Differences between Original Medicare and Medicare Advantage

People with Medicare can get their health coverage through either Original Medicare or a Medicare Advantage Plan. Here's a look at the differences between these two options.

Original Medicare
The traditional program offered directly through the federal government

Medicare Advantage
Private plans that contract with the federal government to provide Medicare benefits

Original Medicare includes Part A (inpatient/hospital coverage) and Part B (outpatient/medical coverage). You will receive a red, white, and blue card to show to your providers when receiving care. Most doctors in the country take your insurance. Additionally, Medicare limits how much you can be charged if you visit participating or non-participating providers.

Medicare Advantage Plans are also known as Medicare private health plans or Part C. Some of the most common types of plans are:

- Health Maintenance Organizations (HMOs)
- Preferred Provider Organizations (PPOs)
- Private Fee-For-Service (PFFS)

If you join a Medicare Advantage Plan, you will not use the red, white, and blue card when you go to the doctor or hospital. Instead, you will use the membership card your plan sends you to get health services covered. Plans must provide the same benefits offered by Original Medicare, but they may apply different rules, costs, and restrictions. They also may offer certain benefits that Medicare does not cover.

If you sign up for Original Medicare and later decide you would like to try a Medicare Advantage Plan–or vice versa–be aware that there are certain enrollment periods when you are allowed to make changes.

Note: Keep in mind that different areas have different Medicare Advantage Plans. A particular plan may not be available where you live. Call 1-800-MEDICARE or your State Health Insurance Assistance Program (SHIP) to find out about plans available in your area.

a plan, speak to a plan representative for more information.

	Original Medicare	Medicare Advantage
Costs	You will be charged for standardized Part A and Part B costs, including monthly Part B premium. Responsible for paying a 20% coinsurance for Medicare-covered services if you see a participating provider and after meeting your deductible.	Your cost-sharing varies depending on plan. Usually pay a copayment for in-network care. Plans may charge a monthly premium in addition to Part B premium.
Supplemental insurance	Have the choice to pay an additional premium for a Medigap to cover Medicare cost-sharing.	Cannot enroll in a Medigap plan.
Provider access	Can see any provider and use any facility that accepts Medicare (participating or non-participating).	Typically can see only in-network providers (Note: PPOs may provide out-of-network coverage).
Referrals	Do not need referrals for specialists.	May need referrals for specialists (Note: PPO enrollees do not need referrals).
Drug coverage	You must sign up for a stand-alone prescription drug plan.	In most cases, plan provides prescription drug coverage (you may be required to pay higher premium).
Other benefits	Does not cover vision, hearing, or dental services.	May cover additional services, including vision, hearing, and/or dental (additional benefits may increase your premium and/or other out-of-pocket costs).
Out-of-pocket limit	No out-of-pocket limit.	Annual out-of-pocket limit. Plan pays the full cost of your care after you reach the limit.

Definitions

Premium: The monthly fee you pay to have Medicare.

Deductible: What you must pay out of pocket before Medicare starts paying for your care.

Copayment / Coinsurance: The amount you pay for each service.

Participating provider: Provider that accepts Medicare's approved amount for services as full payment.

Network: Doctors, hospitals, and medical facilities that contract with a plan to provide services.