Medicare Plan Comparison Worksheet

Use this worksheet before comparing Original Medicare, Medicare Advantage, Part D, or Medigap options. Fill it out once, then verify every answer in current official plan documents.

Name: _____ **ZIP code:** _____ **Coverage year:** _____

1. Current coverage and timing

- ■ I have Medicare Part A. Effective date: _____
- ■ I have Medicare Part B. Effective date: _____
- ■ I have employer, union, retiree, COBRA, Medicaid, VA, TRICARE, or Marketplace coverage.
- ■ I confirmed how my other insurance coordinates with Medicare.
- ■ I confirmed the enrollment period and effective date for any change I am considering.

2. Prescriptions and pharmacies

List every medication, exact dose, quantity, and refill frequency. Add insulin, injections, inhalers, and specialty drugs.

Medication / dose	Quantity & frequency	Preferred pharmacy	Mail order?

3. Doctors, hospitals, and care needs

- Primary doctor and specialists are verified in the plan network for the coverage year.
- Preferred hospitals, laboratories, imaging centers, therapy providers, and suppliers are verified.
- I checked referral and prior-authorization requirements for care I expect to use.
- I checked dialysis, transplant, behavioral health, rehabilitation, and durable medical equipment needs.
- I asked providers directly, and I will also verify with the plan because directories can change.

Provider / facility	Specialty or service	Option A status	Option B status

4. Costs and financial risk

Compare estimated total annual cost, not premium alone. Include premiums, deductibles, copays, coinsurance, drug costs, and the medical out-of-pocket limit when applicable.

Question	Option A	Option B	Notes / verification
Monthly health-plan or Medigap premium			
Monthly Part D premium			
Medical deductible			
Drug deductible			
Estimated annual prescription cost			
Primary/specialist/hospital cost sharing			
Medical out-of-pocket limit			
Estimated total in a typical year			
Estimated total in a high-use year			

5. Travel, flexibility, and extra benefits

- ■ I need routine non-emergency care outside my local service area or spend part of the year elsewhere.
- ■ I checked urgent and emergency coverage while traveling in the U.S.
- ■ I checked coverage outside the U.S. and understand its limits.
- ■ I compared dental, vision, hearing, transportation, fitness, meal, and allowance benefits using official plan documents.
- ■ I understand benefit limits, eligible services, network rules, prior authorization, and expiration rules.

6. Final comparison

Question	Option A	Option B	Notes / verification
My doctors and hospitals are available			
All medications are covered			
Preferred pharmacies have favorable pricing			
Prior authorization fits my care needs			
Travel pattern is supported			
Cost in a typical year is acceptable			
Cost in a high-use year is acceptable			
Dental/vision/hearing needs are addressed			
Rules for changing coverage later are understood			

Preferred option: _____ **Planned effective date:** _____

Reason:

_____

Verify before enrolling

- ■ I used Medicare Plan Compare with my complete drug list and pharmacies.
- ■ I reviewed the plan Summary of Benefits, Evidence of Coverage, formulary, and provider directory.
- ■ I confirmed Medigap enrollment or guaranteed-issue rights before leaving existing coverage.
- ■ I saved confirmation numbers, application records, and effective-date notices.

Primary government sources

Helpful tools: https://www.medicare.gov/basics/get-started-with-medicare/using-medicare/helpful-tools
Coverage comparison:
https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage
Plan Compare: https://www.medicare.gov/plan-compare/

General educational information. Benefits, networks, formularies, costs, and enrollment rights vary by plan, location, year, and individual circumstances. Verify current information with Medicare, the plan, your State Insurance Department, or SHIP.