

Questions to Ask Before Joining a Medicare Advantage Plan

Some people with Medicare choose to enroll in Medicare Advantage plans, sometimes called a Medicare private health plan, rather than stay in Original Medicare. These private health plans contract with Medicare and are paid a fixed amount to provide Medicare benefits. They can be a managed care plan, the most common types being the Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), or a Private Fee-For-Service (PFFS) plan.

Not all Medicare Advantage plans—even plans of the same type—work the same way. For example, most HMOs provide no coverage if you go out of network (except in emergencies), but some do cover some portion of your costs if you see out-of-network doctors. **Before you join a Medicare Advantage plan, make sure you understand that specific plan's network rules.**

If you already have a Medicare Advantage plan and want to switch to another one, you should do so **without disenrolling from your old plan**. It is best to enroll in the new plan by calling 800-MEDICARE, rather than by calling the new plan. Remember, most people can make changes to their Medicare coverage only during Fall Open Enrollment, which runs from October 15 to December 7 of each year.

These are questions you should ask your doctor, friends, family members, and health plan representatives when looking into what a particular plan offers you.

Coordination with Other Benefits

- How does the plan work with my current coverage?
- If I join, could I lose my retiree/employer health coverage?

Doctors, Hospitals and Other Health Care Providers

- Will I be able to use my doctors? Are they in the plan's network and are they taking new patients who have this plan?
- If my doctors aren't in the network, will the health plan pay for me to see them anyway? Will that cost me more?
- Do my doctors recommend joining this plan?
- Which specialists, hospitals, home health agencies and skilled nursing facilities are in the plan's network?

Access to Health Care

- Who can I choose as my Primary Care Physician (PCP)?

Extra Benefits

- What extra benefits does the plan offer? Does it cover dental services, vision care or hearing aids? What rules do I have to follow to get them? Are there limitations on the benefits? How much do I have to pay for them?

Prescription Drug coverage

- Are my prescription drugs on the plan's formulary (list of covered drugs)?
- Does the plan require that I get "prior authorization" before my prescription will be covered, or impose other restrictions (like limiting the quantity or requiring that I try a cheaper medication before it will cover a more expensive one)?
- Do I have to pay a deductible before the plan will cover my drugs?
- How much will I pay for brand-name drugs? How much for generic drugs?
- What will I pay for my drugs during the coverage gap?
- Will I be able to use my pharmacy? Is it in the plan's network? Can I get my drugs by mail order?
- Can I fill my prescriptions if I travel away from the plan's network?

Cost

- How much is my monthly premium?
- Will I pay a higher premium because of my income? (Starting in 2011, individuals with yearly incomes above \$85,000 and couples with yearly incomes above \$170,000 pay more for both Part B and Part D.)
- How much will I have to pay out of pocket before coverage starts (what is the deductible)?
- How much is my copayment for a visit with my PCP or a visit with a specialist?
- How much will I pay if I use a non-network doctor or hospital?
- Are there higher copays for certain types of care, such as home health or skilled nursing facility care?
- What is the annual out-of-pocket maximum? (After you spend a certain amount, your care will be free or very low-cost.) If you're in a PPO, what are the different out-of-pocket limits for in-network and out-of-network care?

Service Area

- What service area does the plan cover?
- What kind of coverage do I have if I travel outside of the service area?