Health Plan Benefit - Comparison

Worksheet Date: _____

Name: _____

Current	New
Current PLAN NAME/#: _____	New PLAN NAME/#: _____
Star Rating: _____	Star Rating: _____
Monthly Plan Premium: _____	Monthly Plan Premium: _____
Medical Deductible: _____	Medical Deductible: _____
In-Ntwrk. Max. Out of Pocket: _____	In-Ntwrk. Max. Out of Pocket: _____
Out-Network MOOP:_____	Out-Network MOOP:_____
Rx Deductible (Tier info): _____	Rx Deductible (Tier info):_____
Fitness/Silver Sneakers: _____	Fitness/Silver Sneakers: _____
Ambulance: _____	Ambulance: _____
Chiropractic: _____	Chiropractic: _____
Dental Allowance: _____	Dental Allowance: _____
Insulin Savings: _____	Insulin Savings: _____
Lab Copay: _____	Lab Copay: _____
PCP Copay: _____	PCP Copay: _____
Specialist Copay: _____	Specialist Copay: _____
Durable Medical Equipment: _____	Durable Medical Equipment: _____
Emergency Care Copay: _____	Emergency Care Copay: _____
Hearing Allowance: _____	Hearing Allowance: _____
Outpatient Surgery Copay: _____	Outpatient Surgery Copay: _____
Over The Counter (OTC): _____	Over The Counter (OTC): _____
Podiatry: _____	Podiatry: _____
Transportation: _____	Transportation: _____
Urgent Care: _____	Urgent Care: _____
Vision Allowance: _____	Vision Allowance: _____
Inpatient Stay Copay: _____	Inpatient Stay Copay: _____
Part B Give Back: _____	Part B Give Back: _____
Insulin Savings: _____	Insulin Savings: _____
Hospital Indemnity: _____	Hospital Indemnity: _____
Cancer Insurance: _____	Cancer Insurance: _____
Critical Illness Ins.:_____	Critical Illness Ins.: _____
Final Expense Life Insurance: _____	Final Expense Life Insurance: _____
Long Term Care Insurance: _____	Long Term Care Insurance: _____