Consumer's Guide to Medicare Advantage in Wisconsin

This guide explains the options under Medicare Advantage, provides important questions to consider, and lists some of the advantages and disadvantages of Medicare Advantage Plans.

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For more information on health insurance call the Medigap Helpline at 1-800-242-1060. This is a statewide toll-free number set up by the Wisconsin Board on Aging and Long-Term Care and funded by the Office of the Commissioner of Insurance to answer questions about health insurance and other health care benefits for Medicare beneficiaries. It has no connection with any insurance company.

Disclaimer

This guide is intended as a general overview of current law in this area but is not intended as a substitute for legal advice in any particular situation. You may want to consult your attorney about your specific rights. Publications are updated annually unless otherwise stated and, as such, the information in this publication may not be accurate or timely in all instances. Publications are available on OCI's website at oci.wi.gov/Publications. If you need a printed copy of a publication, use the online order form (oci.wi.gov/Pages/Consumers/Order-a-Publication.aspx) or call 1-800-236-8517. One copy of this publication is available free of charge to the general public. All materials may be printed or copied without permission.

File a Complaint

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

- Reach out to OCI (1-800-236-8517, ocicomplaints@wisconsin.gov) to speak with our staff. If sending an email, please indicate your name and phone number.
- You can file a complaint online at oci.wi.gov/complaints. If you would like to file your complaint by mail, visit oci.wi.gov/complaints, email ocicomplaints@wisconsin.gov, or call 1-800-236-8517 for a form.

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Introduction to Medicare Advantage Plans

This publication provides basic information to people about the Medicare Advantage program (formerly called Medicare+Choice). The Medicare Advantage program relies on health maintenance organizations (HMOs), defined network plans (also known as managed care plans), and private fee-for-service plans to lower the costs of the Medicare program.

The Office of the Commissioner of Insurance (OCI) offers two publications to help people make decisions about their Original Medicare coverage. The Guide to Health Insurance for People with Medicare in Wisconsin and the Medicare Supplement Insurance Policies List are available at oci.wi.gov/publications or call 1-800-236-8517 to request a copy.

Original Medicare

Medicare is the federal health insurance program primarily for people aged 65 and older and for younger individuals who have a disability and meet certain qualifications.

Original Medicare includes Part A and Part B:

- Part A covers hospitalization, skilled nursing facility care, home health, and hospice care.
- Part B, which is an optional purchase, covers physician services, therapies, diagnostic tests, and outpatient hospital services. It does not cover prescription drugs, dental care, physicals, or other services not related to the treatment of illness or injury.

Under the Original Medicare program, you can choose to see the doctor or hospital of your choice and are responsible for paying out-of-pocket expenses like deductibles and coinsurance. You can purchase a Medicare Supplement (Medigap) policy from an insurance company to cover some out-of-pocket expenses, or you can purchase a Medicare Supplement policy from an HMO, but your coverage will be limited to providers in the HMO's network. Medicare Supplement policies are **not** allowed to include prescription drug coverage. If you want prescription drug coverage, you can join a Medicare Prescription Drug Plan (Part D).

Medicare Advantage

Medicare Advantage was added to the Medicare program as Medicare Part C. Medicare Advantage offers people enrolled in Medicare Part A and Part B another option for obtaining health coverage through the Medicare program. It is important to know that you may choose to stay in Original Medicare if you are satisfied with the program.

All Medicare Advantage plans must provide at least the same benefits as Original Medicare. However, Medicare Advantage plans are not required to provide the same supplemental benefits as those provided under Medicare Supplement policies available in Wisconsin.

Whether you enroll in Original Medicare or Medicare Advantage, you must continue to pay your monthly Medicare Part B premium.

Medicare Advantage plans are offered by private companies approved by Medicare. If you join a Medicare Advantage plan, you still have Medicare. You will receive your Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) coverage from the Medicare Advantage plan and not Original Medicare.

Medicare Advantage plans are annual contracts and are not guaranteed renewable as is required for Medicare Supplement policies. Like Medicare Supplement policies, the premiums you pay for the Medicare Advantage plan may increase. You may be responsible for paying your doctor and hospital bills if you do not follow the Medicare Advantage plan's rules.

Options Under Medicare Advantage

In Wisconsin, insurance companies offering Medicare Advantage health plans must be licensed with OCI before Medicare will enter an arrangement to purchase coverage for you. Medicare Advantage plans are based on your geographic location and are not available in all Wisconsin counties. Most Medicare Advantage plans offer prescription drug coverage. The types of Medicare Advantage plans available in Wisconsin are listed below.

Health Maintenance Organization (HMO)

A type of managed care health plan with a defined list of network providers that an enrollee must use. Generally, HMOs have more restrictions on the providers you may use than other types of health plans. HMOs often provide benefits, such as additional preventive care, that are not available from other types of health plans.

Other than in an emergency, an HMO will not pay for services you obtain from a provider who is not part of the HMO's network. Only in rare cases will an HMO allow referrals to non-network providers. The HMO may require you to obtain a referral from your primary care provider before seeing a specialist. HMOs do not cover services provided by non-network providers that are not emergencies or urgent care situations. Typically, an HMO has small copayments for covered medical services.

Before you enroll in an HMO, you should carefully review the list of providers available through the HMO. You should also review whether the HMO allows access to out-of-state provider networks.

Point of Service Plan (POS)

A type of managed care health plan with a network of providers permitting you to also use non-network providers, usually at an additional cost. The POS plan may require you to obtain

a referral from your primary provider before the plan will agree to pay for out-of-network care. Like an HMO, a POS has small copayments for medical services received from providers in the network.

Preferred Provider Plan (PPP)
A type of managed care health plan offered by private health insurance companies paying a specific level of benefits if certain providers are used and a lesser amount if non-PPP providers are used. Like an HMO, a PPP operates in a certain geographic area and is limited to specific providers.

Private Fee for Service (PFFS)
A type of health plan offered by private health insurance companies. The plan allows you to go to any Medicare-approved provider, such as a doctor or a hospital, who before treating you, has agreed to accept the Medicare PFFS plan's terms and conditions of payment. The provider can decide at every visit whether to accept the plan and agree to treat you. Some providers who accept Original Medicare may not accept PFFS plan enrollees. Some PFFS plans have network providers. You will usually pay more if you see a non-network provider.

PFFS plans are not required to coordinate care or adopt utilization management strategies.

Medicare Medical Savings Account (MSA)
A health plan option that is made up of two parts:

1. A high-deductible health insurance policy covering the same services as Medicare Part A and Part B. The plan will only begin to cover your costs once you meet a high yearly deductible, which varies by plan.
2. A special type of savings account where the Medicare MSA plan deposits money into your account. You can choose to use money from this savings account to pay your health care costs before you meet the deductible.

MSA plan deductibles tend to be very high and can vary by plan. Before you enroll, you should contact the plans you are interested in for information about the deductible amount.

Medicare Special Needs Plan (SNP)
A special type of health plan that is limited to people in certain institutions (such as nursing homes), those eligible for both Medicare and Medicaid, or people with certain chronic or disabling conditions. SNPs are available in limited areas and are designed to provide services to people who benefit the most from the special expertise of plan providers and care management.

If you see a provider who does not accept Medicare assignment, you may be responsible for any charges up to 15% over the Medicare allowed amount. If you see a provider who does not

participate in the Medicare program, you will not be covered and will be responsible for the entire amount charged by the provider. The plan may charge you, through premiums, additional out-of-pocket expenses (such as copayments and coinsurance), or both for any costs exceeding what Original Medicare would pay.

Remember, you do not have to leave Original Medicare unless you choose to. The cheapest policy may not be the best option for you. Generally, plans offering you more freedom in choosing providers or covering additional benefits will cost you more, either in premiums or out-of-pocket expenses.

Some questions to consider if you decide to choose a Medicare Advantage plan include:

1. What providers are available to you?
2. Will the plan allow you to see the providers you want?
3. Are there any additional benefits offered and is there an additional charge for these benefits?
4. What benefits are excluded but would be covered under a Medicare Supplement policy?
5. What is the total cost to you, including premiums, coinsurance, copayments, deductibles, and other out-of-pocket expenses?
6. How often and by how much can the plan raise your premiums?
7. If you have a specific health condition, is one type of plan better suited to provide the services you need?
8. Will the plan coordinate with my current employer-sponsored or union plan?

Important Information You Need When Choosing a Medicare Advantage Plan

Medicare Advantage plans must give you in writing all the information on the list below. If this information is not included in the plan's enrollment materials, call the plan and request it.

- **Summary of Benefits**—An outline of coverage provided by the plan indicating the scope of coverage offered by the plan.
- **Provider Directory**—A list of providers who are contracted with the plan to provide services. This list could include clinics and hospitals available to plan enrollees. (Does not apply to PFFS plans.)
- **Prior Authorization Rules**—Explain what you must do to obtain specialty care or care from a non-network provider.

- **Grievance and Appeal Procedures**—Outlines the steps to take when you are dissatisfied with a coverage decision made by your health plan. There are minimum requirements all plans must meet.
- **Procedures to Protect Patient Confidentiality**—The safeguards in place to ensure only authorized individuals may view your medical records.

Changing a Medicare Advantage Plan

Medicare Advantage plans are required to have a Medicare Annual Open Enrollment Period from **October 15 through December 7** of each year. During the Medicare Annual Open Enrollment Period, Medicare beneficiaries may enroll in or disenroll from any type of Medicare Advantage plan. You may change plans more than once during this timeframe. If you make a change during the Medicare Annual Open Enrollment Period, your coverage will begin on January 1.

Medicare Advantage plans also have a Medicare Advantage Open Enrollment Period from **January 1 to March 31**. During the Medicare Advantage Open Enrollment Period:

- If you are 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 three months you have Medicare.

Medicare Advantage Open Enrollment does not mean you are guaranteed a Medicare Supplement (Medigap) policy. Insurance companies may deny your application for Medicare Supplement coverage if you have preexisting medical conditions.

If you drop your employer group health plan coverage, you might not be able to re-enroll if you are unhappy with your Medicare Advantage plan. For more information, contact your company's human resources department.

In certain situations, you may be able to join, switch, or leave Medicare Advantage plans at other times (if you move, have both Medicare and Medicaid, or live in an institutional setting).

Medicare Advantage Prescription Drug (MA-PD) Plans

Most Medicare Advantage plans available in Wisconsin include prescription drug plan coverage and are referred to as Medicare Advantage prescription drug (MA-PD) plans. MA-PD plans are subject to the same requirements as stand-alone prescription drug plans (PDPs).

The Cost of MA-PD Plan Coverage

In most circumstances, you will pay a premium for prescription drug coverage under a Medicare Advantage plan. In addition to monthly premiums, you may have to pay an annual deductible plus copayments for each of your prescription drugs. With most plans you will pay 100% of the cost of covered drugs until you reach your out-of-pocket limit. The amount of your monthly out-of-pocket expenses will depend on how many prescriptions you need. After you have reached your out-of-pocket spending limit, you will have to pay 5% of the cost of covered prescriptions for the rest of the year.

Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health issuers, group health plans, and employers to issue a HIPAA certificate of creditable coverage when your health coverage ends. The certificate indicates the date on which your coverage ends and how long you had the coverage. You should retain this document for your records because the certificate provides evidence of your prior coverage. If certain conditions are met, evidence of prior coverage may entitle you to a reduction or total elimination of a preexisting condition exclusion period under a subsequent health insurance policy you purchase.

The Medicare Modernization Act (MMA) imposes a late enrollment penalty on individuals who do not maintain creditable drug coverage (coverage at least as good as Medicare Part D coverage) for 63 days or longer following their initial enrollment period for the Medicare prescription drug benefit. MMA mandates that health plans offering prescription drug coverage disclose to all Medicare-eligible individuals with prescription drug coverage whether the coverage is creditable. Retain this document for your records.

SeniorCare Prescription Drug Assistance Program

The Wisconsin legislature created the SeniorCare prescription drug assistance program for residents aged 65 and older who meet certain requirements.

The SeniorCare prescription drug assistance program is considered “creditable coverage.” This means SeniorCare is as good as the standard Medicare Part D plan.

Information about SeniorCare is available at dhs.wisconsin.gov/seniorcare/index.htm or you may contact the SeniorCare Hotline at 1-800-657-2038.

Advantages and Disadvantages of Medicare Advantage Plans

Advantages of Medicare Advantage Plans

- Most Medicare Advantage plans have low monthly premiums. Some may not charge any monthly premium.
- Some plans may provide more benefits than are covered under Original Medicare.
- Generally, you can enroll regardless of your health history.

Disadvantages of Medicare Advantage Plans

- Medicare Advantage plans are annual contracts. Plans may decide not to negotiate or renew their contracts.
- Plans are annual contracts and may change benefits, increase premiums, and increase copayments at the end of each year.
- You may have higher annual out-of-pocket expenses than under Original Medicare with Supplemental insurance coverage.
- Your current doctors or hospitals may not be network providers or may not agree to accept the plan's payment terms.

Important Note

Review the coverage of your existing plan each year, including any changes to the coming plan year, to make sure that it still meets your needs.

If you want to switch to a Medicare Advantage plan, read all the materials from the plan carefully before enrolling. You should contact the plan's customer service department before enrolling in the plan. Each plan should provide written information on covered benefits, total costs to you, lists of available providers, and restrictions on access to providers. If you need to stay with a specific doctor or hospital, you should make sure the provider is part of the health plan you choose.

Questions and Answers

What if I have a problem with my Medicare Advantage plan?

Medicare Advantage is an option under the Medicare program. If you have a complaint regarding enrollment, disenrollment, coverage, or a claim, you must follow the Medicare rules to resolve the problem. You should first contact the plan regarding your problem. If you are not able to resolve your problem with the plan, you should contact Medicare at 1-800-MEDICARE (1-800-633-4227).

State insurance departments, such as OCI, do not have jurisdiction over the Medicare program or Medicare Advantage plans. However, if your problem involves the acts of a licensed insurance agent, you should file a complaint with OCI.

What happens if I am unhappy with my Medicare Advantage plan's claim decision?

A Medicare Advantage plan decision regarding the type of service and the amount to reimburse for the service is an organization determination. Medicare Advantage plans are required to respond promptly to appeals of organization determinations. Medicare Advantage plans are required to provide you with written information on how to file an appeal.

- If you are unhappy with an organization's determination, you must first file a request for reconsideration with the Medicare Advantage plan. The plan must issue its decision on your request within 60 calendar days and must issue an expedited decision within 72 hours.
- If you are still unhappy with the decision, you may then appeal to an independent reviewer. The time frames are the same as those described above.
- Additional reviews are conducted by an administrative law judge and by the U.S. Department of Health and Human Services' appeals counsel. Finally, you may appeal the decision in federal court.
- If the organization's determination affects coverage of a continuing inpatient hospital stay, it may be immediately appealed to a Medicare peer review organization. You are not responsible for any costs incurred while this decision is pending.

If you are unhappy with a plan's decision to not expedite an appeal or with the way you have been treated by plan providers, you should file a grievance with your Medicare Advantage plan. Grievances are separate and different from appeals. The plan is required to explain its grievance process to you and to respond to your grievance in a timely fashion.

Can my Medicare Advantage plan drop me?

Medicare Advantage plans can drop you at the end of the plan year if the plan does not renew its contract with Medicare. A plan not renewing its contract with Medicare may decide to drop select geographic areas of service, or it may choose to not renew the entire plan.

A plan may disenroll you for failure to pay your premiums on time, for disrupting the plan's ability to deliver health care services, or if it cannot meet your medical needs. If you are involuntarily disenrolled, you are automatically returned to coverage under Original Medicare at the beginning of the month following your involuntary disenrollment.

If I lose my Medicare Advantage coverage and return to Original Medicare, can I get Medicare Supplement coverage?

If you are involuntarily disenrolled from Medicare Advantage because the Medicare Advantage plan nonrenews its plan, you have the right to apply for a Medicare Supplement policy if you do so within **63 days** of notice of the nonrenewal.

If you voluntarily disenroll because you decide a Medicare Advantage plan is not right for you, you may have a right to Medicare Supplement coverage if you have not been covered by a Medicare Advantage plan before and you disenroll from the Medicare Advantage plan within 12 months of your enrollment. This right is limited to the same Medicare Supplement policy, excluding any outpatient prescription drug coverage, that you had before you joined the Medicare Advantage plan if the same insurance company you had before still sells the policy. If your former Medicare Supplement policy is not available, you can buy a policy sold by any insurance company selling Medicare Supplement in Wisconsin.

How can I determine if a Medicare Advantage plan is a good choice for me?

Currently, the monthly premiums you will pay for a Medicare Advantage plan are less than the premiums you pay for a Medicare Supplement policy. However, Medicare Advantage plans require you to pay a copayment each time you visit your doctor, for physicals, screening, vision and hearing exams, therapy, and rehabilitation services. For example, you may be required to pay a $150 copayment for the first through the fifth day of inpatient hospital care and a $50 copayment for emergency room visits. You should compare not only the difference in the monthly premium between a Medicare Supplement policy and a Medicare Advantage plan, but also the copayment amounts you will pay for Medicare Advantage coverage.

Can I keep my Medicare Supplement policy and have a Medicare Advantage plan?

Your Medicare Supplement policy is designed to pay 20% of Medicare-approved charges or to "supplement" the benefits payable under Original Medicare. If you enroll in Medicare Advantage, you are no longer covered by Original Medicare, and your Medicare Supplement policy will not pay any benefits toward Medicare Advantage out-of-pocket expenses. You

should decide whether you want coverage under Original Medicare with a Medicare Supplement insurance policy or if you want coverage under a Medicare Advantage plan.

Am I entitled to the mandated benefits required by Wisconsin insurance law under Medicare Advantage plans?

Medicare Advantage policies **are not** subject to the mandated benefit requirements under Wisconsin insurance law.

What happens under Medicare Advantage if I have a medical emergency?

All Medicare Advantage plans are required to use what is known as the "prudent layperson" standard in making coverage decisions about emergency care. Under this standard, if you have acute symptoms, such as severe pain, which would cause a reasonably prudent layperson to expect that a delay in treatment would endanger the health or impair bodily functions, you are permitted to obtain emergency services without prior approval from your health plan. Emergency services must be provided by a qualified provider and are limited to services needed to diagnose and stabilize your condition.

Urgent care is required to be covered by a Medicare Advantage plan. An urgent care situation would include an accident or sudden illness while you are away from home. If you are a frequent traveler, you should inquire about the plan's guidelines for services when you are out of its geographic service area, including refills on prescription drugs and access to non-urgent or emergency medical services. Your Medicare Advantage plan may have a passport provision allowing you to see providers in other parts of the country. Under a PFFS plan, your coverage is not limited by geographic service area. If you need medical attention, you may go to any doctor, specialist, or hospital that is approved for Medicare and accepts the plan's payment terms.

When can I join, switch, or drop my Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare or if you get Medicare due to a disability. You can switch or drop your Medicare prescription drug plan during the Medicare Annual Open Enrollment Period (October 15 through December 7).

The prescription drugs covered by your Medicare drug plan will vary based on the plan you choose. It is important to understand your plan will pay for only those prescriptions in the plan's formulary. Only the cost of drugs covered by your plan will count toward the deductible and out-of-pocket limits. Outpatient prescription drug expenses not covered by the plan or drugs covered by a drug discount card will not count toward your out-of-pocket expense requirement.

What happens after I join a plan?

You will get a letter from the plan telling you when your coverage begins. Once you enroll in a Medicare Advantage plan, you must show your plan ID card every time you visit a health care provider. You cannot use your red, white, and blue Medicare card to get health care because the Original Medicare plan will not pay for your health care while you are enrolled in the Medicare Advantage plan.

Read plan materials carefully to find out about the rules affecting where you get your care and what you must pay, including whether the plan has a network (certain providers you must use) and your share of the cost for services and supplies.

Resources

Other Resources Available Regarding Medicare Supplement and Medicare Advantage Plans

To compare Medicare Advantage plans or to find out what plans are available in your area: medicare.gov/plan-compare/#/?lang=en&year=2025 If you do not have a computer, your local library or senior center may be able to help you access the Medicare website.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Call the insurance company offering the Medicare Advantage plan you are interested in to answer any questions you have about the plan. The company will be able to send you information about the plan and explain all the benefits the plan offers.

Questions or problems with a Medicare Advantage plan must first be referred to the plan.

The federal government works with the Board on Aging and Long-Term Care to provide additional information on MedicareAdvantage plans. You may reach them at **1-800-242-1060** (Medigap Helpline) or longtermcare.wi.gov.

You can also obtain information at **1-800-MEDICARE** (1-800-633-4227) or on the Centers for Medicare & Medicaid Services (CMS) Medicare website at medicare.gov.

Where to Go for Help

If you have a complaint regarding Medicare Advantage, you should refer to your plan's membership materials regarding your complaint, grievance, and appeal rights. If you are unable to resolve your problem with the plan, you may file a complaint by calling **1-800-MEDICARE (1-800-633-4227).** If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved.

If you have a problem or complaint involving an insurance agent, you should contact OCI. To file a complaint online or to print a complaint form:

Website oci.wi.gov/complaints

Phone (608) 266-0103 (In Madison) or 1-800-236-8517 (Statewide)

Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873 Madison, WI 53707-7873

Email ocicomplaints@wisconsin.gov
Please include your name and phone number.
Deaf and hearing or speech-impaired callers may reach OCI through WI TRS

Board on Aging and Long-Term Care (BOALTC)
BOALTC administers Wisconsin's Senior Health Insurance Assistance Program (SHIP) and is funded by OCI. BOALTC provides free insurance counseling services to Medicare beneficiaries and can answer questions about health insurance and other health care benefits for the elderly. It has no connection to any insurance company.

Board on Aging and Long-Term Care
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
longtermcare.wi.gov

Medigap Helpline
1-800-242-1060 (phone)
(608) 246-7001 (Fax)

Medigap Part D and Prescription Drug Helpline
1-855-67PARTD (1-855-677-2783)

Elder Benefit Specialists/Disability Benefit Specialists
All benefit specialists can help people with Medicare questions and concerns. Elder Benefit Specialists are trained to help anyone 60 years of age or older who is having a problem with private or government benefits and are available at either an Aging and Disability Resource Center (ADRC) or a county or tribal aging unit. Disability Benefit Specialists are available at all ADRCs and serve Medicare beneficiaries ages 18-59.

All local contact information can be found at dhs.wisconsin.gov/benefit-specialists/index.htm.

Glossary

Annual Disenrollment Period An annual period during which Medicare beneficiaries can disenroll from their Medicare Advantage plan and return to Original Medicare. The annual disenrollment period occurs January 1 through February 14 each year. Beneficiaries who change coverage to Original Medicare may also purchase a Medicare Part D drug plan. Beneficiaries do not have guaranteed issue rights to a Medicare Supplement policy to cover the Medicare deductibles, coinsurance, and copayments.

Medicare Annual Open Enrollment Period An annual period during which Medicare beneficiaries may enroll in or disenroll from a Medicare Advantage plan. The annual election period occurs from October 15 through December 7 each year. The plan coverage becomes effective on January 1 of the coming year.

Appeal The process for resolving a dispute about a Medicare Advantage plan's failure to provide benefits you believe are Medicare-covered services.

Benefit Determination A decision from the Medicare managed care plan to offer coverage under the provisions of the policy. The benefit could require a deductible or copayment. The benefit could also be limited to a certain amount by the plan.

Coordinated Care Plan Any form of Medicare Advantage plan relying on a provider network to deliver care to enrollees, including HMOs and other managed care plans. Most coordinated care plans will make you pay for all or part of the cost of using a provider who is not part of their network.

Coverage Services meeting the plan requirements for reimbursement. A medical service is not necessarily covered, even if your health care provider says you need it unless the service meets the terms of the health plan.

Creditable Coverage The Medicare Modernization Act (MMA) imposes a late enrollment penalty on individuals who do not maintain creditable drug coverage (coverage at least as good as Part D coverage) 63 days or longer following their initial enrollment period for the Medicare prescription drug benefit. MMA mandates that health plans offering prescription drug coverage disclose to all Medicare-eligible individuals with prescription drug coverage whether such coverage is creditable. Retain this document for your records. For more information on creditable coverage as it relates to Part D, go to cms.hhs.gov/CreditableCoverage/01_Overview.asp.

Disenrollment Leaving a Medicare managed care plan to go to another health plan. Certain plan rules must be followed to leave the plan officially. Your disenrollment will be effective the first of the month following the submission of your disenrollment form.

Disenrollment Form The form necessary to submit to your present Medicare managed care plan indicating your decision to leave the plan. This could be a simple written statement from you to the insurance company, or you can get this form from your local Social Security office or from the plan in which you are presently enrolled.

Drug Formulary A formulary is a list of generic and brand name prescription drugs covered by your insurance policy or health plan.

Emergency Services Services delivered by an appropriately trained health care professional required to diagnose and stabilize an emergency condition.

Grievance A written complaint from you or an individual on your behalf filed with the plan involving issues such as waiting periods, physician behavior, involuntary disenrollment situations, quality of service, and premiums.

Mandatory Supplemental Benefits Additional benefits included in Medicare coordinated care plans that are required to be purchased by you. These benefits differ among Medicare Advantage plans.

Medicare Advantage Eligible Individual An individual who has both Medicare Part A and Medicare Part B.

Medicare Advantage Organization A private or public entity that meets the contractual requirements to offer a Medicare Advantage health plan. A Medicare Advantage organization may offer more than one plan or type of plan.

Medicare Advantage Plan A private health plan offered by a Medicare Advantage organization. Formerly known as Medicare+Choice Plan, also referred to as Medicare Part C.

Medicare Supplement (Medigap) Insurance policies sold by private insurance companies to fill gaps in Original Medicare plan coverage. Medigap policies only work with Original Medicare.

Network A group of doctors or hospitals contracting with a managed care plan to provide health care to plan members. Generally, managed care plan members only receive covered services from providers in the plan’s network.

Optional Supplemental Benefits Additional benefits offered by Medicare coordinated care plans you may choose and may include additional premiums.

Organization Determination A decision by a Medicare Advantage organization regarding the amount of service provided or the price the plan will reimburse for the service.

Out-of-Pocket Expenses Expenses paid by you in addition to plan premiums, which may include any or all the following:

- Deductible: A fixed amount paid for covered services before the plan pays. Deductibles are usually required to be paid annually. Expenses counted toward your Medicare deductible are the amounts Medicare would pay for the service, not what you may have paid.
- Copayment: A fixed dollar amount for use of medical services. For example, many health plans require you to pay a fixed amount for each drug prescription you receive.
- Coinsurance: A fixed percentage of the total cost of services, paid each time you use the service.

Your health plan may have an annual cap on total out-of-pocket expenses. This information is included in your initial enrollment materials.

Passport Plan A network of providers who are outside of your plan's geographic service area, usually in a different state, which can be used by you in nonemergency or urgent care situations. Some managed care plans have these networks available to individuals who travel to certain states. Check with your plan on the availability of this provision.

Plan Determination A decision by a Medicare Advantage plan regarding the amount of service it will provide you or the price the plan will reimburse the provider for the service.

Prescription Drug Plan (PDP) Medicare offers optional prescription drug plan coverage, also called Medicare Part D. There are two types of Medicare plans offering prescription drug coverage: stand-alone PDPs and Medicare Advantage prescription drug plans.

Service Area The area where the plan accepts enrollees and, for managed care plans, where the plan has contracted providers you are required to use. Most coordinated care plans operate in a limited geographic area known as a service area. It is usually stated as county or zip code of operation.

Urgent Care Covered services when you are temporarily out of the area that are medically necessary and needed immediately due to an unforeseen illness, accident, or injury, and when it is not reasonable to obtain services from a network provider.