

**Health Insurance Comparability Checklist** NOTE: Completion of this form is only necessary if a member wishes to retain both insurances (i.e., their own and their spouses).

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Firm: \_\_\_\_\_

Name of Health Insurance Company: \_\_\_\_\_

Please provide the following information:

- A copy of the health insurance coverage or booklet;
- Monthly premium amount that spouse pays "out-of-pocket" to have coverage;

Individual Coverage: \_\_\_\_\_

Family Coverage: \_\_\_\_\_

- Basic Coverage;

	In-Network	Out-Of-Network
Individual Deductible:	_____	_____
Family Deductible:	_____	_____
Hospital Coverage (%):	_____	_____
Doctor's Charges (%):	_____	_____

Calendar year out-of-pocket expense maximum (the limit on what you pay out of your pocket each calendar year for allowable changes, not including deductibles):

Individual: \_\_\_\_\_

Family: \_\_\_\_\_

Prescription Coverage: \_\_\_\_\_

Deductible: \_\_\_\_\_

Co-Pay Prescription Drug: \_\_\_\_\_

Co-Pay Generic Prescription Drug: \_\_\_\_\_

If you were given the choice of the District's Health Plan or the Buy-Out, which would you choose (check one)?

- Buy-Out
- District Health Plan