Section 4:

Medicare Advantage Plans & other options

What are Medicare Advantage Plans?

A **Medicare Advantage Plan** is another way to get your Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are Medicare-approved plans. They're offered by private companies that must follow rules set by Medicare. Most Medicare Advantage Plans include Medicare drug coverage (Part D). In many cases, you'll need to use health care providers who participate in the plan's network. These plans set a limit on what you'll have to pay out of pocket each year for services covered under Part A and Part B. Some plans offer non-emergency coverage out of network, but typically at a higher cost. For certain services or drugs, you may need to get approval (also called prior authorization), from your plan before it covers them. In some cases, you may also need to get a **referral** to use a specialist.

Remember, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Keep your red, white, and blue Medicare card in a safe place because you might need it later.

If you join a Medicare Advantage Plan, you'll still have Medicare but you'll get most of your Part A and Part B coverage from your plan, not **Original Medicare**.

What are the different types of Medicare Advantage Plans?

- **Health Maintenance Organization (HMO) Plan:** Go to page 66.
- **HMO Point-of-Service (HMOPOS) Plan:** May let you get some services out of network for a higher **copayment** or **coinsurance**. Go to page 66.
- **Medical Savings Account (MSA) Plan:** Go to page 67.
- **Preferred Provider Organization (PPO) Plan:** Go to page 68.
- **Private Fee-for-Service (PFFS) Plan:** Go to page 69.
- **Special Needs Plan (SNP):** Go to page 70.

What do Medicare Advantage Plans cover?

Medicare Advantage Plans provide almost all of your Part A and Part B benefits, including most new benefits that come from laws or Medicare policy decisions. Medicare Advantage Plan benefits exclude hospice care and some costs of clinical trials. But if you're in a Medicare Advantage Plan, Original Medicare will still help cover your costs for hospice care and some costs for clinical research studies, and benefits that come from laws or Medicare policy decisions that the plan doesn't cover. The plan can choose not to cover the costs of services that aren't medically necessary under Medicare. In some instances, where Medicare hasn't established coverage criteria, plans may also use their own coverage criteria to determine if certain services are medically necessary. If you aren't sure whether a service is covered, check with your provider before you get the service. If you disagree with a coverage determination, you can file an appeal (pages 98–100).

Plans may offer some extra benefits

With a Medicare Advantage Plan, you may have coverage for things Original Medicare doesn't cover, like fitness programs (gym memberships or discounts) and some vision, hearing, and dental services (like routine check ups or cleanings). Some plans can also choose to cover other benefits, like transportation to doctor visits, over-the-counter drugs that Part D doesn't cover, and other health care services. Check with the plan before you join to find out what benefits it offers, how much they cost, and if there are any limitations.

Plans can also tailor their benefit packages to offer additional benefits to certain chronically ill enrollees. These packages will provide benefits customized to treat specific conditions. Although you can check with a Medicare Advantage Plan before you join to find out if they offer these benefit packages, you'll need to wait until you join the plan to find out if you qualify.

Get the most out of your dental benefits

If you're in a Medicare Advantage Plan, take charge of your oral health. Contact your plan about dental services it may cover and what limitations may apply.

Medicare Advantage Plans must follow Medicare's rules

Medicare pays a fixed amount for your coverage each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like if you need a referral to use a specialist or if you must go to doctors, facilities, or suppliers in the plan's network for non-emergency or non-urgent care). These rules can change each year. The plan must notify you about any changes before the start of the next enrollment year.

Remember, you have the option each year to keep your current Medicare Advantage Plan, choose a different plan, or switch to Original Medicare. Go to page 71.

Providers can join or leave a plan's provider network any time during the year. Your plan can also change the providers in the network any time during the year. If this happens, you usually won't be able to change plans but you can choose a new provider. You generally can't change plans during the year.

Important! Even though the network of providers may change during the year, the plan must still give you access to qualified doctors and specialists. Your plan will notify you that your provider is leaving your plan so you have time to choose a new one. You'll get this notice if it's a primary care or behavioral health provider and you've gone to that provider in the past three years. If any of your other providers leave your plan, you'll get this notice in certain situations.

Your plan will also:

- Help you choose a new provider to continue managing your health care needs.
- Help you continue needed care that's already in progress.
- Notify you about the different enrollment periods available to you and options you may have for changing plans.

Read your notices carefully so you're aware of any changes and can change plans if you aren't satisfied, either during Open Enrollment or a Special Enrollment Period, if you qualify.

When an in-network provider or benefit isn't available or can't meet your medical needs, your plan must help you get any **medically necessary** covered services outside the provider network (at the in-network cost sharing).

Compare: If you have Original Medicare, you don't need a **referral** to use a specialist in most cases (page 57), and you generally don't need prior approval to use a covered benefit.

Important! Read the information you get from your plan

If you're in a **Medicare Advantage Plan**, review the "Annual Notice of Change" and "Evidence of Coverage" from your plan each year.

- **Annual Notice of Change:** Includes any changes in coverage, costs, and more that will be effective in January. Your plan will send you a printed copy by September 30.
- **Evidence of Coverage:** Gives you details about what the plan covers, how much you pay, and more in the next year. Your plan will send you a notice (or printed copy) by October 15. It will include information on how to get it electronically or by mail.

If you don't get these important documents, contact your plan.

Consider signing up for an electronic version of the "Medicare & You" handbook at **Medicare.gov/go-digital** since you'll get cost and coverage information from your plan.

What should I know about Medicare Advantage Plans?

To join a Medicare Advantage Plan, you must:

- Have Part A and Part B.
- Live in the plan's service area.
- Be a U.S. citizen or lawfully present in the U.S.

Joining and leaving

- You can join a Medicare Advantage Plan even if you have a pre-existing condition.
- **You can join or drop a Medicare Advantage Plan only at certain times during the year.** Go to pages 71–72.
- Each year, Medicare Advantage Plans can choose to leave Medicare or make changes in coverage, costs, service area, and more. If the plan decides to stop participating in Medicare, you'll have to join another Medicare Advantage Plan or return to Original Medicare. Go to page 98.
- Medicare Advantage Plans must follow certain rules when giving you information about how to join their plan. Go to pages 105–106 for more information about these rules and how to protect your personal information.

What if I have End-Stage Renal Disease (ESRD)?

If you have ESRD, you can choose either Original Medicare or a Medicare Advantage Plan when deciding how to get Medicare coverage. If you're only eligible for Medicare because you have ESRD and you get a kidney transplant, your Medicare benefits will end 36 months after the transplant. Go to page 52 for more information about continuing coverage for immunosuppressive drugs.

Medicare drug coverage (Part D)

Most Medicare Advantage Plans include Medicare drug coverage (Part D). In certain types of plans that don't include Medicare drug coverage (like Medical Savings Account Plans and some Private Fee-for-Service Plans), you can join a separate Medicare drug plan. However, if you join a Health Maintenance Organization Plan or Preferred Provider Organization Plan, which doesn't cover drugs, you can't join a separate Medicare drug plan.

In this case, you'll either need to use other prescription drug coverage you have (like employer or retiree coverage), or go without drug coverage. If you decide not to get Medicare drug coverage when you're first eligible and your other drug coverage isn't creditable prescription drug coverage, you may have to pay a late enrollment penalty (pages 83–85) if you join a Part D plan later.

What if I have other coverage?

Talk to your employer, union, or other benefits administrator about their rules before you join a Medicare Advantage Plan. In some cases, joining a Medicare Advantage Plan might cause you to lose your employer or union coverage for yourself, your spouse, and your dependents, and you may not be able to get it back. In other cases, if you join a Medicare Advantage Plan, you may still be able to use your employer or union coverage along with the Medicare Advantage Plan you join. Your employer or union may also offer a Medicare Advantage retiree health plan that they sponsor. You can only be in one Medicare Advantage Plan at a time.

What if I have Medicare Supplement Insurance (Medigap)?

> **Important!** If you already have **Medigap** and join a **Medicare Advantage Plan**, you may want to drop Medigap. **Keep in mind, if you drop Medigap to join a Medicare Advantage Plan, you may not be able to get your Medigap policy back depending on your state's Medigap enrollment rules and your situation.** For more details about dropping your Medigap policy, visit **Medicare.gov/health-drug-plans/medigap/ready-to-buy/change-policies**.

You can't buy Medigap while you're in a Medicare Advantage Plan unless you're switching back to **Original Medicare**. You can't use Medigap to pay your Medicare Advantage Plan **copayments**, **deductibles**, and **premiums**.

What do I pay?

Your out-of-pocket costs in a Medicare Advantage Plan depend on:

- Whether the plan charges a monthly premium. Some Medicare Advantage Plans have a $0 premium (but you still may pay the Part B premium). If you join a plan that charges a premium, you pay this in addition to the Part B premium (and the Part A premium if you don't have premium-free Part A).
- Whether the plan pays any of your monthly Part B premiums. Some Medicare Advantage Plans will help pay all or part of your Part B premium. This is sometimes called a "Medicare Part B premium reduction."
- Whether the plan has a yearly deductible or any additional deductibles for certain services.
- The amount you pay for each visit or service, like your copayment or **coinsurance**. Medicare Advantage Plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and days 21–100 of **skilled nursing facility care**.
- The type of health care services you need and how often you get them.
- Whether you get services from a network provider or a provider that doesn't contract with the plan. If you go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan's network for non-emergency or non-urgent care services, your plan may not cover your services, or your costs could be higher.
- Whether you go to a doctor or supplier who accepts **assignment** (if you're in a Preferred Provider Organization Plan, Private Fee-for-Service Plan, or Medical Savings Account (MSA) Plan and you go out of network). Go to pages 59–60 for more information about assignment.
- Whether the plan offers extra benefits (in addition to Original Medicare benefits) and if you need to pay extra to get them.
- The plan's yearly limit on your out-of-pocket costs for all Part A and Part B-covered services. Once you reach this limit, you'll pay nothing for Part A and Part B-covered services.
- Whether you have **Medicaid** or get help from your state through a Medicare Savings Program. Go to pages 91–92.

To learn more about your costs in a specific Medicare Advantage Plan, contact the plan or visit **Medicare.gov/plan-compare**.

How do I find out if my plan covers a service, drug, or supply?
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, drug, or supply. You can also find out how much you'll have to pay. **This is called an "organization determination."** Sometimes you have to do this as prior authorization for your plan to cover the service, drug, or supply. Go to page 101.

You, your representative, or your doctor can request this organization determination. The requested organization determination can be either oral or written. Based on your health needs, you, your representative, or your doctor can ask for a fast decision on your organization determination request. If your plan denies coverage, the plan must tell you in writing, and you have the right to appeal. Go to pages 97–100.

If a plan provider refers you for a covered service or to a provider outside the network, but doesn't get an organization determination in advance, **this is called "plan directed care."** In most cases, you won't have to pay more than the plan's usual cost sharing. Check with your plan for more information about this protection.

Types of Medicare Advantage Plans

HMO

Health Maintenance Organization (HMO) Plan

Can I get my health care from any doctor, other health care provider, or hospital?
No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except for emergency care, out-of-area urgent care, or temporary out-of-area dialysis, which is covered whether it's provided in the plan's network or outside the plan's network). However, some HMO Plans, known as HMO Point-of-Service (HMOPOS) Plans, offer an out-of-network benefit for some or all covered benefits for a higher copayment or coinsurance.

Do these plans cover prescription drugs?
In most cases, yes. If you're planning to enroll in an HMO and you want Medicare drug coverage (Part D), you must join an HMO Plan that offers Medicare drug coverage. If you join an HMO Plan without drug coverage, you can't join a separate Medicare drug plan.

Do I need to choose a primary care doctor?
In most cases, yes.

Do I have to get a referral to use a specialist?
In most cases, yes. Certain services, like yearly mammogram screenings, don't require a referral.

What else do I need to know about this type of plan?

- If you get non-emergency health care outside the plan's network without authorization, you may have to pay the full cost.
- It's important to follow the plan's rules, like getting prior approval for a certain service when needed.
- Visit Medicare.gov or check with the plan for more information.

MSA Medical Savings Account (MSA) Plan

Can I get my health care from any doctor, other health care provider, or hospital?

Yes. You can go to any Medicare-approved doctor, other health care provider, or hospital that agrees to treat you and hasn't opted out of Medicare (for Medicare Part A and Part B items and services). MSA Plans usually don't have a network of doctors, other health care providers, or hospitals.

Do these plans cover prescription drugs?

No. If you join a Medicare MSA Plan and want Medicare drug coverage (Part D), you'll have to join a separate Medicare drug plan.

Do I need to choose a primary care doctor?

No.

Do I have to get a referral to use a specialist?

No.

What else do I need to know about this type of plan?

The plan deposits money into a special savings account for you to use to pay health care expenses. The amount of the deposit varies by plan. You can use this money to pay your Medicare-covered costs before you meet the deductible. Money left in your account at the end of the year stays there. If you keep your plan the following year, your plan will add any new deposits to the amount left over.

- MSA Plans don't charge a premium, but you must continue to pay your Part B premium.
- The plan will only begin to cover your Part A and Part B costs once you meet a high yearly deductible, which varies by plan.
- Some plans may cover some extra benefits, like vision, hearing, and dental services. You may pay a premium for this extra coverage.
- Visit Medicare.gov or check with the plan for more information.

PPO Preferred Provider Organization (PPO) Plan

Can I get my health care from any doctor, other health care provider, or hospital?
PPO Plans have network doctors, specialists, hospitals, and other health care providers you can use. You can also use out-of-network providers for covered services, usually for a higher cost, if the provider agrees to treat you and hasn't opted out of Medicare (for Medicare Part A and Part B items and services). You're always covered for emergency and urgent care.

Do these plans cover prescription drugs?
In most cases, yes. If you're planning to enroll in a PPO and you want Medicare drug coverage (Part D), you must join a PPO Plan that offers Medicare drug coverage. If you join a PPO Plan without drug coverage, you can't join a separate Medicare drug plan.

Do I need to choose a primary care doctor?
No.

Do I have to get a referral to use a specialist?
In most cases, no. But if you use plan specialists (in network), your costs for covered services will usually be lower than if you use non-plan specialists (out of network).

What else do I need to know about this type of plan?
- Because certain PPO providers are "preferred," you can save money by using them.
- Visit Medicare.gov or check with the plan for more information.

PFFS Private Fee-for-Service (PFFS) Plan

Can I get my health care from any doctor, other health care provider, or hospital?

You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms, agrees to treat you, and hasn't opted out of Medicare (for Medicare Part A and Part B items and services). If you join a Private Fee-for-Service Plan that has a network, you can also use any of the network providers who have agreed to always treat plan members. If you choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, you may pay more.

Do these plans cover prescription drugs?

Sometimes. If your PFFS Plan doesn't offer Medicare drug coverage, you can join a separate Medicare drug plan to get Medicare drug coverage (Part D).

Do I need to choose a primary care doctor?

No.

Do I have to get a referral to use a specialist?

No.

What else do I need to know about this type of plan?

- The plan decides how much you pay for services. Each year the plan will send the "Annual Notice of Change" and "Evidence of Coverage" with information about your cost sharing.
- Some PFFS Plans contract with a network of providers who agree to always treat you, even if you've never used them before.
- Out-of-network doctors, hospitals, and other providers may decide not to treat you, even if you've used them before.
- In a medical emergency, doctors, hospitals, and other providers must treat you.
- For each service you get, make sure to show your plan member card to each provider before you get treated.
- Visit Medicare.gov or check with the plan for more information.

SNP Special Needs Plan (SNP)

A SNP provides benefits and services to people with specific severe and chronic diseases, certain health care needs, or who also have **Medicaid** coverage. SNPs include care coordination services and tailor their benefits, provider choices, and list of drugs (formularies) to best meet the specific needs of the groups they serve.

Can I get my health care from any doctor, other health care provider, or hospital?
Some SNPs cover services out of network and some don't. Check with the plan to find out if they cover services out of network, and if so, how it affects your costs.

Do these plans cover prescription drugs?
Yes. All SNPs must provide Medicare drug coverage (Part D).

Do I need to choose a primary care doctor?
Some SNPs require primary care doctors and some don't. Check with the plan to find out if you need to choose a primary care doctor.

Do I have to get a referral to use a specialist?
Some SNPs require referrals and some don't. Certain services, like yearly screening mammograms, don't require a referral. Check with the plan to find out if you need a referral.

What else do I need to know about this type of plan?

- These groups are eligible, but not required, to enroll in a SNP:
  - **Dual Eligible SNP (D-SNP):** People who are eligible for both Medicare and Medicaid. D-SNPs contract with your state Medicaid program to help coordinate your Medicare and Medicaid benefits. Some D-SNPs may provide Medicaid services in addition to Medicare services. Call your State Medical Assistance (Medicaid) office to verify your Medicaid eligibility.
  - **Chronic Condition SNP (C-SNP):** People who have specific severe or disabling chronic conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia). Plans may further limit membership to a single chronic condition or a group of related chronic conditions.
  - **Institutional SNP (I-SNP):** People who live in certain institutions (like nursing homes) or who live in the community but require a high level of nursing care at home.

New! If you have Medicare and get full Medicaid benefits, you can join or switch an integrated D-SNP once a calendar month. For more information, Medicare.gov/special-enrollment-periods and select "I have Medicare and get full Medicaid benefits."

When you're ready to find and compare SNPs in your area, visit Medicare.gov/plan-compare. You can filter your search results by "Special Needs Plans (SNP)."

You can join, switch, drop, or make changes to your Medicare Advantage Plan

Remember, you must have both Part A and Part B to join a Medicare Advantage Plan during these times:

Initial Enrollment Period Go to page 17.	**When you first become eligible for Medicare**	When you first become eligible for Medicare, you can join a Medicare Advantage Plan (with or without drug coverage). If you joined a Medicare Advantage Plan during your Initial Enrollment Period, you can switch to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without a separate Medicare drug plan) within the first 3 months you have Medicare.
General Enrollment Period Go to page 18.	**January 1 to March 31**	If you have Part A coverage and you get Part B for the first time during this period, you can also join a Medicare Advantage Plan (with or without drug coverage). You'll have 2 months after adding Part B to join a plan. Your coverage starts the first day of the month after you sign up.
Open Enrollment Period	**October 15 to December 7**	You can join, switch, or drop a Medicare Advantage Plan (with or without drug coverage) during the Open Enrollment Period each year. Your coverage starts on January 1 (as long as the plan gets your enrollment request by December 7). If you join a Medicare Advantage Plan during this period but change your mind, you can switch back to Original Medicare or change to a different Medicare Advantage Plan (depending on which coverage works better for you) during the Medicare Advantage Open Enrollment Period (January 1 – March 31) described on the next page.

Medicare Advantage Open Enrollment Period	**January 1 to March 31** **Note:** You can only switch plans once during this period. Coverage starts the first of the month after the plan gets your request.	If you're in a Medicare Advantage Plan (with or without drug coverage), during this period you **can**: • Switch to another Medicare Advantage Plan (with or without drug coverage). • Drop your Medicare Advantage Plan and return to Original Medicare. You'll also be able to join a separate Medicare drug plan. During this period, you **can't**: • Switch from Original Medicare to a Medicare Advantage Plan. • Join a separate Medicare drug plan if you have Original Medicare. • Switch from one Medicare drug plan to another if you have Original Medicare. **You can only make one change during this period, and any changes you make will be effective the first of the month after the plan gets your request.** If you're returning to Original Medicare and joining a separate Medicare drug plan, you don't need to contact your Medicare Advantage Plan to disenroll. The disenrollment will happen automatically when you join the drug plan.
Special Enrollment Period Go to page 17.	**Qualifying Life Event**	In most cases, if you join a Medicare Advantage Plan, you must keep it for the calendar year starting the date your coverage begins. However, in certain situations, like if you move or you lose other insurance coverage, you may be able to join, switch, or drop a Medicare Advantage Plan during a Special Enrollment Period. Go to page 80.
5-star Special Enrollment Period	**December 8 to November 30 the following year** **Note:** You can only switch plans once during this period.	Medicare uses ratings from 1–5 stars to help you compare plans based on quality and performance. If a Medicare Advantage Plan, Medicare drug plan, or Medicare Cost Plan with a 5-star quality rating is available in your area, you can use the 5-star Special Enrollment Period to switch from your current Medicare plan to a Medicare plan with a 5-star quality rating. Visit Medicare.gov for more information.

Important! If you drop your Medicare Supplement Insurance (Medigap) policy to join a Medicare Advantage Plan, you may not get the same policy back. Also, if you want to return to Original Medicare and don't drop your Medicare Advantage Plan within 12 months of joining the Medicare Advantage Plan, you may be limited in your ability to get a Medigap policy when you return to Original Medicare. Go to page 78.

Note: In general, when you join a Medicare Advantage Plan, you must keep that plan for the rest of the year, unless you drop it to return to Original Medicare within 12 months of joining the Medicare Advantage Plan. You can drop or change Medicare Advantage Plans during the Open Enrollment Period, or Medicare Advantage Open Enrollment Period, or if you qualify for a Special Enrollment Period.

Does Medicare offer other types of plans or programs to get health coverage?

Yes, Medicare may offer some other plans and programs in your area. Some provide both Part A (Hospital Insurance) and Part B (Medical Insurance) coverage, while others provide only Part B coverage. Some also provide Medicare drug coverage (Part D). They have some (but not all) of the same rules as Medicare Advantage Plans. However, each has special rules and exceptions, so you should contact any plans you're interested in to get more details.

Medicare Cost Plans

Medicare Cost Plans are a type of Medicare health plan available in certain, limited areas of the country.

- In general, you can join even if you only have Part B.
- If you have Part A and Part B and go to a non-network provider, Original Medicare covers the services. You'll pay the Part A and Part B coinsurance and deductibles.
- You can join any time the Medicare Cost Plan is accepting new members.
- You can leave any time and return to Original Medicare.
- You can join a separate Medicare drug plan, or you can get Medicare drug coverage (Part D) from the Medicare Cost Plan (if offered). You can choose to get a separate Medicare drug plan even if the Medicare Cost Plan offers Medicare drug coverage. You can only add or drop drug coverage at certain times (pages 80–81).

Go to Medicare.gov/plan-compare to find out if there are Medicare Cost Plans in your area. You can contact the plan you're interested in for more information. Your State Health Insurance Assistance Program (SHIP) can also help you. Go to pages 114–117 for the phone number of your local SHIP. A trusted agent or broker may also be able to help.

Program of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare and **Medicaid** program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community, like a home, apartment, or other appropriate setting. To qualify for PACE, you must meet these conditions:

- You're 55 or older.
- You live in the **service area** of a PACE organization.
- You're certified by your state as needing a nursing home-level of care.
- At the time you join, you're able to live safely in the community with the help of PACE services.

PACE covers all Medicare- and Medicaid-covered care and services, and other services that the PACE team of health care professionals decides are necessary to improve and maintain your health and wellness. This includes drugs, as well as any other **medically necessary** care, like doctor or health care provider visits, transportation, home care, hospital visits, and even nursing home stays when necessary.

If you have Medicaid, you won't have to pay a monthly **premium** for the long-term care portion of the PACE benefit. If you have Medicare but not Medicaid, you'll be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare drug coverage (Part D). However, in PACE, there's never a **deductible** or **copayment** for any drug, service, or care that the PACE team of health care professionals approves.

Visit **Medicare.gov/pace** to find out if there's a PACE organization that serves your community.

Medicare innovation

Medicare develops innovative models, **demonstrations**, and pilot initiatives to test and measure the effect of potential changes in Medicare. These initiatives help find new ways to connect you to value-based care, which focuses on better quality of care, provider performance, and your patient experience. These initiatives may also include lower costs and may offer you extra benefits and services. They operate only for a limited time and for a specific group of people and/or are offered only in specific areas.

Examples of current and future models, demonstrations, and pilot initiatives include innovations in dementia, primary care, care related to specific procedures (like hip and knee replacements), cancer care, **skilled nursing facility care** or rehabilitation care, and care for people with chronic kidney disease and End-Stage Renal Disease (ESRD). Medicare also explores innovations through **Accountable Care Organizations (ACOs)**.

Ask your doctor if they participate in these models, demonstrations, and pilot programs and what it means for your care. To learn more about the current Medicare models, demonstrations, and pilot initiatives, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Go to pages 10–14 for an overview of your Medicare options.