National Multiple Sclerosis Society

HEALTH INSURANCE Checklist

Use this Checklist to help you better manage your multiple sclerosis

This Checklist is designed to help you compare insurance plans and consider your health needs when shopping for insurance in your state's Health Insurance Marketplace/Exchange.

The Checklist is a useful guide to help you find a plan that will meet your needs. You may not need all of the treatments in the Checklist, and there may be other treatments, costs or aspects of your care that you need to consider.

When to use this Checklist:

- If you have multiple sclerosis (MS), a history of a chronic illness, or are at risk for a chronic illness
- When evaluating insurance plans
- When discussing your insurance needs with your navigator or Marketplace/Exchange representative
- When discussing your MS care needs with your health care provider

Fill in the following worksheets for each insurance plan you are considering. By doing so, you will be able to tell which insurance plan best fits your needs and your budget.

For more information on where to go to get help with paying for health insurance and to get assistance from a navigator in choosing and applying for plan coverage, visit www.healthcare.gov or call 1-800-318-2596 or TTY: 1-855-889-4325.

THIS CHECKLIST WAS CREATED THROUGH A PARTNERSHIP OF:

The Assistance Fund, Association of Community Cancer Centers, Avalere Health, Cancer Support Community, Chronic Disease Fund, Cutaneous Lymphoma Foundation, International Myeloma Foundation, The Leukemia & Lymphoma Society, Living Beyond Breast Cancer, Lung Cancer Alliance, Melanoma Research Foundation, Men's Health Network, National Coalition for Cancer Survivorship, Oncology Nursing Society, Ovarian Cancer National Alliance, Patient Advocate Foundation/National Patient Advocate Foundation, Patient Services, Inc., Prevent Cancer Foundation

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MY CARE

Will the insurance plan cover my provider visits, hospital stays, care centers and medicines?

		ARE THEY COVERED?	
		in-network	out-of-network
MY PRIMARY CARE DOCTOR IS:			
MY NEUROLOGIST IS:			
OTHER SPECIALISTS INCLUDE: *Be sure to include all your doctors.* For example, psychologist, physiologist, urologist, etc.			
OTHER PLACES I GET CARE: For example, laboratory, imaging center, infusion center.			
MY HOSPITAL IS:			
MY MEDICINES ARE: *Be sure to include all of your medicines.* For example: Prescription medicines Medicines I receive in my doctor's office or in the hospital (for example, infusion therapy). Over the counter drugs (for example, aspirin, acid reducers, stool softeners).			

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TREATMENT AND HEALTH SERVICES

Fill in the boxes for the services you think you may need.

	Covered? *(circle one)*	Do I need a referral or pre-authorization?	What is my co-pay / coinsurance?		What are the limits / maximums?
			in-network	out-of-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 MEDICINES	Yes / No	Yes / No			
SCREENINGS *(ex. spinal tap)*	Yes / No	Yes / No			
PREVENTIVE SCREENINGS *(ex. mammogram, colonoscopy)*	Yes / No	Yes / No			
IMAGING *(ex. X-ray, MRI, CT scan, PET scan)*	Yes / No	Yes / No			
SURGERY *(including reconstructive)*	Yes / No	Yes / No			
REGULAR BLOODWORK	Yes / No	Yes / No			
INFUSION SERVICES	Yes / No	Yes / No			
PHYSICAL THERAPY	Yes / No	Yes / No			
MEDICAL EQUIPMENT	Yes / No	Yes / No			
SECOND OPINION	Yes / No	Yes / No			
MENTAL HEALTH SERVICES	Yes / No	Yes / No			
CLINICAL TRIALS	Yes / No	Yes / No			
PALLIATIVE AND SUPPORTIVE CARE	Yes / No	Yes / No			
RESPITE CARE	Yes / No	Yes / No			
HOME HEALTH CARE	Yes / No	Yes / No			
OTHER SERVICES?	Yes / No	Yes / No			
	Yes / No	Yes / No			
	Yes / No	Yes / No			
	Yes / No	Yes / No			
	Yes / No	Yes / No			

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MY COSTS

Fill in the boxes for each plan you are considering.

PLAN NAME		
TYPE OF PLAN		
NUMBER OF PEOPLE IN MY HOUSEHOLD *(adults and children)*		
TOTAL HOUSEHOLD INCOME PER YEAR	$	
HOW MUCH IS THE **PREMIUM?**	Per month: $	
HOW MUCH IS THE **DEDUCTIBLE?**	Per year: $	
HOW MUCH ARE THE **CO-PAYS?**	Primary care visits: $	
	Specialist visits: $	
	Hospital visits: $	
	Emergency room: $	
	Urgent care: $	
	Prescription drugs: $	
	Other:	$
	Other:	$
HOW MUCH IS THE **COINSURANCE?**	$ or %	
WHAT IS THE MAXIMUM **OUT-OF-POCKET EXPENSE?** *(does not include premium)*	Per individual per year: $ Per family per year: $	
DO I QUALIFY FOR A REDUCTION IN MAXIMUM **OUT-OF-POCKET** COSTS?		
CAN I GET A TAX CREDIT FOR THE **PREMIUM?**	Amount per year: $	
ARE THERE ANY OTHER COSTS?		