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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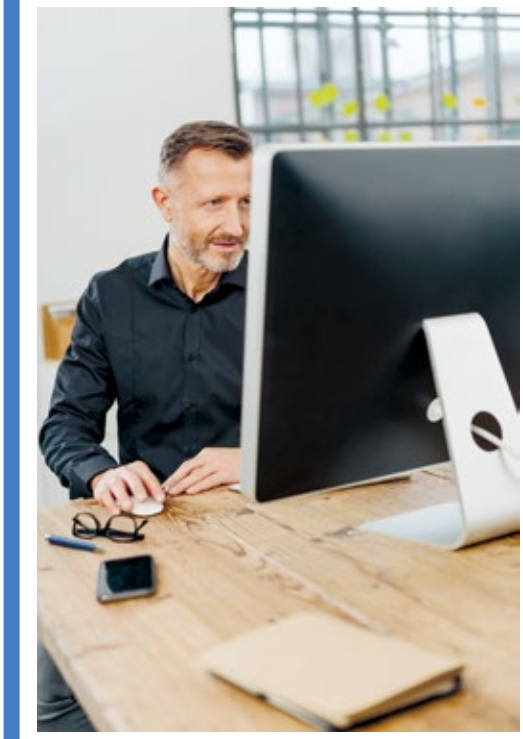
Introduction



When you first sign up for Medicare and during certain times of the year, you can choose how you get your Medicare coverage.

There are 2 main ways to get Medicare:

- **Original Medicare** is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles). If you want Medicare drug coverage (Part D), you can join a separate Medicare drug plan.
- **Medicare Advantage (also known as "Part C")** is a type of Medicare health plan offered by a private company that contracts with Medicare. These plans include Part A, Part B, and usually Part D. Plans may offer some extra benefits that Original Medicare doesn't cover.

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).
- You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).
- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- To help pay your out-of-pocket costs in Original Medicare (like your 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**

This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage
(also known as Part C)

- Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D.
- In most cases, you can only use doctors who are in the plan's network.
- In many cases, you may need to get approval from your plan before it covers certain drugs or services.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Plans may offer some extra benefits that Original Medicare doesn't cover—like vision, hearing, and dental services.

☑ **Part A**

☑ **Part B**

Most plans include:

☑ **Part D**

☑ **Some extra benefits**

Some plans also include:

☐ **Lower out-of-pocket-costs**

Original Medicare vs. Medicare Advantage

Doctor & hospital choice

Original Medicare	Medicare Advantage (Part C)
You can go to **any doctor or hospital that takes Medicare, anywhere in the U.S.**	In many cases, you can only use **doctors and other providers who are in the plan's network and service area** (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost.
In most cases, you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist.

Cost

Original Medicare	Medicare Advantage (Part C)
For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible. This amount is called your coinsurance.	**Out-of-pocket costs vary**—plans may have lower or higher out-of-pocket costs for certain services.
You **pay a premium (monthly payment) for Part B**. If you choose to join a Medicare drug plan, you'll pay a separate premium for your Medicare drug coverage (Part D).	You pay the monthly **Part B premium** and may also have to **pay the plan's premium**. Some plans may have a $0 premium and may help pay all or part of your Part B premium. Most plans include Medicare drug coverage (Part D).
There's **no yearly limit** on what you pay out of pocket, unless you have supplemental coverage—like Medicare Supplement Insurance (Medigap).	Plans have a **yearly limit** on what you pay out of pocket for services Medicare Part A and Part B cover. Once you reach your plan's limit, you'll pay nothing for services Part A and Part B cover for the rest of the year.
You **can get** Medigap to help pay your remaining out-of-pocket costs (like your 20% coinsurance). Or, you can use coverage from a former employer or union, or Medicaid.	You **can't buy and don't need** Medigap.

Original Medicare vs. Medicare Advantage
(continued)

Coverage

Original Medicare	Medicare Advantage
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some benefits like eye exams, most dental care, and routine exams.	Plans must cover all medically necessary services and supplies that Original Medicare covers. Plans may also **offer some extra benefits that Original Medicare doesn't cover**—like vision, hearing, and dental services.
You can join a **separate Medicare drug plan** to get Medicare drug coverage (Part D).	**Medicare drug coverage (Part D) is included in most plans**. In most types of Medicare Advantage Plans, you can't join a separate Medicare drug plan.
In most cases, you don't have to get a service or supply approved ahead of time for Original Medicare to cover it.	In many cases, you have to get a service or supply approved ahead of time for the plan to cover it.

Foreign Travel

Original Medicare	Medicare Advantage
Original Medicare generally **doesn't cover medical care outside the U.S.** You may be able to buy a Medicare Supplement Insurance (Medigap) policy that covers emergency care outside the U.S.	Plans generally **don't cover medical care outside the U.S.** Some plans may offer a supplemental benefit that covers emergency and urgently needed services when traveling outside the U.S.

Medicare Advantage Plans

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 offered by Medicare-approved private companies that must follow rules set by Medicare. Most Medicare Advantage Plans include drug coverage (Part D). There are several types of Medicare Advantage Plans (see page 17). Each of these Medicare Advantage Plan types have special rules about how you get your Medicare-covered Part A and B services and any supplemental benefits your plan covers.

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 Medicare Advantage Plan, not Original Medicare.

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 may need to show your Medicare card for some services. Also, you'll need it if you ever switch back to 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 your Medicare Advantage Plan. Companies that offer Medicare Advantage Plans 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 whether you need a referral to see a specialist or whether you have to go to doctors, facilities, or suppliers that belong to 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.

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 do Medicare Advantage Plans cover?

Medicare Advantage Plans provide all of your Part A and Part B benefits, excluding clinical trials (clinical research studies), hospice services, and, for a temporary time, some new benefits that come from legislation or national coverage determinations. Be sure to contact your plan if you have questions about covered services.

What do Medicare Advantage Plans cover? (continued)

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). Plans also have a **yearly limit** on your out-of-pocket costs for all Part A and Part B services. Once you reach this limit, you'll pay nothing for services Part A and Part B cover.

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 or Preferred Provider Organization plan which doesn't cover drugs, you can't join a separate Medicare drug plan. See pages 18–19 for more information.

Note: If you're in a plan that doesn't offer drug coverage, and you don't have a Medicare drug plan, you may have to pay a late enrollment penalty if you decide to join a Medicare drug plan 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. The plan may change what you pay only once a year, on January 1.

You have to pay the Part B premium. In 2022, the standard Part B premium amount is $170.10 (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 services Medicare covers.
- Whether the plan offers extra benefits (in addition to Original Medicare benefits) and if you need to pay extra to get them.
- Whether you have Medicaid or get help from your state through a Medicare Savings Program to pay your Medicare costs.
- The maximum out-of-pocket limit set by your plan.

What are my costs? (continued)

What's the difference between a deductible, coinsurance, copayment, and a maximum out-of-pocket limit?

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your Medicare Advantage Plan, your Medicare 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.

Maximum Out-of-Pocket Limit—The maximum amount you must pay for Part A and Part B covered services if you join a Medicare Advantage Plan.

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:** Includes any changes in coverage, costs, and more that will be effective starting 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, which will include information on how to access the Evidence of Coverage electronically or request a printed copy.

Organization determinations

You or your provider can get a decision, either orally or in writing, from your plan in advance to see 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."** To get prior authorization for your plan to cover a service, drug, or supply, you might have to ask for an organization determination.

You, your representative, or your doctor can request an organization determination. A representative is someone you can appoint to help you. Your representative can be a family member, friend, advocate, attorney, financial advisor, doctor, or someone else who will act on your behalf. 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.

What are my costs? (continued)

If a plan provider refers you for a 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.

Who can join a Medicare Advantage Plan?

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.

What if I have a pre-existing condition?

You can join a Medicare Advantage Plan even if you have a pre-existing condition.

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

If you have ESRD, you can join a Medicare Advantage Plan during Open Enrollment (October 15–December 7) for coverage starting January 1, during your Initial Enrollment Period when you are first eligible for Medicare, or during a Special Enrollment Period if you qualify for one.

In many Medicare Advantage Plans, you can only use health care providers who are in the plan's network and service area. Before you join, you may want to check with your providers and the plan you're considering to make sure the providers you currently see (like your dialysis facility or kidney doctor), or want to see in the future (like a transplant specialist), are in the plan's network. If you're already in a Medicare Advantage Plan, check with your providers to make sure they'll still be part of the plan's network. Read the plan materials or contact the plan you're considering for more information.

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

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.

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:

Open Enrollment Period—Between October 15 and 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).

Medicare Advantage Open Enrollment Period—Between January 1 and March 31 of each year, you can make these changes:

- 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 drop your Medicare Advantage Plan and return to Original Medicare. You'll also be able to join a separate Medicare drug plan.

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

- Switch to a Medicare Advantage Plan.
- Join a Medicare drug plan.
- Switch from one Medicare drug plan to another.

You can only make one change during the Medicare Advantage Open Enrollment 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. If you already have Part A coverage and you sign up for Part B for the first time between January 1 and March 31 of each year, you can also join a Medicare Advantage Plan at the same time. In this situation, your coverage will start the first of the month after the plan gets your request.

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

Initial Enrollment Period—When you first become eligible for Medicare, you can join a Medicare Advantage Plan during your Initial Enrollment Period. For many, 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're under 65 and have a disability**, you'll automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the Railroad Retirement Board for 24 months.

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 join a Medicare Advantage Plan the month you turn 65 or during the last 3 months of your Initial Enrollment Period, your start date for coverage will be delayed.

Note: Beginning January 1, 2023, if you sign up during the last 3 months of your Initial Enrollment Period, your coverage starts the first day of the month after you sign up.

If you join 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 a separate Medicare drug plan) within the first 3 months you have Medicare.

Special Enrollment Period—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.

Note: Beginning January 1, 2023, you may be eligible for a Special Enrollment Period to sign up for Medicare (and join a Medicare Advantage Plan) if you miss an enrollment period because of certain exceptional circumstances, like being impacted by a natural disaster or an emergency. Visit Medicare.gov or check with your plan for more information.

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/plan-compare or calling 1-800-MEDICARE. TTY users can call 1-877-486-2048. Once you understand the plan's rules and costs, use one of these ways to join:

- Visit Medicare.gov/plan-compare and search by ZIP code to find a plan and join. You can also log in for personalized results. If you have questions about a plan, select "Plan Details" to get the plan's contact information.
- Call the plan you want to join, or 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 1-800-MEDICARE (1-800-633-4227).

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

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

Remember, when you join 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 (like hospice care), you may need to show your red, white, and blue Medicare card.

Notes

Types of Medicare Advantage Plans

There are different types of Medicare Advantage Plans:

- Health Maintenance Organization (HMO) plans: See page 18.
- Preferred Provider Organization (PPO) plans: See page 19.
- Private Fee-for-Service (PFFS) plans: See pages 20–21.
- Special Needs plans (SNPs): See pages 21–23.
- Medical Savings Account (MSA) plans: See pages 24–25.

The area where you live might have all, some, or none of these plan types available. In addition, multiple plans of the same type might be available in your area, if private companies choose to offer them. To find available Medicare Advantage Plans, visit Medicare.gov/plan-compare, read your "Medicare & You" handbook, or call 1-800-MEDICARE. TTY users can call 1-877-486-2048.

Types of Medicare Advantage Plans (continued)

Health Maintenance Organization (HMO) plans

An HMO plan is a type of Medicare Advantage Plan that generally provides health care coverage exclusively from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or temporary out-of-area dialysis). 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?

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.

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 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 the plan requires it.

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.

Types of Medicare Advantage Plans (continued)

Preferred Provider Organization (PPO) plans

A Preferred Provider Organization (PPO) plan is a Medicare Advantage Plan that has network doctors, specialists, hospitals, and other health care providers you can use.

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

Yes. 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.

Before you get services from an out-of-network provider, you may want to ask for an organization determination of coverage from your PPO plan to ensure that the services are medically necessary and that your plan covers them. See page 11 for more information on organization determinations.

Do these plans cover prescription drugs?

In most cases, yes. If you're planning to join 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.

Types of Medicare Advantage Plans (continued)

Private Fee-for-Service (PFFS) plans

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

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 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. Typically, your plan ID card tells your provider that you belong to a PFFS plan.

If your provider agrees to the plan's terms and conditions of payment, your provider must follow them, and bill the plan for your services. However, your provider can decide on any future visit to stop treating you.

If your provider doesn't agree to the plan's terms and conditions of payment, the plan is only required to pay your provider for emergency services, urgently needed services, and out of area dialysis. For other covered services, you'll need to find another provider that will accept the PFFS plan.

However, if your provider chooses to treat you, they can only bill you for plan-allowed cost sharing. They must bill the plan for your covered services. You're only required to pay the copayment or coinsurance the plan allows for your services when you get them. Then the provider will bill the plan for the amount of the covered services.

Note: A PFFS plan may also allow "balance billing" which means that a provider can charge up to 15% more than the amount Medicare pays, and bill you for that amount.

If your plan allows balance billing, you may have to pay both the plan's copayment or coinsurance and the difference between what the provider charged and the amount Medicare pays.

Types of Medicare Advantage Plans (continued)

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

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).

Special Needs Plans (SNP)

Special Needs Plans provide benefits and services to people with specific diseases, certain health care needs, or who also have Medicaid coverage. SNPs tailor their benefits, provider choices, and list of covered drugs (formularies) to best meet the specific needs of the groups they serve.

SNPs are either PPO, HMO, or HMOPOS plan types, and cover the same Medicare Part A and Part B services that all Medicare Advantage Plans cover. However, 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. SNPs must also provide Medicare drug coverage (Part D).

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.

You may qualify for an SNP if you live in the plan's service area and meet the requirements for one of the 3 SNP types:

1. **Chronic condition SNP (or C-SNP):** You have one or more specific severe or disabling chronic conditions like:
   - Chronic alcohol and other drug dependence
   - Certain autoimmune disorders
   - Cancer (excluding pre-cancer conditions)
   - Certain cardiovascular disorders
   - Chronic heart failure
   - Dementia

Types of Medicare Advantage Plans (continued)

Chronic condition SNP (continued)

- Diabetes mellitus
- End-stage liver disease
- End-Stage Renal Disease (ESRD) requiring dialysis (any mode of dialysis)
- Certain severe hematologic disorders
- HIV/AIDS
- Certain chronic lung disorders
- Certain chronic and disabling mental health conditions
- Certain neurologic disorders
- Stroke

2. **Institutional SNP (or I-SNP)**: You live in the community but need the level of care a facility offers, or if you live (or are expected to live) for at least 90 days straight in a facility like a:
   - Nursing home
   - Intermediate care facility
   - Skilled nursing facility
   - Rehabilitation hospital
   - Long-term care hospital
   - Swing-bed hospital
   - Psychiatric hospital
   - Other facility that offers similar long-term, health care services and whose residents have similar needs and health care status as residents of the facilities listed above

Types of Medicare Advantage Plans (continued)

Special Needs Plans (SNP) (continued)

3. **Dual Eligible SNP (or D-SNP):** You're eligible for both Medicare and Medicaid. D-SNPs contract with your state Medicaid program to help coordinate your Medicare and Medicaid benefits.

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

If your SNP is an HMO, 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). You may be required to have a primary care doctor.

However, if your SNP is a PPO, then you may get services from any qualified provider or hospital, but usually at a higher cost than you would pay for services from a network provider.

SNPs typically have specialists in the diseases or conditions that affect their members. Both an HMO and PPO SNP 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 provide the services of a care coordinator to help members monitor their blood sugar and follow their diet.

Do these plans cover prescription drugs?

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

Types of Medicare Advantage Plans (continued)

Medicare Medical Savings Account (MSA) plans

Medicare 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:** The second part of an MSA plan is a special type of savings account. The MSA plan deposits money into your account.

Once you decide which MSA plan you want, you'll need to contact the plan for enrollment information and to join. 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 the plan can process your enrollment. After you join, you'll get a letter from the plan telling you when your coverage begins. Once you join and have MSA coverage:

- Medicare gives the plan an amount of money each year for your health care.
- The plan deposits money into your account on your behalf. You can't deposit your own money.
- You can use the money in your account to pay for health care costs, including health care costs that aren't covered by Medicare.
- 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.
- 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.
- Your payments for Medicare-covered Part A and Part B services count toward your plan's deductible. After you reach your deductible, your plan will cover your Medicare-covered services.
- 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.

Types of Medicare Advantage Plans (continued)

MSA plans and your taxes

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

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 equal to at least this amount, or you may have to pay taxes and additional penalties.

The IRS offers more tax information related to MSA plans, like a list of Qualified Medical Expenses. Visit irs.gov/forms-pubs/about-publication-969.

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

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

MSA plans generally don't have a network of health care providers. You can get Medicare Part A and Part B services from any Medicare eligible provider in the U.S. or U.S. territories.

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.

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.

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 most plans charge a monthly premium?**	Yes Many charge a premium in addition to the monthly Part B premium.	Yes Many charge a premium in addition to the monthly Part B premium.	Yes Many charge a premium in addition to the monthly Part B premium.	Yes Many charge a premium in addition to the monthly Part B premium.	No You won't have to pay a separate monthly premium, but you'll continue to pay the monthly Part B premium.
Drugs **Does the plan offer Medicare prescription drug coverage (Part D)?**	Usually If you join an HMO plan that doesn't offer drug coverage, you can't get a separate Medicare drug plan.	Usually If you join a PPO plan that doesn't offer drug coverage, you can't get a separate Medicare drug plan.	Usually If you join a PFFS plan that doesn't offer drug coverage, you can get a separate Medicare drug plan.	Yes All SNPs must provide Medicare prescription drug coverage (Part D).	No You may join a separate Medicare drug plan. If you already have a Medigap policy with drug coverage, you can continue to use this coverage.
Providers **Can I use any doctor or hospital that accepts Medicare for covered services?**	Sometimes You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency or urgent care or out-of-area dialysis). In an HMOPOS plan 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. You may also go out of the plan's provider network, but your costs may be higher.	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).	Sometimes If your SNP is an HMO, you must get your care and services from doctors or hospitals in the SNP's network (except emergency or urgent care or out-of-area dialysis). However, if your SNP is a PPO you can get Medicare covered services out of network.	Yes MSA plans generally don't have network providers. You may go to any Medicare-approved provider for services Original Medicare covers.
Referral **Do I need a referral from my doctor to see a specialist?**	Yes	No	No	Maybe If the SNP is an HMO, you need a referral. If the SNP is a PPO, you don't need a referral.	No

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

If you join a Medicare Advantage Plan, you may not buy Medigap. However, if you have an existing Medigap policy, there are several exceptions (depending on the state) that may let you keep this policy. For example, if you already had a Medigap plan when joining an MSA, you can keep your Medigap policy and use it for prescription drug coverage. Check with your State Insurance Department if you want to keep a Medigap policy and join a Medicare Advantage Plan. You can't use Medigap to pay your Medicare Advantage Plan copayments, deductibles, and premiums.

If you want to cancel your Medigap policy, contact your insurance company. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you may not be able to get the same policy back. If you're in 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 aren't planning to leave your Medicare Advantage Plan, and someone tries to sell you a Medigap policy, report it to your State Insurance Department.

If you join a Medicare Advantage Plan for the first time and you aren't happy with the plan, you have a "trial right" under federal law to buy a Medigap policy and a separate Medicare drug plan if you return to Original Medicare within 12 months of joining the Medicare Advantage Plan.

- If you had Medigap 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 policy.
- If you joined a Medicare Advantage Plan when you were first eligible for Medicare (and you aren't happy with the plan), you can choose from any Medigap policy when you switch to Original Medicare within the first year of joining.
- Some states provide additional special rights to buy a Medigap policy.

Medigap plans sold to people who are newly eligible for Medicare aren't allowed to cover the Part B deductible. For more information about Medigap plans, see "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

Where can I get more information?

- **Find a Medicare plan**

  Compare health and drug plans to find coverage that meets your needs. You can also enter your drugs to get more accurate costs for plans in your area. Visit Medicare.gov/plan-compare to shop and compare plans that meet your needs.

- **1-800-MEDICARE**

  1-800-MEDICARE can help you with specific questions about billing, claims, medical records, expenses, and more. Call 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. 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 shiphelp.org, or by calling 1-800-MEDICARE.

- **Medicare Advantage Plans**

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

CMS Accessible Communications

The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format, you can:

1. **Call us:**
   For Medicare: 1-800-MEDICARE (1-800-633-4227)
   TTY: 1-877-486-2048
2. **Send us a fax:** 1-844-530-3676
3. **Send us a letter:**

   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

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your state or local Medicaid office.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (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.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, state or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health & Human Services, Office for Civil Rights:

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

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

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Official Business
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Understanding Medicare Advantage Plans

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

This booklet is available in Spanish. To get a free copy, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en Español. Para obtener una copia gratis, visite Medicare.gov o llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.

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