



## How This Worksheet Can Help:

The Kidney Care Insurance Worksheet is designed to help kidney patients compare plans offered in the health insurance marketplaces established by the Affordable Care Act, so they can choose the most affordable and comprehensive plan. The worksheet helps patients calculate an estimate of what their out-of-pocket costs will be for each plan they are considering. Kidney patients may not need all of the services in the worksheet, and there may be other treatments, costs or aspects of their care that need to be considered.

## When to Use the Worksheet:

- You are shopping for an individual or family health insurance plan in the marketplace for the first time
- During open enrollment each year, when you already have an individual or family health insurance plan through the marketplace, so you can see if a new or a different option works better for you
- You are enrolled in the health insurance marketplace, become eligible for Medicare, and are considering enrolling, but want to compare your current coverage and costs to Medicare

## How to Use the Worksheet:

- Use one worksheet for each plan you are comparing.
- Fill in the boxes for the care and services you think you will need during the year.
- Use the cost sheet to help you total up the amount you will have to pay for premiums and services out of your own pocket.
- Lay the worksheets out side by side and compare them with each plan you reviewed.



# My Care

Complete the information about the healthcare you currently receive during the year to see if the plan covers your healthcare practitioners, services, and medications.

	Is the care I need covered?	
	In-network/ on-the-drug	Out-of-network/ not-on-the-drug
<b>Plan name:</b>		
<b>My primary care doctor is:</b>		
<b>My specialists are:</b> Be sure to include all your doctors (nephrologist, endocrinologist, cardiologist).		
<b>My hospital is:</b>		
<b>My transplant center is:</b>		
<b>Other places I get care:</b> (imaging center, laboratory)		
<b>My medicines are:</b> Be sure to include all of your medicines, such as:		
<b>• Prescription medicines:</b> (including anti-rejection medicines if you have or expect to receive a kidney transplant)		
<b>• Medicines, I receive in my healthcare provider's office or clinic:</b> (EPO, phosphate binders)		
<b>• Nutritional supplements:</b>		



# Treatment, Health Services, and Costs

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

Plan name:					
	Covered? (Circle one.)	Do I need a referral or pre- authorization?	What is my co-pay/coinsurance? (Enter dollar amount or percentage below.)		What are the limits or maximums? (Number of visits covered.)
			In-network	Out-of-network	
<b>Primary care visits</b>	Yes / No	Yes / No			
<b>Specialist visits</b>	Yes / No	Yes / No			
<b>Emergency room or urgent care</b>	Yes / No	Yes / No			
<b>Hospital care</b>	Yes / No	Yes / No			
<b>Kidney transplants</b>	Yes / No	Yes / No			
<b>Living donor evaluation and surgical expenses</b>	Yes / No	Yes / No			
<b>Prescription medicines</b> (ask if you are required to use a mail order pharmacy)	Yes / No	Yes / No			
<b>Imaging</b> (X-ray, MRI)	Yes / No	Yes / No			
<b>Laboratory tests</b>	Yes / No	Yes / No			
<b>Vascular access placement or intervention</b>	Yes / No	Yes / No			
<b>Mental health services</b> (depression screening, psychotherapy, counseling)	Yes / No	Yes / No			
<b>Palliative and supportive care</b> (for pain, nausea, and other side effects)	Yes / No	Yes / No			
<b>Physical therapy</b>	Yes / No	Yes / No			
<b>Home healthcare</b>	Yes / No	Yes / No			
<b>Medical equipment</b> (walkers, wheelchairs)	Yes / No	Yes / No			
<b>Hospice care</b>	Yes / No	Yes / No			



## My Costs

There are many costs to consider beyond the monthly premium.  
Fill in the boxes to estimate all of the costs you will be responsible for.

<b>How much is the premium per year?</b> <i>Ask if you qualify for an advanced tax credit to lower the premium</i>	\$
<b>How much is the deductible per year?</b>	\$
<b>Total estimated annual co-insurance or copayments for expected services</b> (add these up from "Treatment, Health Services, and Costs" page)	% or \$
<b>Health plan's out-of-pocket maximum</b> (does not include the premium and does not apply to any services you use that are out-of-network or any drugs not on the plan's drug formulary) <i>Ask if you qualify for a lower out-of-pocket maximum. (for Silver Plans only)</i>	\$