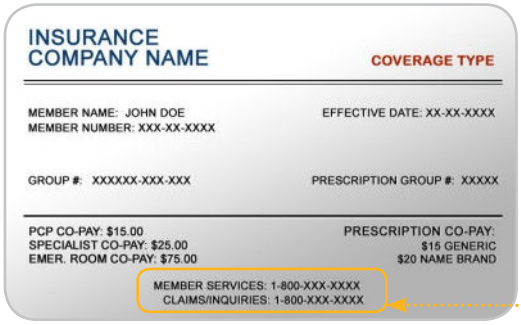
MDA® Muscular Dystrophy Association

HEALTH INSURANCE WORKSHEET

This worksheet is designed to help individuals with a neuromuscular disease and their families choose a health insurance plan. You may use this worksheet to calculate estimated costs of care in order to make an informed decision when choosing an insurance plan that is right for you.

HOW TO USE THIS DOCUMENT

1. Fill in the boxes for the care and services you anticipate you will need during the year based on a treatment plan that you've discussed with your doctor using the **My Neuromuscular Care Worksheet (Worksheet A).**
2. Use the **Treatment, Health Services and Cost Worksheet (Worksheet B)** to help you calculate the amount you will have to pay for services out of your own pocket. Complete this worksheet for each of the plans you are considering.
3. Use the **My Additional Costs and Considerations Worksheet (Worksheet C)** to calculate additional costs outside of your anticipated co-payments or co-insurance. Complete this worksheet for each of the plans you are considering.
4. Using the **Total Annual Costs Worksheet (Worksheet D),** compare the total anticipated costs for each of the plans from Worksheets B and C to help determine your total estimated annual cost. Complete this worksheet for each of the plans you are considering.
5. Comparing information from all of the completed worksheets, determine which plan may be most appropriate to fit your needs.



If you are having trouble locating the information required to complete these worksheets, try visiting the insurance benefits overview website for each plan or call the number on your insurance card for more information about your existing plan.

Your plan's phone number

If you have any questions about the information provided in this sheet, please contact the MDA National Resource Center at 1-833-ASK-MDA1 or ResourceCenter@mdausa.org

MY NEUROMUSCULAR CARE

Complete the information below about your health care needs. Use the current calendar year as a guide to anticipate what your health care costs will be in the coming year.

Worksheet **A**

NETWORK

		Is the care I need covered? In-Network	Out-Network
Plan name:		◯	◯
My primary care physician:		◯	◯
My specialists:		◯	◯
My hospital:			
My MDA Care Center:		◯	◯
Other places I receive care:		◯	◯
My medications:		◯	◯
		◯	◯
		◯	◯
		◯	◯
		◯	◯
		◯	◯
		◯	◯
		◯	◯
Routine lab tests and preferred laboratories:		◯	◯
Therapeutic Costs:		◯	◯
Other:		◯	◯

TREATMENT, HEALTH SERVICES AND COSTS

Fill in the boxes below for the services you may need during the next year. If you are comparing coverage options, complete one worksheet for each plan considered.

If you are unsure of the resources you will need for your care, consider speaking with your care provider to determine the anticipated number of visits, devices, etc. that you will need in order to complete this worksheet.

Worksheet **B**

TREATMENT, HEALTH SERVICES AND COST WORKSHEET

Plan name	Covered? (fill one)	Need a referral?	No. of visits	Co-pay/co-ins. per visit? ($ or %)		Annual expense (est.)
				In-network	Out-network	
Primary care visits	○ Yes ○ No	○ Yes ○ No				
Specialist visits	○ Yes ○ No	○ Yes ○ No				
Emergency room or urgent care	○ Yes ○ No	○ Yes ○ No				
Hospital care	○ Yes ○ No	○ Yes ○ No				
Prescription medicine	○ Yes ○ No	○ Yes ○ No				
Imaging (MRI or X-rays)	○ Yes ○ No	○ Yes ○ No				
Genetic testing	○ Yes ○ No	○ Yes ○ No				
Laboratory tests	○ Yes ○ No	○ Yes ○ No				
Mental health services	○ Yes ○ No	○ Yes ○ No				
Rehab services (physical, occupational, speech, respiratory)	○ Yes ○ No	○ Yes ○ No				
Home health care (including IVs)	○ Yes ○ No	○ Yes ○ No				

Worksheet B continues on the following page.

B

TREATMENT, HEALTH SERVICES AND COST WORKSHEET *(continued)*

Worksheet

Plan name	Covered? (fill one)	Need a referral?	No. of visits	Co-pay/co-ins. per visit? ($ or %)		Annual expense (est.)
				In-network	Out-network	
Skilled nursing facility	○ Yes ○ No	○ Yes ○ No				
Hospice care	○ Yes ○ No	○ Yes ○ No				
Prenatal/maternity care	○ Yes ○ No	○ Yes ○ No				
Durable medical equipment	○ Yes ○ No	○ Yes ○ No				
Adaptive strollers, scooters, wheelchairs (power and manual)	○ Yes ○ No	○ Yes ○ No				
Commodes/Bath chairs	○ Yes ○ No	○ Yes ○ No				
Hoyer Lifts	○ Yes ○ No	○ Yes ○ No				
Ankle and foot orthotics and specialty shoes	○ Yes ○ No	○ Yes ○ No				
Standers	○ Yes ○ No	○ Yes ○ No				
Respiratory assistive devices (airway clearance, etc.)	○ Yes ○ No	○ Yes ○ No				
Communication devices	○ Yes ○ No	○ Yes ○ No				
Other	○ Yes ○ No	○ Yes ○ No				

Annual Co-pay/Co-insurance Total **$ 0.00**

MY ADDITIONAL COSTS AND CONSIDERATIONS

There are many health care costs to consider beyond your monthly premium. Fill in the boxes below to estimate all the health care costs for which you may be responsible. If you are comparing one or more health care plans, complete the worksheet below for each individual plan.

This worksheet will give you a comprehensive look at your total anticipated costs for the year.

C

Worksheet

MY ADDITIONAL COSTS AND CONSIDERATIONS WORKSHEET

1	How much is my premium per year?	
2	Do I qualify for a tax credit? If so, how much is my tax credit?	
3	How much is my deductible per year?	
4	Health plan's out-of-pocket maximum	

Pay special attention to your Out-of-Pocket Maximum (C4):

- If your **Out-of-Pocket Maximum (C4**) is lower than the **Estimated Total Annual Cost** found in Worksheet C, you can anticipate that your final estimated total annual cost will be the **Estimated Total Annual Cost.**
- If your **Out-of-Pocket Maximum (C4)** is higher than your **Estimated Total Annual Cost**, you can anticipate that your final estimated cost will be your **Out-of-Pocket Maximum**.

FINDING THE RIGHT PLAN FOR YOU

Once you have completed the above three worksheets (A through C), compare the total anticipated costs for each plan (Worksheet D) to help decide which plan is right for you.

If you are having trouble locating the information required to complete these worksheets, try visiting the insurance benefits overview website for each plan or call the number on your insurance card for more information about your existing plan.

TOTAL ANNUAL COSTS

Use the information from Worksheets B and C to calculate your estimated annual cost.

Worksheet D

TOTAL ANNUAL COSTS WORKSHEET

Annual Premium (C1)	$ 0.00
Annual Tax Credit (C2)	$ 0.00
Annual Deductible (C3)	$ 0.00
Annual Co-pay/Co-insurance (Total from Worksheet B)	$ 0.00
Estimated Total Annual Cost	$ 0.00

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KEY QUESTIONS AND CONSIDERATIONS WHEN CHOOSING YOUR HEALTH INSURANCE PLAN

This section references the worksheets in this document.
Here are some of the key questions a person with a neuromuscular disease may want to ask when considering an insurance plan. Work from this checklist with a member of your health care team and a representative from your insurance company to help you determine your benefit selections.

Cost-Related Questions

- What is my monthly Premium ?
- What is my annual Deductible?
- What is the Out-of-pocket maximum/limit?
- Are all services included in the out-of-pocket maximum? For example, some plans may not include the deductible or cost of prescription medications in their out-of-pocket maximum calculations.
- How much will I pay for out-of-network? See sidebar for more information.
- What are the Out-of-pocket costs for each benefit (including but not limited to pharmacy benefits, inpatient and outpatient care, DMEs, lab tests, and visits to your care center)?
- Does the plan require Coinsurance?

A health care provider who is not contracted with the health insurance plan is considered "out-of-network". Every health insurance plan has a maximum out-of-pocket amount. In most cases, you will still be responsible for out-of-network costs even when you reach your maximum out-of-pocket amount. This is something you should verify with every plan you are considering.

Benefit-Related Questions

- Is my MDA Care Center team in the provider network? https://www.mda.org/services/your-mda-care-center
- Are visits to my care center covered? Is there a limit to how many visits are covered? Are the various multidisciplinary providers also covered?
- Is durable medical equipment (such as adaptive strollers, bath chairs, braces, standers, respiratory assistive device/airway clearance devices, wheelchairs (power and manual), ankle and foot orthotics, specialty shoes and augmentative communication devices covered)?
- Does the plan cover repairs or modifications to wheelchairs? Does the plan cover the cost to replace the battery for the wheelchair?

Benefit-Related Questions continues on the following page.

KEY QUESTIONS AND CONSIDERATIONS WHEN CHOOSING YOUR HEALTH INSURANCE PLAN

Benefit-Related Questions *(continued)*

- Does the plan cover patient lifts or commodes (bathroom chairs)?
- Does the plan cover inpatient hospitalization and outpatient procedures? Are there any restrictions?
- Does the plan cover genetic testing?
- Does this plan cover laboratory tests?
- Does the plan cover in-home care services (including home IV's)?
- Are all my medications on the plan's preferred drug list or Formulary? If a plan doesn't cover your medications, what are the alternatives for you to consult with your physician? Are there benefits to using a mail order pharmacy? Does this plan cover using a specialty pharmacy for drugs not sold at retail pharmacy?
- Does the plan cover vitamins and nutritional supplements?
- Are mental health care and substance abuse services covered?
- Does the plan cover physical, occupational, speech and respiratory therapy? Does the plan have any limits to the number of visits for these services?

CLICK TO LINKS ▶

Medicaid

Social Security Disability

Access-Related Questions

- What are the Prior Authorization requirements?
- Do I need a Referral to see a specialist? How easy is it to get referrals for specialists from my primary care physician (PCP)? How long does each referral last?
- Does my doctor need to get approval from the plan to admit me to a hospital?
- What happens if my care center is not in-network? Is there a network exception and how do I begin this process?
- Is there a specific pharmacy that I must use to fill specialty medications? Can I obtain a network exception if I want to continue using my current pharmacy?
- What do I have to do in an emergency to ensure my care will be covered?
- Am I covered when I travel?

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