

Extra Benefit Check Worksheet

Document what you checked, what you found, and what questions remain before you decide. Fill in one worksheet per plan you are evaluating.

Plan details

Plan name: _____

Plan year: _____ County / state: _____

Evidence of Coverage found at: _____

Benefit-by-benefit check

Dental

Covered in my county? Yes No Not sure

Provider / network restriction: _____

Can change at renewal? Yes No Not sure

Dollar value to me (realistic): \$_____

What I give up for it: _____

Vision

Covered in my county? Yes No Not sure

Provider / network restriction: _____

Can change at renewal? Yes No Not sure

Dollar value to me (realistic): \$_____

What I give up for it: _____

Hearing

Covered in my county? Yes No Not sure

Provider / network restriction: _____

Can change at renewal? Yes No Not sure

Dollar value to me (realistic): \$_____

What I give up for it: _____

OTC / Allowance Card

Covered in my county? Yes No Not sure

Provider / network restriction: _____

Can change at renewal? Yes No Not sure

Dollar value to me (realistic): \$_____

What I give up for it: _____

Gym / Fitness

Covered in my county? Yes No Not sure

Provider / network restriction: _____

Can change at renewal? Yes No Not sure

Dollar value to me (realistic): \$_____

What I give up for it: _____

Other: _____

Covered in my county? Yes No Not sure

Provider / network restriction: _____

Can change at renewal? Yes No Not sure

Dollar value to me (realistic): \$_____

What I give up for it: _____

My overall assessment

Is the extra worth the trade? Yes No Need more information

Questions I still need to answer:

Next step: Talk it through with Fern (joinclearing.com/fern) Contact SHIP (shiphelp.org) Call the plan directly

The Clearing is commission-free and member-funded. General education, not advice. Confirm with a licensed professional or your free SHIP counselor (shiphelp.org). joinclearing.com