Health Plan Cost Comparison Worksheet

Plan Name			
Plan type (EPO, HMO, PPO, POS)			
Does the plan require you to choose a primary care physician (PCP)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If so, is your *current* PCP in network?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Annual Premium	$	$	$
Financial (deductible/co-insurance/annual limits)			
Deductible (in network): Individual Family	$ $	$ $	$ $
Deductible (out of network): Individual Family	$ $	$ $	$ $
Is the deductible included in the out of pocket?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Are any services covered before the deductible is met?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Coinsurance (i.e. 80/20, 70/30)	%	%	%
Maximum out of pocket: Individual Family	$ $	$ $	$ $
Does the plan have annual limits?[1]	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If so, what is the limit?	$	$	$
Preventive Care[2]			
Physical exam	$	$	$
Routine pediatric care	$	$	$
Immunizations[3]	$	$	$
Major Medical			
Do you have a copy of the plan's provider list?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

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In Network			
Please note: cost shares may vary when using out of network providers			
If permitted, indicate plan's percentage of cost for out of network services	%	%	%
Outpatient Care			
Physician office co-pay	$	$	$
Specialist co-pay	$	$	$
Surgery	$	$	$
Laboratory services	$	$	$
Hospital Care (inpatient services)			
Physician's and surgeon's services	$	$	$
Semi-private room and board	$	$	$
All drugs and medications	$	$	$
Emergency Care[4]			
Emergency room	$	$	$
Urgent care center	$	$	$
Maternity Care			
Prenatal and postnatal care (per visit)	$	$	$
Hospital services (mother and child)	$	$	$
Substance Abuse			
Inpatient: ___ visits allowed per calendar year	$	$	$
Outpatient: ___ visits allowed per calendar year	$	$	$
Mental Health[5]			
Inpatient: _____ visits allowed per calendar year			
Outpatient: ____ visits allowed per calendar year			
Pharmacy Benefit (do you have a copy of the plan's drug formulary list?)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Yearly deductible (pharmacy)	$	$	$
Co-pay Tier 1 (generics)	$	$	$
Co-pay Tier 2 (brand/preferred)	$	$	$

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Plan Name			
Co-pay Tier 3 (brand/nonpreferred)	$	$	$
Coinsurance Tier 4 (specialty tier) % cost share or co-pay	$ or %	$ or %	$ or %
If your plan has a specialty tier with coinsurance is there a per prescription maximum?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Is there a yearly maximum out of pocket?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Is clotting factor covered under the pharmacy benefit?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you have more than one choice of pharmacy provider?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Other (if offered)			
Chiropractic	$	$	$
Short-term rehabilitation: inpatient	$	$	$
Short-term rehabilitation: outpatient	$	$	$
Skilled nursing facility (SNF) (Is clotting factor covered while inpatient?)	$	$	$
Home healthcare	$	$	$
Hospice care: inpatient	$	$	$
Hospice care: outpatient	$	$	$
Durable medical equipment (DME)	$	$	$
Total Estimated Cost			

[1] For any plan issued after 9/23/12, the annual limit can be no less than $2 million, unless the plan receives a waiver from the rule. For any plan issued after 01/01/14, annual dollar limits are prohibited.

[2] For a complete list of preventive services for which there is no co-pay allowed under the ACA, go to: http://www.healthcare.gov.

[3] The ACA bans co-pays for recommended vaccines for adults and children.

[4] For group plans and individual policies created or issued after 3/23/2010, the ACA bans higher co-pays or coinsurance for out-of-network ER services.

[5] The Mental Health Parity and Addiction Equity Act prohibits plans from imposing higher deductibles or co-pays or tighter limits on visits than are allowed for medical services in the plan.