



HEALTH INSURANCE WORKSHEET

This worksheet is designed to help individuals with Gaucher 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 Gaucher 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.

INSURANCE COMPANY NAME	COVERAGE TYPE
MEMBER NAME: JOHN DOE MEMBER NUMBER: XXX-XX-XXXX	EFFECTIVE DATE: XX-XX-XXXX
GROUP #: XXXXXX-XXX-XXX	PRESCRIPTION GROUP #: XXXXX
PCP CO-PAY: \$15.00 SPECIALIST CO-PAY: \$25.00 EMER. ROOM CO-PAY: \$75.00	PRESCRIPTION CO-PAY: \$15 GENERIC \$20 NAME BRAND
MEMBER SERVICES: 1-800-XXX-XXXX CLAIMS/INQUIRIES: 1-800-XXX-XXXX	

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 Gaucher Community Alliance at info@gauchercommunity.org

MY GAUCHER 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.

A	NETWORK	Is the care I need covered?	
		In-Network	Out-Network
Worksheet	Plan name:	<input type="radio"/>	<input type="radio"/>
	My primary care physician:	<input type="radio"/>	<input type="radio"/>
	My specialists:	<input type="radio"/>	<input type="radio"/>
	My hospital:	<input type="radio"/>	<input type="radio"/>
	My Gaucher Care Center:	<input type="radio"/>	<input type="radio"/>
	Other places I receive care:	<input type="radio"/>	<input type="radio"/>
	My medications:	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
	Routine lab tests and preferred laboratories:	<input type="radio"/>	<input type="radio"/>
	Therapeutic Costs:	<input type="radio"/>	<input type="radio"/>
Other:	<input type="radio"/>	<input type="radio"/>	

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.

B

TREATMENT, HEALTH SERVICES AND COST WORKSHEET

Worksheet

Plan name	Covered?		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.

TREATMENT, HEALTH SERVICES AND COSTS



B

TREATMENT, HEALTH SERVICES AND COST WORKSHEET (continued)

Worksheet

Plan name	Covered?		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				
Commodore/Bath chairs	Yes	No	Yes	No				
Ankle and foot orthotics and specialty shoes	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

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

MY ADDITIONAL COSTS AND CONSIDERATIONS WORKSHEET

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

5 Do I qualify for co-pay & deductible assistance from the manufacturers? If yes, how much?

6 Do I qualify for additional patient assistance funds based on my AGI?

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**.

Additional assistance may be available if your AGI is below 700% of the Federal Poverty Level



FINDING THE RIGHT PLAN FOR YOURSELF



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.

D

TOTAL ANNUAL COSTS WORKSHEET

Worksheet

Annual Premium (C1)

\$

Annual Tax Credit (C2)

\$

Annual Deductible (C3)

\$

Annual Co-pay/Co-insurance
(Total from Worksheet B)

\$

Manufacturer Co-pay / Deductable Assistance

\$

Third Party Patient Assistance

\$

Estimated Total Annual Cost

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 Gaucher 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 Gaucher care team in the provider network?

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)?

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 inpatient hospitalization and outpatient procedures? Are there any restrictions?
- Does the plan cover genetic testing?
- Does the plan cover laboratory tests?
- Does the plan cover in-home care services (including home IV)?
- 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?