to help with blood sugar management and meal planning.

Do Special Needs Plans (SNPs) Cover Prescription Drugs?

Yes! All Special Needs Plans (SNPs) must include Medicare Part D prescription drug coverage. This means your medications are covered as part of the plan, making it easier to manage both your healthcare and medication needs in one place.

Medicare Medical Savings Account (MSA) Plans: How They Work

Medicare MSA Plans are a unique type of Medicare Advantage plan that pairs a high-deductible health plan with a medical savings account. Here's how it works:

1

High-Deductible Plan

Your plan won't start covering costs until you meet a high yearly deductible. The amount varies by plan.

2

Savings Account

The plan deposits money into a special medical savings account for you. You use these funds to pay for healthcare expenses, including services Medicare doesn't typically cover.

Who Can't Join an MSA Plan?

You're not eligible if you:

- Have other coverage that would pay toward the MSA deductible.
- Are in another Medicare Advantage Plan.
- Get benefits from TRICARE, the VA, Medicaid, or certain federal employee plans.
- Receive hospice care or live outside the U.S. for more than 183 days a year.

Enrollment Process

To join an **MSA** Plan

1

Contact the plan for enrollment information

2

Set up the required savings account with a bank chosen by the plan

3

Once enrolled, the plan deposits funds into your account each year, which you can use for approved healthcare costs

MSA Plans can be a smart option for people who want flexibility and control over their healthcare spending.

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Can I Use Any Doctor or Hospital with an MSA Plan?

Yes! MSA Plans generally don’t have a network. You can receive Medicare Part A and Part B services from any provider in the U.S. or its territories that accepts Medicare. This gives you the freedom to choose doctors and hospitals without worrying about network restrictions.

Do MSA Plans Cover Prescription Drugs?

No, MSA Plans don’t include drug coverage. If you want Medicare Part D for prescriptions, you’ll need to enroll in a separate Medicare drug plan.

What Happens if I Have a Medigap Policy?

Medigap is extra insurance that helps cover out-of-pocket costs in **Original Medicare.** However, it doesn't work with Medicare Advantage Plans. Here's what you need to know:

- If you join a Medicare Advantage Plan, you **cannot use Medigap** to pay for your plan's copayments, coinsurance, deductibles, or premiums.
- It's illegal for someone to sell you a Medigap policy while you're in a Medicare Advantage Plan unless you're switching back to Original Medicare.
- If you already have Medigap and join a Medicare Advantage Plan, you may want to drop Medigap since it won't provide any additional coverage.

If you encounter any issues, report them to your **State Insurance Department.**

Trial Right to Buy Medigap

If you join a Medicare Advantage Plan for the first time and decide it's not the right fit, you have a **"trial right"** under federal law to return to **Original Medicare** and buy a Medigap policy, along with a separate Medicare drug plan. Here's how it works:

- **If you had Medigap before joining Medicare Advantage, you may be able to get the same policy back if the company still offers it. If not, you can buy another available policy.**
- **If you joined a Medicare Advantage Plan when you were first eligible for Medicare and switched back to Original Medicare within your first year, you can choose any Medigap policy available.**

State-Specific Rights

Some states offer additional special rights for purchasing Medigap. Contact your **State Insurance Department** to learn more about your options.

Key Reminders

If you're feeling overwhelmed by all the Medicare options, know that you don't have to figure it out alone. At The Modern Medicare Agency, we pride ourselves on offering a truly **human interaction —a** conversation tailored to your needs, not just facts and figures from a script

Unlike government agencies like SHIP or Medicare, we're compensated for helping you, and that's a good thing! Your satisfaction matters to us because the longer you stay happy with your plan, the better we do, too. This motivates us to go the extra mile to ensure you're in the right plan—not just today, but for years to come.

As brokers, we have insider knowledge about which plans have stronger networks, easier rules, and fewer headaches. We don't just look at numbers; we know the real-life details that make a difference. That's why working with us offers an advantage you won't get anywhere else.

Ready to simplify your Medicare journey? Let's chat and find the perfect plan for you!

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