Health Plan Cost Comparison Worksheet

Enter Plan Names here to compare : _____. _____. _____

Plan Type (EPO, HMO, PPO, POS)	yes/no	yes/no	yes/no
Does the plan require you to choose a primary care physician (PCP)? If so, is your current PCP in network?			
Annual Premium	$	$	$
Financial (deductible / Co-insurance/annual limits)			
Deductible (in network):			
Individual	$	$	$
Family	$	$	$
Deductible (out of network):			
Individual	$	$	$
Family	$	$	$
Is the deductible included in the out of pocket	yes/no	yes/no	yes/no
Are any services covered before the deductible is met?	yes/no	yes/no	yes/no
Coinsurance (ie. 80/20, 70/30)	%	%	%
Accumulator Adjuster	yes/no	yes/no	yes/no
Maximum out of pocket:			
Individual	$	$	$
Family	$	$	$
Does the plan have annual limits?	yes/no	yes/no	yes/no

If so, what is the limit?	$	$	$
Preventative Care			
Physical exam	$	$	$
Routine Pediatric Care	$	$	$
Immunizations	$	$	$
Major Medical			
Do you have a copy of the plan's provider list?	yes/no	yes/no	yes/no