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Section 1
Health insurance plan/policy costs

	Example	Option 1	Option 2	Option 3
	ABC Health			
Monthly premium amount	$ 800 per month x 12 months = $ 9600	$____ per month x 12 months = $____	$____ per month x 12 months = $____	$____ per month x 12 months = $____
General office visit copay/coinsurance	$ 50 per visit x 6 visits = $ 300	$____ per visit x ____ visits = $____	$____ per visit x ____ visits = $____	$____ per visit x ____ visits = $____
Hospital visit copay/coinsurance	$ 100 per visit x 2 visits = $ 200	$____ per visit x ____ visits = $____	$____ per visit x ____ visits = $____	$____ per visit x ____ visits = $____
Specialist copay/coinsurance	$ 75 per visit x 2 visits = $ 150	$____ per visit x ____ visits = $____	$____ per visit x ____ visits = $____	$____ per visit x ____ visits = $____
Dental copay/coinsurance	$ 0 per visit x ____ visits = $ Not covered	$____ per visit x ____ visits = $____	$____ per visit x ____ visits = $____	$____ per visit x ____ visits = $____
Total estimated costs on copay/coinsurance (Add up your estimate for each in this section.)	$ 10,250	$____	$____	$____

Cost of prescription medicines and supplies

	Example	Option 1	Option 2	Option 3
Is the cost of prescription medicines covered? If yes, what is the yearly prescription cost? (Could be copay/coinsurance)	☒ Yes ☐ No $ 50 per prescription X 5 number of prescriptions filled = $ 250 x 12 months = $ 3,000	☐ Yes ☐ No $____ per prescription X ____ number of prescriptions filled = $____ x 12 months = $____	☐ Yes ☐ No $____ per prescription X ____ number of prescriptions filled = $____ x 12 months = $____	☐ Yes ☐ No $____ per prescription X ____ number of prescriptions filled = $____ x 12 months = $____

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Does the plan/policy cover the prescriptions you need?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the plan/policy cover the cost of supplies (for injections, testing, etc)?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
My estimated yearly prescription costs	$ 3,000	$______	$______	$______

Eye care

Total yearly estimated costs for eye care	$ 50 per visit X 2 visits Out-of-pocket costs $ 150 lenses $ 100 frame	$____ per visit X ____ visits Out-of-pocket costs $____ lenses $____ frames	$____ per visit X ____ visits Out-of-pocket costs $____ lenses $____ frames	$____ per visit X ____ visits Out-of-pocket costs $____ lenses $____ frames
My estimated yearly eye care costs	$ 350	$______	$______	$______
Total estimated yearly health care costs (Add up boxes to calculate the total out-of-pocket costs for each option)	$ 13,600	$______	$______	$______

Annual deductibles

Many plans come with a deductible that you may need to meet. This example assumes you've met your deductible. Remember to include the cost of the deductible as you look at each plan.

Is there an annual deductible to meet before benefits take effect?	$ 2,000	$______	$______	$______
Is there a separate annual deductible for prescriptions?	$ 300	$______	$______	$______
My estimated yearly deductible costs (add all lines above)	$ 2,300	$______	$______	$______
What is the yearly out-of-pocket limit? Does it include the deductible?	$ 5,000 ☒ Yes ☐ No	$______ ☐ Yes ☐ No	$______ ☐ Yes ☐ No	$______ ☐ Yes ☐ No

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Section 2
Accessing medical services

Question	Plan 1	Plan 2	Plan 3	Plan 4
Do I have to complete a health questionnaire to get the insurance?	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do all my providers accept this insurance?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are all my providers in network?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do I need referrals for specialists?	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do I need prior authorization for medical procedures?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this insurance accept the provider's billing?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If No, do I have to pay at time of service and get the insurance company to reimburse me?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section 3
Coverage

Question	Plan 1	Plan 2	Plan 3	Plan 4
What services does the plan/policy cover (for example, emergency services, hospitalization, laboratory services, prescription medicines, eye care coverage, dental care)?	Emergency care, hospitalization, prescription medicines, eye care			
Are any treatments or care excluded?	☒ Yes ☐ No Dental	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How are covered services paid for (must I first meet a deductible, which services apply to the deductible, which services require me to pay a copay or coinsurance)?				

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