

## HEALTH PLAN CHECKLIST

<b>Premiums:</b>			
<b>Yearly Deductible:</b>			
<b>Annual Maximum Benefit:</b>			
<b>Lifetime Maximum Benefit:</b>			
<b>Out of Pocket Maximum:</b>			
<i>[You should find out the following information as it applies to the physician(s) you will be using]</i>			
<b>SERVICE</b> (as appropriate)	<b>COVERAGE</b> (List one of the following: "unrestricted," "pre-authorized," "referral only," "not covered")	<b>COPAYMENT REQUIRED</b> (List amount)	<b>DEDUCTIBLE?</b> (List "yes" or "no", yes means you must have paid the full deductible before the health plan will pay anything)
<b>Services</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>
Acupuncture			
Alcohol and Drug Abuse 9 Inpatient 9 Outpatient			
Allergy Testing or Treatment			
Ambulance			
Blood Transfusion			
Chiropractic			
Durable Medical Equipment (crutches, beds, etc.)			
Emergency Care 9 In area 9 Out-of-area			
Eye Examinations			
Eyeglasses or Contact lenses			
Hearing testing			
Home Health Care			
Hospice Care			
Immunizations			
Infertility Treatment			

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Mammograms			
Mental Health 9 Inpatient 9 Outpatient			
Inpatient Treatment			
Outpatient Treatment			
Occupational Therapy			
Organ Transplants			
Pap Tests			
Physician Office Visits			
Physical Exams or Checkups			
Physical Therapy			
Plastic/Reconstructive Surgery			
Prescription Drugs 9 Generic 9 Formulary 9 Non-formulary			
Skilled Nursing Facility			
Speech Therapy			
Well-Baby Care			
Other Services			

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