# 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

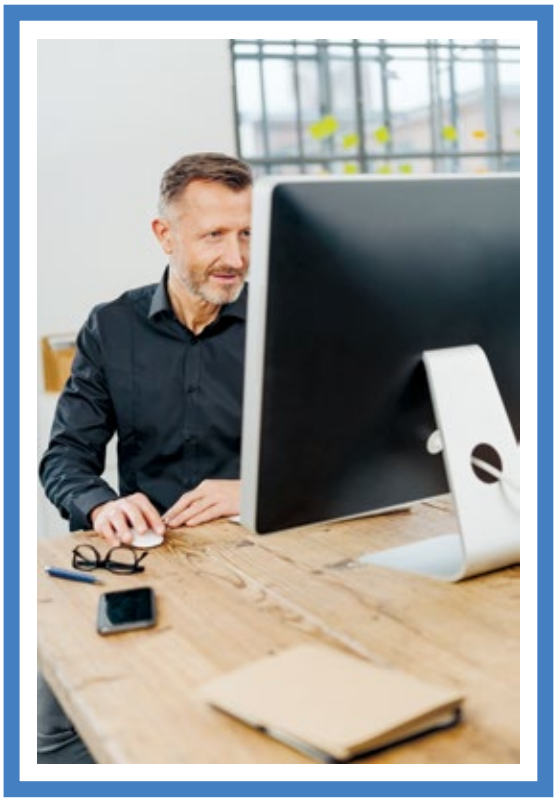
**"Understanding Medicare Advantage Plans"** isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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.

# Contents



# Introduction



When you first enroll in 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** includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). If you want drug coverage, you can join a separate Medicare drug plan (Part D).
- **Medicare Advantage (also known as "Part C")** is an "all in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D. Most plans offer extra benefits Original Medicare doesn't cover–like vision, hearing, dental, and more.

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 Medicare drug plan (Part D).
- To help pay your out-of-pocket costs in Original Medicare (like your 20% coinsurance), you can also shop for and buy supplemental coverage.
- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.

☑ **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 an "all in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D.
- Plans may have lower out-of- pocket costs than Original Medicare.
- In many cases, you'll need to use doctors who are in the plan's network.
- Most plans offer extra benefits that Original Medicare doesn't cover — like vision, hearing, dental, and more.

☑ **Part A**

☑ **Part B**

**Most plans include:**

☑ **Part D**

☑ **Extra benefits**

**Some plans also include:**

☐ **Lower out-of-pocket-costs**

# Original Medicare vs. Medicare Advantage

## Doctor & hospital choice

| Original Medicare | Medicare Advantage |
|---|---|
| You can go to **any doctor or hospital that takes Medicare, anywhere in the U.S.** | In many cases, you'll need to use **doctors and other providers who are in the plan's network and** service area for the lowest costs. Some plans won't cover services from providers outside the plan's network and service area. |
| 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 |
|---|---|
| For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible. This is called your coinsurance. | **Out-of-pocket costs vary**—plans may have lower 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 (Part D), you'll pay that premium separately. | You may **pay the plan's premium** in addition to the monthly **Part B premium**. (Most plans include drug coverage (Part D).) Plans may have a $0 premium or may help pay all or part of your Part B premiums. |
| 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 covers. Once you reach your plan's limit, you'll pay nothing for services Part A and Part B covers 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. |

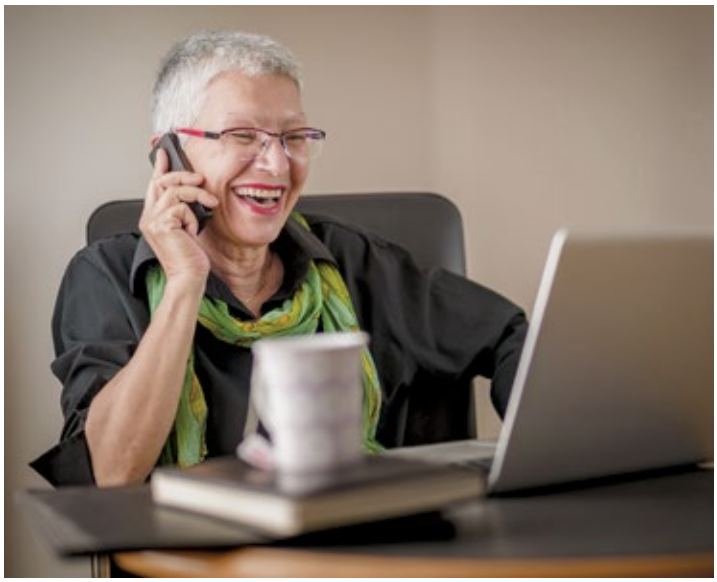
# Original Medicare vs. Medicare Advantage
(continued)

## Coverage

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

## Travel

| Original Medicare | Medicare Advantage |
|---|---|
| Original Medicare generally **doesn't cover care outside the U.S.** You may be able to buy a Medicare Supplement Insurance (Medigap) policy that covers care outside the U.S. | Plans generally **don't cover care 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" 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 15). Each of these Medicare Advantage Plan types have special rules about how you get your Medicare covered Part A and B services and your plan's supplemental benefits.

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'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 if 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 cover almost all 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.

## What do Medicare Advantage Plans cover? (continued)

Most Medicare Advantage Plans offer coverage, for some things Original Medicare doesn't cover, like some vision, hearing, dental, and fitness programs (like gym memberships or discounts). Plans also have a **yearly limit** on your out-of-pocket costs for all Part A and Part B medical 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 15–24 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. Visit Medicare.gov/drug 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.

You have to pay the Part B premium. In 2020, the standard Part B premium amount is $144.60 (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.

## 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:** 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:** 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 Evidence of Coverage electronically or request a printed copy.

### Organization determinations

You can get a decision 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."** Sometimes you have to do this as prior authorization for your plan to cover the service, drug, or supply.

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.

### 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 enroll in a Medicare Advantage Plan during Open Enrollment (October 15–December 7, 2020) for coverage starting January 1, 2021.

In many Medicare Advantage Plans, you'll need to use health care providers who participate in the plan's network and service area. Before you enroll, 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 in 2021. 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 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:

- **Initial Enrollment Period—**When you first become eligible for Medicare, you can sign up 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 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 this period (between January 1—March 31 each year), you can also join a Medicare Advantage Plan. Your coverage may not start until 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).

### Can I make changes to my coverage after December 7?

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

During this 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 drug plan to another if you're in Original Medicare.

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

**You can only make one change during this period, and any changes you make will be effective the first of the month after the plan gets your request.** If you're returning to Original Medicare and joining a 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.

**Note:** 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 a drug plan) within the first 3 months you have Medicare.

## 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. 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. You can also log in for personalized results. If you have questions about a particular plan, select "Plan Details" to get the plan's contact information.
- 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/plan-compare to get your plan's contact information.
- Call 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.

# 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/plan-compare or your Medicare & You handbook.

## Health Maintenance Organization (HMO) plans

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

## Types of Medicare Advantage Plans (continued)

### Health Maintenance Organization (HMO) plans (continued)

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.

**Do these plans cover prescription drugs?**

In most cases, yes. If you want Medicare drug coverage, you must join an HMO that offers drug coverage. If you join an HMO that doesn't include drug coverage, you can't get a separate Medicare 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 doctors, specialists, hospitals, and other health care providers you can use, but you can also use out-of-network providers for covered services, usually for a higher cost. You also can choose to go to any doctor, specialist, or hospital not on the plan's list (out-of-network), 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?

Yes. PPO plans have network doctors, specialists, hospitals, and other health care providers you can use, but you can also use out-of-network providers for covered services, usually for a higher cost. You're always covered for emergency and urgent care.

If you choose to get services from an out-of-network provider, you may want to ask for an advance determination of coverage from your PPO plan to ensure that the services are medically necessary and that your plan covers them.

#### Do these plans cover prescription drugs?

In most cases, yes. If you want Medicare drug coverage, you must join a PPO plan that offers 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 a Medicare Supplement (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 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 to accept the plan and agree to treat you.

# Types of Medicare Advantage Plans (continued)

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

### 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.

However, if the provider chooses to treat you, then 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 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).

### Do these plans cover prescription drugs?

Sometimes. If you want Medicare prescription drug coverage, and it's offered by the plan, you must get your drug coverage from that plan.

If your PFFS plan doesn't offer drug coverage, you can join a separate Medicare drug plan 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, certain health care needs, or limited incomes. 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 HMO or PPO plan types, and cover the same Medicare Part A and Part B benefits 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.

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're eligible for 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). However, if your Special Needs Plan 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.

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

**Do these plans cover prescription drugs?**

All SNPs must provide Medicare drug coverage.

## 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.

Once you decide which MSA plan you want, you'll need to contact the plan for enrollment information and to join. Once you're enrolled, 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 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.
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.

## Types of Medicare Advantage Plans (continued)

**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.

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

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

If you have Medigap and join a Medicare Advantage Plan, you may want to drop Medigap. You can't use Medigap to pay your Medicare Advantage Plan copayments, deductibles, and premiums because Medicare Advantage Plans provide other protections that Medigap doesn't.

If you want to cancel your Medigap policy, contact the insurance company. **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're not 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'll have special rights under federal law to buy a Medigap policy and a 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're not happy with the plan), you can choose from any Medigap policy within the first year of joining.

Medigap plans sold to people who are newly eligible for Medicare aren't allowed to cover the Part B deductible. Because of this, Plans C and F aren't available to people who are newly eligible for Medicare on or after January 1, 2020. If you already have or were covered by Plan C or F (or the Plan F high deductible version) before January 1, 2020, you can keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans that cover the Part B deductible.

## Where can I get more information?

- **Medicare Plan Finder**

  Compare health and drug plans to find coverage that works for you. 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**

  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.

- **Medicare Advantage Plans**

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

## CMS 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 free auxiliary aids and services, including information in accessible formats like Braille, large print, data/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. **Email us:** to altformatrequest@cms.hhs.gov.
3. **Send us a fax:** 1-844-530-3676
4. **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 enrolled 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.

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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 Prescription 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 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. 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 and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201

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## Notes

## Notes

**U.S. DEPARTMENT OF HEALTH AND 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

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

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