

## Health Care Plan Comparison Worksheet

| Plan Name   | 1.     | 2.     | 3.     |
|---|--------|--------|--------|
| Premium Amount  | \$     | \$     | \$     |
| Type of plan (HMO, OAP, POS, PPO)   |        |        |        |
| Deductible (per year)   | \$     | \$     | \$     |
| <b>Copayment Required:</b>  |        |        |        |
| Physician Office Visit  | \$     | \$     | \$     |
| Prescription Drugs  | \$     | \$     | \$     |
| Urgent Care   | \$     | \$     | \$     |
| Emergency Room  | \$     | \$     | \$     |
| Other   | \$     | \$     | \$     |
| What is the Coinsurance % ? (ie: 90/10, 80/20 etc.)   |        |        |        |
| Out of Pocket Maximum   | \$     | \$     | \$     |
| Does the policy have lifetime limits?   | Yes No | Yes No | Yes No |
| If so, what are the lifetime limits?  | \$     | \$     | \$     |
| Are physicians you currently use signed up with the plan?   |        |        |        |
| Primary Care Provider   | Yes No | Yes No | Yes No |
| Hematologist/HTC  | Yes No | Yes No | Yes No |
| Other   | Yes No | Yes No | Yes No |
| Is clotting medication covered in this plan?*   | Yes No | Yes No | Yes No |
| *Is it covered under Major Medical or Drug  |        |        |        |
| Do you have choices of factor providers?  |        |        |        |
| Can you use the HoG pharmacy with the plan?   | Yes No | Yes No | Yes No |
| Is emergency care covered?  | Yes No | Yes No | Yes No |
| Are there any limitations/restrictions in hospitalization coverage?                                       | Yes No | Yes No | Yes No |
| If yes, what are they?  |        |        |        |
| Are your annual visits to the HTC covered?  | Yes No | Yes No | Yes No |
| If you need a specific specialist who is not part of the plan, will the plan refer you to that physician? | Yes No | Yes No | Yes No |
| What will it cost?  | \$     | \$     | \$     |
| Are any of the following services covered?  |        |        |        |
| Dental Care   | Yes No | Yes No | Yes No |
| Vision Care   | Yes No | Yes No | Yes No |
| Mental Health   | Yes No | Yes No | Yes No |
| Chemical Dependency   | Yes No | Yes No | Yes No |
| Preventive Health Screenings  | Yes No | Yes No | Yes No |
| Other   |        |        |        |
| Are there clear directions on how to use the grievance/appeals procedure?                                 | Yes No | Yes No | Yes No |
| Are you covered if you become ill away from home (including travel abroad)?                               | Yes No | Yes No | Yes No |