The difference between Original Medicare and Medicare Advantage

Who is this for?

If you're new to Medicare, this page will help you understand what you get from Medicare Advantage that you don't with Original Medicare.

You're probably familiar with Original Medicare. You may know that when you turn 65 you'll get certain health care benefits from the government. You might not know as much about Medicare Advantage.

Medicare Advantage got its start in 1995. The federal government created it as a way to give people more options. Private health insurance companies sell Medicare Advantage plans. The federal government regulates them.

Before we get into how Medicare Advantage is different from Original Medicare, let's look at how it's the same. All Medicare Advantage plans have to offer at least the same benefits as Medicare Parts A and B. That means if Original Medicare covers hospital care at a certain level, so will every Medicare Advantage plan on the market.

But the benefit of Medicare Advantage plans is that they offer more coverage than Original Medicare. Here are three key ways in which Medicare Advantage gives you more than Original Medicare:

Original Medicare vs. Medicare Advantage

Overview	Original Medicare	Medicare Advantage
Coverage	Covers medical and hospital costs only.	Many plans cover dental, vision, hearing and prescription drugs, in addition to medical and hospital costs.
Cost	No cap on what you pay out of pocket. Medicare only pays for a certain number of days in the hospital or in a skilled nursing facility.	Has an out-of-pocket maximum each year. Once you hit a certain dollar amount, your plan pays 100% of the cost for most services it covers.
Travel	Except in very rare cases, Medicare doesn't cover care you get when you're out of the country, even in an emergency.	May cover emergency care when you're out of the country.

More differences

There are a few other key differences between Medicare Advantage and Original Medicare:

Coinsurance vs. copay

With Original Medicare, you pay 20 percent of the cost, or 20 percent coinsurance, for common health services like office visits or outpatient surgery. Most Medicare Advantage plans use copays instead of coinsurance for these services. That means you pay a fixed cost.

For example, your Medicare Advantage plan might have a $15 copay when you see the doctor. That means you'll pay $15 every time you see the doctor, no matter how much the visit costs your health insurance company. If you have Original Medicare, you'll pay 20 percent of the total cost of the visit. If the visit costs $200, you pay $40.

Network

With Original Medicare, you can go to any doctor or facility that accepts Medicare. Medicare Advantage plans have fixed networks of doctors and hospitals. Your plan will have rules about whether or not you can get care outside your network. But with any plan, you'll pay more for care you get outside your network.

What do Medicare Parts A, B, C and D mean?

Who is this for?

If you're new to Medicare, this information will help you understand the different parts and what they do.

There are four parts of Medicare. Each one helps pay for different health care costs.

Part A helps pay for hospital and facility costs. This includes things like a shared hospital room, meals and nurse care. It can also help cover the cost of hospice, home health care and skilled nursing facilities.

Part B helps pay for medical costs. This is care that happens outside of a hospital. It includes things like doctor visits and outpatient procedures. It also covers some preventive care, like flu shots.

Parts A and B together are called Original Medicare. These two parts are run by the federal government.

Part C helps pay for hospital and medical costs, plus more. Part C plans are only available through private health insurance companies. They're called Medicare Advantage plans. They cover everything Parts A and B cover, plus more. They usually cover more of the costs you'd have to pay for out of pocket with Medicare Parts A and B. Part C plans put a limit on what you pay out of pocket in a given year, too. Some of these plans cover preventive dental, vision and hearing costs. Original Medicare doesn't.

Part D helps pay for prescription drugs. Part D plans are only available through private health insurance companies. They're called prescription drug plans. They cover commonly used brand-name and generic drugs. Some plans cover more drugs than others.

HMO, PPO: What do these acronyms mean?

Who is this for?

If you're new to Medicare, this information will help you understand some common terms.

If you've been shopping for Medicare Advantage plans, you've probably noticed a lot of acronyms. HMO and PPO – these signify different plan types.

We'll spell it out for you.

- HMO stands for health maintenance organization.
- PPO stands for preferred provider organization.

All these plans use a network of doctors and hospitals. The difference is how big those networks are and how you use them.

HMO plans

Navigating the health care industry on your own can be complicated. There are lots of doctors out there. And it's hard to know which ones will be the right fit for you. At times, you might feel like you're the only one advocating for your health. HMO plans help with that.

When you have an HMO plan, you choose a primary care physician who works as your partner. They coordinate all your care and refer you to trusted doctors and specialists in your network.

Here's an example of how an HMO plan works.

Alberto has an Advantage HMO. Last weekend, he helped his son move. Now his back hurts.

Because he has an HMO plan, he goes to see his primary care physician first. Alberto's primary care physician will help him if he can. If not, he'll refer him to a specialist in his network.

With an HMO plan, Alberto is able to develop a relationship with his primary care physician. He doesn't have to search for doctors on his own. He knows his primary care physician will refer him to other doctors he trusts.

Another thing to know about HMO plans is that most health care isn't covered outside your network. That means if you're traveling outside your coverage area, we'll only cover emergency or urgent care in most cases.

You have to live in Michigan for at least six months out of the year to get one of our HMO plans.

PPO plans

PPO plans have more flexibility than HMO plans. You don’t need a primary care physician, and you can go to a specialist directly. You don’t need referrals. You can see doctors inside or outside your network. But if you stay in your network, you’ll pay less.

Here's an example of how a PPO plan works.

Grace has a PPO plan. She's been having some pain in her wrist and thinks it might be related to her osteoporosis. Because she has a PPO plan, she can go see her rheumatologist to get it checked out. She doesn't need a referral.

Which one is right for me?

If you want low monthly premiums and copays and you don’t travel much, an HMO plan might be right for you.

If you want to be able to coordinate your own health care and see specialists without a referral, a PPO plan might be right for you.

Many Medicare Advantage plans help cover emergency care outside the U.S.

How do copays, coinsurance and deductibles work with Medicare plans?

Who is this for?

If you're shopping for Medicare, this page will help you understand some common terms you might come across while you're researching.

Copays, coinsurance and deductibles are all terms to describe money you pay toward health care services and prescription drugs when you have a health insurance plan.

Copays and coinsurance

A copay is a fixed amount of money you pay for a certain service. Your health insurance plan pays the rest of the cost. Coinsurance refers to percentages.

Our Medicare Advantage plans use copays for most services. You pay 20 percent coinsurance for most services with Original Medicare.

Here's an example of how copays and coinsurance work with a Medicare Advantage plan.

Miriam has a HMO plan. This year, she gets knee replacement surgery.

The total bill for the surgery is $30,000. With her plan, she pays a copay of $115 per day for the first six days in the hospital. She stays in the hospital for three days. So she pays $345. Her plan pays for the rest of her hospital costs.

Miriam will also need crutches to get around while her knee heals. Crutches are considered durable medical equipment. With her plan, Miriam pays 20 percent coinsurance for durable medical equipment. That means she pays 20 percent of the cost. The crutches cost $40, so she pays $8. Her plan pays the rest.

There are probably other costs associated with a knee replacement surgery that we won't go over in this example. But this should give you a good idea of how copays and coinsurance work.

Deductible

A deductible is the amount of money you pay for health care services before your plan kicks in and starts paying. For most services, you'll pay full cost until you reach the deductible. After you reach your deductible, you'll still have to pay any copays or coinsurance. Some services will be covered by your plan before you reach the deductible.

Here's an example of how a deductible works.

Grace has Medicare Advantage PPO plan . This plan has a $160 deductible. Her plan year starts in January with the deductible intact. That month, she sees her primary care physician for a wellness exam. It's her annual preventive physical.

Preventive care is covered by her plan with no copay or deductible, so she pays nothing for the visit. That means her $160 deductible is still intact.

In May, she's out hiking when she falls and twists her ankle. So she goes to her primary care physician to get it checked out. The visit costs $160. Because she hasn't reached her deductible yet, she pays the full amount for the visit. Her doctor says she needs to use crutches until her ankle heals. Because she's now met her deductible, she pays 20 percent coinsurance for the crutches.

Most Medicare Advantage plans have separate medical and pharmacy deductibles. That means that in addition to the $160 medical deductible we used as an example above, you might also have a Part D prescription drug deductible that you'll need to meet before your plan starts covering your medications.

Original Medicare has its own deductibles. Which are much higher

Tip: A Medicare Part A benefit period starts when you first go into the hospital or other inpatient facility. It ends when you've been out of the hospital or facility for 60 days in a row. If you have a Medicare Advantage plan, you don't have to pay Original Medicare deductibles. But your plan might have its own deductible.

How copays, coinsurance and deductible work together

With a Medicare Advantage plan, we'll track all the costs you pay – deductible, copays and coinsurance. We pay for most covered services once you reach a certain amount. This is called the out-of-pocket maximum.

Original Medicare doesn't have an out-of-pocket maximum. There's no cap on what you pay out of pocket. And if you're in the hospital or a skilled nursing facility, Original Medicare only pays for a certain number of days. After that point, you pay the full amount each day.