Medicare Minute Teaching Materials — August 2025
Choosing Between Original Medicare and Medicare Advantage

1. What are Original Medicare and Medicare Advantage?
People with Medicare can get their health coverage through either Original Medicare or a Medicare Advantage (MA) plan (also known as a Medicare private health plan or Medicare Part C).

Original Medicare, sometimes called Traditional Medicare, or Fee-For-Service (FFS) Medicare, is coverage provided directly by the federal government. Fee-for-service means that providers are paid set amounts for each service or procedure they provide. The fees are set by Medicare each year. Providers send claims, or requests for payment, to Medicare, and the government pays them for the services you have received. You can go to any doctor or hospital that takes Medicare, anywhere in the country.

When you have Original Medicare:

- You go directly to the doctor or hospital when you need care. You do not need to get permission or authorization from Medicare or a referral from your primary care doctor for most services.
- You are responsible for a monthly premium for Part B, and if applicable, Part A. If you have or wish to enroll in supplemental coverage you may pay a separate premium.
- You typically pay a coinsurance, or percentage of the full cost, for each service you receive.
- There are limits on the amounts that doctors and hospitals can charge for your care.

If you want prescription drug coverage with Original Medicare, in most cases you will need to choose and join a stand-alone Medicare private drug plan, also called a Part D plan. Part D is offered through private insurance companies. You pay a separate premium for Part D.

Unless you choose otherwise, you will have Original Medicare when you first enroll in Medicare.

Medicare Advantage plans, also known as Medicare private health plans or Part C, are plans that contract with the federal government and are paid a fixed amount per person to provide Medicare benefits. The most common types of Medicare Advantage plan are:

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

You may also see:

- Special Needs Plans (SNPs)
- Provider Sponsored Organizations (PSOs)
- Medical Savings Accounts (MSAs)

In Medicare Advantage plans:

- You still have Medicare. This means that you still must pay a monthly premium for Part B (and, for some, Part A), as well as potentially an additional premium for the Medicare Advantage plan. Medicare Advantage plans are required to cover the same care paid for by Original Medicare. Many Medicare

Advantage plans include prescription drug coverage–these plans are often referred to as MAPDs. The prescription drug coverage component of the plan must meet all the requirements that separate, or stand-alone, Part D plans must meet.

- You generally need to see providers who are in your plan's network and service area to pay the lowest cost for services. In many plans, you must get prior authorization or a referral from your primary care provider for specialty services, procedures, and durable medical equipment.
- You will often pay fixed copayments per service or item you receive. These costs vary from plan to plan. Plans cannot charge higher copayments or coinsurances than Original Medicare for certain services, like chemotherapy and dialysis, but they can charge higher cost-sharing for other services.
- All Medicare Advantage plans must include a limit on your out-of-pocket expenses for Part A and B services. For example, the maximum out-of-pocket cost for HMO plans in 2025 is $9,350. These limits tend to be high but can protect you from unlimited costs if you need a lot of care or expensive treatments.
- A Medicare Advantage plan may offer certain benefits that Medicare does not cover, such as dental and vision care, caregiver counseling and training, and certain in-home support like housekeeping. Not all Medicare Advantage plans cover additional benefits, so check with a plan directly to learn what benefits it covers.

Medicare Advantage plans may have different:

- Networks of providers
- Coverage rules, including prior authorization and referral requirements, that can constrain how and when you receive care
- Premiums (in addition to the Part B premium)
- Cost-sharing, including deductibles and copayments for covered services (see question 4)

Even plans of the same type offered by different companies may have different rules, so you should always check with a plan directly to find out how its coverage works.

You can join a Medicare Advantage plan if:

- You have Medicare Parts A and B
- You live in the plan's service area

Many Medicare Advantage plans also offer prescription drug coverage (Part D). If you join an MSA plan or a PFFS plan without drug coverage, you can enroll in a stand-alone Part D plan. Remember that people with Original Medicare who want Part D coverage also can enroll in a stand-alone Part D plan.

If you have health coverage from your union or employer (current or former), when you become eligible for Medicare, you may automatically be enrolled in a Medicare Advantage plan that they sponsor. You have the choice to stay with this plan, switch to Original Medicare, or enroll in a different Medicare Advantage plan. Be aware that if you switch to Original Medicare or enroll in a different Medicare Advantage plan, your employer or union could terminate or reduce your health benefits, the health benefits of your dependents, and any other benefits you get from your company. Talk to your employer/union and your plan before making changes to find out how your health benefits and other benefits may be affected.

2. What is a Medigap?
Medigaps are health insurance policies that offer standardized benefits to work with Original Medicare (not with Medicare Advantage). They are sold by private insurance companies. If you have a Medigap, it pays part or all of certain remaining costs after Original Medicare pays first. Medigaps may cover outstanding deductibles, coinsurance, and copayments. Medigaps may also cover health care costs that Medicare does not cover at all, like care received when traveling abroad. Remember, Medigaps only work with Original Medicare. If you have a Medicare Advantage plan, you cannot buy a Medigap.

Depending on where you live and when you became eligible for Medicare, you have up to 10 different Medigap policies to choose from: A, B, C, D, F, G, K, L, M, and N (policies in Wisconsin, Massachusetts, and Minnesota have different names). Each policy offers a different set of standardized benefits, meaning that policies with the same letter name offer the same benefits. However, premiums can vary from company to company.

Before you buy a Medigap policy, be sure to do your research. Some steps you may wish to take include the following:

- Make sure you are eligible to purchase a Medigap. Remember that you can only have a Medigap if you have Original Medicare. If you are enrolled in a Medicare Advantage plan, Medigaps cannot be sold to you. Learn when you have the right to buy a Medigap without restriction. There are federal protections for people over 65 that prohibit insurers from denying coverage or charging more to people with health conditions in certain situations. Some states have additional protections for individuals under 65 and/or for those over 65 during additional times.
- Once you decide you want a Medigap and know you are eligible to enroll, compare the different types of policies that exist. As mentioned above, there are 10 different standardized policies in most states, each covering a different range of Medicare cost-sharing.
- Learn how Medigap covers prior medical conditions to know if any of your medical costs may be excluded from Medigap coverage. Depending on your circumstances, a Medigap policy may exclude coverage for prior medical conditions for a limited amount of time.
- Find out how Medigap premiums are priced so you can make cost comparisons. It is important to understand the ways that insurers may set premiums in your state to find the best deal for you.
- Have a list of questions to ask when shopping for a Medigap to remind you what you should consider. Buying a Medigap can be complicated but using a set of written questions and asking for help when needed can help you stay organized and simplify the process.

3. What should I consider if I'm deciding between Original Medicare and Medicare Advantage?
It is important to understand your Medicare coverage choices and to pick your coverage carefully. How you choose to get your benefits and who you can get them from can affect your out-of-pocket costs and where you can get your care. Some of the factors to consider when you are deciding between Original Medicare and Medicare Advantage are:

- Costs: What premiums and out-of-pocket costs will I be responsible for (see number 4)?
- Supplemental insurance (also known as Medigap): Will I have the choice to purchase a Medigap policy (see number 2)? How will my retiree coverage work with this choice?
- Provider access: What kind of providers can I see? Do I need to use a network of providers or get referrals to see specialists? (see number 5)?

- Drug coverage: Is there prescription drug coverage included in my coverage or will I need to purchase a separate stand-alone plan (see question 1)? How will my retiree coverage work with this choice?
- Additional/supplemental benefits: Are additional services, like vision, hearing, or dental covered in the Medicare Advantage plan, if any, and at what cost (see number 6)?
- Out-of-pocket limit: Is there an annual limit on out-of-pocket costs in the Medicare Advantage plan and what counts toward it (see question 7)?

4. What are the costs associated with Original Medicare and Medicare Advantage?
In Original Medicare, you will have standard Part A and Part B costs. These costs change annually. In 2025, these costs include:

- Part A monthly premium: The Part A monthly premium may be different depending on your work history. If you or your spouse has worked more than 10 years, you will generally not have to pay a Part A premium. If you have worked between 7.5 and 10 years, your Part A premium will be $285/month. If you have worked less than 7.5 years, your Part A premium will be $518/month.
- Part B monthly premium: The monthly Part B premium is $185 for people with a yearly income equal to or below $106,000 (or $212,000 for a married couple). If your income is higher than that, you may have to pay more. This is known as an income-related monthly adjustment amount (IRMAA). IRMMA is an amount you pay in addition to your Part B premium if your income is over a certain level.
- Part A deductible and coinsurance:
  - The hospital deductible (the amount you have to pay before Medicare begins covering your costs) is $1,676 per benefit period.
  - The hospital coinsurance is $0/day for days 1-60 of a hospital stay after meeting your deductible. The coinsurance is $419/day for days 61-90 and $838/day for days 91-150.
  - The skilled nursing facility (SNF) coinsurance is $0 for the first 20 days after a qualifying inpatient hospital stay, and the coinsurance for days 21-100 is $209.50/day.
- Part B deductible and coinsurance: In Original Medicare, you will pay a Part B deductible (the amount you have to pay before Medicare begins covering your costs) of $257 in 2025. There is a coinsurance of 20% for most services that are covered by Part B.

Keep in mind that if you have a Medigap (see question 2), it can pay some of the Original Medicare out-of-pocket costs. The plans are lettered (A, B, C, and so on) and the letters indicate which out-of-pocket costs are paid (or covered).

If you have a Medicare Advantage plan, you will be responsible for paying:

- Part A monthly premium, if you have one (see above).
- Part B monthly premium (see above).
- A Medicare Advantage plan monthly premium, in many plans. The amount of this premium can vary widely.
- Medicare Advantage plan deductible: Your Medicare Advantage plan might have a deductible—an amount you are responsible for paying out of pocket before your plan will begin to cover your services.
- Copayments and coinsurances: The cost-sharing for Medicare Advantage-covered services can vary from plan. Contact your plan to learn more about the cost-sharing you'll be responsible for.

If you have a Medicare Advantage plan, your plan has an out-of-pocket limit (see question 7).

5. What kind of providers do I need to see if I have Original Medicare vs. if I have Medicare Advantage?
If you have Original Medicare, you can see any provider who accepts Original Medicare payment. Once you have met your deductible, your Part B costs can vary depending on the type of provider you see. There are three kinds of agreements that Part B providers can have with Medicare about how they will be reimbursed for services they provide to Medicare beneficiaries. To pay the least for services, see a participating provider when possible.

- **Participating providers** accept Medicare and always take Medicare assignment. Taking assignment means that the provider accepts Medicare's approved amount for health care services as full payment. These providers are required to bill Medicare for care you receive. Medicare will process the bill and pay your provider directly for your care. If you see a participating provider, you are responsible for paying a 20% coinsurance for most Medicare-covered services.
- **Non-participating providers** accept Medicare but do not agree to take assignment in all cases. They may do so only on a case-by-case basis. Non-participating providers can charge up to 15% more than Medicare's approved amount for the cost of services you receive. This is known as the limiting charge. This means you could be responsible for up to 35% of Medicare's approved amount for covered services instead of 20%.
- **Opt-out providers** do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. Medicare will not pay for care you receive from an opt-out provider except in emergencies. These providers can charge whatever they want for services, but they must follow certain rules to do so. An opt-out provider must give you a private contract describing their charges and confirming that you understand you are responsible for the full cost of your care and that Medicare will not reimburse you.

You can find providers who accept Medicare payment and find out whether they are participating by calling 1-800-MEDICARE or by using Medicare's Physician Compare tool on www.medicare.gov.

If you have a Medicare Advantage plan, you may be restricted to a network of providers in order for the plan to cover your care at the lowest out-of-pocket cost. Each type of Medicare Advantage plan has different network rules. A network consists of pharmacies, doctors, hospitals, and medical facilities that contract with a plan to provide services. There are various ways a plan may manage your access to specialists or out-of-network providers. Remember that your costs are typically lowest when you use in-network providers and facilities, regardless of your plan.

Your Medicare Advantage plan is required to cover emergency and urgent care anywhere in the U.S. without imposing additional costs or coverage rules (such as prior authorization). This means that if you seek emergency care from an out-of-network provider, your Medicare Advantage plan must cover the care as if you had gone to an in-network provider. Medicare Advantage plans define an emergency by the prudent person standard. Prudent means acting with care or thought about the future. This standard ensures that even if your condition turns out not to be a medical emergency, it will still be covered as long as a prudent person would have assumed it was an emergency at the time you got care.

It is important to know that not all Medicare Advantage plans—even plans of the same type—work the same way. Make sure you understand a plan's network and coverage rules before enrolling. If you have questions, contact your plan for more information.

This table provides a general overview of provider access rules for HMOs, PPOs, and PFFS plans:

	HMO	PPO	PFFS
Do I need to get a referral before I can see an in-network specialist?	Yes, usually	No	Yes
Will the plan pay for care from a doctor or hospital that is not in the plan's network?	No, unless you need urgent or emergency care or if you have a Point of Service (POS) option that allows you to use out-of-network providers	Yes, but you will pay more, unless it is an emergency	Yes, but you will usually pay more and the provider must agree to treat you, unless it is an emergency

Note: This chart does not include SNPs or Medicare MSA plans. A SNP is a managed care plan that serves people with special needs. In an MSA plan, you can go to any doctor or hospital who accepts Medicare and is willing to accept the plan's fees. If you are considering joining a SNP or an MSA, ask about that specific plan's network rules.

6. What are Medicare Advantage (MA) supplemental benefits?

A Medicare Advantage supplemental benefit is an item or service not covered by Original Medicare. These items or services do not need to be provided by Medicare providers or at Medicare-certified facilities. To receive them, you just need to follow your plan's rules. There are different types of MA supplemental benefits you may receive, like:

- Commonly offered primarily health-related benefits include dental care, vision care, hearing aids, and gym memberships. These Medicare Advantage supplemental benefits can be available with no additional premium. However, some Medicare Advantage supplemental benefits are optional and require paying an additional premium. This is often the case for dental and vision benefits.
- Less commonly offered are non-primarily health-related Medicare Advantage supplemental benefits for beneficiaries who have chronic illnesses. These benefits address environmental factors that may affect the health, functioning, quality of life, and levels of risk. Examples of these benefits are meal delivery, transportation for non-medical needs, and home air cleaners. You are considered chronically ill if you:

    - Have at least one medically complex chronic condition that is life-threatening or significantly limits your health or function,
    - Have a high risk of hospitalization or other negative health outcomes, and
    - Require intensive care coordination.

    If you meet these criteria, a Medicare Advantage plan may offer you one of these benefits if it has a reasonable expectation of improving or maintaining your health or function. Medicare Advantage plans can create sets of Medicare Advantage supplemental benefits to meet your needs. Your set of Medicare Advantage supplemental benefits may be different from another person in the same Medicare Advantage plan. For example, a plan might cover services like home air cleaning and

carpet shampooing if you have severe asthma. Whil you may be able to get that service covered, a person whose asthma is mild, would not.

In some cases, there may be no Medicare Advantage plan in your area that covers the Medicare Advantage supplemental benefits that you need.

7. What is the maximum out-of-pocket limit?
All Medicare Advantage plans must set an annual limit on your out-of-pocket costs, known as the maximum out-of-pocket (MOOP). This limit is high, but it may protect you from excessive costs if you need a lot of care or expensive treatments. After reaching your MOOP, you will not owe cost-sharing for Part A or Part B covered services for the remainder of the year. Some plans may also apply the MOOP to supplemental benefits, such as vision, hearing, or dental.

The out-of-pocket costs that help you reach your MOOP include all cost-sharing (deductibles, coinsurance, and copayments) for Part A and Part B covered services that you receive from in-network providers. Part D cost-sharing does not count towards your plan's MOOP.

In 2025, the MOOP for Medicare Advantage plans is $9,350, but plans may set lower limits. If you are in a plan that covers services you receive from out-of-network providers, such as a PPO, your plan will set two annual limits on your out-of-pocket costs. One limit is for in-network costs and the other is for combined in-network and out-of-network costs.

Call your plan directly if you have questions about your annual out-of-pocket limit.

8. How can I protect myself from misleading marketing?
Health insurance companies try to reach people in various ways, like television commercials, radio ads, events, mailings, phone calls, and texts. The Centers for Medicare & Medicaid Services (CMS) has rules for marketing Medicare Advantage plans and Part D plans. These rules protect Medicare beneficiaries from aggressive or misleading marketing.

Before you enroll in a plan, make sure you understand what the plan covers, how it affects your Medicare benefits and other health benefits (like Medicaid or your retiree/union coverage), and whether it covers the drugs you need. Contact a plan directly to confirm if it will cover certain services for you, and make sure that you get everything in writing.

Remember that an agent or broker should never pressure or mislead you into joining a plan. They should also never offer gifts to sign up or say they were sent by Medicare or Social Security. If you feel an agent has pressured or misled you, save all the information such as an agent's business card, messages, marketing handouts, or other contact information. You should report this to your local Senior Medicare Patrol (SMP) or State Health Insurance Assistance Program (SHIP) and they can help you review the concern and report it to CMS as a potential marketing violation. Contact information for your local SMP and SHIP are on the last page of this document.

Your local SHIP can also help you seek a Special Enrollment Period (SEP) to switch plans if you are misled into a plan that does not cover the services you need.

9. Where can I find alternative coverage for services that Original Medicare does not cover?

- Medicaid: Medicaid is a federal and state program that provides health coverage for certain people with limited income and assets. In some states, Medicaid covers services that are not covered by Medicare, including dental, vision, long-term care, and transportation. A state may also have a Medicaid waiver program that covers additional services, too. To learn more about your state's Medicaid program, contact your local State Health Insurance Assistance Program (SHIP). Contact information for your local SHIP is on the last page of this document.
- Reduced-cost or free clinics: You may be able to access the services you need through a free or reduced-cost clinic in your area. Use resources available at needymeds.org, healthcare.gov, freeclinics.com, and hhs.gov for more information.
- Donated dental service programs or dental schools: Donated dental services programs operate in some states. Dentists in these programs offer free dental services if you qualify. You may also be able to get low-cost dental care at a dental school, where dental students work with patients under the supervision of experienced, licensed dentists.
- Administration for Community Living (ACL) Eldercare Locator: Visit eldercare.acl.gov to learn about other resources in your community, such as long-term care and legal aid.

10. Who should I contact with questions?

State Health Insurance Assistance Program (SHIP): Contact your local SHIP to further discuss the differences between Original Medicare and Medicare Advantage and which may be a better fit for you. SHIP counselors provide unbiased Medicare counseling and assistance. Contact information for your SHIP is on the last page of this document.

Senior Medicare Patrol (SMP): Contact your SMP if you have experienced potential Medicare fraud, errors, or abuse, or misleading marketing. Contact information for your local SMP is on the last page of this document.

Medicare: Call 1-800-MEDICARE or use the Physician Compare tool on Medicare.gov to learn which doctors participate in Medicare. You can also call or use the website's Plan Finder tool to compare Medicare Advantage and Part D plans.

Medigap: After you make your Medigap policy selection, you will need to contact the insurance company directly to enroll. Ask questions and be sure to confirm all information in writing, such as the name of the Medigap policy and its effective date.

SHIP case study

Donna is turning 65 and becoming eligible for Medicare. She has heard a lot about her options and seen ads on TV for some plans, but she wants to make an informed decision. She has free, creditable drug coverage through her retiree plan, so she does not want Part D. She wants to be able to see doctors in Ohio, where she lives, and in New Mexico, where she visits her daughter's family for several months per year. She sees many providers, and she would like to limit how much she pays every time she sees one.

What should Donna do?

- Donna should call her State Health Insurance Assistance Program (SHIP) for help comparing her Medicare coverage options.
    - If Donna doesn't know how to contact her SHIP, she can call 877-839-2675 or visit www.shiphelp.org.
- The SHIP counselor can help Donna consider her options, which include getting Original Medicare with or without a Medigap and choosing a Medicare Advantage plan.
    - Since Donna prioritizes seeing multiple providers in different places, the SHIP counselor can explain that this might be easiest to do with Original Medicare, which would allow her to see any doctor in any part of the country, as long as they accept Medicare payment.
    - If Donna chooses a Medicare Advantage plan, she will likely face denials and/or higher out-of-pocket costs if she sees doctors outside that plan's network.
- Since Donna is trying to limit her out-of-pocket costs, the SHIP counselor can help her understand her options.
    - If she is considering Medicare Advantage plans, she should learn what their deductibles, copays, and coinsurances are. She should also find out about the plans' out-of-pocket limits.
    - If Donna is considering Original Medicare, the SHIP counselor should also provide her with information about choosing and purchasing a Medigap policy, which can limit her out-of-pocket costs.
- The SHIP counselor can also tell Donna about Medicare Advantage supplemental benefits like dental, vision, and hearing benefits.
    - If Donna is considering a Medicare Advantage plan, she can ask if the plan covers any of these benefits and, if so, what the costs and restrictions related to this coverage are.
    - If Donna would prefer to enroll in Original Medicare, or if there are no Medicare Advantage plans that cover the supplemental benefits she is looking for, the SHIP counselor can provide her with resources about where and how to access these types of services and benefits outside of a Medicare Advantage plan.

SMP case study

Luis was thinking of switching to a Medicare Advantage plan. He had one specific plan in mind. He was especially interested in joining this plan because of its dental coverage and reimbursement for gym membership. He called the plan to see if it covered his medications and visits with his doctors. The plan representative confirmed that all four of his regular doctors were in the plan's network, and it covered all his medications, too. Luis was very excited! He eagerly enrolled in the Medicare Advantage plan.

A couple of months later, after Luis had been officially enrolled, he went to the pharmacy to fill his prescriptions. The pharmacist informed him his new Medicare Advantage plan would not cover one of the medications. Another medication might be covered, but Luis has to go to his doctor and try a generic version first. When Luis called his doctor's office and they asked for his new insurance information, they told him his doctor is out of the plan's network and has been for years. They'll give him a sample of his medications in the meantime, but he'll need to find a solution by next month. Luis doesn't know how this all could have happened and how to fix it.

What should Luis do?

- Luis should contact his local Senior Medicare Patrol (SMP).

- The SMP team member may ask Luis if he has any information or messages from his conversation(s) with the Medicare Advantage plan representative.
    - If so, they should collect it all. This may include communications like emails, texts, voicemails, or date/time of their call.
    - If not, they may try to get other information about the call like the representative's name, phone number, or date/time of their phone call.
    - The SMP team member can encourage Luis to always keep records and ask for information in writing after phone calls with plan representatives. He could also use a My Health Care Tracker or the SMP Medicare Tracker mobile app to take notes.
- The SMP can help Luis report the misleading marketing (the representative telling him the plan covered his doctors and medications when it did not) to CMS.
- The SMP can also refer Luis to his local SHIP for help requesting an SEP from Medicare so that he can switch plans or retroactively disenroll from this one.
    - Together, the SHIP and Luis can compare plans that cover his medications and include his doctor in the provider network. Luis should also confirm with his doctor's offices that they do take the plan he is about to enroll in.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: 800-247-4422 **SHIP email:** IdahoSHIBA@doi.idaho.gov **SHIP website:** https://doi.idaho.gov/SHIBA/ **To find a SHIP in another state:** Call 877-839-2675 and say "Medicare" when prompted or visit www.shiphelp.org.	**SMP toll-free:** **SMP email:** **SMP website:** **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

This document is supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $2,534,081 with 100 percent funding by ACL/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS, or the U.S. Government.

SHIP Technical Assistance Center: 877-839-2675 | www.shiphelp.org | info@shiptacenter.org
SMP Resource Center: 877-808-2468 | www.smpresource.org | info@smpresource.org