

# CHAPTER TWO

## Assessing Your Financial Position



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*efore you begin the transplant procedure, you will want to assess your financial position, including what kind of health-care plan you have and what is covered under your policy. The next step is calculating your current living costs. Finally, you will need to take a financial inventory, which involves reviewing your other assets, including disability or mortgage insurance, savings, and personal property.*

This handbook is meant to provide general financial information; it is not meant to substitute for, or to supersede, professional, legal, or medical advice.

The National Endowment for Financial Education® does not intend to provide any advice regarding treatments discussed in this material. Medical treatments and related health issues should be discussed with a qualified medical professional.

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After you have all this information, you will know how much money you have and how many additional funds you might have to raise to afford the transplant procedure you need. Developing a spending plan based on this information will help you manage the money you have available for your medical and living costs.

## Take a look at your health-care coverage

Your health-care plan usually will be the largest source of coverage for your transplant procedure. It is important to understand the type of plan you have so you can understand the benefits



*Joe (donor) and wife, Diane*

it includes. You should know what procedures are covered under your plan, and how to contact the plan representative to discuss questions about your coverage.

Many different types of health-care plans are available. For example, if you are employed, you may be covered under the group plan offered by your employer. If you are self-employed or not currently employed, you may have an individual policy. Veterans may be covered under the veterans' health-care plan. Other government insurance programs exist for people who are over age 65, disabled, or who fall within certain income guidelines.

Each plan varies in what treatments or procedures it covers. Some plans require that you get pre-authorization prior to receiving certain treatments. This means that the treatment must be approved before the plan will pay for it. Plans also may have deductibles. A deductible is a specified amount you must pay before the plan begins to pay. In addition, each plan will have its own guidelines for appealing a denial of coverage for a procedure recommended by a physician. You may have a summary of your policy, but you also should request a written response from your health-care plan provider to determine if this type of transplant is covered.



Following are some common types of health-care plans:

### **Private insurance**

You already may have private medical insurance either through a group plan or through an individual policy. A group plan—the kind you get through work—usually offers more benefits for less money than an individual policy does. You might have to pay a deductible or a co-payment, but the group plan still may be less expensive in terms of the benefits that it offers. Each plan defines which benefits are covered under the policy.

If you disagree with a decision by your insurance carrier on the type of services covered or amount of coverage under your group plan, you can appeal the decision by following the procedures set forth in the policy. (See Chapter Four, “Helping Yourself” on page 36 for more information.) The state commissioner of insurance regulates private health-care plans. As a last resort, you can contact the commissioner of insurance for your state if you have a complaint against the insurance carrier. Check your local phone book or call the National Association of Insurance Commissioners at 1-816-842-3600. You also can visit [www.naic.org](http://www.naic.org).

### **Self-funded plan**

A self-funded plan is one created by a group or employer rather than purchased from an insurance carrier. The group or employer provides money to fund the plan from payments it collects from the group members. The group or employer also decides what is covered under the plan and how much coverage will be offered for different treatments. The plan administrator is the employer or group that offered the plan, or a third party administrator, and decisions about coverage are based on the guidelines provided by the group or employer.

If you want to appeal a decision made under a self-funded plan, the first point of contact is the employer’s health-plan administrator—



generally someone in human resources or a third party hired by the employer. Unlike private health-care plans, self-funded plans are not regulated by the state commissioner of insurance for your state. Instead, a federal law—the Employee Retirement Income and Security Act (ERISA) of 1974—regulates them.



*Leandra (transplant recipient) and Robin (donor)*

## Managed care

Managed-care plans are popular today because they can cost less for both employers and employees. Managed-care plans work by controlling the services provided and the number of providers who can provide them. If you have a managed-care plan, you may be required to help pay for the cost of treatment by making a co-payment. Many plans also require you to get pre-authorization for many procedures before the plan will pay for them. You may be restricted to the physicians and the hospitals that are part of the managed-care plan.

Be sure to ask about your plan's policies for pre-authorization and choice of doctors. If you are in a managed-care plan such as an HMO or a PPO, you most likely need pre-authorization for hospital treatments and procedures. You also may have to choose doctors and Transplant Centers in the network of designated providers for your plan.

If you have this type of health-care coverage, your Transplant Center will have to obtain approval for the transplant procedure from the managed-care plan before beginning the transplant process. In addition, the Transplant Center will need approval for the testing required to find a matched donor.

Here are the three basic types of managed-care plans:

✦ **Health Maintenance Organization (HMO)**

HMOs offer an approved network that includes a limited choice of doctors and hospitals. You must choose a primary care physician (PCP) from the list of approved doctors in this network. Your PCP must approve the majority of services before they will be covered by the plan. If you go to doctors, hospitals, or Transplant Centers outside the HMO plan network without plan approval, then you usually will have to pay those costs. The plan most likely will not pay them.

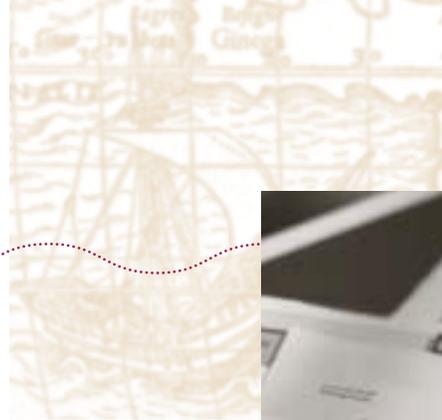
✦ **Preferred Provider Organization (PPO)**

Like an HMO, this plan offers an approved network of physicians, hospitals, and Transplant Centers. If you choose a physician or hospital within the PPO-approved network, then your costs for treatment are lower. Most PPOs, unlike HMOs, allow you to see a doctor outside the plan network, but your costs will be higher than if you stayed with an in-network provider. You also may be asked to pay a yearly deductible and coinsurance if you go outside the PPO network of doctors and hospitals.



✦ **Point of Service (POS)** A point-of-service plan combines features of an HMO, a PPO, and an indemnity plan (a plan that asks you to pay a certain amount before the insurance plan begins payment). POS plans are usually less restrictive than HMO and PPO plans, and the indemnity plan portion is the least restrictive for the out-of-pocket costs. Although you can choose doctors and hospitals outside the network, your costs will be lower if you stay in the network.

It is important to note that many plans today are not pure HMO or PPO plans. There are many variations in how a specific plan works. Review your plan and ask questions to determine exactly how your plan operates.

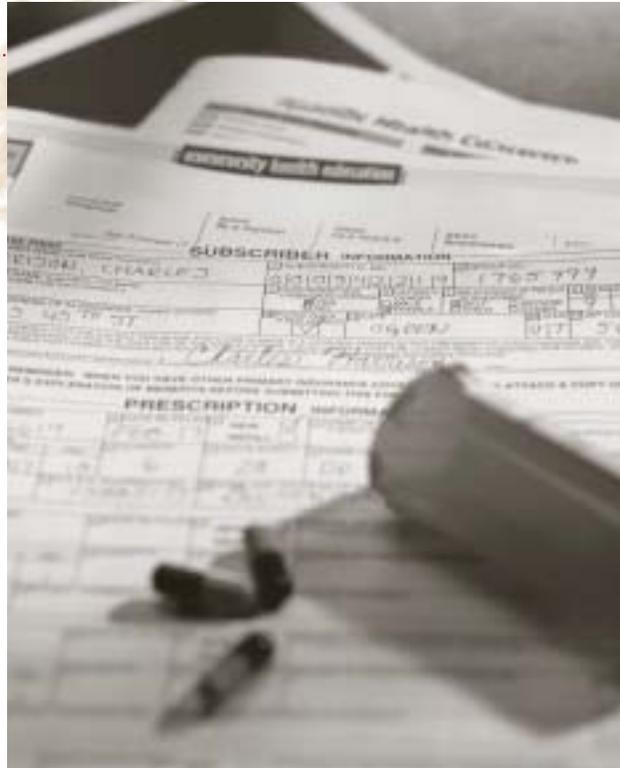


## **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)**

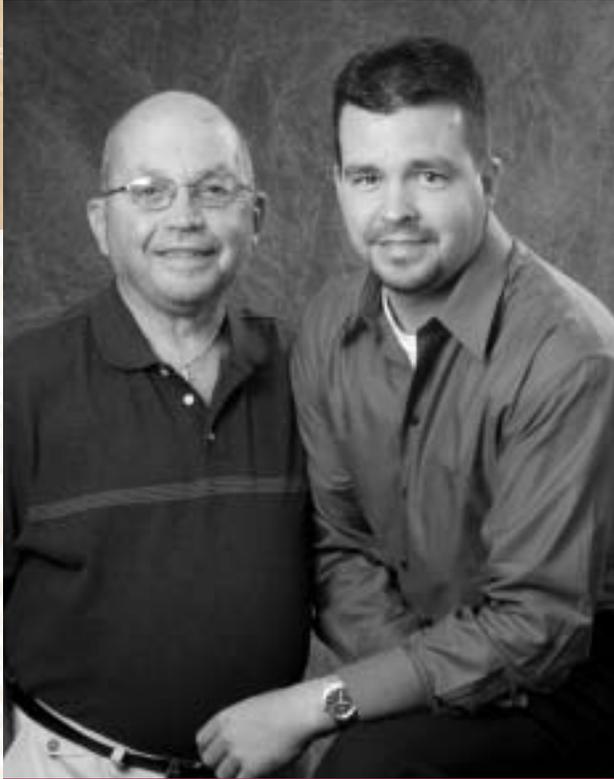
COBRA is a law that lets you stay on your former employer's health plan, if there was one. You qualify for COBRA if you leave your job due to termination, layoff, or resignation. Under COBRA, you can keep your health coverage for either 18, 29, or 36 months after you leave your job, depending on the circumstances. There are many provisions to COBRA, so it is important to talk to your benefits or human resources department about the plan.

COBRA applies to group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local governments. The law does not apply to plans sponsored by the federal government and certain church-related organizations.

If you elect to go on COBRA after you leave your job, it is important to not let your coverage lapse between when your employer's extended coverage ends under COBRA and replacement coverage begins. If you have a lapse in coverage, then you can be labeled as having a "pre-existing" condition under the new coverage. If you are labeled with having a pre-existing condition, then you may find that you have exclusions under future policies. Therefore, be sure that you do not let coverage lapse for more than 62 days between the end of one policy and the beginning of the next one.



In addition to COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as the Kennedy-Kassenbaum Act, provides protection to individuals who might be classified as having a pre-existing condition when moving to a new health plan. HIPAA limits exclusions for pre-existing conditions and prohibits discrimination against employees and dependents based on their health status. For more information on HIPAA, go to: [www.dol.gov/pwba](http://www.dol.gov/pwba).



*James and son, Jeffrey (donors)*

## **Medicare**

Medicare is a government program that pays for medical care. Many doctors and hospitals accept Medicare. You qualify for Medicare if you are over age 65 and retired. You also may qualify for Medicare if you are under the age of 65 and disabled. You are considered disabled if you have been on Social Security for 24 months or less, depending on your illness.

For details, please see the “Patient Resources” section starting on page 52 for information on how to contact your local Medicare office.

Medicare has two parts: Part A and Part B. Part A helps pay for inpatient hospital care and certain follow-up services. Part B helps pay for doctor’s services, outpatient hospital care, and other medical care. You must be enrolled in both Part A and Part B to have transplant coverage. However, Medicare does not pay for transplants for all diagnoses. Generally, your prescription drugs will not be covered under Medicare.

## **Medicaid**

Medicaid, also called Medical Assistance, is a jointly funded, federal-state health-care program for individuals with low-income levels. To qualify, your income and assets must be below a certain level, which is determined by the state where you live. Medicaid can be restrictive because not all hospitals and doctors accept it. Not all Transplant Centers will accept Medicaid from other states because of low reimbursement levels or the lack of reimbursement. You can contact your state’s Department of Health and Human Services for eligibility information, or ask for assistance from the financial or social services department of the Transplant Center.



### **Veterans benefits**

If you are a veteran, you may be able to qualify for benefits from the federal government. The Veterans Health Administration (VHA) may require that you go to a special hospital, which is not always the closest one. On the other hand, the VHA also may pay for some out-of-pocket expenses, such as housing. The number of VHA hospitals is decreasing, and VHA benefits are changing as well, so you should contact the U.S. Department of Veterans Affairs at 1-800-733-8387 for information or visit the Department of Veterans Affairs Web site at [www.va.gov/elig/](http://www.va.gov/elig/).

### **Disability programs**

Disability coverage is insurance that pays a portion of your income if you are unable to work. Many post-transplant patients are not able to work for at least a year after the procedure. Having disability coverage is important to your peace of mind during your healing and recovery process. There are two categories of disability programs: work related and government sponsored. Disability income insurance plans vary, so check with the plan administrator to see how your policy defines a disability. There are many variations in the definition of disability, so read the policy carefully and ask questions about things that you're not sure about.

#### **Work-related disability programs**

Some employers offer disability coverage as one of the options in the benefits package. Disability coverage generally falls into two types: long term and short term.

- ✦ ***Short-term disability insurance*** usually pays benefits for six months to two years. How much money you get depends on how much you earned.
- ✦ ***Long-term disability insurance*** usually pays for at least a year, and often lasts until age 65, or for life. If it is an employee benefit, it will be a percentage of your base salary or wages. If it is personally owned, it will be a specified amount.

If you are not covered by work-related disability coverage, then a government-sponsored disability program may cover you.

### **Government-sponsored disability programs**

There are two basic types of government-sponsored disability programs: *Social Security Disability Insurance (SSDI)* and *Supplemental Security Income (SSI)*. SSDI is based on money you have paid into Social Security through payroll tax. SSI is a program for people, including children under 18, who are disabled and have limited income and resources. Both programs will provide a monthly payment if you are unable to work. (Most patients are unable to work for at least a year after the procedure.)

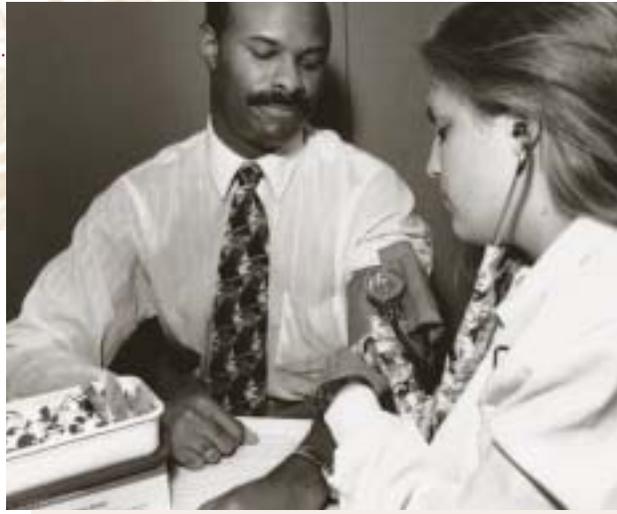
It is possible to qualify for both SSDI and SSI. Eligibility is based on a determination by your doctor that your disability will last for one year or longer. You already may qualify to start receiving benefits based on your income or date of disability. If you are covered under your employer's disability plan, either short or long term, your employer will assist you in deciding when to apply. Your Transplant Center staff also can help you get information about these programs.

✦ ***Social Security Disability Insurance (SSDI)*** provides monthly cash benefits to people who are unable to work for a year or more because of a disability. SSDI has two basic requirements: that you qualify as disabled,



and that you have worked a certain length of time and have paid Social Security taxes during that time. Contact the Social Security Administrator at 1-800-772-1213 to see if you qualify or visit their Web site at [www.ssa.gov/disability](http://www.ssa.gov/disability).

✦ ***Supplemental Security Income (SSI)*** is a federal income supplement program funded by general taxes, not by Social Security taxes. SSI is needs based and can start right away. SSI helps people who qualify as disabled and have little or no income. SSI provides money to pay for basic needs such as food, clothing, and shelter. If you qualify for SSI by meeting minimum income requirements, then you also may be eligible for Medicaid, which can help cover medical costs. To see if you qualify for SSI, call the Social Security Administration at 1-800-772-1213. You also can contact a social worker at your Transplant Center for assistance.



In addition to the work-related and government-sponsored disability programs, your auto loan, mortgage, or credit cards may have disability waivers to help pay for costs if you are unable to work. Contact the individual companies to see if they have disability waivers as part of the loan.

My health-care plan is: \_\_\_\_\_

Contact information: \_\_\_\_\_

My disability plan is: \_\_\_\_\_

Contact information: \_\_\_\_\_

**Comprehensive health insurance for high-risk individuals**

Comprehensive health insurance may be available—even if you are considered a “high-risk” individual. State programs, sometimes called “risk pools,” serve people who have been restricted or denied health insurance coverage because of a pre-existing health condition, or who cannot afford the high rates of private insurance. For more information about risk pools, you may call the NMDP Office of Patient Advocacy at 1-888-999-6743 or the Patient Advocate Foundation at 1-800-532-5274.

**Understanding your health-care plan**

In the previous section, you learned about the different types of health-care plans and were asked to find out what kind of coverage you have. The next step is to understand the important features of your plan. You will want to know how your plan defines and treats coverage for pre-existing conditions, deductibles, co-payments, exclusions, and maximum lifetime amounts of coverage.



## Medical Plan Features and Definitions

Feature	Definition
Pre-existing condition exclusion period	A health condition that you had before you were covered by a medical plan. You may have to wait for a certain period of time after the plan goes into effect before treatment for the condition will be covered. Note: If you had continuous coverage before this plan, you will probably not have a pre-existing exclusion period.
Clinical trial	A series of carefully controlled scientific studies using a limited number of patients.
Deductibles	An amount of money you must spend on medical bills before the plan begins to pay.
Co-insurance	The portion of the expense that you pay. For example, the plan may pay up to 80% of the approved cost of a treatment. You would then have to pay the remaining 20%.
Out-of-pocket limit	The most that you would have to spend per person, per year. This amount will vary according to your plan.
Co-payment (co-pay)	The amount of money you are required to pay each time you visit your health-care provider. (Co-pays for emergency care, medical treatment, and hospital stays are generally higher.)
Exclusions	Certain illnesses the plan will not cover. Ask if unrelated stem cell transplants are covered.
Lifetime maximum payment	A limit to the amount your plan will pay during your life or for certain conditions. A good plan has unlimited or \$1 million lifetime maximum payments.
Pre-authorization	Approval you must get before you begin a procedure.



*Zak (transplant recipient) and his father, Gary*

## Clinical trials coverage

Your Transplant Center may be conducting clinical trials for transplant procedures. These clinical trials might be a way for you to receive state-of-the-art treatment for your medical condition. If you have an opportunity to be part of a clinical trial, you should find out from your plan representative if participation in these trials will reduce the amount of coverage that you receive. If your health-care plan will not approve coverage for clinical trials, then you and your representative from the Transplant Center will be sent a letter of denial. The letter of denial will outline the reasons you have been denied coverage for clinical trials. Even if this happens, you should not be denied coverage of routine patient care costs for being part of a clinical trial. If you are denied coverage for clinical trials, follow the steps in Chapter Four, “Helping Yourself,” on page 36.

## Pre-authorization process

Many health-care plans require you to get approval before you begin a procedure. This is called “pre-authorization.” Your doctor or other health-care provider will gather information about your case and present it to your health-care plan. The health-care plan either will approve or deny the procedure. You will receive a letter of denial if the health-care plan does not approve the procedure. This letter of denial will outline the reasons why the plan did not approve your procedure. If you are denied coverage, take the steps in Chapter Four, “Helping Yourself,” to appeal the denial.

## Second opinions

After you receive a diagnosis or a treatment recommendation from your doctor, you may want to get another opinion from a different doctor. This is known as “getting a second opinion,” and it may not be covered under your health-care plan. You also may find that your health-care plan will only approve second opinions from doctors within the provider network. If you want to get a second opinion and your request has been denied, take the steps in Chapter Four, “Helping Yourself,” to appeal the denials.

## Coverage for new treatment options

Your Transplant Center may offer new treatment options. These treatment options may not be accepted by your health-care plan. Sometimes, health-care plans don't have enough information yet to make informed decisions about new treatment possibilities. In other cases, your health-care plan representative might not agree with the recommended new treatment. If you have requested that this new treatment be covered and have received a letter of denial, then you should follow the steps for appealing denials that are outlined in Chapter Four, "Helping Yourself," on page 36.

Not all health-care plans cover blood stem cell transplants. Some health-care plans will cover your unrelated transplant, but may not cover all the services that you need before or after the transplant. Some of the indirect costs of a blood stem cell transplant may not be covered. Indirect costs are items or services you need in order to get your transplant, but are not part of the actual transplant. These costs may include: tests to find an unrelated donor, some prescriptions, or lodging and transportation to be near the Transplant Center.



Here's how to find out what your plan does cover. First, you will need a detailed copy of your health-care plan. This is different from the short summary of benefits you may have received from the insurance company. You can ask a representative from the health-care plan for the benefit booklet that outlines the coverage guidelines. Once you have read through the benefit booklet, call the plan representative and ask questions about coverage for your specific procedure. Before you make the call, complete the chart on the next page about your plan and have it in front of you.



## Information Your Health-Care Plan Representative Will Need

Employer \_\_\_\_\_

Employee name \_\_\_\_\_

Employee Social Security or ID number \_\_\_\_\_

Policy number \_\_\_\_\_

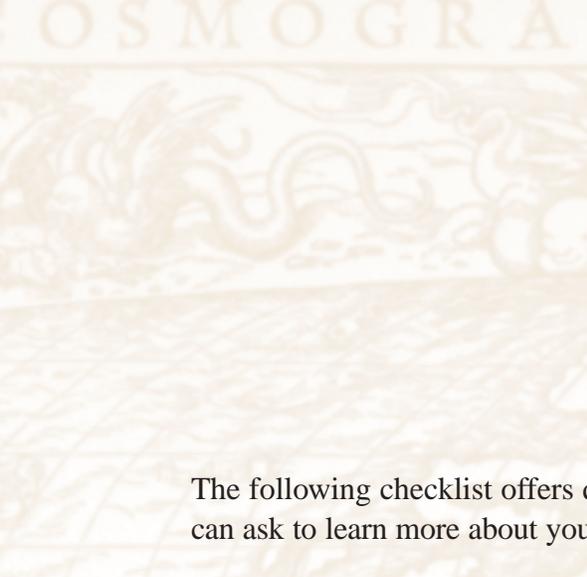
Group number \_\_\_\_\_

Member number \_\_\_\_\_

Effective date for employee and/or dependents \_\_\_\_\_

Remember to always take notes when you talk to plan representatives or health-care providers. Be sure to write down the name of the person with whom you talked and the date of the call. Take notes during the conversation and keep these notes. You may need this information later if you try to appeal a denial from the health-care plan.

The person with whom you speak may offer an interpretation of the plan over the phone. Many health-care plans do not consider a verbal interpretation as a guarantee of payment. If you do receive a verbal interpretation, be sure to also ask for it in writing.



The following checklist offers questions you can ask to learn more about your exact coverage.

### Questions to Ask Your Health-Care Plan Representative

<b>I talked to:</b>	<b>Date:</b>	
<b>Question to Ask</b>	<b>Yes / No</b>	<b>Comments</b>
Am I covered for treatment of my medical diagnosis under my plan?		
Does my plan have a pre-existing condition clause? If so, how is it defined?		
Is my illness considered a pre-existing condition?		
Does my plan have deductible and coinsurance amounts? If yes, what are they?		
Does my plan have a co-payment? If yes, how much?		
Does my plan have a co-payment for prescriptions? If yes, what is the co-payment?		
Is there a maximum amount of money out-of-pocket that I would be responsible for each year? If yes, how much?		
Which costs are considered for my out-of-pocket maximum?		

Question to Ask	Yes / No	Comments
Does my plan cover unrelated stem cell transplant for my diagnosis? If yes, are there limits?		
Does my plan have a maximum amount it will pay out in charges (a lifetime amount)? If yes, how much?		
Are there any coverage exclusions in my plan? If yes, how long is coverage excluded?		
If my plan covers a blood stem cell transplant, does this amount include outpatient as well as inpatient services?		
Does my plan cover expenses for testing to find a matched donor?		
If my plan covers testing to find a matched donor, are there any limits or exclusions to this coverage? If so, what are they?		
Does my plan cover the costs to obtain stem cells from an unrelated donor? If yes, are there limits?		
Does my plan have a limit to the number of transplants that I can receive in my lifetime?		
Does my plan cover the costs for clinical trials? If yes, are there limits?		
Can my health-care plan tell me what criteria it uses in selecting providers?		
Does my plan have any restrictions on which Transplant Centers I can use (designated provider network)?		
Are the Transplant Centers I'm considering in the plan's provider network?		

**Question to Ask****Yes / No****Comments**

Will my plan provide coverage for me at an out-of-network provider? If yes, will my out-of-pocket expenses be higher?		
Does my plan cover a consultation at one or more Transplant Centers?		
Is pre-authorization necessary for treatment? If so, who may request this approval? To whom should the request be made?		
Will the plan pay for a second opinion?		
Does the plan cover indirect expenses, such as travel, food, and lodging costs while I am at the Transplant Center? My family's indirect expenses?		
If the plan covers travel, food, and lodging costs, how much will it pay for these items? Does it include coverage to support a person to come with me?		
Does the plan cover outpatient medications? If yes, is there an approved list of covered prescriptions?		
If there is an approved list for prescriptions, will the plan ever make an exception? If yes, how do I request this exception?		
If I have a complaint, or want to appeal my coverage, how do I do that?		
Is there a time limit for making a complaint or an appeal?		
Is there a limit to the number of appeals that can be made on my behalf? If yes, what is it?		
Who is my case manager and what is his/her phone number?		



## Costs assessment

You can use the answers you receive about coverage for your transplant procedure to help you estimate your out-of-pocket costs for the procedure. In addition to the costs related directly to the transplant procedure, there are indirect costs—costs related to the transplant that are not part of the medical procedure—that you need to include. An example of an indirect cost would be temporary living arrangements for you and your family. Once you have completed the worksheets in this section, you’ll know how much money you will need to have for your procedure and its related indirect costs. You’ll also know if you need to raise money for the transplant procedure.

Your Transplant Center staff will assist you in gathering this information. They will initiate benefits inquiries with your health-care plan once you and the Transplant Center staff



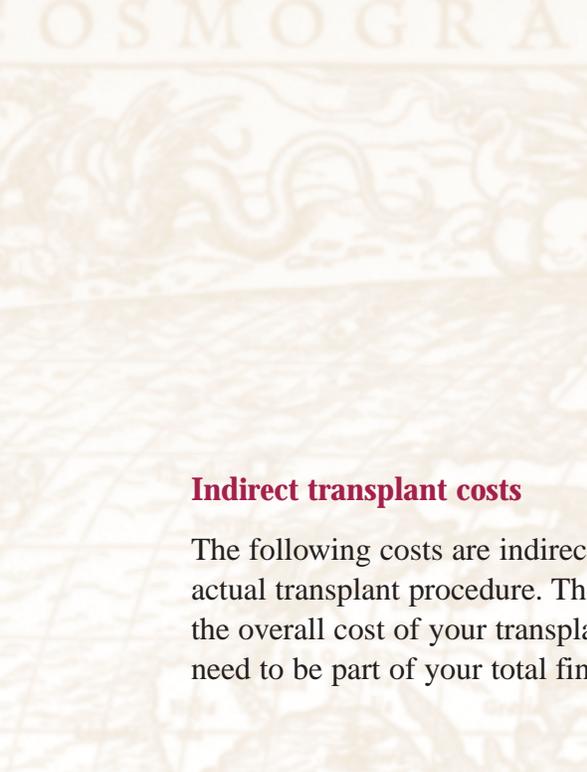
*Kevin (donor)*

decide to search the NMDP Registry for an unrelated donor. You also should work closely with the Transplant Center staff to discuss payment options.

### Current living costs

Use the Monthly Expense Worksheet on pages 32-33 in Chapter Three, “Developing a Financial Plan,” to calculate your current living costs.





### Indirect transplant costs

The following costs are indirectly related to the actual transplant procedure. They are related to the overall cost of your transplant, however, and need to be part of your total financial plan. You

may have covered some of these costs when you talked to the health-care plan representative. These are often large costs that are sometimes covered, but often are not. Be sure not to overlook these costs in your financial plan.

Indirect costs		
Cost	Estimate	Amount covered by insurance
Testing to find a matched unrelated or related donor		
Donor costs		
Transplants for a rare diagnosis		
Travel and lodging expenses to and from the Transplant Center for patient and/or support person		
Food costs while staying near Transplant Center		
Parking costs		
Prescriptions for post-transplant discharge or outpatient medications		
Office visits coverage		
Home health care		



Cost	Estimate	Amount covered by insurance
Psychiatric coverage		
IV Neupogen injections		
Procurement of stem cells from the donor		
Harvest/storage fees prior to transplant		
Backup collection of stem cells		
Clinical trials		
Sperm/egg storage		
Insurance premiums when patient is not employed		
Fees for post-transplant home-preparation (carpet and drapery cleaning, replacing filters on heaters, air conditioning cleaning)		
Change in cost of living after transplant (different food needs, for example)		
Wigs		
Child-care costs		
<b>Total</b>		



### Transplant Center estimates and payment requirements

Use the table below to estimate the total costs and coverage at the Transplant Center. Call your Transplant Center staff and ask them to provide you with a cost estimate for your procedure.

Once you know how much your procedure will cost, you will know how much to plan for. Your Transplant Center staff will assist you in gathering this information. Ask to speak to the Transplant Center financial representatives. They will work with you on payment options.

#### Cost and coverage table

Costs	Amount
Requested initial deposit	\$
Estimate of indirect costs	+ \$
Estimate of uncovered costs	+ \$
Estimate of total cost	= \$
Estimate of covered costs	- \$
<b>Balance remaining</b>	<b>= \$</b>

Once you know the total cost of the transplant procedure and how much you have to cover, ask a representative of the Transplant Center the following questions:

1. How can I break the cost into payments?
2. What is the amount of each payment?
3. When is each payment due?



## Taking your financial inventory

What is a financial inventory and what does it include? A financial inventory is a list of your assets (what you own) and your liabilities (what you owe). If you subtract your liabilities from your assets, you will know your net worth. Use the worksheet on the next page to list your assets and liabilities. The worksheet will help you calculate your net worth.

Here are some examples of assets:

### Personal savings and investments

Checking and savings accounts in a bank or credit union, money market funds, mutual funds, stocks or bonds, or any other financial assets you own.

### Personal property

Real estate, such as houses or land, furniture, cars, artwork, jewelry, coin collections, or other valuables.

### Retirement benefits

Money you have in 401(k) plans, Individual Retirement Accounts (IRAs), and pension plans from your company.

### Life insurance

Either term (set period of time) or permanent coverage. Term insurance does not have a cash surrender value. It pays money to your beneficiary when you die. If you stop paying premiums, the coverage ends. Permanent insurance builds up cash value as you make payments. This cash value is an investment feature of a permanent

policy because you can borrow against it if needed. It is also the key factor in making the policy capable of lasting a lifetime—even to age 100.

### Long-term care insurance

Long-term care insurance pays for care in a long-term care facility, such as a nursing home. Or, it may pay for home care, adult day care, and sometimes respite care so the caregiver can take a break.

### Mortgage insurance

Mortgage insurance comes in many forms. It may be nothing more than a life insurance policy that pays an amount adequate to pay off a mortgage when the insured dies. Or, it may make the payments on your mortgage if you are sick or disabled.

### Disability programs

Disability programs offer coverage that pays a portion of your income if you are unable to work. Having some kind of disability coverage may be one of your main sources of income during the time you are recovering from your transplant procedure, so it is important to understand your coverage.

There are two categories of disability programs: work related and government sponsored. Work-related programs usually fall into two categories: short-term or long-term coverage. The two types of government programs are Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). See the “Disability programs” information on page 11 in the “Take a look at your health-care coverage” section for more information on disability programs.

## Calculating your net worth

Using this table as a guideline, make a list of what you own (your assets). Next make a list of what you owe (debts or liabilities). Subtract what you owe from what you own to estimate your net worth.



### Net Worth

<b>Assets</b>	<b>Value</b>
Home	\$
Car	\$
Checking account(s)	\$
Savings account(s)	\$
Other investments (mutual funds, stocks, bonds, etc.)	\$
Retirement plan(s)	\$
Life insurance cash values	\$
Furniture and artwork	\$
Jewelry and collections	\$
Rental property	\$
Business	\$
Other	\$
<b>Total assets</b>	<b>\$</b>



<b>Liabilities</b>	<b>Amount Owed</b>
Home mortgages(s)	\$
Car loan balance	\$
Credit card debt(s)	\$
Other loans	\$
Other debts	\$
<b>Total liabilities</b>	<b>\$</b>
<b>Net Worth (Assets minus Liabilities)</b>	<b>\$</b>



**Note:** List assets at liquidation value rather than replacement value. Liquidation value is the value at which items can be sold; replacement value is the cost to replace the item with a new one.