Personal Health Experience Status Sheet

When researching plans that best meet your needs, consider the following questions to project your out-of-pocket health costs for the upcoming year.

In the past 12 months:

I visited my primary care physician _____ times.

- My spouse visited his/her primary care physician _____ times.
- My child(ren) visited their primary care physician _____ times.

I saw a specialist _____ times.

- Spouse: _____ times.
- Child(ren): _____ times.

I visited an ER or urgent care center _____ times.

- Spouse: _____ times.
- Child(ren): _____ times.

I purchased _____ (#) prescriptions (including for my family) at my pharmacy.

I purchased _____ (#) specialty medications through a specialty pharmacy or medical benefit.

- Name(s) of servicing pharmacy(ies):

I was admitted to the hospital for an overnight stay _____ times.

- Spouse: _____ times.
- Child(ren): _____ times.

I needed home health services (such as nursing care) _____ times.

I required rehabilitation services (such as physical therapy or pulmonary rehab) _____ times.

I required oxygen therapy _____ times.

Health Plan Cost Comparison Worksheet

You can find information to record here on the health plan's Summary of Benefits and Coverage document available on the insurance company's website. If you do not have Internet access or cannot find the information, call the insurer directly and ask them to explain or mail benefits and coverage information to you.

Health care plans (Put name of each plan offered in separate column.)				
Name of plan		1)	2)	3)
Plan type (EPO, HMO, PPO, POS)				
Coverage tier (Platinum, Gold, Silver, Bronze)				
Is your current primary care physician (PCP) in network?		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Premiums				
List premium amount and whether it is due monthly, annually, quarterly or every pay period.		$	$	$
Financial				
Health deductible:	Individual Family	$ $	$ $	$ $
Out-of-pocket limit:	Individual Family	$ $	$ $	$ $
Is anything covered before deductible (note: preventive services may be covered before the deductible)? If yes, what is covered?		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Preventative care: Even if you haven't met your yearly deductible, all ACA-compliant health plans (both on and off marketplace) must cover the following list of preventive care services without charging you a copayment or coinsurance, as long as a network provider delivers these services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Most other health plan types also cover certain preventive services at little or no cost to you, even prior to having met any applicable deductibles. Check with non-ACA-compliant plans directly to confirm which they offer.				
Outpatient care costs (Ongoing costs after deductible is met.) $=copay; coinsurance=%				
Physician office visit		$ or %	$ or %	$ or %
Specialist office visit		$ or %	$ or %	$ or %
Surgery		$ or %	$ or %	$ or %
Emergency room visit		$ or %	$ or %	$ or %
Urgent care center visit		$ or %	$ or %	$ or %
Nursing visit _____ (#) visits allowed per year		$ or %	$ or %	$ or %
Other costs				
Hospital care (In-patient services)		$ or %	$ or %	$ or %
Maternity care (In-pt for mother and child)		$ or %	$ or %	$ or %

Pre-natal and post-natal care	$ or %	$ or %	$ or %
Substance abuse (in-pt) ______ (#) visits allowed per year	$ or %	$ or %	$ or %
Substance abuse (out-pt) ______ (#) visits allowed per year	$ or %	$ or %	$ or %
Mental health (in-pt) ______ (#) visits allowed per year	$ or %	$ or %	$ or %
Mental health (out-pt) ______ (#) visits allowed per year	$ or %	$ or %	$ or %
Chiropractic ______ (#) visits allowed per year	$ or %	$ or %	$ or %
Hospice care (in-pt) ______ (#) visits allowed per year	$ or %	$ or %	$ or %
Hospice care (out-pt) ______ (#) visits allowed per year	$ or %	$ or %	$ or %
Palliative care ______ (#) visits allowed per year	$ or %	$ or %	$ or %
Durable medical equipment	$ or %	$ or %	$ or %
Other:	$ or %	$ or %	$ or %
Are your preferred providers in network? (Obtain a copy of the plan's provider list and check with the provider.)			
Preferred hospital	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pharmacy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Specialty pharmacy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Home health company	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pulmonary therapy rehab facility	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physical therapy rehab facility	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Skilled nursing facility	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Primary care and specialist coverage (Obtain a copy of the plan's provider list and check with the provider.)			
Doctor name ______ Phone (____) ______ ☐ Primary care ☐ Specialist	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %
Doctor name ______ Phone (____) ______ ☐ Primary care ☐ Specialist	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %
Doctor name ______ Phone (____) ______ ☐ Primary care ☐ Specialist	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %
Doctor name ______ Phone (____) ______ ☐ Primary care ☐ Specialist	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %
Doctor name ______ Phone (____) ______ ☐ Primary care ☐ Specialist	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %	In network? ☐ Yes ☐ No $ or %

Pharmacy benefit costs

Annual deductible: Individual:	$	$	$
Family:	$	$	$
Tier 1 (Preferred generics)	$ or %	$ or %	$ or %
Tier 2 (Non-preferred generics)	$ or %	$ or %	$ or %
Tier 3 (Preferred brand)	$ or %	$ or %	$ or %
Tier 4 (Non-preferred brand)	$ or %	$ or %	$ or %
Tier 5 (Specialty)	$ or %	$ or %	$ or %
Is there an annual pharmacy maximum out of pocket?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there a preferred specialty pharmacy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, who is the specialty pharmacy?			
Is mail order covered?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medication coverage (Don't forget to include upcoming changes to your drug treatment in your plan search. It is important to confirm your plan will still provide needed coverage after any changes.)

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy (Circle all that apply for each medication.)

Drug name: ______ Current dose: ______ Current quantity: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______
Drug name: ______ Current dose: ______ Current quantity: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______
Drug name: ______ Current dose: ______ Current quantity: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______
Drug name: ______ Current dose: ______ Current quantity: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______
Drug name: ______ Current dose: ______ Current quantity: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______
Drug name: ______ Current dose: ______ Current quantity: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______
Drug name: ______ Current dose: ______ Current quantity: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______	On formulary? ☐ Yes ☐ No PA QL ST Tier: ______

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We're Here to Help.

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