



**BlueCross BlueShield  
of Florida**

An Independent Licensee of the  
Blue Cross and Blue Shield Association

## **Medicare Advantage Private Fee-for-Service Plans Questions & Answers for Medicare Beneficiaries**

### **1. What Is a Private Fee-For-Service Plan?**

A Private Fee-For-Service plan is a Medicare Advantage health plan offered by a private insurance company under contract to the Medicare program. Medicare pays a set amount of money every month to the Private Fee-For-Service organization to arrange for health care coverage for Medicare beneficiaries who have enrolled in the Private Fee-For-Service plan.

### **2. How Do Private-fee-for-service Plans Work?**

You may go to any eligible doctor or hospital anywhere in the U.S. that is willing to provide care and accepts your Private Fee-For-Service plan's terms of payment. Before joining a Private Fee-For-Service plan you should carefully check how much your out-of-pocket costs will be.

- When you are enrolled in a Medicare Advantage Private Fee-For-Service plan you are entitled to all medically necessary health care services that are covered by Medicare.
- Some Private Fee-For-Service plans may have extra benefits that Medicare does not cover. However, you may have to pay more for these extra benefits.
- Private Fee-For-Service plans may charge you a premium amount above the Medicare Part B premium.
- Private Fee-For-Service plans can charge deductible, co-payment and co-insurance amounts that are different than those under Original Medicare.
- Private Fee-For-Service plans can charge a premium for extra benefits like prescription drugs.

### **3. How Do I Obtain Care When I Am in a Private Fee-For-Service Plan?**

When you go to a doctor or hospital you must inform the provider that you are enrolled in a Medicare Private Fee-For-Service plan.

- Your provider can decide if he or she will treat you as a member of a Medicare Private Fee-For-Service plan.
- If the doctor or hospital decides to treat you, you are only required to pay the cost-sharing amount allowed by your Private Fee-For-Service plan. The doctor or hospital will bill your Private Fee-For-Service plan for the rest of its fee.

- If you have any question whether your Private Fee-For-Service plan will pay for a service, including inpatient hospital services, you have the right under the law to have a written/binding advance coverage determination made for the service. Call your plan and tell them you want a decision in writing if the service will be paid for by the plan.
- Your Private Fee-For-Service plan may require that you get pre-approval before obtaining some specific services. Check your Evidence of Coverage document if you are not sure.

#### **4. How Do I Receive Emergency Care?**

You have the right to get emergency care when and where you need it without any prior approval from your Private Fee-For-Service plan. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness or an illness quickly getting much worse you can get emergency care anywhere in the United States.

#### **5. What if my provider won't accept my Private Fee-For-Service plan?**

Providers are not required to furnish services to enrollees in a Private Fee-For-Service plan. If your providers does not want to participate in your Private Fee-For-Service plan than you must seek care from another provider who is willing to furnish services to Private Fee-For-Service enrollees.

#### **6. Does a Private Fee-For-Service Plan Cover Everything That Original Medicare Covers?**

Yes. By law, a Private Fee-For-Service plan must provide enrollees with the same benefits they would receive under Original Medicare. At a minimum a private fee-for-service plan must provide you with:

- All medically necessary services covered under Medicare Part A and Part B.

A Private Fee-For-Service plan may provide extra benefits, like outpatient prescription drugs, but you may have to pay more for these extra benefits.

#### **7. Do I Need to Continue to Pay My Part B Premium with Private Fee-For-Service?**

Yes. You must continue to pay your Part B premium to participate in a Medicare Advantage Private Fee-For-Service plan.

#### **8. What Is the Cost of a Private Fee-For-Service Plan?**

When enrolled in a Medicare Advantage Private Fee-For-Service plan you must continue to pay your monthly Medicare Part B premium. In addition, you must pay the Private Fee-For-Service plan premium and any cost sharing amounts the Private Fee-For-Service

plan requires that you pay when you obtain health care services as discussed below. Private Fee-For-Service plans will differ in the amount they charge in premiums, deductibles, and co-payments for health care services. Your costs in a Private Fee-For-Service plan will depend on:

- Which Private Fee-For-Service plan you choose.
- Any additional monthly premium the Private Fee-For-Service plan charges above the Medicare Part B premium.
- Any Private Fee-For-Service plan deductible required when obtaining a service; and
- Any cost sharing amounts that you will be required to pay providers when you obtain health care services.
- Whether the Private Fee-For-Service plan lets doctors, hospitals, and other providers bill you more than the Private Fee-For-Service plan pays (up to a limit) for services. If this is allowed, you must pay the difference up to a limit of 15% of the total payment.
- How often and the type of health care you get.
- Which extra benefits are covered by the Private Fee-For-Service plan.

## **9. Who Can Join a Private Fee-For-Service Plan**

You can join a Private Fee-For-Service plan if:

- You have both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- You do not have End-Stage-Renal Disease (permanent kidney failure treated by dialysis or a transplant, sometimes called ESRD), unless you are an enrollee of a plan offered by the Medicare Advantage organization offering the PFFS plan.
- You live in the service area of the Private Fee-For-Service plan.

## **10. How Do I Join a Private Fee-service Plan?**

If you want to join:

- Call the Private Fee-For-Service plan and ask for an enrollment form.
- Fill out the form and mail it to the Private Fee-For-Service plan.
- The Private Fee-For-Service plan cannot refuse to enroll you if you are eligible to enroll in a Medicare Advantage Private Fee-For-Service plan. To be eligible to enroll in a MA Private Fee-For-Service plan, you must be enrolled in Medicare Part A and B and not have end stage renal disease (ESRD).
- You will get a letter from the Private Fee-For-Service plan telling you when your coverage begins.

## **11. How Is Private Fee-For-Service Different from Managed Care?**

In a Private Fee-For-Service plan, you are not restricted to a network of providers. You can choose which provider you will see and you do not need a referral to see a specialist. A managed care organization requires that you see its contracted providers and you usually must obtain a referral for specialist services from your primary care provider.

## **12. When Compared to Original Medicare, What Are the Advantages of a Private Fee-For-Service Plan?**

Depending on the cost of the Private Fee-For-Service plan some beneficiaries may find that a Private Fee-For-Service plan is less costly than Original Medicare with a Medigap policy. Additionally, if you so choose, you have the right under the law to get a binding, written, advance determination as to whether the Private Fee-For-Service plan will cover the service you desire.

## **13. When Compared to Original Medicare, What Are the Disadvantages of Private Fee-For-Service?**

It may not be as easy to obtain care from providers under Private Fee-For-Service as when you are enrolled in Original Medicare. Your provider will have to accept the terms and conditions of payment. Excluding emergency situations, a provider must be informed in advance of providing a service that you are enrolled in a Private Fee-For-Service plan. Some providers may choose to not provide care to enrollees of a Private Fee-For-Service plan. You should carefully consider all of your out-of-pocket costs in obtaining services through a Private Fee-For-Service plan. You should look at the plan premium, copays when you obtain services and whether you can be balance billed by the provider.

## **14. When Compared to Managed Care, What Are the Advantages of Private Fee-For-Service?**

The key point to remember is that you are never locked in to a network under a Private Fee-For-Service plan. You can seek care for Private Fee-For-Service plan covered services from any licensed provider in the U.S. who can be paid by Medicare. However, excluding emergency situations, the provider has the option of deciding whether or not they will provide care.

## **15. When Compared to Managed Care, What Are the Disadvantages of Private Fee-For-Service**

A Private Fee-For-Service plan may be more costly than a Medicare managed care organization. In addition, Private Fee-For-Service plans are not managed care organizations so you may not receive as many preventative services as you would in a managed care organization.

**16. Can I Use the Same Doctors and Hospitals That I Use Now or Do I Need to Use a Network of Physicians?**

You can see any licensed provider who can be paid by Medicare and who is willing to accept the Private Fee-For-Service plan's terms and conditions of payment when you are enrolled in a Private Fee-For-Service plan. You cannot be locked into a network of providers. However, providers are not required to accept enrollees of a Private Fee-For-Service plan. You will need to verify in advance of receiving services that a particular provider is willing to see you.

**17. Do I Have to Use a Primary Care Doctor like Managed Care?**

No, under Private Fee-For-Service you can directly obtain care from any licensed provider who can be paid by Medicare including specialists who are willing to accept the Private Fee-For-Service plan's terms and conditions of payment.

**18. How Do I Know If a Service I Need Will Be Medically Necessary?**

Private Fee-For-Service plans must use Medicare coverage rules to decide what services are medically necessary. This means that if a service is medically necessary under original Medicare, then the Private Fee-For-Service plan must cover the service. You can also ask for a written (binding) advance coverage decision from the Private Fee-For-Service plan to make sure the service, especially inpatient hospitalization, will be covered by the plan. If you ask for an advance coverage decision, you have the right to get a decision from the Private Fee-For-Service plan.

**19. Do Private Fee-for Service Plans Cover Services that Medicare Does Not Consider Medically Necessary?**

Private Fee-For-Service plans are not required to pay for services that are not medically necessary under Medicare. Your Private Fee-For-Service plan may pay for additional benefits, and in that case, it will only pay for services that are covered by the Private Fee-For-Service plan and are medically necessary. If you obtain a service that is not covered by the Private Fee-For-Service plan, you will be responsible for the cost of that service. If you are not sure whether a service will be covered by your Private Fee-For-Service plan you have the right to call your Private Fee-For-Service plan and ask for an advance coverage decision.

## **APPEALS**

### **20. What Can I Do if My Private Fee-For-Service Plan Will Not Pay for a Service I Think I Need?**

If your plan will not pay for or does not allow a service that you think should be covered (including medically necessary services), you can file an appeal.

### **21. What Are My Appeals Rights under Private Fee-for Service?**

If you are in a Private Fee-For-Service plan, you can file an appeal if your Private Fee-For-Service plan will not pay for, does not allow, stops, or limits a service that you think should be covered or provided. If you think waiting for a decision about a service could seriously harm your health, ask or have your physician ask the Private Fee-For-Service plan for a fast decision. They must answer you within 72 hours.

The Private Fee-For-Service plan must tell you in writing how to appeal. After you file an appeal, the Private Fee-For-Service plan will review its decision. Then, if your Private Fee-For-Service plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the Private Fee-For-Service plan. See your Private Fee-For-Service plan's membership materials or contact your Private Fee-For-Service plan for details about your Medicare appeal rights.

If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization in your area. The Peer Review Organization is a group of doctors and health professionals, which monitors and reviews your complaints about the quality of care.

## **FRAUD AND ABUSE**

### **22. Do I Need to Worry about Fraud and Abuse with this Type of Private Fee-For-Service Plan? If Yes, What Should I Look for and Who Should I Report it to?**

In general you want to make sure you do not pay the provider any more than your Private Fee-For-Service plan requires. In addition, you should be certain your provider only bills your Private Fee-For-Service plan for services that you have received.

If you believe fraud has occurred, you may call the Inspector General's hotline to report Medicare fraud. The hotline number is 1-800-447-8477. Your name will not be used if you ask that it not be used.