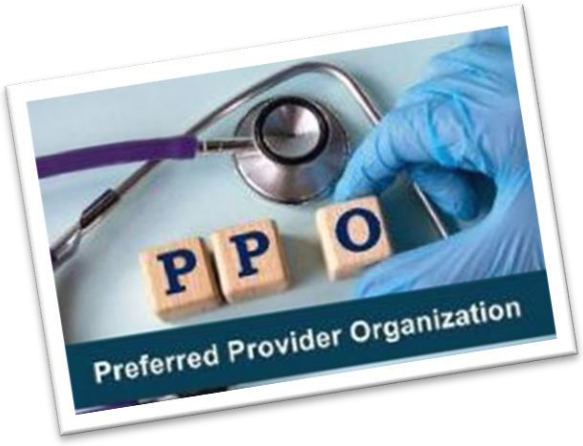
Medicare Advantage PPO Plans



Questions and Answers for Preferred Provider Organizations (PPO's)

What is a Medicare Advantage PPO?

All Medicare Advantage Plans provide medical benefits equal to those offered by Traditional Medicare. HMO Plans require referrals to specialists and use local network providers. PPOs offer a nationwide network of providers and allow out-of-network care with a higher cost to you.

What is the provider network for in-network services?

The PPO in-network covers much of the USA through providers which have individual contracts with the insurance plan. In Contra Costa County, this includes many John Muir Health, Hill Physicians, Affinity, and BASS affiliates; however, not all providers in these groups are in-network. You should verify coverage prior to your visit with the provider. This is done with the provider's office, the PPO Plan, or using the Medicare provider lookup tool in Plan Finder. See our handout on using Plan Finder for more detail on that lookup option.

Are referrals to specialists required?

Referrals are not required to visit doctors or specialists, whether they are in-network or out-of-network. In certain cases, specialists may request a referral for medical purposes rather than for insurance reasons.

What services are subject to the annual deductible?

Each plan has its own rules for which services are subject to the annual deductible. Those are detailed in the 'Summary of Benefits' documents. There is a link to that under each plan in HICAP's MAPD Summary Chart. Generally, it does not apply to in-network regular medical services such as doctor visits, emergency care or lab tests. It does apply for services like CT scans, physical therapy, outpatient surgery and most out-of-network charges. Until you have made payments totaling an amount above the deductible amount, you must pay the full Medicare approved charge.

What is the cost basis for the Out-of-Network coinsurance?

Members pay a percentage coinsurance based on the 'Medicare Limiting Charge', which is set by Medicare for covered services—not the provider's billed amount. Unless it is an emergency, providers aren't required to treat you, but most accept the plan's reimbursement plus your coinsurance as full payment of the Medicare approved charge. It is still best to confirm ahead of any visit with out-of-network providers that they will accept your PPO insurance.

How is the Out-of-Pocket maximum figured?

These limits exclude premiums, Part D drugs, and non-covered Medicare services like dental care.

In Network: Once a member reaches the in-network out-of-pocket limit, all in-network covered services are fully paid for the rest of the year.

Mix of in and out of network. After reaching the combined in and out-of-network limit, no further out-of-pocket costs apply for the year.

Are these plans available for full Medi-Cal eligible beneficiaries (duals)?

Yes. All plans offer lower premiums and no copays or co-insurance when you use in-network providers. Federal regulations prohibit discrimination against Medi-Cal status by in-network providers. Contracts with Medicare require they cannot bill dual eligibles for Medicare covered costs. Some providers may ask for a copay at time of service. You can contest this if you choose. Out-of-network providers don't have to accept patients, so confirm they take Medi-Cal and Medicare before visiting. Not identifying yourself as a full dual prior to service may result in billing problems.

How does the Drug coverage compare to other plans?

PPO plans are comparable to other Medicare Advantage Plans but check formularies and costs using Medicare's Plan Finder.

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