SpendWize

LIFE 1010 Prepared for Life

Major Medical Health Insurance Comparison

Instructions: Complete this form for each health insurance policy you are considering and compare the results.

Health Insurance Carrier Name:	
Plan Name:	
Insurance Carrier Rating (AM Best & Co):	
Name of Preferred Provider Organization/Network:	

Deductible, Coinsurance and Out-of-Pocket	In-Network:	Out-of-Network:
Calendar Year **Deductible** per INDIVIDUAL	$	$
Coinsurance (the % the plan pays after the deductible)	%	%
Calendar Year **Maximum Out-of-Pocket** per INDIVIDUAL (your financial responsibility after the deductile is satisfied until the plan pays the remainder of covered expenses for the calendar year.)	$	$
Calendar Year **TOTAL FINANCIAL EXPOSURE** per **INDIVIDUAL** (the sum of Deductible + Maximum Out-of-Pocket)	$	$
Total Number of Deductibles per FAMILY that must be satisfied	#_____	#_____
Total Number of **Maximum Out-of-Pocket** per FAMILY	#_____	#_____
Calendar Year **TOTAL FINANCIAL EXPOSURE** per **FAMILY** (the sum of Deductibles per Family + Maximum Out-of-Pocket per Family)	$	$

Policy Limits	
Calendar Year Maximum Benefit per Individual:	$
Lifetime Maximum Benefit per Individual:	$
Other	
Rate Guarantee:	_____ # of Year(s) or _____ # Months
One-Time Enrollment Fee: -Refundable	$ ☐ Yes ☐ No
ANNUAL PREMIUM:	$

Carrier Name: **Plan Name:**

Date Completed _____/_____/_____

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Outpatient Coverage:			
Physicial Office Visit Charge	☐ Deductible & Coinsurance	or	☐ Copay
-Limit on the number of services?	☐ Yes ☐ No		
Lab Sercices & Tests	☐ Deductible & Coinsurance	or	☐ Copay
-Limit on the number of services?	☐ Yes ☐ No		
-Cap on the dollar amount?	☐ Yes ☐ No		
X-Rays	☐ Deductible & Coinsurance	or	☐ Copay
-Limit on the number of services?	☐ Yes ☐ No		
-Cap on the dollar amount?	☐ Yes ☐ No		
Advanced Diagnostic Imaging (CAT Scans, MRI, etc.)	☐ Deductible & Coinsurance	or	☐ Copay
-Limit on the number of services?	☐ Yes ☐ No		
-Cap on the dollar amount?	☐ Yes ☐ No		
Non-Surgical Back Treatment (Chiropractic Services)	☐ Deductible & Coinsurance	or	☐ Copay
-Limit on the number of services?	☐ Yes ☐ No		
-Cap on the dollar amount?	☐ Yes ☐ No		
Mental, Nervous and Chemical Dependency	☐ Deductible & Coinsurance	or	☐ Copay
-Limit on the number of services?	☐ Yes ☐ No		
-Cap on the dollar amount?	☐ Yes ☐ No		
Outpatient Surgery	☐ Deductible & Coinsurance	or	☐ Copay
Ambulance (Ground, Air and Water)	☐ Deductible & Coinsurance	or	☐ Copay
-Cap on the dollar amount?	☐ Yes ☐ No		
Preventive / Wellness Care:			
Routine Mammography & Pap Smears	☐ Deductible & Coinsurance	or	☐ Copay
Routine Physicals	☐ Deductible & Coinsurance	or	☐ Copay
-Waiting Period	☐ Yes ☐ No		
-Limit on the number of services?	☐ Yes ☐ No		
-Cap on the dollar amount?	☐ Yes ☐ No		
Child Immunizations and Health Screenings	☐ Deductible & Coinsurance	or	☐ Copay
Colorectal Cancer Screening / PSA Testing	☐ Deductible & Coinsurance	or	☐ Copay
Inpatient Coverage:			
Hospitalization	☐ Deductible & Coinsurance	or	☐ Copay
-Additional Copayment?	☐ Yes ☐ No		
Surgery	☐ Deductible & Coinsurance	or	☐ Copay
-Additional Copayment?	☐ Yes ☐ No		
Mental and Nervous Care:	☐ Deductible & Coinsurance	or	☐ Copay
-Limit on the number of services?	☐ Yes ☐ No		
-Cap on the dollar amount?	☐ Yes ☐ No		
Prescription Drugs:			
Generic Rx	☐ Deductible & Coinsurance	or	☐ Not Covered
-Dollar limit per Rx or calendar year	☐ Yes ☐ No		
Brand Name Rx - Preferred or Formulary	☐ Deductible & Coinsurance	or	☐ Not Covered
-Dollar limit per Rx or calendar year	☐ Yes ☐ No		
Brand Name Rx - Non-Preferred or Non-Formulary	☐ Deductible & Coinsurance	or	☐ Not Covered
-Dollar limit per Rx or calendar year	☐ Yes ☐ No		
Specialty Medications	☐ Deductible & Coinsurance	or	☐ Not Covered
-Dollar limit per Rx or calendar year	☐ Yes ☐ No		
Other:			
Pre-Existing Condition Limitation:			
Exclusions & Limitations/Other Provisions:			

Date Completed _____/_____/_____