Understanding **Healthcare Plan Choices:**

Points to Consider When Preparing for Medicare Enrollment

(2021 Update for 2022 Open Enrollment)

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This brochure “Understanding Healthcare Plan Choices: Points to Consider When Preparing for Medicare Enrollment” provides an overview of important information to help you decide which type of Medicare plan is right for you. After you become eligible for Medicare, the Centers for Medicare and Medicaid Services (CMS) will mail you the “Medicare and You” handbook every year. You can find a copy of this handbook and other useful information at medicare.gov.

This brochure is designed to serve as a general reference tool to help you navigate the process of a choosing a healthcare plan. This is not an exhaustive or all-inclusive guide.

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Overview of Health Insurance Plans

Medicare is similar to private health insurance in many ways, but there are some important differences. After a brief comparison of Medicare and private insurance, this brochure will focus on points to consider as you make choices during Medicare Open Enrollment.

Medicare vs Private Health Insurance

Medicare

- Administered by the federal government
- Typically, only people 65 years and over are eligible
- Check with Medicare (medicare.gov) to find out if you are eligible

VS

Private Health Insurance

- Offered through an employer
- Purchased through the Health Insurance Marketplace *(Affordable Care Act)*
- Purchased through a third-party healthcare broker

Some individuals maintain their private insurance and enroll in Medicare. In this case, Medicare typically functions as primary payer and private insurance as secondary payer.

Points to Consider

Both Medicare and private health insurance have varying benefits and costs, which may change year to year. **When considering a new plan or reviewing your current plan, keep the following 6 points in mind.** They will be reviewed in more detail in later sections.

1. Premium cost
2. Deductible amount
3. Coinsurance or copayment amount
4. Out-of-pocket maximums
5. Formulary coverage (prescription medication)
6. In-network vs out-of-network coverage for providers and hospitals

Open Enrollment Dates

In the fall, Medicare plans and most private insurance plans offer an open enrollment period for the upcoming year. **A general guide is below, but be sure to verify these dates each year.**

Medicare	Private Health Insurance	Health Insurance Marketplace
Oct. 15 to Dec. 7, 2021 (plans start Jan. 1, 2022) Initial enrollment occurs year-round based on the enrollee's birthday	**Dates vary by plan** Employer-provided: Check with your Human Resources department Self-purchased: Check with your plan or insurance broker	**Nov. 1 to Dec. 15, 2021** (plans start Jan. 1, 2022)

Jan. 1 - Mar. 31, 2022 (only if enrolled in a Medicare Advantage Plan)
One coverage switch is permitted during this time period, either to a different Medicare Advantage Plan or to Original Medicare (along with a separate Medicare drug plan)

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The remaining pages of this document will focus on Medicare Open Enrollment. Much of the content will also apply when evaluating private insurance plans.

Comparing Medicare Plans

The Alphabet of Medicare Plans

The original Medicare Benefit was broken down into 2 parts: Part A - Hospital Insurance and Part B - Medical Insurance. Additional options, added to allow for more complete coverage and flexibility, include Part C - Medicare Advantage, Part D - Prescription Drug Coverage, and Medigap - Supplemental Insurance.

ORIGINAL MEDICARE

PART A HOSPITAL INSURANCE

- Part of original Medicare
- Covers inpatient hospital care and skilled nursing facility care
- Covers hospice care and limited home care
- In some cases, beneficiaries will not pay a premium for Part A

PART B MEDICAL INSURANCE

- Part of original Medicare
- Covers doctor visits, medically necessary services and supplies, preventive services, and other items and services
- Beneficiaries typically pay a premium to receive Part B coverage
- Covers a limited number of prescription drugs administered in a provider's office

PRESCRIPTION DRUG COVERAGE

PART D PRESCRIPTION DRUG COVERAGE

- Helps cover the cost of prescription drugs
- Usually purchased as a stand-alone prescription drug plan to use with Original Medicare Part A and Part B coverage

COMPREHENSIVE COVERAGE

PART C MEDICARE ADVANTAGE

- Bundled version of Part A, Part B, and usually Part D
- Run by private companies that contract with CMS to provide benefits
- Options to include vision, hearing, or dental benefits at an additional cost

MEDIGAP (MEDICARE SUPPLEMENTAL INSURANCE)

- Supplements Medicare Part A and Part B
- Can help pay costs that original Medicare Parts A and B do not cover
- Sold by private companies
- Some plans offer coverage for travel outside the US
- May not be used in combination with Medicare Advantage Plans (Part C)

Building a Medicare Plan to Fit Your Needs

You have the opportunity to set up your Medicare plan to fit your specific needs.

- **"Original" Medicare:** Includes Part A and Part B. Part D and/or supplemental coverage can be added separately
- **Medicare Advantage (also known as Part C):** Bundled version of Part A, Part B, and usually Part D. Vision, hearing, or dental benefits may also be included (additional cost)
  - Plans are run by private companies that contract with Medicare to provide benefits
  - **Note: Part C plans do not allow the use of Medigap supplemental policies (described on the next page)**

Comparing Medicare Plans (cont.)

Original Medicare, Medigap, and Medicare Advantage Comparison

Original Medicare		Medigap		Medicare Advantage
There is **no limit** on how much you pay out-of-pocket per year unless you have supplemental coverage.	**Out-of-pocket cost**	Helps pay some copayments, coinsurance, and deductibles that Original Medicare does not cover.		**Out-of-pocket costs depend on the plan selected;** be sure to investigate your total out-of-pocket costs before choosing a plan.
Covers medical services and supplies in hospitals, doctors' offices, and other healthcare settings.	**Coverage**	May pay for some services not covered by Original Medicare. Generally, **does not cover vision, dental,** or **hearing.**		Covers all of the services that Original Medicare covers. Plans may **offer additional benefits** such as **vision, hearing, or dental.**
You will **need to join a Medicare Prescription Drug Plan (Part D)** to get coverage.	**Prescription drugs**	Helps pay some copayments that Original Medicare does not cover.		Most Medicare Advantage Plans **include prescription drug coverage (Part D).**
You can **go to any provider that accepts Medicare.** You do not need a referral to see a specialist.	**Provider and hospital choice**	May help cover some costs for providers who do not accept Medicare.		In most cases, you will need to **use healthcare providers who participate in the plan's network.** You may pay more if you use providers outside of the plan's network. You may need a referral to see a specialist.

You cannot buy a Medigap policy if you are enrolled in a Medicare Advantage Plan.

Note: Medigap does not replace Medicare Parts A & B, but is purchased in addition to supplement the coverage.

You can use the Star Rating System to learn more about the quality of care that healthcare providers (and facilities) give their patients by using the Medicare Plan Finder at **medicare.gov/find-a-plan.** See page 8 for additional information.

Plans usually do not cover care outside of the US.

Comparing Medicare Plans (cont.)

Out-of-Pocket Payments

Many factors can impact the total amount you must pay out-of-pocket. Consider the following elements of cost when comparing your open enrollment opportunities:

Premium?

The **premium** is the amount beneficiaries pay each month for Medicare coverage.

Deductible?

The **deductible** is the amount beneficiaries must pay for health care or prescriptions before the health plan or other insurance begins to pay.

Coinsurance or copayment amounts?

Beneficiaries often have to pay a share of the cost of healthcare services:

- **Coinsurance** is usually a flat percentage (for example, 20%)
- **Copayment** is usually a set amount (for example, $10 for a prescription drug or $20 for a doctor's visit)

Out-of-pocket expenses?

Total out-of-pocket costs vary by plan. Some plans may have a yearly limit on what you pay out-of-pocket, but others may not.

Look Beyond the Premium

When choosing Medicare coverage each year, it is important to look beyond the monthly premium cost. Medicare plans vary greatly and many times choosing a plan with the lowest monthly premium does not necessarily mean you are choosing the least expensive plan.

Medicare Part D and Medicare Advantage plans tend to change the most from year to year, so evaluate these plans carefully before choosing. **A good habit to develop is to check your plan every year for needed coverage and benefits prior to enrollment/re-enrollment.**

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Comparing Medicare Plans (cont.)

Plan Coverage Restrictions

Restrictions on formulary (prescription medication) and care provider coverage can impact your choice of providers and potentially increase the amount you must pay. Consider the following as you review plans:

Formulary coverage and restrictions

Formulary coverage:

Does the plan cover the costs for your current medications?

Look to see if a particular medication has been moved to a different "tier" for the next plan year *(example: tier 2 to tier 4)*. Be sure to review this each year as changes in coverage each year may increase your out-of-pocket costs

Refill restrictions:

Are there restrictions on the amount of medication you can get per refill?

Prior authorization required:

Does the plan request additional information from your doctor before granting approval for the prescription? *This is sometimes called prior authorization but could also be stated as "request for additional information"*

Pharmacy restrictions:

Are you required to fill prescriptions at a specific in-network retail pharmacy or only by mail order pharmacy?

Copay Tiers

Every plan will encourage you to use the lowest-cost drug to treat your medical condition.

Tier 1: Generic	Tier 2: Preferred	Tier 3: Non-preferred	Tier 4: Specialty
$	$$	$$$	$$$$
The **least expensive drugs** your plan covers (usually generics and select brands)	**Brand name drugs** that have proven to be the most effective in their class	Drugs considered **non-preferred** as well as **preferred specialty drugs**	**The most expensive drugs** because they are classified as brand name, specialty, *and* non-preferred

Medicare Part D vs Part B Coverage for Medication

Medicare Part D is the payer for most prescription costs, but medications such as infusions and injections that are administered in the doctor's office are usually covered by Medicare Part B.

Part D Drugs

- Usually purchased from your pharmacy
- May be subject to a formulary preferred drug list and copay tiers

Part B Drugs

- May be shipped to you, a local pharmacy, or directly to your doctor's office
- Part B does not have a formulary or preferred drug list but does require an approval process

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Comparing Medicare Plans (cont.)

Care provider coverage and restrictions

Physician and hospital network coverage: Confirm that your current providers accept Medicare patients or are in-network (for a Medicare Advantage plan). Using healthcare providers and facilities that are out of the plan network may increase your out-of-pocket costs. *Plans may change the physicians and hospital networks that are covered year to year, so be sure to review this every year.*

Part D Cost of Prescriptions

The amount of money you spend at the pharmacy may change throughout the year as the total costs add up. The graphic below will help you understand minimum coverage required for a Part D plan.

DEDUCTIBLE	INITIAL COVERAGE PERIOD	COVERAGE GAP	CATASTROPHIC COVERAGE
	Your plan pays 75%	Your plan pays 0% but drug discounts apply	Your plan pays 95%
You pay 100%	You pay 25%		You pay 5%

Note: Medicare Part D plans may differ in costs and coverage. It is important to be sure that medications prescribed by your doctor are covered.

2022 Coverage Gap for Part D Beneficiaries

Beneficiaries enter the coverage gap after the beneficiary and plan have spent **$4,430** on covered drugs and exit at the catastrophic coverage amount, which is **$7,050.**

Coinsurance in the gap is different between brand-name prescriptions and generics.

- Brand-name prescription coinsurance is **25%; 95%** of the price (what the beneficiary pays plus the **70%** manufacturer discount) counts toward out-of-pocket costs to advance the beneficiary closer to the exit point of the coverage gap
- Generic prescription coinsurance is **25%.** This same **25%** is applied toward out-of-pocket costs

Example 1:
If a brand-name medication has a retail cost of **$100,** the beneficiary will pay **$25** for the formulary medication. In addition, **$95** is applied toward the out-of-pocket spending limit.

Example 2:
If a generic medication has a retail cost of **$100,** the beneficiary will pay **$25.** This **$25** will count toward the out-of-pocket spending limit.

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Comparing Medicare Plans (cont.)

Extra Help/Low-Income Subsidy (LIS)

Extra Help

The Extra Help/Low-Income Subsidy (LIS) program assists patients who meet certain financial criteria with paying Part D costs. In most cases, those who qualify receive reduced premiums, deductibles, and coinsurance amounts on their prescription drugs. For more information on this program, or to check your eligibility and apply, call **1-800-MEDICARE (1-800-633-4227) or visit medicare.gov.**

Researching a Plan

Star Rating System

Medicare uses a **5-star rating scale** to rate plans on quality and performance for the types of services they offer. A growing number of plans have achieved 4- and 5-star ratings in recent years, making it well worth the time to research these plans.

Plan Finder

Medicare's website offers a Plan Finder tool that can be used to sort and compare plans and that provides details on how plan ratings were achieved. The Plan Finder tool can be found at: **medicare.gov/find-a-plan/questions/home.aspx**

How to Enroll

It is recommended to complete enrollment online (medicare.gov) to create an official record of selections, or you can also do it by phone at 1-800-MEDICARE (1-800-633-4227). Having a record may be helpful if there are errors in enrollment and selections need to be updated. Enrollment in Medicare can only occur at certain times, but some people are automatically enrolled:

- **Initial enrollment:** You can first sign up for Part A and/or Part beginning 3 months before you turn 65 up until 3 months after you turn 65
- **Automatic enrollment:** You may automatically get Part A and Part B under certain circumstances:
  - If you are already getting benefits from Social Security or the Railroad Retirement Board (RRB), you will automatically get Part A and Part B starting the first day of the month you turn 65 (or the first day of the prior month if your birthday is on the first day of the month)
  - If you are under 65 and have a disability, you will automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months
  - If you have amyotrophic lateral sclerosis (ALS, also called Lou Gehrig's disease), you will get Part A and Part B automatically the month your Social Security disability benefits begin

Free Assistance Is Available

- The Medicare Rights Center can walk beneficiaries through the differences among traditional Medicare plans, Medicare Advantage plans, and prescription drug plans **(1-800-333-4114)**
- A local State Health Insurance Assistance Program (SHIP) can also offer personalized health insurance counseling at no cost to you **(shiptacenter.org)**
- Research and reach out to your local "office of the aging" for more information on local assistance programs

Evaluating Medicare Plans

Factors to Consider When Researching a Plan

Costs vary greatly among policies. When enrolling in a new plan or renewing a current plan, take into account the following factors which may affect your cost:

Designing Your Medicare Plan You can customize your Medicare plan to suit your needs	You may choose: • **"Original Medicare"** and add Part D and/or Medigap; **or** • **Medicare Advantage** (Part C) *If you select Medicare Advantage be sure prescription coverage is included.*
Premium Amount the beneficiary pays to maintain health insurance coverage	If you select Original Medicare: • The standard premium for Medicare Part B is $148.50 per month plus the premiums for adding Part D and/or Medigap If you select Medicare Advantage: • Premiums vary based on the plan and provider you select
Deductible Amount the beneficiary pays for covered health services before the healthcare plan pays a portion of the medical and/or prescription costs	Deductibles differ based on the plan you select. Health services, such as doctors' visits and hospital stays, often have a deductible. Prescription coverage may also have a deductible. • Some plans cover **100%** of preventive services, such as routine check-ups and screenings, regardless of deductible
Coinsurance or Copayment Portion of costs of a covered healthcare service paid by the beneficiary	Beneficiaries often pay a share of the cost each time they use a healthcare service. • Coinsurance is usually a flat percentage, for example, 20% • Copayment is usually a set amount, for example, $10 for a prescription drug or $20 for a doctor visit
Plan Coverage Restrictions You may need to pick from a preferred physician list or select specific prescriptions to avoid extra costs	Be sure to make a list of the physicians you see and the prescriptions you take. • Check your medical benefit to be sure your physicians are on the in-network list • Check to see if your prescriptions are on the preferred drug list for your Part D plan You may choose to see an out-of-network physician or take a non-preferred prescription medication at a higher cost to you.

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Enrollment Checklist

Complete this form to help you decide if you are selecting the best plan for your needs.

Evaluation

Does this plan include the benefits that are most important to you? ◯ Yes ◯ No

Are preventive services covered without out-of-pocket costs? ◯ Yes ◯ No

Are your preferred physicians, hospitals, and pharmacies considered in-network? ◯ Yes ◯ No

Does the plan cover your current medications? ◯ Yes ◯ No

- List your current medications here: _____

_____

_____

Do you have all of the information needed to enroll in the plan? ◯ Yes ◯ No

Do you qualify for the Extra Help plan (low-income subsidy for Medicare)? ◯ Yes ◯ No

Do you need a Medigap policy? (see pages 3-4 for more on Medigap) ◯ Yes ◯ No

What is the Star Rating for this plan? ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Costs

How much is the monthly premium? _____

How much is the annual deductible? _____

How much is the out-of-pocket maximum? _____

How much are out-of-network provider visits? _____

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Medicare Cost Overview/Worksheet*

Basic Benefits

Basic Benefits

Part A Benefit

- Generally no monthly premium for those who worked (or whose spouse worked) for at least 10 years
- Deductible and Copay applies per hospitalization, dependent on length of stay and type of facility
- *See medicare.gov for details*

+

Part B Benefit

Standard Monthly Premium (2022)

$ 148.50

Deductible†

$ _____

Coinsurance

20% of cost of service

You May Add

Part D

Average Monthly Premium

$ 30.50

Deductible

$ 480.00

Copay/Coinsurance

25%

&/OR

Medigap

Costs vary by plan and by age of beneficiary

Medicare Advantage

All Included Benefits (Part A, Part B, Other – usually including prescription coverage/Part D)

Monthly Premium $ _____

Deductible $ _____

Copay/Coinsurance for Services $ _____

Copay/Coinsurance for Prescriptions $ _____

Important Notes:

- Out-of-pocket maximums apply that can limit your overall spend
- Out-of-pocket maximum

  $ _____

*Please note, these worksheets are for reference purposes only. Call your plan administrator for more details.
†Deductible for 2022 will be published on medicare.gov later in 2021.

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Medicare Cost Worksheet

Medicare Plans

Use the following worksheet as a guide to help compare Medicare options. Please note, these worksheets are for reference purposes only. Call your plan administrator for more details.

Medicare Part D *(prescriptions you pick up at a pharmacy to use at home)*

Deductible	Coinsurance Before "Donut Hole"	Coinsurance In "Donut Hole"	Coinsurance After "Donut Hole"
Deductible $480	**25% of medication costs** $_____	**25% of medication costs** ("Donut Hole" begins at $4,430 and ends at $7,050) $_____	**5% of medication costs** $_____

Medicare Part C *(Medicare Advantage)*

Deductible	Copay or Coinsurance	Out-of-pocket Maximum
Deductible: $_____	**Medication and treatment costs** Copay: $_____ or Coinsurance:_____%	**Out-of-pocket maximum:** $_____ *Out-of-pocket costs vary by plan. You may pay more than the plan's out-of-pocket maximum if you use out-of-network services.*

Medicare Part B *(medications administered in a doctor's office or outpatient clinic)*

Deductible	Copay or Coinsurance	Percent Covered by Medicare Part B
Deductible $203 (in 2021)*	**Medication and treatment costs** 20% Coinsurance: $_____	**Out-of-pocket maximum:** $_____ *Out-of-pocket costs vary by plan. You may pay more than the plan's out-of-pocket maximum if you use out-of-network services.*

Medicare Part B + Medicare Supplemental *(Medigap)* Plan

Deductible	Copay or Coinsurance	Percent Covered by Medicare Part B
Total deductible $203 (in 2021)* **Does the Medigap plan cover the deductible?** ☐ Yes ☐ No **Amount of deductible you pay with Medigap plan:** $_____	**Percentage of medication, infusion, or injection costs covered by Medigap plan:** _____% **Does the Medigap plan have an out-of-pocket maximum?** ☐ Yes ☐ No **Out-of-pocket maximum:** $_____	**Medicare Part B covers _____% of medication, infusion, or injection costs** **Your total out-of-pocket cost:** $_____

*Deductible for 2022 will be published on medicare.gov later in 2021

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Terms to Know

Coinsurance – Percentage of a medical charge or medication cost you must pay. The plan pays the remaining percentage. A common coinsurance plan is 80/20, meaning you pay the first 20% of all charges and the plan pays the remaining 80%.

Copayment (copay) – Amount you pay for medical services or prescriptions. Charges may be fixed (for example, $25 for each prescription), or a set percentage (for example, 20% of the cost of a hospital visit). This payment is typically made directly to the provider at the time you receive service, for example at a doctor visit or when you pick up medications at the pharmacy.

Coverage – Can refer to the services that an insurance company will cover (for example, routine check-ups and wellness visits) or to the amount that will be covered by the insurance company.

Deductible - A specified amount you must pay before the insurance plan begins to pay a portion. Deductible amounts can influence the price of an insurance policy and should be considered when choosing a plan.

Extra Help/Low-Income Subsidy (LIS) Program – A Medicare program that helps people with limited income and resources pay Medicare Part D program costs such as premiums, deductibles, and coinsurance.

Formulary – List of medications that are covered for eligible patients under an insurance plan, sometimes called a drug list.

Group Health Insurance – Insurance obtained through an employer for most people under the age of 65 with medical insurance. Employers and other organizations with a large number of individuals to cover can get better rates, similar to a bulk discount. They can pass this discount to plan participants in the form of lower premiums than those found in individual health insurance plans, and the premiums are the same price for everyone in the group regardless of their health.

Health Insurance Marketplace – Service for finding insurance plans in the state where you live; also called the Exchange. For more information, visit healthcare.gov.

Medicaid – A healthcare program for low-income people; one of the largest payers for health care in the United States. For more information, visit medicaid.gov.

Medicare Part A – Hospital insurance; helps cover inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care.

Medicare Part B – Medical insurance; helps cover provider services, outpatient care, home health care, durable medical equipment such as wheelchairs or walkers, and many preventive services such as screenings and immunizations.

Medicare Part C (Medicare Advantage Plan) – A type of Medicare plan run by private companies that contract with Medicare. Includes Part A and Part B benefits and prescription drug coverage.

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Terms to Know (cont.)

Medicare Part D – Prescription drug coverage; these plans are run by private insurance companies.

Medigap – Supplemental insurance policy for Medicare beneficiaries; provides additional coverage for many out-of-pocket costs after Medicare pays its portion of medical bills. Medigap cannot be used with Medicare Part C plans.

Network – Group of physicians, hospitals, or other healthcare providers that agree to provide services at prenegotiated prices and rates.

Out-of-Pocket Maximum – Maximum amount you must pay for covered services in a plan year. After reaching this amount on deductibles, copayments, and coinsurance, the plan pays 100% of covered costs.

Plan Year – The 12-month period of benefit coverage for an insurance plan. ***Note:*** *This may not be the same as the calendar year; check carefully when signing up for an insurance policy as this can affect when your deductibles and other financial obligations change.*

Preferred Pharmacy Networks – Groups of pharmacies selected by a prescription drug plan. These preferred pharmacies may be big retailers, such as Wal-Mart, CVS Health, or Walgreens, or a delivery-by-mail option. These pharmacies may or may not be convenient for you, so make sure you are comfortable with the delivery network for plans that you are considering.

Premium – Regular and defined payment for an insurance plan, usually monthly.

Prior Authorization – Also known as a PA, this requires a healthcare provider to obtain approval from the insurance company prior to prescribing a specific medication.

Provider Networks – Groups of doctors and hospitals that provide care at negotiated rates to patients of specific plans. These providers are considered in-network; providers that do not participate in the network are non-network or out-of-network providers. It is important to visit in-network providers when possible – charges from out-of-network providers may not be covered. When considering various health plans, be sure to look at which providers and hospitals are in the plan network.

Step Therapy – Plan requirement to try medications or therapies in a specific order, usually reserving the most expensive therapy as a later option. This may require trying a different medication than the physician prescribed and documenting that it failed before permitting a claim for the one the physician prescribed.

Tier – Cost level assigned to prescription medication that determines your portion of the drug cost.

TRICARE – Healthcare program for U.S. military service members, retirees, and their families around the world. For more information, visit tricare.mil.

Additional Resources

Resource	Details
Medicare	
Medicare 1-800-MEDICARE (1-800-633-4227) medicare.gov	Information on Medicare plan offerings, coverage, eligibility, costs, contact information, and other resources to manage your health care.
Counseling and Assistance Get one-on-one help with the various policies, programs, and benefits available to you.	
BenefitsCheckUp® benefitscheckup.org	Free service from the National Council on Aging to improve the health and economic security of older adults. This program can research policies and programs for you and provide information about benefits available in your state. Medicare Part D beneficiaries can also use this resource to determine whether they qualify for the low-income subsidy.
State Health Insurance Assistance Programs (SHIP) 1-877-839-2675 shiptacenter.org	SHIP provides one-on-one help with Medicare health or prescription drug plan options, program enrollment, and eligibility for financial assistance options.
Financial Assistance Use these resources to find help for out-of-pocket costs. ***Note:*** *Copay cards cannot be used for prescriptions eligible for reimbursement in whole or in part by Medicare or other federal or state prescription drug programs.*	
GoodRx 855-268-2822 goodrx.com	Features a drug price comparison tool. GoodRx does not sell medications, but the website will show prices, coupons, and savings tips for prescriptions at pharmacies near you.

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Additional Resources (cont.)

Resource	Details
Healthwell Foundation 800-675-8416 healthwellfoundation.org	Provides a disease-specific fund that addresses the needs of individuals who cannot afford their insurance copayments, premiums, coinsurance, or other out-of-pocket healthcare costs.
Medicine Assistance Tool (MAT) medicineassistancetool.org	Learn more about resources available through pharmaceutical assistance programs.
Needy Meds 800-503-6897 needymeds.org	Find information on assistance programs to help you afford your medications and other healthcare costs.
Pharmaceutical Assistance Program Finder medicare.gov/pharmaceutical-assistance-program/	Search tool on medicare.gov website to find pharmaceutical assistance programs.
Rx Assist rxassist.org	Find information about free and low-cost medication programs.
State Pharmaceutical Assistance Program Finder medicare.gov/pharmaceutical-assistance-program/state-programs.aspx	Search tool on medicare.gov website to find state programs that offer help paying drug plan premiums and/or drug costs.
Other	
AARP aarp.org	United States-based interest group focused on issues related to the elderly. Offers a Medicare Advantage plan through UnitedHealthcare.
Families USA familiesusa.org	National nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans.
Modest Needs Foundation 844-667-3776 modestneeds.org	Nonprofit organization that can help provide short-term financial assistance. Low-income workers can apply for an "emergency" grant.

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