Understanding Medicare Advantage Plans

This official government booklet tells you:

- How Medicare Advantage Plans are different from Original Medicare
- How Medicare Advantage Plans work
- How you can join a Medicare Advantage Plan

CENTERS FOR MEDICARE & MEDICAID SERVICES

"Understanding Medicare Advantage Plans" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

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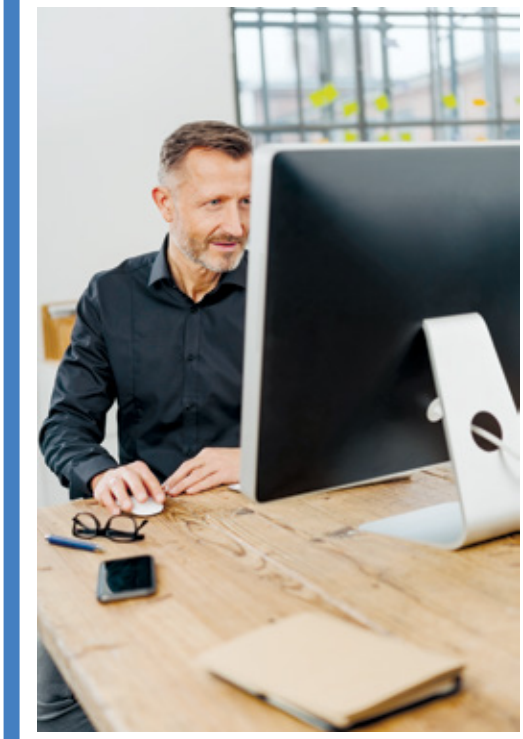
Introduction



When you first enroll in Medicare and each year after that, you'll need to decide how you want to get your Medicare coverage.

You have 2 main coverage options:

- **Original Medicare** includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). If you want prescription drug coverage, you'll need to join a Medicare Prescription Drug Plan (Part D).
- **Medicare Advantage** is an "all in one" alternative to Original Medicare. These "bundled" plans (sometimes called "Part C" or "MA Plans") include Part A, Part B, and usually Part D. They also might include additional benefits that aren't available in Original Medicare.

Your Medicare health plan decisions affect how much you pay for coverage, what services you get, what doctors you can use, and your quality of care.

Learning about your Medicare coverage choices, getting help from people you trust, and comparing different plans can help you understand all the options available to you.

What are the differences between Original Medicare and Medicare Advantage?

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- If you want drug coverage, you can join a separate Part D plan.
- To help pay your out-of-pocket costs in Original Medicare (like your deductible and 20% coinsurance), you can also shop for and buy supplemental coverage.

☑ **Part A**

☑ **Part B**

You can add:

☐ **Part D**

You can also add:

☐ **Supplemental coverage**

(Some examples include coverage from a Medicare Supplement Insurance (Medigap) policy, or coverage from a former employer or union.)

Medicare Advantage
(also known as Part C)

- Medicare Advantage is an "all in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D.
- Some plans may have lower out-of- pocket costs than Original Medicare.
- Some plans offer extra benefits that Original Medicare doesn't cover — like vision, hearing, or dental.

☑ **Part A**

☑ **Part B**

Most plans include:

☑ **Part D**

Some plans also include:

☐ **Lower out-of-pocket-costs**

☐ **Extra benefits**

Original Medicare vs. Medicare Advantage

Doctor and hospital choice

Original Medicare	Medicare Advantage
You can go to **any doctor that accepts Medicare**.	In most cases, you'll need to use **doctors who are in the plan's network** (for non-emergency or non-urgent care). It may cost you more if you go to a doctor outside of the plan's network. Ask your doctors if they participate in any Medicare Advantage Plans.
In most cases you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist.

Costs

Original Medicare	Medicare Advantage
Most people don't pay a premium (monthly payment) for Part A. For hospital services, you pay a deductible and coinsurance.	**Out-of-pocket costs vary** —some plans have low or no out-of-pocket costs. Medicare Advantage Plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care.
You pay a **premium for Part B (The 2019 Part B premium is $135.50)** If you choose to buy prescription drug coverage, you'll pay that premium separately.	You may **pay a premium for the plan** (most include prescription drug coverage) **and a premium for Part B**. Some plans have a $0 premium or will help pay all or part of your Part B premium.
For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible.	You pay your plan's deductibles and copayments (usually a fixed amount, like $10 or $20 when you see a doctor). You could pay more for medical care if you don't follow your plan's rules, like using the plan's network providers.
There's **no yearly limit** on what you pay out-of-pocket.	Plans have a **yearly limit** on what you pay out-of-pocket for Medicare Part A and B covered services. Once you reach your plan's limit, you'll pay nothing for Part A and Part B covered services for the rest of the year.
You **can buy** supplemental coverage to help pay your out-of-pocket costs (like your deductible and 20% coinsurance).	You **can't buy or use** separate supplemental coverage — but some plans have lower out-of-pocket costs than Original Medicare.

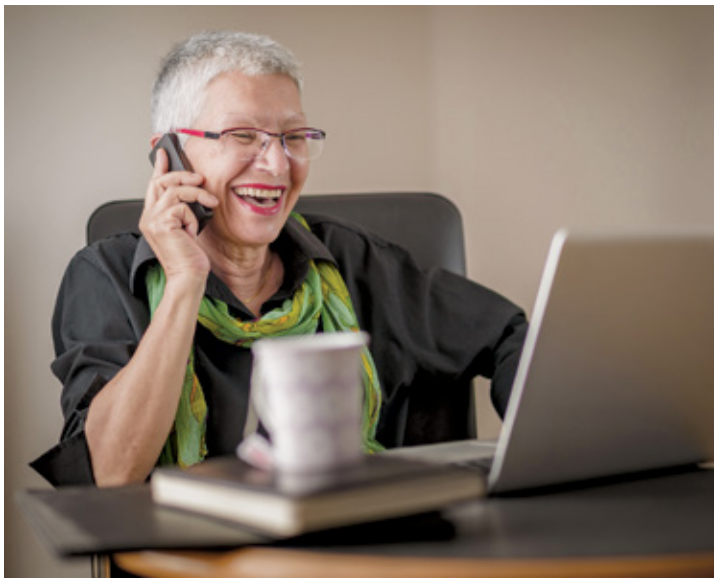
Original Medicare vs. Medicare Advantage
(continued)

Coverage

Original Medicare	Medicare Advantage
Original Medicare covers medical services and supplies in hospitals, doctors' offices, and other health care settings.	Plans must cover all of the services that Original Medicare covers (with a few exceptions, like hospice or some clinical trial costs). Some plans **offer extra benefits that Original Medicare doesn't cover**—like vision, hearing, dental, and/or health and wellness programs.
You can join a **separate Medicare Prescription Drug Plan** to get drug coverage.	**Prescription drug coverage is included in most plans**.
In most cases, **you don't have to get a service or supply approved** ahead of time for it to be covered.	In some cases, **you have to get a service or supply approved** ahead of time for it to be covered by the plan.

Travel

Original Medicare	Medicare Advantage
Original Medicare covers care when you're traveling in any of the 50 U.S. states, the District of Columbia, Puerto Rico, and any other U.S. territory. In general, health care you get while traveling outside of the U.S. isn't covered. In some rare cases, Medicare may pay for urgent or emergency care you get in a foreign country. For more information about coverage when traveling, visit Medicare.gov/coverage/travel-when-you-need-health-care-outside-the-us.	Medicare Advantage Plans cover care when you're traveling in any of the 50 U.S. states, the District of Columbia, Puerto Rico, and any other U.S. territory. In general, health care you get while traveling outside of the U.S. isn't covered. In some rare cases, Medicare may pay for urgent or emergency care you get in a foreign country. For more information about coverage when traveling, visit Medicare.gov/coverage/travel-when-you-need-health-care-outside-the-us.



Medicare Advantage Plans
Overview

What are Medicare Advantage Plans?

Medicare Advantage Plans are another way to get your Medicare coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by Medicare-approved private companies that must follow rules set by Medicare. If you join a Medicare Advantage Plan, you'll still have Medicare but you'll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare.

How do Medicare Advantage Plans work?

When you join a Medicare Advantage Plan, Medicare pays a fixed amount for your coverage each month to the company offering that plan. These companies must follow Medicare's coverage rules. Medicare Advantage Plans have yearly contracts with Medicare. The plan will notify you about any changes before the start of the next enrollment year.

If you join a Medicare Advantage Plan, you'll have all of the same rights and protections that you would have under Original Medicare.

What's covered?

Medicare Advantage Plans cover all Medicare Part A and Part B services. However, if you're in a Medicare Advantage Plan, Original Medicare will still cover the cost for hospice care, some new Medicare benefits, and some costs for clinical research studies. In all types of Medicare Advantage Plans, you're always covered for emergency and urgent care.

Some Medicare Advantage Plans offer extra coverage, for things like vision, hearing, dental, and other health and wellness programs. Plans have a **yearly limit** on what you pay out-of-pocket for Medicare Part A and B covered services. Once you reach your plan's limit, you'll pay nothing for Part A and Part B covered services for the rest of the year.

What's covered? (continued)

Prescription drug coverage

Most Medicare Advantage Plans include Medicare prescription drug coverage (Part D). In certain types of plans that don't include drug coverage (like Medical Savings Account plans and some Private-Fee-for-Service plans), you can join a separate Medicare Prescription Drug Plan. You can also add prescription drug coverage in one of the following ways:

- You can switch during certain times to another Medicare Advantage Plan or other Medicare health plan in your area that offers Medicare prescription drug coverage.
- You can switch to Original Medicare, and add a Medicare Prescription Drug Plan.

Note: If you're in a plan that doesn't offer drug coverage, and you don't have a Medicare Prescription Drug Plan, you may have to pay a late enrollment penalty if you decide to join a Medicare Prescription Drug Plan or get a plan with drug coverage later. Visit Medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d-late-enrollment-penalty to learn more about the Part D late enrollment penalty.

What are my costs?

Each year, plans set the amounts they charge for premiums, deductibles, and services. The plan (rather than Medicare) decides how much you pay for the covered services you get. What you pay the plan may change only once a year, on January 1.

The standard Part B premium amount in 2019 is $135.50 (or higher depending on your income). Some people with Social Security benefits pay less ($130 on average).

When calculating your out-of-pocket costs in a Medicare Advantage Plan, in addition to your premium, deductible, copayments, and coinsurance, you should also consider:

- The type of health care services you need and how often you get them.
- Whether you go to a doctor or supplier who accepts assignment. Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.
- Whether the plan offers extra benefits that require an extra premium.
- Whether you have Medicaid or get help from your state with health care costs.

What are my costs? (continued)

What's the difference between a deductible, coinsurance, and a copayment?

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

More cost details from each plan

If you join a Medicare Advantage Plan, review these notices you get from your plan each year:

- **"Annual Notice of Change" (ANOC)**. Includes any changes in coverage, costs, service area, and more that will be effective starting in January. Your plan will send you a printed copy by September 30.
- **"Evidence of Coverage" (EOC)**. Gives you details about what the plan covers, how much you pay, and more. Your plan will send you a notice (or printed copy) by October 15, which will include information on how to access the EOC electronically or request a printed copy.

Organization determinations

In a Medicare Advantage Plan, you (or a provider acting on your behalf) can request to see if an item or service will be covered by the plan, before you get it. Sometimes you must do this for the service to be covered. This is called an "organization determination." If your plan denies coverage for the item or service, the plan must tell you in writing.

If a network provider didn't get an organization determination before providing an item or service, you don't have to pay more than the plan's usual cost sharing for a service or supply if either of these is true:

- The provider gave you or referred you for services or supplies that you reasonably thought would be covered.
- The provider referred you to an out-of-network provider for plan-covered services.

Who can join a Medicare Advantage Plan?

You can join a Medicare Advantage Plan if:

- You have Part A and Part B.
- You live in the plan's service area.
- You're a U.S. citizen, U.S. national, or lawfully present in the U.S.
- You don't have End-Stage Renal Disease (ESRD), except as explained on page 14.

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, if you join a Medicare Advantage Plan, you may still be able to use your employer or union coverage along with your Medicare Advantage Plan. In other cases, joining a Medicare Advantage Plan might cause you to lose your employer or union coverage for yourself, your spouse, and dependents.

When can I join, switch, or drop a Medicare Advantage Plan?

You can only join, switch, or drop a Medicare Advantage Plan during the enrollment periods below:

- **Initial Enrollment Period**—When you first become eligible for Medicare, you can sign up during your Initial Enrollment Period. This is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

  If you sign up during the first 3 months of your Initial Enrollment Period, in most cases, your coverage starts the first day of your birthday month. However, if your birthday is on the first day of the month, your coverage will start the first day of the prior month.

  If you enroll the month you turn 65 or during the last 3 months of your Initial Enrollment Period, your start date for coverage will be delayed.

- **General Enrollment Period**—If you have Part A coverage and you get Part B for the first time during the General Enrollment Period (between January 1—March 31 each year), you can also join a Medicare Advantage Plan at that time. Your coverage will start July 1.

- **Open Enrollment Period**—Between October 15—December 7, anyone with Medicare can join, switch, or drop a Medicare Advantage Plan. Your coverage will begin on January 1, as long as the plan gets your request by December 7.

Note: In certain situations (like if you move), you may be able to join, switch, or drop a plan at other times.

When can I join, switch, or drop a Medicare Advantage Plan? (continued)

Can I make changes to my coverage after December 7?

Starting in 2019, between January 1–March 31 each year, you can make these changes during the **Medicare Advantage Open Enrollment Period:**

- If you're 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, but you may not be able to buy a Medigap policy. If you choose to return to Original Medicare, 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 3 months you have Medicare.

During the Medicare Advantage Open Enrollment Period, you **can't**:

- Switch from Original Medicare to a Medicare Advantage Plan.
- Join a Medicare Prescription Drug Plan if you're in Original Medicare.
- Switch from one Medicare Prescription Drug Plan to another if you're in 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.

Always review the materials your plan sends you (like the "Annual Notice of Change"), and make sure your plan will still meet your needs for the following year.

What if I have a pre-existing condition?

You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease (ESRD), for which there are special rules. See "Can I join A Medicare Advantage Plan if I have End-Stage Renal Disease (ESRD)?" on page 14.

How can I join a Medicare Advantage Plan?

Not all Medicare Advantage Plans work the same way. Before you join, you can find and compare Medicare health plans in your area by visiting Medicare.gov/find-a-plan. Once you understand the plan's rules and costs, use one of these ways to join:

- Use Medicare's Plan Finder at Medicare.gov/find-a-plan. You can search by ZIP Code or use your MyMedicare.gov account for information tailored just for you.

How can I join a Medicare Advantage Plan? (continued)

- Visit the plan's website to see if you can join online.
- Fill out a paper enrollment form. Contact the plan to get an enrollment form, fill it out, and return it to the plan. All plans must offer this option.
- Call the plan you want to join. Visit Medicare.gov/find-a-plan and put in the ZIP Code (under General Search) to get your plan's contact information. You can also search by plan name at Medicare.gov/find-a-plan/questions/search-by-plan-name-or-plan-id.aspx.
- Call us at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

When you join a Medicare Advantage Plan, you'll have to provide this information from your Medicare card:

- Your Medicare Number
- The date your Part A and/or Part B coverage started.

Remember, when you enroll in a Medicare Advantage Plan, in most cases, **you must use the card from your Medicare Advantage Plan** to get your Medicare-covered services. For some services, you may be asked to show your red, white, and blue Medicare card.

Can I join a Medicare Advantage Plan if I have End-Stage Renal Disease (ESRD)?

If you have End-Stage Renal Disease (ESRD), you can only join a Medicare Advantage Plan in certain situations:

- If you're already in a Medicare Advantage Plan when you develop ESRD, you can stay in your plan or you may be able to join another Medicare Advantage Plan offered by the same company.
- If you're in a Medicare Advantage Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan.
- If you have an employer or union health plan or other health coverage through a company that offers one or more Medicare Advantage Plan(s), you may be able to join one of that company's Medicare Advantage Plans.
- If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan.
- You may be able to join a Medicare Special Needs Plan (SNP) that covers people with ESRD if one is available in your area.

For more information, visit Medicare.gov/Publications to view the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

Types of Medicare Advantage Plans

There are different types of Medicare Advantage Plans:

- Health Maintenance Organization (HMO) plans: See pages 15–16.
- Preferred Provider Organization (PPO) plans: See page 17.
- Private Fee-for-Service (PFFS) plans: See pages 18–19.
- Special Needs Plans (SNPs): See pages 20–21.
- Medical Savings Account (MSA) plans: See pages 22–23.

The area where you live might have all, some, or none of these types available. In addition, there might be multiple plans available in your area within the same type, if private companies choose to offer them. To see Medicare Advantage Plans available to you, visit Medicare.gov/find-a-plan.

Health Maintenance Organization (HMO) plans

A Health Maintenance Organization (HMO) plan is a type of Medicare Advantage Plan that usually provides health care coverage from doctors, specialists, or hospitals in the plan's network, except in an emergency or urgent care situation. A network is a group of doctors, hospitals, and medical facilities that contract with a plan to provide services. Most HMOs also require you to get a referral from your primary care doctor for specialist care, so that your care is coordinated.

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

In HMO Plans, you generally must get your care and services from doctors or hospitals in the plan's network, (except for emergency care, out-of-area urgent care, or out-of-area dialysis).

Types of Medicare Advantage Plans (continued)

Health Maintenance Organization (HMO) plans (continued)

You'll pay less if you see doctors and use medical facilities that are in your plan's network. If you get health care outside the plan's network, you may have to pay the full cost. It's important that you follow the plan's rules, like getting prior approval for a certain service when needed. In most cases, you need to choose a primary care doctor. Certain services, like yearly screening mammograms, don't require a referral. If your doctor or other health care provider leaves the plan's network, your plan will notify you. You may choose another doctor in the plan's network.

HMO Point-of-Service (HMOPOS) plans are HMO plans that **may allow you to get some services out-of-network for a higher copayment or coinsurance**. It's important that you follow the plan's rules, like getting prior approval for a certain service when needed.

The POS portion of the plan has a separate deductible. The care you get in-network through the HMO has a different deductible than care you get out-of-network through the POS. You must reach the two deductibles separately.

Are prescription drugs covered?

In most cases, prescription drugs are covered in Medicare HMO plans. If you want drug coverage, you must join an HMO plan that includes prescription drug coverage. If you join an HMO that doesn't include prescription drug coverage, you can't get a separate Medicare Prescription Drug Plan (Part D).

Types of Medicare Advantage Plans (continued)

Preferred Provider Organization (PPO) plans

A Preferred Provider Organization (PPO) plan is a Medicare Advantage Plan that has a network of primary care doctors, specialists, and hospitals that you may go to. You also can choose to go to any doctor, specialist, or hospital not on the plan's (out-of-network) list, but it will usually cost more. Because certain providers are "preferred" (as the name suggests), you can save money by using them.

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

In most cases, you can get your health care from any doctor, other health care provider, or hospital in PPO Plans.

PPO Plans have network doctors, other health care providers, and hospitals. Each plan gives you the choice to go to doctors, specialists, or hospitals that aren't on the plan's list, but it will usually cost less if you get your care from a network provider.

You can get care from specialists without a referral or prior authorization from another doctor. If you use plan specialists, your costs for covered services will usually be lower than if you use non-plan specialists.

Are prescription drugs covered?

In most cases, prescription drugs are covered in PPO plans. If you want Medicare drug coverage, you must join a PPO plan that includes prescription drug coverage. If you join a PPO plan that doesn't include prescription drug coverage, you can't join a separate Medicare Prescription Drug Plan (Part D).

Types of Medicare Advantage Plans (continued)

Private Fee-for-Service (PFFS) plans

A Private Fee-for-Service (PFFS) plan is a Medicare Advantage Plan offered by a private health insurance company. A PFFS plan isn't the same as Original Medicare or a Medicare Supplement (Medigap) policy.

Insurance companies that offer PFFS plans can decide that a plan will be available to everyone with Medicare in a state, or be available only in certain counties. Insurance companies may also offer more than one plan in an area, with different benefits and costs. Each year, insurance companies offering PFFS plans can decide whether to offer such a plan in a given area.

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

You can go to any Medicare-approved provider like a doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. If you join a PFFS plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but you may pay more.

Before you get any services, ask your doctor or hospital if they can contact the plan for payment information and accept the plan's payment terms. If you need emergency care, it's covered whether the provider accepts the plan's payment terms or not.

If your provider agrees to the plan's terms and conditions of payment

The provider must follow the plan's terms and conditions for payment, and bill the plan for the services they provide for you. However, the provider can decide at every visit whether or not to accept the plan and agree to treat you.

If your provider doesn't agree to the plan's terms and conditions of payment

The provider shouldn't provide services to you except in emergencies, and you'll need to find another provider that will accept the PFFS plan.

If the provider chooses to treat you, then they can't bill you. They must bill the plan for your covered health care services. You're only required to pay the copayment or coinsurance the plan allows for the types of services you get at the time of the service. You may have to pay an additional amount (up to 15% more) if the plan allows providers to "balance bill" (when a provider bills you for the difference between the provider's charge and the allowed amount).

Types of Medicare Advantage Plans (continued)

Private Fee-for-Service (PFFS) plans (continued)

Note: If your PFFS plan has a network of providers for some or all categories of services, you can still see providers who aren't part of the plan's network. As long as providers accept the plan's payment terms, you can get your services from them, but you may pay more if they're out of the network.

Are prescription drugs covered?

Prescription drugs may be covered in a PFFS plan. If you want Medicare prescription drug coverage, and it's offered by the plan, you must get your Medicare prescription drug coverage from that plan.

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

Types of Medicare Advantage Plans (continued)

Special Needs Plans (SNP)

A Special Needs Plan (SNP) provides benefits and services to people with specific diseases or health care needs. SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.

SNPs cover the same Medicare services that all Medicare Advantage Plans cover. Medicare SNPs might also cover extra services tailored to the special groups they serve. For example, if you have a severe or chronic condition, like cancer or chronic heart failure and you require a hospital stay, an SNP may cover extra days in the hospital.

You may qualify for an SNP if you live in the plan's service area and meet one of these requirements:

- You have a chronic illness like one or more of the conditions below (also called **a Chronic condition SNP** or **C-SNP):**
    - Chronic alcohol and other dependence
    - Autoimmune disorders
    - Cancer (excluding pre-cancer conditions)
    - Cardiovascular disorders
    - Chronic heart failure
    - Dementia
    - Diabetes mellitus
    - End-stage liver disease
    - End-Stage Renal Disease (ESRD) requiring dialysis (any mode of dialysis)
    - Severe hematologic disorders
    - HIV/AIDS
    - Chronic lung disorders
    - Chronic and disabling mental health conditions
    - Neurologic disorders
    - Stroke

Types of Medicare Advantage Plans (continued)

Special Needs Plans (SNP) (continued)

- You live in an institution (like a nursing home), or need nursing care at home **(also called an Institutional SNP** or **I-SNP)**.
- You have both Medicare and Medicaid (also called a **Dual Eligible SNP** or **D-SNP**).

Each SNP limits its membership to people in one of these groups, or a subset of one of these groups. You can only stay enrolled in an SNP if you continue to meet the special conditions that the plan serves.

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

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 out-of-area dialysis).

In most cases, SNPs may require you to have a primary care doctor, or the plan may require you to have a care coordinator to help with your health care. A care coordinator is someone who helps make sure people get the right care and information. For example, an SNP for people with diabetes might use a care coordinator to help members monitor their blood sugar and follow their diet.

SNPs typically have specialists in the diseases or conditions that affect their members. Generally, you must get your care and services from doctors or hospitals in the plan's network, except:

- When you need emergency or urgent care, like care you get for a sudden illness or injury that needs medical care right away
- If you have End-Stage Renal Disease (ESRD) and need out-of-area dialysis

Are prescription drugs covered?

All SNPs must provide Medicare prescription drug coverage (Part D).

Types of Medicare Advantage Plans (continued)

Medical Savings Account plans

Medical Savings Account (MSA) plans combine a high-deductible insurance plan with a medical savings account that you can use to pay for your health care costs.

1. **High-deductible health plan:** The first part of an MSA plan is a special type of high-deductible Medicare Advantage Plan. The plan will only begin to cover your costs once you meet a high yearly deductible, which varies by plan.
2. **Medical Savings Account (MSA):** The second part of an MSA plan is a special type of savings account. The 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.

In addition to the Medicare Part A and Part B services that all MSA plans must cover, some MSA plans may cover extra benefits for an extra cost, like:

- Dental
- Vision
- Long-term care not covered by Medicare

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

With an MSA plan, you can choose your health care services and providers.

Are prescription drugs covered?

If you join an MSA plan, you'll need to join a Medicare Prescription Drug Plan (Part D) to get drug coverage.

However, if you join an MSA plan and already have a Medigap policy with drug coverage (some policies sold before January 1, 2006 had drug coverage), you can continue to use this coverage to pay for some of your drugs.

Once you decide which MSA plan you want, you'll need to contact the plan for enrollment information and to join. When you get the enrollment form, fill it out and mail it to the plan, or give it to a plan representative. The plan will tell you how to set up your account with a bank that the plan selects. You must set up this account before your enrollment can be processed. After you get a letter from the plan telling you when your coverage begins:

1. Medicare gives the plan an amount of money each year for your health care.

Types of Medicare Advantage Plans (continued)

Medical Savings Account plans (continued)

2. The plan deposits money into your account on your behalf. You can't deposit your own money.
3. You can use the money in your account to pay your health care costs, including health care costs that aren't covered by Medicare. When you use account money for Medicare-covered Part A and Part B services, it counts towards your plan's deductible.
4. If you use all of the money in your account and you have additional health care costs, you'll have to pay for your Medicare-covered services out-of-pocket until you reach your plan's deductible.
5. During the time you're paying out-of-pocket for services before the deductible is met, doctors and other providers can't charge you more than the Medicare-approved amount.
6. After you reach your deductible, your plan will cover your Medicare-covered services.
7. Money left in your account at the end of the year stays in the account, and may be used for health care costs in future years. If you stay with the same MSA plan the following year, the new deposit will be added to any leftover amount.

MSA plans and your taxes

If you use funds from your account, you must include IRS Form 8853 with information on how you used your account money when you file taxes.

Each year, you should get a 1099-SA form from your bank that includes all of the withdrawals from your account. You'll need to show that you've had Qualified Medical Expenses in at least this amount, or you may have to pay taxes and additional penalties.

For a list of services and products that count as Qualified Medical Expenses and for other tax information, visit irs.gov/forms-pubs/about-publication-969 to get a free copy of the IRS publication #969 for the year that you're filing to get more information about tax form 8853.

Contact your personal financial advisor (if you have one) for counseling and advice on how choosing an MSA plan could affect your financial situation.

Compare Medicare Advantage Plans side-by-side

The chart below shows basic information about each type of Medicare Advantage Plan.

	HMO	PPO	PFFS	SNP	MSA
Premium **Do I have to pay a monthly premium?**	Yes May charge a premium in addition to Part B premium.	Yes May charge a premium in addition to Part B premium.	Yes May charge a premium in addition to Part B premium.	Yes May charge a premium in addition to Part B premium.	No You won't have to pay a monthly premium, but you'll continue to pay the monthly Part B premium.
Drugs **Does the plan offer Medicare prescription drug coverage?**	Usually If you join a HMO that doesn't offer drug coverage, you can't get a separate Medicare Prescription Drug Plan.	Usually If you join a PPO plan that doesn't offer drug coverage, you can't get a separate Medicare Prescription Drug Plan.	Usually If you join a PFFS plan that doesn't offer drug coverage, you can get a Medicare Prescription Drug Plan.	Yes All SNPs must provide Medicare prescription drug coverage.	No You'll have to join a Medicare Prescription Drug Plan. If you already have a Medigap policy with drug coverage, you can continue to use this coverage to pay for some of your drugs.
Providers **Can I use any doctor or hospital that accepts Medicare for covered services?**	Maybe You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care or out-of-area dialysis). In an HMOPOS you may be able to get **some** services out-of-network for a higher copayment or coinsurance.	Yes Each plan has a network of doctors, hospitals, and other providers that you may go to. Your costs may be higher if you use providers outside the plan.	Yes You can go to any Medicare-approved doctor, other health care provider, or hospital **that accepts the plan's payment terms and agrees to treat you**. If the plan has a network, you can use any of the network providers (if you go to an out-of-network provider that accepts the plan's terms, you may pay more).	No Generally, you must get your care and services from doctors or hospitals in the SNP's network (except emergency or urgent care, or if you have End-Stage Renal Disease and need out-of-area dialysis).	Yes You have flexibility in choosing your health care services and providers.
Referral **Do I need a referral from my doctor to see a specialist?**	Yes	No	Maybe Plans may vary.	Maybe	No

What if I have a Medicare Supplement Insurance (Medigap) policy?

Medigap policies can't work with Medicare Advantage Plans. If you have a Medigap policy and join a Medicare Advantage Plan, you may want to drop your Medigap policy. Your Medigap policy can't be used to pay your Medicare Advantage Plan copayments, deductibles, and premiums.

If you want to cancel your Medigap policy, contact the insurance company that offers your policy. **If you cancel the Medigap policy, you might not be able to get the same, or in some cases, any Medigap policy back.** If you have a Medicare Advantage Plan already, it's illegal for anyone to sell you a Medigap policy unless you're switching back to Original Medicare.

If you join a Medicare Advantage Plan for the first time and decide the plan isn't right for you, you'll have a special right (called a "trial right") to buy a Medigap policy. You have this right if you return to Original Medicare within 12 months of joining.

- If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.
- The Medigap policy can no longer have prescription drug coverage even if you had it before, but you may be able to join a Medicare Prescription Drug Plan.
- If you joined a Medicare Advantage Plan when you were first eligible for Medicare, you can choose from any Medigap policy available in your state.

Where can I get more information?

- **Medicare Plan Finder**

  The Medicare Plan Finder is an online resource to help you view and compare all available drug and health plan choices. To find and compare available plans in your area, visit the Medicare Plan Finder at Medicare.gov/find-a-plan.

  You can search by ZIP code or use your MyMedicare.gov account for information tailored just for you.

- **1-800-MEDICARE**

  The Medicare Call Center can help you with specific questions about billing, claims, medical records, expenses, and more. Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

- **SHIPs (State Health Insurance Assistance Programs)**

  SHIPs are state programs that get money from the federal government to give local health insurance counseling to people with Medicare at no cost to you. SHIPs aren't connected to any insurance company or health plan. SHIP volunteers can help you with these Medicare questions or concerns:

  - Your Medicare rights
  - Billing problems
  - Complaints about your medical care or treatment
  - Plan choices
  - How Medicare works with other insurance
  - Finding help paying for health care costs

  You can find the phone number for your state's SHIP by visiting shiptacenter.org or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

- **Medicare Advantage Plans**

  Contact the plans you're interested in for detailed information about costs and coverage.

Notice of Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides auxiliary aids and services to help us better communicate with people with disabilities. Auxiliary aids include materials in Braille, audio/data CD or other accessible formats.

Note: You can get the "Medicare & You" handbook electronically in standard print, large print, or as an eBook.

For general Medicare inquiries and Medicare publications, call us at 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

For all other CMS publications and documents in accessible formats, you can contact our Customer Accessibility Resource Staff:

Call 1-844-ALT-FORM (1-844-258-3676). TTY: 1-844-716-3676.

- Send a fax to 1-844-530-3676.
- Send an email to altformatrequest@cms.hhs.gov.
- Send a letter to:

  Centers for Medicare & Medicaid Services
  Offices of Hearings and Inquiries (OHI)
  7500 Security Boulevard, Mail Stop S1-13-25
  Baltimore, MD 21244-1850
  Attn: Customer Accessibility Resource Staff

You can also contact the Customer Accessibility Resource staff:

- To inquire about a request for accessible formats.
- To submit concerns and issues about accessible communications, including the quality and timeliness of your request.

Note: Your request for a CMS publication or document should include:

- Your name, phone number, and the mailing address where we should send the publications or documents.
- The publication title and CMS Product No., if known.
- The format you need, like Braille, large print, or data/audio CD.

Note: If you're enrolled in a Medicare Advantage or Medicare Prescription Drug Plan, you can contact your plan to request their documents in an accessible format.

Nondiscrimination Notice

CMS doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

How to file a complaint

If you believe you've been subjected to discrimination in a CMS program or activity, there are 3 ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. Online at hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
2. By phone: Call 1-800-368-1019. TDD user can call 1-800-537-7697.
3. In writing: Send information about your complaint to:

   Office for Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201

Paid for by the Department of Health & Human Services.

Notes

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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Understanding Medicare Advantage Plans

- Medicare.gov
- 1-800-MEDICARE (1-800-633-4227)
- TTY: 1-877-486-2048

¿ Necesita usted una copia en español?
Llame GRATIS al 1-800-MEDICARE (1-800-633-4227).

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