Helping America's Seniors
—RESOURCES FOR YOUR NEXT CHAPTER—

Your Guide to the

Ins and Outs of Medicare



Your Medicare Plan Review Guide

2026 Edition

All premiums, deductibles, and coinsurance amounts reflect figures published by the Centers for Medicare & Medicaid Services for calendar year 2026.

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Determine What's Important

If you're having trouble deciding which Medicare program to choose for your health needs, you're not alone. There are a lot of options, and the process of evaluating what's available can often feel overwhelming. The best way to get started is by evaluating what kind of health coverage you need.

Do you need more than basic coverage?

While Original Medicare could be considered basic coverage, you should ask yourself if that's enough. Are you also looking for prescription drug coverage? Or perhaps you want coverage that helps with Medicare deductibles, copayments, and coinsurance.

What is your budget?

Plans that cover more than Original Medicare may have a monthly premium, though as you will learn, many Medicare Advantage plans have $0 premiums beyond what you already pay for Part B. In 2026, about three in four people enrolled in an individual Medicare Advantage plan with drug coverage pay no premium other than the standard Part B premium. If you know your budget before you get started, you can narrow down your options.

What are your retirement plans?

If you plan to travel or have a summer home, the best Medicare plan for you may be different than if you will stick mostly to one home area.

How often do you use care, and where?

Think about the doctors and hospitals you already use, the prescriptions you take, and how often you expect to need specialty care. Networks, referral rules, and prior authorization requirements differ meaningfully from one plan type to the next.

Choose the Plan Best Suited for Your Needs

If it were an easy choice, everyone would pick the same thing, and you wouldn't have to figure it out. Likely, you have friends and family on Medicare, and they may have each chosen something different.

If you have questions about how to get started, we'd love to help you understand your options. Call 844-790-7235, TTY: 711, Mon–Sun 8 am–9 pm to speak with a licensed insurance agent about what's available.

This guide will show you the different options and explain in easy-to-understand terms what you need to know to decide what best fits your needs.

Do I Need to Enroll in Medicare?

You may be wondering if you even need to enroll in Medicare.

Medicare is designed to be a benefit and is available to all Americans turning 65. It may also be available to those under 65 who have a qualifying disability. Most people choose to enroll in Medicare when they are first eligible, typically when they turn 65. However, no one will force you to enroll.

It's important to know that if you don't sign up when you're first eligible, you may have to wait to sign up and go months without coverage. You might also pay a monthly penalty for as long as you have Part B, and the penalty goes up the longer you wait to sign up. The Part B late enrollment penalty adds 10% to your monthly premium for each full 12-month period you could have had Part B but didn't.

Typically, you are first eligible to enroll in Medicare during your Initial Enrollment Period (IEP), which runs from three months prior to your 65th birthday month through three months after your birthday month. However, if you are covered under another creditable plan when you turn 65 — for example, if you are still working or covered under a spouse's active employer plan — you may be able to defer enrollment until you lose that coverage and use a Special Enrollment Period instead.



Original Medicare Components

Original Medicare is the combination of Medicare Part A and Part B. Each part covers different services. With Original Medicare, you'll be covered for any visit with a doctor who accepts Medicare anywhere in the U.S. There may be deductibles, copays, and coinsurance involved.

Medicare Part A Is Hospital Insurance

Medicare Part A has a $1,736 deductible per benefit period in 2026. Once the deductible is met, Medicare covers inpatient hospital stays up to 60 days requiring $0 coinsurance. A benefit period begins the day you are admitted and ends when you have been out of the hospital or a skilled nursing facility for 60 days in a row. If you are readmitted after a benefit period has ended, a new benefit period starts and another deductible applies.

From days 61–90, you'll be required to pay $434 per day in coinsurance in 2026. Beyond 90 days, Medicare will cover up to 60 lifetime reserve days, requiring $868 per day in coinsurance.

Part A also covers skilled nursing facility stays. For the first 20 days, Medicare covers the whole cost of staying at a skilled nursing facility. Then, each additional day through day 100 requires a $217 daily coinsurance in 2026, and starting at day 101, Medicare provides no coverage. Part A also covers hospice and limited home health care.

Medicare Part B Is Medical Insurance

Unlike Part A's deductible, which can apply with every new benefit period, the Part B deductible only needs to be met once a year. The deductible for Part B in 2026 is $283.

Part B covers outpatient doctor visits and doctor services at 80% of the Medicare-approved amount once you've met your deductible — you pay the remaining 20%. Part B also covers durable medical equipment at 80%. Many preventive services, such as annual wellness visits and most screenings, are covered at 100%.

PART A VERSUS PART B *WHAT IS THE DIFFERENCE?*	
Medicare Part A is Hospital Insurance	**Medicare Part B is Medical Insurance**
Covers inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care	Covers services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and many preventive services
MAY NOT COVER: Private rooms, private-duty nursing care, TV or phone in your room (if there is a separate charge), personal items, long-term custodial care	**MAY NOT COVER:** Routine dental care, eyeglasses, routine foot care, hearing aids, dentures
Included in Original Medicare	**Included in Original Medicare**

Original Medicare Premiums and Costs

Most individuals do not have to pay a premium for Part A because they or a spouse paid Medicare taxes for at least 40 quarters. That's why you should generally enroll in Part A as soon as you're eligible, even if you have other insurance — in most cases you won't pay a premium, but you could receive a benefit.

If you don't have enough work credits, you can buy into Part A. In 2026, that premium is $565 per month, or $311 per month for people with 30–39 quarters of coverage.

Part B requires a standard monthly premium of $202.90 in 2026, up from $185.00 in 2025. If you don't sign up for Medicare Part B when you're first eligible, and you don't qualify for a Special Enrollment Period, you'll pay a penalty based on how long you went without coverage in addition to the base premium.

Higher-Income Beneficiaries

If your modified adjusted gross income is above $109,000 for an individual or $218,000 for a married couple filing jointly, you'll pay an income-related monthly adjustment amount (IRMAA). In 2026, Part B premiums with IRMAA range from $284.10 to $689.90 per month, and Part D IRMAA surcharges range from $14.50 to $91.00 per month on top of your plan premium. About 8% of beneficiaries pay these adjusted amounts.

Annual Cost for Those with Original Medicare

In addition to your Part B monthly premium, it's important to understand that Original Medicare generally pays 80% of the Medicare-approved amount for Part B services, leaving you responsible for the other 20% — with no annual cap on what you can spend out of pocket. That's why most people choose to add a supplemental form of coverage, either a Medigap plan or a Medicare Advantage plan, which does have an out-of-pocket maximum.



We can help you sort through your options. Call 844-790-7235, TTY: 711, Mon–Sun 8 am–9 pm to speak with a licensed insurance agent to discuss the options that are right for you.

Medicare Savings Programs

Individuals who meet income and resource requirements may be eligible for assistance paying for Medicare premiums, deductibles, coinsurance, and copayments. These programs are offered through your state Medicaid program, and income and asset limits are updated each year.

Qualified Medicare Beneficiary (QMB) Program — Those who qualify will not be charged by Medicare for Part A premiums (if applicable) and Part B premiums, deductibles, coinsurance, or copayments for Medicare-covered services. They may receive a bill for a copayment for Part D prescriptions from Medicaid. QMB participants are not eligible for full Medicaid benefits.

Qualified Medicare Beneficiary Plus (QMB+) Program — Eligible individuals can receive full Medicaid benefits. This program is similar to the QMB program but offers a higher level of coverage.

Specified Low-Income Medicare Beneficiary (SLMB) Program — Those who qualify will not need to pay Part B premiums and will also receive assistance with prescription drug costs through the Part D Extra Help program. Participants pay cost-sharing for most medical services, as this program does not provide full Medicaid benefits.

Specified Low-Income Medicare Beneficiary Plus (SLMB+) — Qualifying individuals are not responsible for paying Part B premiums, and SLMB+ provides full Medicaid benefits. This program also offers limited assistance from state Medicaid agencies to cover cost-sharing. Services covered by both Medicaid and Medicare require 0% cost-share.

Qualifying Individual (QI) Program — Qualifying individuals are eligible to have Part B premiums covered. This program is offered on a first-come, first-served basis, and you must apply yearly. Therefore, not all who qualify will receive benefits. The state Medicaid office is not responsible for cost-sharing.

Qualified Disabled Working Individual (QDWI) Program — This savings program covers Part A premiums. Individuals must meet income and disability requirements. State Medicaid offices will not pay cost-sharing, and this program does not offer full Medicaid benefits.

Full Benefits Dual Eligible (FBDE) Program — Individuals who qualify for this program are eligible for full Medicaid benefits and may receive limited assistance from Medicaid for Medicare cost-sharing.

Enrollment in any Medicare Savings Program automatically qualifies you for Extra Help, which lowers Part D premiums, deductibles, and copays.

These savings programs are administered by each state. To apply, contact your state Medicaid program.

WHEN DOES COVERAGE START?	
If You Qualify for Premium-Free Part A	Your coverage starts on the 1st of the month you turn 65. If your birthday is the first of the month, your coverage starts the month before you turn 65.
Part B (and Premium Part A)	Coverage starts based on the month you sign up.
If You Sign Up Before the Month You Turn 65	Coverage starts the month you turn 65.
The Month You Turn 65, or During the Three Months After	Coverage starts the first day of the month after you sign up.
General Enrollment Period (January 1 – March 31)	Coverage starts the first day of the month after you sign up.

YOUR MEDICARE COVERAGE STARTS BASED ON YOUR SIGN-UP PERIOD AND WHEN YOU SIGN UP

Initial Enrollment Period: Your first chance to sign up. This is often when you turn 65, and it lasts for 7 months. It begins 3 months before the month you turn 65 and ends 3 months after the month you turn 65.

What Is the Initial Enrollment Period (IEP)?

The Initial Enrollment Period (IEP) starts on the first day of the month three months before the month of your birth. The day of your birth has no bearing on your enrollment period. For example, someone born on January 1 will have the same enrollment period as someone born on January 31.

To determine when your enrollment eligibility starts, go to the first of the month three months before your month of birth. If your birthday is in January, initial enrollment starts on October 1. If your birthday is in June, your initial enrollment starts on March 1.

This initial period extends three months past your birth month. So those born in January can enroll until April 30, and those born in June can enroll until September 30.

This period gives everyone seven months to enroll, so there's no need to panic as your 65th birthday approaches. You have several months to work through your options. Keep in mind that signing up during or after your birthday month delays the start of your coverage — coverage begins the first day of the month after you enroll — so enrolling early avoids a gap.

What Is the Annual Enrollment Period (AEP)?

Each year from October 15 until December 7, Medicare open enrollment occurs. This period is often referred to as the Annual Enrollment Period, or AEP. During this period, you can switch your current Medicare Advantage plan or your Part D plan for any reason. You can also choose to enroll in a Medicare Advantage plan for the first time if you are currently on Original Medicare, or drop a Medigap plan and enroll in a Medicare Advantage plan. When you change your plan during the Annual Enrollment Period, your new coverage starts on January 1.

AEP is worth using even if you are happy with your plan. Plans change their premiums, formularies, provider networks, and cost-sharing every year, and your plan's Annual Notice of Change (mailed each fall) explains what will be different in January.

If you're getting ready to enroll in Medicare or considering switching plans, we can help you understand your options. Call 844-790-7235, TTY: 711, Mon–Sun 8 am–9 pm to speak with a knowledgeable licensed insurance agent.

What Is the Open Enrollment Period (OEP)?

The Medicare Advantage Open Enrollment Period (OEP) is similar to the Annual Enrollment Period, but you must already be enrolled in a Medicare Advantage plan to use it. During OEP, you can make a one-time change to a different Medicare Advantage plan, switch prescription drug coverage as part of that change, or drop Medicare Advantage, return to Original Medicare, and enroll in a stand-alone Part D plan. Medicare Advantage Open Enrollment runs from January 1 through March 31 each year.

Note that switching back to Original Medicare during OEP does not guarantee you a Medigap policy. Outside of your Medigap open enrollment window or a guaranteed-issue situation, insurers in most states can use medical underwriting.

Now that we've discussed enrollment options, let's talk about what Medicare options you have. There are two main classifications: Original Medicare and Medicare Advantage.



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AEP VERSUS OEP *WHAT IS THE DIFFERENCE?*		
	AEP	**OEP**
WHEN?	The Medicare Annual Enrollment Period begins October 15 and ends December 7	The Medicare Advantage Open Enrollment Period begins January 1 and ends March 31
WHAT?	**During this time, you may:** • Switch from Medicare Advantage to Original Medicare (and vice versa) • Switch from one Medicare Advantage plan to a different one • Swap from an MA plan without prescription drug coverage to a plan with it (and vice versa) • Switch prescription drug plans • Switch to a totally new plan with a different carrier	**During this time, you may:** • Change Medicare Advantage plans • Switch from Medicare Advantage to Original Medicare and add a Part D plan **During this time, you may NOT:** • Join a stand-alone Part D plan if you are staying on Original Medicare without having left an MA plan • Switch from Original Medicare to Medicare Advantage
HOW MANY?	You may make multiple changes to your Medicare Advantage or Part D coverage during this time	You may make only one change to your Medicare Advantage coverage during this time
WHAT ELSE?	Changes made to your coverage become active on January 1 of the following year	Changes made to your coverage become active the first of the month after the plan receives your request

What Is a Special Enrollment Period (SEP)?

Special Enrollment Periods (SEPs) are times when individuals can sign up for Medicare or change plans outside the Annual Enrollment Period, if your circumstance meets the criteria. Examples include:

- You move. This can include moving into or out of an assisted living or skilled nursing facility, moving outside your plan's coverage area, or moving within your coverage area to a place where new options are available.
- You lose your health coverage. If you had Medicaid and are no longer eligible, or if your employer, retiree, or COBRA coverage ends, you could be eligible for a Special Enrollment Period.
- You're eligible for another type of health coverage.
- Your Medicare plan provider changes or terminates its contract with Medicare.
- You qualify for Extra Help or a Medicare Savings Program, or your eligibility for one of them changes.
- You experience an exceptional circumstance, such as a FEMA-declared emergency or disaster in your area, or you were given incorrect information by a plan or federal employee.

Several other situations qualify you for special enrollment. If you experience a major life change, you should evaluate your eligibility for a Special Enrollment Period.



Medicare Advantage

Medicare Advantage is also called Medicare Part C. Medicare Advantage policies are an alternative to Original Medicare. They're offered by private insurance companies but must cover at least the same benefits as Original Medicare. Most Medicare Advantage plans include Part D coverage. So, if you choose a Medicare Advantage plan that includes prescription drug coverage, you don't need to purchase a separate Part D policy. Every Medicare Advantage plan must include an annual out-of-pocket maximum for Part A and Part B services. In 2026, that limit cannot exceed $9,250 for in-network care, or $13,900 for in-network and out-of-network care combined, and many plans set lower limits. Part D drug spending is capped separately. In 2026, the average Medicare beneficiary can choose from about 32 Medicare Advantage plans with prescription drug coverage, and more than half of eligible beneficiaries — roughly 55%, or about 35 million people — are enrolled in one.

Types of Medicare Advantage Plans

There are four main types of Medicare Advantage plans, and this is where many people can start to feel confused. You don't need to worry, though, because we'll help you work through the differences in a way you can understand and act on:

- Health Maintenance Organization (HMO) Plans
- Preferred Provider Organization (PPO) Plans
- Private Fee-For-Service (PFFS) Plans
- Special Needs Plans (SNPs)

MEDICARE ADVANTAGE PLANS	
HMO — Health Maintenance Organization	• See only in-network providers • May cover additional services including vision, hearing, and dental • In most cases, the plan provides prescription drug coverage • Usually requires a primary care physician and referrals for specialists • Must have Parts A and B
PPO — Preferred Provider Organization	• See any provider, but you may pay more out of network • May cover additional services including vision, hearing, and dental • In most cases, the plan provides prescription drug coverage • No referral usually required to see a specialist • Must have Parts A and B
PFFS — Private Fee for Service	• See any provider who accepts the plan's payment terms • May cover additional services including vision, hearing, and dental • Not required to select a primary care provider • Must have Parts A and B
SNP — Special Needs Plans	• For individuals with specific chronic conditions, institutional needs, or dual Medicare–Medicaid eligibility • Provider choices, benefits, and drug formularies are tailored to the population served • Now cover nearly one in four Medicare Advantage enrollees • Must have Parts A and B

HMO Plans and What They Cover

An HMO plan provides coverage for doctors and hospitals within a network. You don't have the freedom to choose whatever hospital or doctor you want. However, if your established primary care physician and hospital are already in the HMO, you can easily transition to a Medicare Advantage HMO plan.

Generally, the only types of care covered by out-of-network hospital systems or physicians are emergency care, urgent care, and temporary dialysis.

An HMO plan is best for individuals who do not travel and have a good network of participating doctors and specialists in their region.

PPO Plans, Networks, and Coverage

As with an HMO, a PPO will have an organization of in-network providers. The difference is that PPO plans will cover other out-of-network hospitals and physicians who accept Medicare, though the coverage will be better with those in the network.

You can choose any hospital or specialist you want with a PPO, but you'll pay less if you choose an in-network provider or hospital.

PFFS Plans and Coverage

These plans do not require the policyholder to have a primary care physician, so individuals with a PFFS plan do not need a referral to see a specialist. Depending on the plan, there may or may not be coverage for out-of-network providers, and providers can decide at each visit whether to accept the plan's terms.

PFFS plans tend to be more expensive and less popular than HMO and PPO plans. Most individuals who choose a Medicare Advantage plan opt for an HMO or PPO.

Special Needs Plans (SNP)

Special Needs Plans are designed for specific situations: chronic or disabling conditions, beneficiaries in institutional care, or beneficiaries who qualify for some form of Medicaid from their state. The typical person eligible for Medicare isn't eligible for an SNP. If you become eligible, you can switch to an available SNP at that time. SNPs have driven most of the recent growth in Medicare Advantage and now account for roughly 23% of all Medicare Advantage enrollment.

A Note on Prior Authorization

Medicare Advantage plans commonly require prior authorization for services such as inpatient stays, skilled nursing care, and imaging. Original Medicare generally does not, though a limited pilot program is testing prior authorization for a small set of outpatient services in a handful of states. If you take frequent or high-cost services, it's worth checking a plan's prior authorization rules before enrolling.

Medicare Part D

You may have realized that Original Medicare doesn't cover most prescription drugs. That's where Medicare Part D comes in. You can enroll in a prescription drug plan when you enroll in Medicare.

You don't have to enroll in a Part D plan. But if you don't enroll during your initial enrollment, you are not receiving creditable coverage under another health plan, and you go 63 days or more without coverage, you'll pay a permanent late enrollment penalty when you do enroll. The penalty is 1% of the national base beneficiary premium ($38.99 in 2026) for each full month you went without coverage, added to your monthly premium for as long as you have Part D. Because of this penalty, most people sign up for drug coverage upon initial enrollment.

The Part D Out-of-Pocket Cap

Part D now includes a hard annual cap on what you pay out of pocket for covered prescription drugs. In 2026, that cap is $2,100. Once your out-of-pocket drug spending reaches the cap, you pay nothing more for covered drugs for the rest of the calendar year.

Spreading Your Drug Costs Across the Year

The Medicare Prescription Payment Plan lets you spread your out-of-pocket drug costs into capped monthly payments over the course of the year rather than paying large amounts at the pharmacy counter. Participation is voluntary and doesn't change what you owe overall — only when you pay it. It tends to help most if you have high drug costs early in the year.

Plan Availability

The stand-alone drug plan market has consolidated. In 2026, 360 stand-alone Part D plans are offered nationwide, down about 22% from 2025, and beneficiaries in each state can choose among roughly 8 to 12 plans. Comparing plans each fall matters more than it used to, because a plan you liked last year may no longer be offered or may have changed its formulary or premium.

Medicare Supplement Insurance (Medigap)

Many people on Original Medicare purchase a supplemental insurance plan called a Medicare Supplement plan, also known as a Medigap plan. Note that a Medicare beneficiary cannot have both a Medigap plan and a Medicare Advantage plan at the same time.

What Is Medigap?

Medigap is a supplemental policy. As the "gap" in its name implies, this supplemental coverage fills some of the gaps in Original Medicare coverage. When you choose a Medigap plan, Medicare will cover its portion of the doctor and hospital bills. The Medigap plan will then cover deductibles, copays, and coinsurance according to the individual policy terms. Medigap plans are standardized by letter. Plan G's benefits are identical no matter which company sells it — only the price and the service differ. Plans C and F, which cover the Part B deductible, are no longer available to people who became eligible for Medicare on or after January 1, 2020. If you were eligible before that date, you may still be able to buy them. The chart on the following page shows what each standardized plan covers.



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MEDIGAP PLANS

COMPARISON CHART — 2026

FEATURES	PLAN A	PLAN B	PLAN C	PLAN D	PLAN F	PLAN G	PLAN K	PLAN L	PLAN M	PLAN N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayments	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility care coinsurance	✗	✗	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible	✗	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible	✗	✗	✓	✗	✓	✗	✗	✗	✗	✗
Part B excess charges	✗	✗	✗	✗	✓	✓	✗	✗	✗	✗
Foreign travel emergency (up to plan limits)	✗	✗	80%	80%	80%	80%	✗	✗	80%	80%
Out-of-pocket limit (2026)	N/A	N/A	N/A	N/A	N/A	N/A	$8,000	$4,000	N/A	N/A

*** For Plans K and L, after you meet your yearly out-of-pocket limit and your yearly Part B deductible, the Medigap plan pays 100% of covered services for the remainder of the calendar year. Plans C and F are available only to people who became eligible for Medicare before January 1, 2020. High-deductible versions of Plans F and G require you to pay $2,950 in 2026 before the policy begins to pay*

Medigap Costs

If you enroll in a Medigap plan, you will still have to pay your Part B premium, and then you'll pay an additional premium for your Medigap policy. The premium for Medigap will vary by the plan you select, the insurance company that issues it, and where you live. Generally, more coverage equates to higher premiums.

Since private insurers sell Medigap policies, you may find a significant difference in cost between companies even for identical coverage. Because the benefits are standardized by letter, comparing quotes for the same letter plan is a direct price comparison.

Medigap plans do not include prescription drug coverage, so most people who choose Medigap also purchase a stand-alone Part D plan and pay the premium associated with their choice.

Also consider how a carrier prices its policies over time — attained-age policies increase as you get older, issue-age policies are based on your age when you bought them, and community-rated policies charge everyone in an area the same. All three can increase with inflation and claims experience.

Everyone has different circumstances, making it a challenge to determine which options are best for you. Speaking with a knowledgeable licensed insurance agent can help. Call 844-790-7235, TTY: 711, Mon–Sun 8 am–9 pm to get the help you need.



Enrolling in Medigap

Unlike Medicare Advantage and Part D, there's no annual open enrollment period for Medigap — you can apply at any time of year. However, your one guaranteed window is the six-month Medigap open enrollment period that begins the month you are 65 or older and enrolled in Part B. During that window, insurers must sell you any plan they offer at their best available rate regardless of your health. If you apply outside that window and don't have a guaranteed-issue right, insurers in most states can charge higher premiums or decline coverage based on preexisting conditions.

Medigap Versus Medicare Advantage

Medigap and Medicare Advantage are not the same. While they may provide similar financial protection, they are alternatives, not companions. Medigap is supplemental coverage that works alongside Original Medicare, while Medicare Advantage is a private plan that replaces the way you receive your Original Medicare benefits and often includes additional coverage as well.

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Is Medicare Advantage Better Than Original Medicare?

This is the question everyone wants answered. The good news is that a Medicare Advantage plan, or Original Medicare paired with a Medigap and Part D plan, are both strong options — they just distribute cost and flexibility differently.

Medicare Advantage has become the more common choice: about 55% of eligible Medicare beneficiaries are enrolled in a Medicare Advantage plan in 2026, up from 19% in 2007, and the Congressional Budget Office projects that share will reach roughly 63% by 2034.

To speak with a licensed insurance agent about your Medicare needs, call 844-790-7235, TTY: 711, Mon–Sun 8 am–9 pm.

The Choice for Travelers

Medigap plans may be a better option for travelers because they don't use a preferred network. Medigap will pay for care covered by Original Medicare provided by any doctor or hospital that accepts Medicare, and Medigap plans don't require a referral from a primary care physician. Additionally, several Medigap plans cover 80% of emergency medical costs outside the U.S., up to plan limits.

Medicare Advantage or Medigap for Prescription Drugs, Vision, and Dental

Nearly all Medicare Advantage plans include coverage for prescription drugs, and the vast majority include some vision, dental, and hearing benefits. Medigap plans do not include any of these — you would add a separate Part D plan for drugs and, if you want them, stand-alone dental and vision policies.

Pre-approval for Medical Care

With Original Medicare and Medigap plans, you don't usually need hospital stays or procedures pre-approved. With Medicare Advantage, you typically must have those same treatments pre-approved to have them covered.

Your Local Network of Hospitals and Physicians

Individuals who live in metropolitan areas often have several hospital and physician options that participate in Medicare Advantage HMOs and PPOs. Those living in rural areas won't have as many options. Their local hospital may not be in-network, leaving them with limited coverage for many treatments they may receive there. For individuals without nearby participating providers, Medicare Advantage plans are often not the best option.

Predictability Versus Premium

A useful way to frame the decision: Medigap generally means a higher fixed monthly premium and very low, predictable costs when you use care. Medicare Advantage generally means a low or $0 premium with costs that arrive as copays and coinsurance when you use care, capped at the plan's annual out-of-pocket maximum — up to $9,250 in-network in 2026. Which is "cheaper" depends on how much care you use and how much variability you can absorb.

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MEDIGAP AND MEDICARE ADVANTAGE

Medicare Supplement (Medigap)	Medicare Advantage
The Pros • Fewer and more predictable out-of-pocket expenses • Access to any provider nationwide who accepts Medicare • No referrals or prior authorization in most cases • Foreign travel emergency coverage on several plans	**The Pros** • Extra coverage often included (vision, dental, hearing) • May have a $0 plan premium • Covers Part A, Part B, and usually Part D in one plan • Annual out-of-pocket maximum, capped at $9,250 in-network in 2026
The Cons • Higher monthly premiums • Ten standardized plans to compare • No prescription coverage included (add a Part D plan) • May require medical underwriting outside your open enrollment window	**The Cons** • Your preferred providers need to be in the plan network • Coverage while traveling may be limited • Prior authorization is common • Costs arrive as copays and coinsurance when you use care
Financial Protection Works with Original Medicare to cover most or all of your remaining Part A and Part B cost-sharing	**Offers Special Needs Plans** Tailored plans for people with chronic conditions, institutional care needs, or dual Medicare–Medicaid eligibility
Can I Have Both? No. You cannot have Medicare Advantage and a Medicare Supplement plan at the same time	**Can I Change My Plan?** Yes. You may change your Medicare Advantage plan each year during the Annual Enrollment Period without a health screen or medical underwriting, and once during the Medicare Advantage Open Enrollment Period

Frequently Asked Questions

Can you use Medigap with Medicare Advantage?

You cannot use both coverages. In fact, it's illegal for someone to sell you a Medigap policy if you have Medicare Advantage.

Can you switch back and forth between Original Medicare and Medicare Advantage?

You can switch from one to the other during the Annual Enrollment Period, during the Medicare Advantage Open Enrollment Period if you are leaving an MA plan, or if you qualify for a Special Enrollment Period. Keep in mind that returning to Original Medicare does not automatically guarantee you a Medigap policy.

Can you get the same Medigap plan after dropping it?

If you had Original Medicare with Medigap and switched to Medicare Advantage for the first time, you have a trial right: you can switch back to your Medigap plan within 12 months if you're unhappy with your Medicare Advantage plan. If your Medigap plan is no longer available, you can choose a new one.

Can you use Medicaid with Medicare?

If you're eligible for both Medicaid and Medicare, you can use Medicaid as supplemental coverage. Each state sets its own criteria for Medicaid eligibility, starting with income requirements. If you are eligible for Medicaid, services such as personal care and long-term nursing home care may be provided — services Medicare does not cover. For more information, contact the eligibility office in your state.

What's the difference between Medicare Advantage and Medigap?

Medicare Advantage plans are offered by private insurance companies, must meet coverage minimums, and must be approved by Medicare. They are intended to replace the way you receive coverage from Original Medicare. Medigap plans are also offered by private insurers, but they supplement Original Medicare — you must be enrolled in Original Medicare to buy one.

Is Medicare Advantage or Original Medicare with Medigap cheaper?

When you consider total cost, the two can be similar, and which one wins depends on how much care you use. Medicare Advantage typically costs less per month and more when you use services; Original Medicare with Medigap typically costs more per month and much less at the point of care. In 2026, about 55% of eligible beneficiaries are enrolled in Medicare Advantage, an indication of the growing popularity of Part C plans.

Is there a cap on what I pay for prescription drugs?

Yes. Whether your drug coverage comes through a stand-alone Part D plan or a Medicare Advantage plan with drug coverage, your out-of-pocket spending on covered prescriptions is capped at $2,100 in 2026.

Do I have to review my coverage every year?

You aren't required to, but it's a good idea. Premiums, formularies, networks, and cost-sharing change each January, and plans sometimes exit the market entirely. Reviewing your Annual Notice of Change each fall takes far less time than correcting a coverage surprise in the spring.

You probably still have questions that haven't been addressed. The good news is that we have licensed insurance agents ready to help. Give them a call today at 844-790-7235, TTY: 711, Mon–Sun 8 am–9 pm.



References

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Medicaid.gov — Medicare Savings Programs and Beneficiary Resources

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This guide is for general educational purposes only and is not insurance, tax, or legal advice. Plan availability, costs, and benefits vary by location and change annually. Confirm details with Medicare.gov or a licensed insurance agent before enrolling.