Cancer Insurance Checklist

HOW THIS CHECKLIST CAN HELP

The Cancer Insurance 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.

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 THE CHECKLIST:

- If you have cancer, a history of cancer, or are at risk for cancer
- When evaluating insurance plans
- When discussing your insurance needs with your navigator, Marketplace representative, care provider or patients in your family
- When discussing your cancer 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

*Remember that no plan will pay 100 percent of your medical expenses. Please be sure to spend time understanding your out-of-pocket costs, by checking on the prescription drugs, treatments, physicians and hospitals that are included in each plan.

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 specialists are: *Be sure to include all your doctors. For example, oncologist or psychologist.*			
My hospital is:			
Other places I get care: *For example, laboratory, imaging center, infusion center*			
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, chemotherapy) • Over the counter drugs (for example, aspirin, acid reducers, stool softeners)			

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 or 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 *(including oral chemotherapy)*	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			
Radiation therapy	Yes / No	Yes / No			
Chemotherapy *(oral, IV and injectable)*	Yes / No	Yes / No			
Second opinion	Yes / No	Yes / No			
Care plan *(Can I get a written cancer care plan–including survivorship–from my doctor?)*	Yes / No	Yes / No			
Clinical trials	Yes / No	Yes / No			
Mental health services *(ex. distress screening, psychotherapy)*	Yes / No	Yes / No			
Palliative and supportive care *(ex. care for nausea, pain, fatigue and other side effects)*	Yes / No	Yes / No			
Physical therapy	Yes / No	Yes / No			
Home health care	Yes / No	Yes / No			
Medical equipment *(ex. compression garments, cane)*	Yes / No	Yes / No			
Genetic / biomarker testing and counseling	Yes / No	Yes / No			
Fertility preservation	Yes / No	Yes / No			
Transplants *(ex. stem cell and bone marrow)*	Yes / No	Yes / No			
Preventive treatments *(ex. preventive mastectomy)*	Yes / No	Yes / No			
Respite care	Yes / No	Yes / No			
Hospice care	Yes / No	Yes / No			

MY COSTS

Fill in the boxes for each plan you are considering.

Plan name			
Type of plan *(circle one)*	PLATINUM GOLD SILVER BRONZE CATASTROPHIC		
How much is the premium?	*Per month:*	$	
	Per year:	$	
How much is the deductible?	*Per year:*	$	
What is the maximum out-of-pocket expense? *(does not include premium)*	*Per individual per year:*	$	
	Per family per year:	$	
How much are the co-pays and/or coinsurance?	*Primary care visits:*	$	%
	Specialist visits:	$	%
	Hospital visits:	$	%
	Emergency room:	$	%
	Urgent care:	$	%
	Prescription drugs tier 1:	$	%
	Prescription drugs tier 2:	$	%
	Prescription drugs tier 3:	$	%
	Prescription drugs tier 4:	$	%
	Other:	$	%
	Other:	$	%
Number of people in my household *(adults and children)*			
Total household income per year	$		
Can I get a tax credit for the premium?	*Amount per year:*	$	
Do I qualify for a reduction in maximum out-of-pocket costs? *(silver plans only)*			
Are there any other costs?			

The partners would like to thank NOVARTIS ONCOLOGY for its generous support for the development and production of this resource.