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Navigating Your Health Benefits

FOR
DUMMIES®

3rd Edition

**Making
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Easier!™**

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Includes NEW
information on
the Health Care
Reform law

**Wendy A. Richards, MD,
MBA, FAAP**

Aetna

Tracey A. Baker, CFP®

Financial Planning Association



"If ever there were a time for people to get smart about health benefits — it's now. Concerns about increasing health-care costs, coupled with what can be elusive facts on health reform, can lead to consumer confusion. And that lack of understanding can be a barrier to better health.

Millions of people are beginning to make the connection between health reform and their own health benefits. In fact, close to 70 percent of Americans say they are paying more attention to what health-care options are available to them due to the new health reform law*. Yet, more than half of Americans think reading Shakespeare is easier than reading their health insurance policy.

Navigating Your Health Benefits For Dummies continues to provide the wealth of information you need to help maximize your benefits. We've also updated the book with key facts to help you stay up to speed on health reform changes.

As always, we've used easy-to-understand explanations to help you get the most from your health benefits — now and over the next several years."

— *Susan M. Kosman, RN, MS*
Aetna's Chief Nursing Officer

***About the Survey**

These results are based on a survey conducted by Kelton Research between September 13 and 21, 2010, using an e-mail invitation and an online survey. A total of 1,015 people responded to the survey. Quotas are set to ensure reliable and accurate representation of the U.S. population, ages 18 and over who have health insurance.

Navigating Your Health Benefits

FOR
DUMMIES®

3RD EDITION

**by Wendy A. Richards, MD,
MBA, FAAP**

and Tracey A. Baker, CFP



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The 5th Wave

By Rich Tennant



"The first thing we should do is get you two some good insurance. Let me get the 'Magic 8-Ball' and we'll run some options."

Introduction

N*avigating Your Health Benefits For Dummies*, 3rd Edition, guides you through the twists and turns on the road to health. Signs posted along the route point to avenues you need to visit and side trips you may want to explore. In this edition, you also get useful information about how the Health Care Reform law affects you. We hope you enjoy the ride!

About This Book

This small book offers concise, easy-to-read, and easy-to-understand explanations of many aspects of health benefits. This includes finding the right coverage, deciding what options you want (the selections can seem overwhelming), using your benefits to your best advantage during various stages of your life, and dealing with paying for it all.

You pay good money for your health benefits and have a right to know how they work. This book gives you information to help you understand them.

All this in what we fervently hope is an enjoyable manner and in a format designed to let you dip in wherever you like to get complete information about the topic you're interested in.

Conventions Used in This Book

Words and terms in *italics* are defined in the surrounding text. **Boldface** type indicates the key term in a bulleted list — the salient point, as it were.

Foolish Assumptions

The only assumptions we make are that you read English and are interested in making the most of your health benefits.

How This Book Is Organized

This book's seven chapters each focus on one aspect of the health-benefits landscape:

- ✔ **Chapter 1, Maximizing Your Health Benefits in a Tough Economy**, tells you how to make the most of your health plan in an unkind economy. From the financial basics of health plans to being paid to live a healthy lifestyle, this chapter tells you how to get the most benefits for your bucks.
- ✔ **Chapter 2, Choosing Your Health Benefits**, takes you through the process of understanding the range of benefits to deciding which of those benefits you need and finding a plan that has them. This chapter also offers info on dealing with the once-a-year Open Enrollment opportunity to make changes to your benefits, if you are enrolled in a plan offered by an employer.
- ✔ **Chapter 3, Making the Most of Your Health Benefits**, offers insight into the nuts and bolts of dealing with everyday issues such as finding a doctor, getting prescriptions filled, and dealing with emergencies.
- ✔ **Chapter 4, Meeting Life Head-On**, talks about the adjustments you face getting married or divorced, starting a family or adapting to an empty nest, finding a job, losing a spouse, and easing into retirement.
- ✔ **Chapter 5, Paying Up**, lets you know what you have to pay for and explains how your health plan keeps you informed of your financial responsibilities.
- ✔ **Chapter 6, Speaking Up**, suggests ways to communicate with your health plan and offers pointers on how to file a claim and appeal a decision.
- ✔ **Chapter 7, Tracking Needs for Next Year**, shows you how to evaluate your current benefits in preparation for making an informed choice next time.
- ✔ Last but not least, no *For Dummies* book would be complete without a Part of Tens element. Here we give you a handy cheat sheet called **Ten (Or So) Important Points to Remember** outlining simplified main elements of the Health Care Reform law passed by congress in March 2010, along with some ways to, well, maximize your health benefits, what else?

Icons Used in This Book

For Dummies books all use little pictures in the margins to point to information of special interest. These are the icons in this book.



The Internet is a prime source of health information, and this icon points you to useful and informative Web sites.



The old string-around-the-finger image highlights tidbits to keep in mind as you pursue the topic at hand.



Advice that can make your health-benefits life a little smoother is indicated with this on-target bull's-eye.

Where to Go from Here

Simply turn the page.

The 5th Wave

By Rich Tennant



"I was just surprised you put the word 'Marriage' next to the question asking if you suffered from a chronic condition."

Chapter 1

Maximizing Your Health Benefits in a Tough Economy

.....

In This Chapter

- ▶ Understanding the workings of a health plan
 - ▶ Stretching your health-care dollars
 - ▶ Taking advantage of preventive care
-

Face it: Today's economy is challenging. People are cutting costs everywhere they can. They're searching out sales and taking "stay-cations" instead of vacations. Sadly, some people are losing their jobs, and as a result, their health benefits. Others are just finding life's expenses too tight and are foregoing health insurance altogether.

But health benefits make the bite of everyday medical costs bearable and the specter of major medical problems a bit less threatening, at least from a financial viewpoint.

In this chapter we talk about what a health plan is designed to do, which is to help safeguard you from the considerable costs of hospital stays, surgical procedures, visits to the doctor, prescription drugs, and routine preventive care. We also talk about the fact that with medical costs continuing to rocket ever higher, you need as strong a shield as you can get.

How a Health Plan Works

In return for paying a *premium* (basically the cost of a health plan), you gain protection from the potentially high cost of

medical care. Even when you add in other costs, such as the *deductible* (the fixed amount you have to pay before your insurance starts kicking in its share of your health-care costs), a *copayment* and/or *coinsurance* (a set amount or percentage you pay to a health-care provider), the cost of paying for health benefits can be far less than paying for medical care on your own. Plus, belonging to a health plan opens the door to a network of medical providers who agree to accept lower rates negotiated by the health plan.



A health plan offers a wealth of information to help you make the best decisions about your and your family's health. Tools provided by your plan can help you choose a doctor, and programs can offer ways to help you work toward achieving your health goals.

Stretching Your Dollars

Want to hear a secret? Your health benefits can *save* you money. You may be able to put thousands of dollars per year back into your bank account and say “adios” to your “stay-cation.”



The next sections offer ways to stretch your health-care dollars. Be sure to also check out the handy tear-out sheet at the end of this guide for top tips on maximizing your health benefits.

Being uninsured is hazardous to your health — and your finances

Groups such as the National Coalition on Health Care that have looked at how health-care coverage affects your health have discovered that being uninsured is related to several undesirable tendencies:

- ✓ You receive less preventive care, including screening tests that can detect health problems in earlier, more treatable stages.

- ✓ You delay going to the doctor. And, a late diagnosis may limit your treatment options.
- ✓ You are 30 to 50 percent more likely to end up in the hospital for an avoidable condition.

So, even if times are tough, it's easy to see that going without health benefits can put you and your family at serious health and financial risk.

Anticipating savings “in the mail”

Many health plans offer discounts if you use mail-order pharmacies. You may get a three-month supply of a routine drug for the cost of a two-month prescription. You’d certainly take advantage of a “buy two, get one free” deal at the grocery store, so why not do it with your prescriptions as well? And the convenience of home delivery can’t be beat!



Be sure you understand the ramifications of using a mail-order prescription drug service. It takes a few days to get your meds, so plan ahead. You may also have only ten days to return an order if there is a problem (perhaps you didn’t receive all your pills). Be sure to contact the mail-order pharmacy right away if you need a situation fixed.

Going generic

In 2008, the average brand-name prescription drug cost about \$85 more than the average generic. By switching just one prescription for a medication you take routinely to generic, you could save more than \$1,000 a year!



Talk to your doctor if you have concerns, but generally doctors are in favor of generic drugs.

Staying inside the network

Make sure your doctors are in your health plan’s “network” of medical providers — and if they aren’t, ask them to join. Even if your health-benefits plan has “out-of-network” benefits, using an in-network physician usually costs considerably less.

A simple outpatient procedure such as a colonoscopy could cost you significantly more if you go out of network.

Visiting your doctor online

Some doctors offer online consultations, which are often more convenient than in-person visits — and you save on gas and time. Talk to your doctor or your insurer to find out whether online visits are available and covered, and how to use online visits properly as well. (Turn to Chapter 3 for tips on maximizing talks with your doctor.)

Taking advantage of discounts

You may be able to access money-saving discounts through your health plan, like discounts for vision and dental care, or on services such as acupuncture, nutritional supplements, and massage therapy. Consider taking advantage of discounts on gym or health club memberships, exercise programs and equipment, smoking cessation programs, and more. You wouldn't throw away valuable coupons from the Sunday paper, so why not take advantage of these discounts?

Being Paid to Be Healthy

Many health insurance companies as well as more and more employers are offering *wellness incentives* — rewards for living a healthy lifestyle.

Just for making healthy lifestyle choices and tracking your progress, you could earn wellness rewards, in some cases up to \$600 per year — enough money for about ten fill-ups at the gas station, unless you're stuck driving a gas hog. Keeping your health insurer updated on your health also enables your doctor to tailor your health program to fit your needs. Personal Health Records are a great way to maintain your health information. (Chapter 3 has details on these records.)



Get routine health screenings to help you identify problems early; doing so can increase your options for treatment. Look to local agencies for free or low-cost programs (Chapter 4 has more about these programs).

Maintaining your health — by living a healthy lifestyle that includes eating right, exercising, and not smoking — may reduce your risk of getting cancer as well as serious, chronic diseases.



Health is not merely the absence of disease; it's a lifestyle. Whether it's getting enough sleep, taking a walk after a stressful day, or enjoying a hobby, it's important to balance work, home, and play.

Chapter 2

Choosing Your Health Benefits

In This Chapter

- ▶ Making sense of the plans
 - ▶ Making your choice
 - ▶ Gearing up for Open Enrollment
-

Yes, you may make bigger decisions — choosing who to marry or whether to marry, which house to buy, whether to accept that job overseas. Yet, deciding on your health-benefits plan has a strong impact as well, at least in the short term until Open Enrollment or another opportunity to adjust your benefits comes along.

This chapter takes you through the factors to consider as you enter the wild and wonderful world of health benefits.

Picking Up the Basics of Benefits Plans

Multiple types of health benefits abound, with acronyms ranging from HSA to HBO, er, make that HMO. Helping you understand the difference between a health savings account (HSA) and a health maintenance organization (HMO) — as well as the rest of the health alphabet — is what this section is all about. (Home Box Office, or HBO, doesn't come into play unless you're laid up for a while.)

And, as long as we're in back-to-basics mode, what is a health-benefits plan anyway? Well, at a basic level, a *health-benefits plan* provides payment for certain health-care services. Plans range from those that cover only specific services such as hospitalization or dental care to plans that offer more complete benefits for nearly every health need and everything in between.

You generally join a health plan through your job (or your spouse's or partner's job), in which case your employer may pay all or part of the *premium*, which is the cost of a health plan. You can also purchase coverage on your own (see the upcoming section, "Buying your own benefits").

States offer coverage of health-care costs through Medicaid or the Children's Health Insurance Program for folks at low-income levels who can't afford health benefits. Contact your state's health and human services department to find out more.

Expanding on the plans

If you have health benefits through your job, your employer selects the coverage options available through your health plan. If you want coverage of something your plan doesn't have — chiropractic care, for example — talk to your company's health benefits or human resources director.

Your company may offer more than one type of health plan to encompass most of your health needs. The next sections explain the major types of health-benefits plans that cover medical expenses, such as hospital stays and services, and may include coverage of prescription drugs, dental, and behavioral/mental health services.

The evolution of health-care plans has gone from traditional plans (in which you pay a percentage of the cost of your medical care after meeting a *deductible*, the fixed amount you have to pay before your insurance starts kicking in its share of your health costs) to managed care (in which you have a network of physicians as well as programs to help manage your care) and on to newer plans (in which you have the option to direct how your health-care money is spent).

Honoring traditional plans

In a traditional *fee-for-service plan*, you are reimbursed for a percentage of the cost of covered services you receive (although the payment may go directly to your doctor or other care provider).

The upside is that your applicable fees (such as deductibles, copays, and coinsurance) are the same for any doctors you choose, regardless of whether they're in the health plan's network; the downside is that the doctors you choose may charge more for some services than the insurance company pays. You may be making up the difference more than you'd like.

Networking within a managed care plan

Managed care plans introduced a raft of acronyms into the modern health lexicon, starting with HMO. *Managed care plans* are characterized by having a network of physicians and hospitals. If you stay within the plan's network of participating health-care providers, your out-of-pocket expenses generally are lower; if you stray outside the network, however, you may feel it in your wallet.

Popular managed care plans come in three flavors, known best by their abbreviations:

- ✔ **HMO (Health Maintenance Organization):** Generally, you select a primary care physician (PCP) who coordinates your care and refers you to specialists when needed.

If you get care from someone not in the network, expect to pay more of the cost and potentially the full cost yourself unless you need care that no physician in the network can provide.

- ✔ **PPO (Preferred Provider Organization):** As with an HMO, you can choose from doctors within your network, but you don't have to designate one doctor as your PCP. PPOs also offer out-of-network coverage, though you pay a higher portion of the cost.

- ✔ **POS (Point-of-Service):** Almost a combination of an HMO and a PPO — check the two previous plans — with a POS you can choose to get care from both network and out-of-network physicians. In many POS plans, if you get a referral from your PCP, you don't pay as much as you do if you bypass your PCP.



Directing your own plan

Consumer-directed health plans (CDHPs) are relatively new types of health plans that have been gaining in popularity in recent years. They are designed to give you more control over your health-care spending.

These acronym-heavy plans combine a *high-deductible health plan* (with a deductible of at least \$1,200 for an individual and \$2,400 for a family, periodically adjusted for inflation) with some type of health account that you can draw on to pay for qualified medical expenses. What a qualified expense is depends on what type of account it is.

Most health funds allow you to roll over unused dollars from year to year — with Flexible Spending Accounts the notable exception (keep reading) — as long as you stay in the plan. Some plans allow the funds to go with you, even if you change jobs.



Whether you already have a consumer-directed plan or are thinking about signing up for one, finding out how they work is the first step to making sure you spend your health-care dollars wisely.

CDHPs have many of the features of traditional plans or PPOs (see the preceding two sections) but also include an account you manage yourself. The current funding choices include

✓ **Health Savings Account (HSA):** To put money in an HSA, your health plan has to qualify as high-deductible. The good news is that if it does, you can use funds from your account to pay that deductible.

If you qualify to open an HSA, you can deduct your contributions from your income tax or contribute pre-tax dollars from your paycheck if your employer has a cafeteria plan (also known as an IRS 125 plan) that offers a choice of benefit options. You may also add in a contribution from your employer, and have your spouse or Uncle Elmer kick in, too — money from family members is welcomed. The amount of annual deposits to your account is limited under IRS guidelines, so check with your employer or the IRS to find out what your limits are — and don't be disappointed when the sky isn't the limit.



Your HSA money, which you may be able to invest in a variety of funds, earns tax-free interest and is available to you whenever you need it. You can take the account with you if you change jobs and let the balance keep growing as long as you like.

As of this writing, technically no rule exists that says you have to spend HSA dollars for health-care costs. You can usually withdraw cash from your account. However, if you spend the money on nonqualified expenses, it's taxable and will generally be subject to additional penalties of up to 20 percent. You may want to save your HSA dollars for a big health expense (perhaps having a baby or having extensive dental work done — not that having a baby is anything like having teeth pulled) or for future health costs. So, think before you spend.

- ✓ **Health Reimbursement Arrangement (HRA):** Your employer is the one who funds an HRA. You use the money to pay deductibles and covered medical expenses and don't count it as income. Just be aware that your employer defines how you can use the money and that you cannot draw it out in cash.

Note: Leftover dollars remain as long as you stay in the plan, but are lost if you leave it.

Some employers provide a version of this fund, a Retiree Reimbursement Account (RRA), aptly enough, to help employees save for retirement. Ask your employer if your company offers an RRA.

- ✓ **Flexible Spending Account (FSA):** With an FSA, money is taken from your paycheck before taxes and put into an account that you can use to pay for eligible health-care-related services and products as well as certain expenses for your dependents, such as eligible day-care costs. Essentially, you keep more of the money you earn.

The IRS determines which expenses are eligible, so check to see what's allowable either through your human resources department or through the IRS Web site at www.irs.gov/publications/p502/index.html.

Take advantage and use your pre-tax FSA money to pay for them.



FSAs have a “use it or lose it” provision, meaning that if you don’t use all the money you put into the account by the end of the year, your employer gets to keep it. (Some plans extend the deadline to March 15, but you still need to be aware of the cut-off date.) You already give a lot at the office, so stay on top of your FSA contributions and expenditures. You also lose your FSA money if you leave your current employer.



Check your employer’s Certificate of Coverage or Summary Plan Description to find out whether you can contribute to an FSA.

Starting on January 1, 2011, expenses for medicines or drugs that can be purchased over the counter are only eligible for reimbursement if the medicine has been prescribed by a doctor.



Estimate your health expenses and determine which option best suits your needs. The health expense calculator at www.PlanforYourHealth.com can help you to get a sense of your health-care costs.

Understanding other options

Even if your employer offers just one health plan, you may still have additional options, including

- ✓ A separate vision or dental plan
- ✓ Coverage of alternative health-care practices, such as acupuncture or chiropractic care
- ✓ A Flexible Spending Account or Health Savings Account (both explained in the earlier “Directing your own plan” section).

Choosing a Plan That Suits You

Whether you have a choice of plans through your employer or are purchasing your own coverage, you need to understand your choices and pick the plan that’s right for you and your family.

Ranking your preferences

With decision-making increasingly shifting into consumers' hands, you need to know what you're looking for in order to make the most of your health-care dollars.



One way to find out what you value in a health plan is to rank the items in the following list on a scale from one to five, where five means it's a must-have and one means you couldn't care less about it:

- ✓ **Affordability:** Everything from the *premium* (cost of a health plan) to deductibles to the copayment and coinsurance amounts — the specified dollar amount or percentage you're required to pay toward the cost of your medical expenses.

The Health Expense Calculator at www.PlanforYourHealth.com can help you estimate your annual medical, dental, vision, and prescription expenses.

- ✓ **Coverage:** Inclusion of coverage for your key health concerns (such as planning a family or addressing a current health problem).
- ✓ **Convenience:** Having participating doctors, medical centers, and hospitals near home or office is important to many.
- ✓ **Decision support tools:** How helpful is the data provided on the health plan's Web site? Consider the information and tools a plan offers, such as hospital comparison tools, physician search tools, health-care cost calculators, and so on. Does the plan offer care management and wellness programs?
- ✓ **Ease of access:** Whether your primary care physician must refer you to specialists; whether there are significant financial costs for using a doctor or hospital that's not part of the plan's network.
- ✓ **Flexibility in choice of providers:** How wide and varied is the plan's network of medical providers? Check whether your doctor participates in the plan you're interested in. Likewise, access to the hospital nearest (or dearest) to you may be an issue.



- ✓ **Option for savings accounts:** Check “Directing your own plan” earlier in this chapter for the ins and outs of health savings accounts.

Match your rankings to the options in the plans available to you. With the variety out there, you can find the perfect match in no time.

Counting the cost to your piggy bank

Your health plan needs to fit both your medical and financial needs. As you consider various plans and options, make sure you take into account the total cost of the benefits you’re considering. Chapter 5 addresses the costs associated with health benefits.

In the meantime, keep in mind that although your employer may help pay for your premium, you’re responsible for any out-of-pocket costs, such as meeting deductibles, forking over copayments and coinsurance, and paying out-of-network fees. These out-of-pocket expenses can mount up.



Managing your out-of-pocket medical costs helps you control your overall finances. Some of the things you may want to consider include the following:

- ✓ Explore discounts for living a healthy lifestyle. See whether following an exercise program or being a non-smoker can benefit your pocketbook as well as your health. (Chapter 1 has more on wellness incentives.)
- ✓ Check whether your plan offers discounts or group rates on gym memberships or other cool stuff like fitness equipment, nutrition books, and so on.
- ✓ Participate in a Flexible Spending Account or Health Savings Account if they’re offered and your plan has high out-of-pocket costs. (See the sections earlier in this chapter.)
- ✓ Consider lowering your premium by opting for a plan with a higher deductible.

Working the Internet

If you have the luxury of choice in determining which health plan you will join, you can turn to the Internet to help you research plans and companies to your heart's content. Some of the information you may be interested in collecting includes

- ✓ The doctors and other health-care professionals in the plan's network.
- ✓ Hospitals, laboratories, and urgent care facilities in the plan's network.
- ✓ How easy — or not! — it is to navigate the Web site. If the Internet is your preferred method of contact, ease of operation may be a big factor.



Surf the Web sites of your state's health department or insurance department — they may shed light on plan performance, comparisons between plans, and more.



Other Web sites offering information on general health care and health plans include

- ✓ www.ahip.org: America's Health Insurance Plans represents insurance companies. Their Consumer Information link provides information on health insurance plans and consumer guides.
- ✓ www.ahrq.gov: The Agency for Healthcare Research and Quality is a government site, aiming to improve the quality of health care for Americans.
- ✓ www.healthfinder.gov: Supported solely by U. S. government funds, Healthfinder offers health information resources coordinated by the Office of Disease, Prevention, and Health Promotion (ODPHP) and its health information referral service, the National Health Information Center.
- ✓ www.intelihealth.com: Aetna IntelliHealth is a resource for health information from trusted sources including Harvard Medical School.
- ✓ www.jointcommission.org: The Joint Commission is an independent not-for-profit organization that is the

nation's predominant body for setting standards and accrediting organizations in the health-care field.

- ✓ www.ncqa.org: The National Committee for Quality Assurance is an independent not-for-profit organization dedicated to improving the quality of health care. It offers the NCQA seal to qualifying organizations.
- ✓ www.healthcare.gov: This is a federal government Web site managed by the U.S. Department of Health and Human Services to provide information to consumers about the Health Care Reform law and how it affects them.

Buying your own benefits

Being between jobs, becoming a sole proprietor, or having an employer who doesn't offer insurance doesn't mean you have to go without health benefits. Although choosing benefits isn't always easy, it is always important. Options for finding a health plan on your own include

- ✓ Using federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provisions to stay insured temporarily through your previous employer. Visit www.cobrainsurance.net or talk to your former boss or human resources department about this program. Keep in mind that the election period has time limits. You must sign up promptly if you lose your job or a dependent loses eligibility.



As part of the 2009 economic stimulus package, the federal government announced it would subsidize the cost of COBRA plans for certain people who were laid off and who selected COBRA coverage. Check www.dol.gov/ebsa/cobra.html to find out details, such as the specific time frame, for this special subsidy.

- ✓ Purchasing an individual health plan. More and more people — nearly 20 million to be specific — purchase their own health benefits. This trend is likely to continue as more Americans change jobs, become self-employed, or work for small employers.

As of this writing, you may have to fill out a health questionnaire, depending on where you live. Your answers can affect the price of the plan because insurers typically utilize medical underwriting, which means that you pay less if you are healthy, and you could pay more — or even be denied coverage — based on your current or past health. However, most people are accepted for coverage: A 2007 study found that about 89 percent of those who applied for individual health insurance were eligible for plans.



Should you be denied for a health reason, your state may help you enroll in a state-sponsored plan. The cost can be high and the coverage limited, but paying for a serious injury without health benefits costs even more. Call your state's insurance commission or check online.



Even if your employer offers health benefits, an individual health plan may be less expensive than your company plan. It's worth looking into.

An insurance broker (paid by the health plan) can help you find coverage, or you can usually buy directly from the health plan carrier. Check out health plan Web sites or call the health plan's toll-free number to get more info.



Visit www.ehealthinsurance.com to get a quote for an individual health plan. This online broker offers a variety of plans in each state.

- ✔ Seeing whether you qualify for low-income health coverage through your state's Department of Health and Human Services. (Look for information on Medicaid in Chapter 3.) Also, check out the state-by-state guide for low-cost or free health insurance for uninsured people at www.PlanforYourHealth.com/insure.
- ✔ Checking with organizations such as AARP or your local Chamber of Commerce, as well as alumni or professional associations. Civic or religious groups you belong to sometimes offer health-benefits plans.

For more tips on looking for and buying an individual plan, visit www.PlanforYourHealth.com/career.

Making the Most of Open Enrollment

If you're like millions of other Americans with health benefits through an employer, you get one chance each year to rethink your options for the following year. (If only you could get a similar do-over on that lemon of a car.) *Open Enrollment*, generally scheduled from October through December or during the three months before the effective date of the employer's benefit plan, is a window of opportunity during which you can make changes to your benefits package without having to jump through hoops.

Of course, a smaller company may have just one health-benefits plan, in which case your choices are narrowed.



One of the best ways to protect your financial future is to plan in advance for your health-care needs.

During Open Enrollment, health plans pull out all the stops to shower you with information. You may snag an invite to at least one seminar on a topic that may include changes to benefits, new plan choices, and options for your finances.

Take full advantage of the health plan's Web-based features, such as comparison tools and tutorials available to you during Open Enrollment. After all, such features are put together by people who really understand health benefits and financial options; you can only benefit from their knowledge.



Though life events and changes, such as adding a spouse or a child, may be exceptions, with most plans you cannot make changes to your benefits at any time other than Open Enrollment, so take advantage while you can.

Looking at what you have

Prior to Open Enrollment, your health insurance company — often through your human resources office — provides you with a rundown of your current coverage. In addition to a

summary of your current benefits, you may receive a fairly thick booklet listing what you could have in the future. Many health insurance companies now offer this information online.



Take the time to review your current benefits even if you don't anticipate making changes. It's not uncommon to find that you don't have exactly the benefits you think you do. You may have forgotten that you started a Health Savings Account (see Chapter 4 for an explanation of various payment and savings options) or mistakenly think you opted for vision coverage.

Now is the time to make sure you have health benefits that meet your health-care needs and fit into your overall financial plan.

The four Cs of checking your plan are

- ✓ **Changes** to current plan options: Sometimes change is thrust upon you, so make sure that the benefits you have are still available next year.
- ✓ **Cost** of premiums, deductibles, copayments, and coinsurance: Costs vary from year to year and plan to plan. Knowing what you're paying now helps you recognize a better deal.
- ✓ **Coverage** information: Check that your doctors are still in your network, that the dental and vision insurance you like is still offered, and so on.
- ✓ **Choices** of benefits: Newer, consumer-driven health care options include Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). Make sure you have what you want and want what you have.



See the checklist for making money-saving choices during Open Enrollment at www.PlanforYourHealth.com/openenrollment. And, if you're confused by a term or two (or 20!) as you review your options, check the glossary at www.PlanforYourHealth.com.

Your human resources department at work may be able to help as well.

Projecting your needs

Anticipating major life events during Open Enrollment may be easy to do. You should have a pretty good idea about whether you're planning to get married, add to the family or, conversely, see your baby graduate from college as a young adult and perhaps no longer qualify to be on your plan.

Less obvious possibilities call for careful consideration of changes; for example, if you're starting treatment for a recently diagnosed condition, you may be especially interested in prescription drug coverage. And, by all means, if you didn't use all the funds in your FSA, plan to downgrade your contributions next year.



If you're like most people, neither your resources nor your options are unlimited. It's important to strike a balance between your ideal plan and the plan you can afford.

Chapter 3

Making the Most of Your Health Benefits

In This Chapter

- ▶ Getting to know your plan
- ▶ Discovering Dr. Right
- ▶ Taking your meds
- ▶ Acing tests and coping with emergencies
- ▶ Reaping the rewards of staying healthy

You have a health plan, and you're sticking with it. If you have your plan through an employer, you're pretty much forced to stick with the plan until Open Enrollment season hits. Still, it pays to know how to make the most of what you have.

Accessing and Understanding Your Plan

When you sign up for health benefits, you may get a booklet or a link to online information that explains what your plan covers, what it doesn't cover, and what you need to do in either situation.



Your benefits book or online resource is a source of information you can access at any time. And, if you suffer from insomnia, you probably can glean a little information before your eyes glaze over.

Coordinating two policies

Some people are covered by not just one health plan but two. Families in which both spouses work, children whose parents are divorced, and people with Medicare benefits may have supplemental insurance and health benefits from two plans.

Generally one policy is deemed the primary policy and the other secondary or supplemental. Still, customer service representatives get

tons of calls asking for help in figuring out which policy pays for what.

Your plan's customer service department is a good source of information — call or e-mail your questions. You can also consult the National Association of Insurance Commissioners' Web site (www.naic.org), which provides information on insurance plans and terms.

To actually access your benefits, you may just need to present your ID card to the receptionist at the physician's office, hospital, lab, or pharmacy (although you may have to pay your deductible, copayment, or coinsurance as well).



Your plan may require precertification before you consult a specialist or undergo certain procedures. Be sure you understand whether you need this precertification (sometimes called “prior authorization”) and how to get it.



Health plans have a lot of specific information you can access on their Web sites, or you can call your plan's customer service department with specific questions.

Choosing Your Doctors

As with finding any professional, one good method is to ask friends, family members, and colleagues whether they can recommend someone. Keep in mind, though, that the doctor your grandmother loves may not be right for you. (You may not need a doctor who specializes in elder care just yet!) Another good method is to consult your health plan's network of participating doctors and medical professionals. You can find out about participating physicians' specialties, board certifications, and other details through your health plan.



Whether you're looking for a doctor, dentist, ophthalmologist, or candlestick maker, check that the person you choose is in your health plan's network.



When you actually have a doctor and an appointment, cut down on the time you spend in the aptly named “waiting room” by booking the first appointment of the day, before the physician's first emergency puts him or her behind schedule. Just don't be late yourself!

Picking your primary care physician

Your *primary care physician (PCP)*, or doctor, often serves as your main contact with the health-care world, providing basic care and referring you and your family to specialists as the need arises.

Your relationship with your doctor is like no other. Your doctor gets to know things about you that even your mother or mate doesn't know (at least not yet). Your doctor-patient relationship is likely to be a long one — possibly outlasting your mate, though never your mother — so finding Dr. Right is important.

Exploring your options

If at all possible, choose a PCP who's part of your insurer's network. Otherwise, paying out-of-pocket for regular medical care can explode your budget in a hurry.



Check your health plan's Web site for a list of physicians in your area. You can also use resources such as the Doctor Finder on the American Medical Association's site at www.ama-assn.org. Plus, you can check out the listings at the American Academy of Family Physicians' Web site at www.aafp.org.

If you just can't give up your old family doctor even though the doctor isn't in your network, see whether your health plan allows you to nominate doctors to join their network. (It's not an Oscar, but they say the honor is in being nominated.) Then, ask your doctor about joining your network.

In any case, see whether you can set up a Flexible Spending Account so that you can use tax-free dollars from that account to lessen the financial bite (tax-advantaged accounts are explained in Chapter 2).

Talking with your doctor

When you find a PCP you trust, make sure you can communicate with him or her easily.

Poor communication between you and your doctor can lead to trouble. Your doctor may have a hard time figuring out what is causing your health problem from what you say and send you for tests you don't need.



See the following handy checklist, “Checking the keys to successful doctor visits,” to help make your doctor visits more successful.

Checking the keys to successful doctor visits

Visiting your doctor typically means spending time and money. To make the most of both, use this checklist when you visit.

✓ Prepare

- ☐ Bring your insurance card.
- ☐ Write down the medicines you take or bring them with you.
- ☐ Make a list of questions you want answered.
- ☐ Ask what language your doctor speaks, and if necessary, bring a translator to the visit.

✓ Share

- ☐ Know and share your family's medical history.
- ☐ Mention recent changes in your health.

✓ Ask

- ☐ If you don't understand what the doctor, nurse, or assistant is saying, ask the person to rephrase or repeat the information.
- ☐ Find out whether your insurance covers what your doctor recommends.

✓ Act

- ☐ Take notes during your appointment.
- ☐ Follow the doctor's instructions.
- ☐ Talk to your doctor about a healthy diet and an exercise plan that are right for you.

Visit www.PlanforYourHealth.com for more tips on successful doctor visits.

Seeing specialists

A *specialist* is an expert in a specific area of medicine. You may need a podiatrist to treat foot problems, an allergist to help you deal with asthma, or a humorologist to tickle your funny bone.



Make sure you follow your health plan's directives — some require you to get a referral to a specialist from your PCP — and check to see that any specialist you consult is participating in your plan's network.

Aside from asking your PCP, family, and friends for recommendations, other avenues for locating a specialist include

- ✓ Check your health plan's Web site for quality rankings on specialists and hospitals.
- ✓ Visit the Web site of an organization or academy associated with your specialty needs. For example, you can view lists of pediatricians at the American Academy of Pediatrics' Web site at www.aap.org.
- ✓ Check the National Committee for Quality Assurance's Web site at www.ncqa.org to find out whether a physician has received any recognition.



If you have trouble getting an appointment with a specialist, your PCP may be able to help, especially if you're looking to book an appointment quickly.

Dealing with dentists and eye doctors

One or two possible options in your health-benefits package are separate plans for dental and vision care. And, if you can't opt for an actual benefits plan, you may be able to make use of discounts on products and services.



The terms of these policies may be very different from your regular health benefits, so don't assume that presenting your ID card is all you need to do. Your vision or dental plan may have unique provisions. For example, a dental plan

may limit how often they will pay to replace a crown or bridge. Check your health plan for details.

Dental plans often are structured the same way as health-care plans — you'll find that in traditional plans, managed care plans and PPOs, dental costs generally are qualified expenses for a tax-advantaged health savings account. All these options are explained in Chapter 2.

Additionally, you may join a network or choose a primary care dentist to recommend a specialist for such things as orthodontics, periodontal treatment, and oral surgery, for example.

Tapping into mental (or behavioral) health benefits

Your mental health is as important as your physical health. Most health plans cover behavioral health care. Check to see whether yours does.



Deductible, copayment, and coinsurance amounts may apply to your behavioral health benefits as well as your medical coverage. Certain types of services may be excluded from coverage or have limited coverage.

Often, employers offer an *Employee Assistance Program (EAP)* for advice on health and life management concerns ranging from caring for your children or parents to alcohol and drug abuse treatment. EAPs offer mental health and life management services including confidential assessment and short-term counseling. If your marriage is ending, if you're experiencing worrisome financial or legal troubles, if you're suddenly overwhelmed by stress, your EAP can put you in touch with a counselor from the privacy of your home phone 24 hours a day.

Branching out of the traditional

If your chiropractor is an important part of your health-care team, check whether your health plan covers chiropractic adjustments.

Some plans have coverage options or discount programs that offer lower prices for alternative care providers such as acupuncturists, chiropractors, and hypnotherapists. But, even if your plan offers coverage, that coverage may not be as extensive as for more traditional professionals, so it pays to know what your options are if you're venturing out of the mainstream.



If your plan doesn't accommodate alternative health care, look into setting aside money to pay for such expenses, perhaps through a Flexible Spending Account (explained in Chapter 2).

Filling Prescriptions

Perhaps one of the first things you looked at when deciding on your health benefits was the prescription drug coverage available to you. You may even have chosen a plan based on its prescription drug coverage.



Consider getting your prescriptions through a mail-order pharmacy (more on this in Chapter 1). If you opt for the convenience and potential lower cost of a mail-order pharmacy, see whether you can call and speak to a pharmacist if you have questions.

Understanding your plan's formulary

A *formulary* is simply a list of the drugs a health plan covers. The list usually includes both brand-name and generic drugs (see the next section).

Your health plan may offer different levels of coverage within its formulary, based on how expensive the drug is, how safe it is, whether there is a generic equivalent available, and so on. The different levels of coverage often translate into different copay or coinsurance amounts for you.



Your health plan may require precertification for some drugs before the plan pays for them. Generally these drugs are listed in the plan's formulary guide, available on the plan's Web site or through its customer service department.

Going generic or brand-name

According to the Food and Drug Administration (FDA), a *generic drug* is a copy of a drug that is the same as a brand-name drug in dosage, safety, and strength, how it is taken, quality, performance, and intended use.

As we mention in Chapter 1, you can usually save money by going the generic route. Typically generic drugs are less expensive than brand-name drugs.



Get into the habit of asking your doctor whether generic equivalents for your prescriptions are appropriate for you. If they are, you'll save money all around.

Opting for over-the-counter meds

Over-the-counter medications, such as aspirin, that you can purchase without a prescription are sometimes an option for treating a health concern. Ask your doctor if you're unsure.

Going In for Tests and Handling Emergencies

Keeping up with your health care involves having tests: You have your cholesterol levels checked; you get a yearly mammogram if you're a woman over a certain age (not over the hill, just over 40); you go in for an x-ray to determine whether that bike collision caused a sprain or a break.



Often, health plans will tell you what tests are recommended, and when. You're wise to take advantage of your plan's benefits and discuss with your doctor having these tests done. Don't delay!

You may need to visit a hospital, too, if you happen to break a limb, have a baby, or need your gall bladder removed.

When you access these and other aspects of your health plan, it pays to know what to look for. The next sections point the way.

Scheduling lab work and diagnostic tests

Making a phone call ahead of time costs a lot less than paying for tests that aren't covered by your plan. Visit your health plan's Web site, call your health plan, or check with your human resources department — it doesn't matter so long as you find out whether your plan covers the tests your doctor wants you to have. And, if you have to have lab work done, find out which labs your plan prefers (and pays for).

If you need more than one test, work with your doctor to schedule them together, if possible.

Dealing with an emergency

Although you can't plan for the unexpected, accidents do happen, and odds are that you'll make at least one visit to the emergency room in your lifetime.



Check now to find out what emergency services your plan covers and what after-hours care your doctor offers (if any). Health Care Reform prohibits health plans (except grandfathered plans) from requiring authorization for emergency services.

Some plans offer a 24-hour hotline or nurse helpline you can call to help determine whether you need to visit the emergency room or can handle your problem in a less stressful venue, such as a doctor's office or walk-in clinic.

Benefiting from Being Healthy

Don't underestimate the benefit of wellness. One of the primary goals of your health plan is to help you stay healthy. In fact, many plans offer incentives to do just that. Check to see whether your plan offers

- ✓ Coverage for checkups, well-adult and well-child visits, and flu shots. Many plans are required to offer 100 percent coverage for these preventive visits in response to Health Care Reform, meaning no money out of your pocket! Some exceptions to this rule do exist however, even after Health Care Reform.
- ✓ Coverage or discounts for weight-loss and fitness programs, smoking-cessation programs, and alternative-medicine services.

Getting the 4-1-1 on Personal Health Records (PHRs)

Not since you learned the ABCs have three little letters meant so much. *Personal Health Records*, or *PHRs*, store all of your health-related information in one secure, password-protected online record. The at-a-glance record helps you play a more active role in your health care — and may even save you time and money. Approximately 70 million people have PHRs through their health insurers, and millions more are expected to have this resource available in the near future.

Enjoying the benefits of a PHR

Typically offered by health insurers, a PHR is a snapshot of key health information such as insurance claims, lab tests, doctors' visits, and prescribed medications.

Some information is automatically added to your PHR by your health-benefits plan. You usually can personalize your PHR by adding your own details — anything from immunizations and allergies to your family medical history, even your current diet and exercise regimens.

Keeping your personal health information handy can make communicating with your doctor easier and more efficient. This enhanced communication can also help make the most of your doctors' visits, leading to more informed, personalized care and fewer mistakes. And, cha-ching — using a PHR may also help you save money! Because previous tests and lab results are on your PHR, your doctor can avoid ordering duplicate or unnecessary tests.

Tracking your prescriptions and doctors' visits helps you keep your own health top of mind and may help you better follow treatment recommendations: Did you finish all your antibiotics? Are you sticking to your diet? The more information you have at your fingertips, the more likely you are to follow your physician's advice.



If you have a PHR, populate it with details. Advanced PHRs can scan your tests, prescriptions, and treatment recommendations, alerting you and your doctor about opportunities to improve your health.

A PHR can come in handy when you're traveling — whether you're around the globe on vacation or displaced from home due to a natural disaster. With a PHR, your health history is available online 24 hours a day, seven days a week. Some PHRs even allow you to print out an emergency wallet card, so your key information is at your fingertips.

Talk to your insurance company or your employer to see whether an online PHR is available to you. Print it out and take it with you to your doctor appointment and when you travel.



More tips on disaster-proofing your health benefits can be found at www.PlanforYourHealth.com/family/prepared. Check out benefits-related travel tips at www.PlanforYourHealth.com/family/healthpass/.

Protecting your personal information

You may wonder whether security is a concern with personal information on the Internet. Rest assured that the privacy of PHRs provided by insurers is protected under a federal regulation. The Privacy Rule, part of the Health Insurance Portability and Accountability Act (HIPAA), protects health information that can be linked to an individual.



Hold on tight to your insurance card! Medical identity theft is a growing problem in the United States. Experts estimate that about half a million people have been victimized. To protect your medical identity, safeguard your insurance

card, carefully review your Explanation of Benefits, shred any outdated health-care paperwork, and check your credit report frequently. If you identify a problem, immediately bring it to the attention of your health insurer for further investigation.

Chapter 4

Meeting Life Head-On

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In This Chapter

- ▶ Peering into a working life
 - ▶ Looking at married life
 - ▶ Taking family life into consideration
 - ▶ Being single
 - ▶ Focusing on retirement
-

Life happens, often at a dizzying pace. At certain points in your life you may want to take a fresh look at your health benefits. You may need to add or subtract a spouse, partner, or child from your health plan, expand your health savings account, or start a retirement account. Major life changes may require major benefits changes.

You can gain some small measure of control and security by anticipating changes and adjusting your benefits accordingly. This chapter shows you how.

Starting a New Job

What with worrying about what you're going to wear on your first day, how well you'll adjust to your job challenges, and whether the coffee is any good, you have a lot on your mind when you start a job — especially if it's your very first professional experience.

Getting your first job

As you enter the job market, you have a lot of adjustments to make. You have to adapt to a new routine, a new culture, maybe a new city, and possibly to the wonders of employer-sponsored health benefits.

Be aware that not every job or every employer offers health benefits. And even if yours does, you may not be eligible right away. Health Care Reform requires plans with dependent coverage to cover dependents up to age 26 without regard to employment status or eligibility for other coverage, in most circumstances. In addition, COBRA (Consolidated Omnibus Budget Reconciliation Act) provisions may allow you to continue under your parents' health benefits (or those from your previous job) for a maximum of 18 months if you lose your job, or 36 months if you lose eligibility as a dependent under a parent's plan. This may be all you need to tide you over until you get your own plan.

Some employers who hire part-time, hourly, or seasonal help offer limited benefits plans. If you're in this boat, make sure you understand the extent of your coverage.



It may be worth your while to look into an individual plan, which could cost you less than an employer-sponsored plan or provide specific coverage you are looking for. If you don't have access to benefits through your employer, you can try professional and alumni associations. See Chapter 2 for more information on individual plans.

Accepting an offer

In today's job market, an employer's benefits package can determine whether you take the job or not. And health benefits are a major part of that package, which may also include paid vacation, employee discounts, and an office with a view (though don't set your heart on the latter until you're upper management). As you consider the invitation to join a new company, take time to weigh the insurance benefits along with the salary and vacation that your potential employer is offering. These may include the following:

- ✓ Insurance including health, life, long-term care, disability, and dental, vision, and prescription drug plans
- ✓ Consumer-directed health accounts such as Health Reimbursement Arrangements and Health Savings Accounts
- ✓ 401(k) or other retirement plan



If you're switching jobs, whether you're changing careers or just heading for greener pastures, make sure you know what you're getting yourself into concerning your benefits. Compare your current benefits to your future benefits before you jump ship. And, if you need to continue the benefits from your old job, COBRA provisions often let you do so for up to 18 months. You may find that an individual plan is more affordable for you than COBRA, so be sure to compare. (See Chapter 2 for tips on finding benefits on your own.)

Getting an invisible bonus

Your employer already realizes that your benefits can add significantly to your annual salary. Table 4-1 shows that for someone making \$35,000 a year, the benefits can add up to an additional \$16,782, raising total annual compensation to \$51,782 — it's sort of like getting a bonus they don't tell you about.

Table 4-1 Typical Benefits Costs	
<i>Benefit</i>	<i>Cost to Employer</i>
401(k) plan	\$2,170
Disability	\$560
Health benefits	\$5,328
Social Security/Medicare	\$2,678
Pension	\$1,470
Paid time off	\$4,576
TOTAL	\$16,782

Source: Salary.com.

Dealing with disability insurance

Having a baby. Breaking your leg. Suffering a heart attack. What all these events have in common is that they're considered disabilities that affect your ability to work and earn an income.

You may experience debilitating financial loss if you're unable to work for an extended period of time. That's where disability insurance comes

in. Short-term disability insurance typically covers you for up to three months if you're unable to work due to an injury, illness, or health event. Long-term disability insurance extends that coverage if you are unable to work for longer periods or are totally disabled. Check with your human resources department to find out what type of disability coverage is available.



Whether you're starting your first job or switching to a new one, realize that your benefits can add up to a significant chunk of your overall compensation.

Setting out on your own

Whether you're starting that restaurant you always dreamed of or just cutting corporate ties and going the independent-contractor route, make sure that along with a business plan you have a plan for handling your health benefits.



If you had health benefits through your previous employer, you're probably eligible to continue those benefits for 18 months through COBRA. The folks in your old human resources department can help you find out.

If you need to find health benefits on your own, Chapter 2 has a section with some tips.

Tying the Knot

So you're taking the plunge, getting hitched, becoming *we* instead of *me*. First of all, congratulations on your engagement!

To start wedded life off right, sometime soon after the honeymoon — or even before then as you take a break from cooing at each other — make the time to figure out how to make your benefits work for both of you.



Getting married is actually a good opportunity to look at any health-care issues you have and perhaps make changes to your own plan or join your partner's plan. If you're entering into a domestic partnership, check to see whether your mate is eligible for coverage under your plan (or vice versa).

Discovering your paired priorities

Marriage means balancing individual objectives with goals that benefit both of you. What may have worked well for you as a single may not be best for the two of you.

When it comes to health benefits, your main priority may be staying with the doctor you've come to know and love (second to your spouse, of course). Your partner, on the other hand, may not care which doctor he or she sees as long as the office is close to work. You may have children from a previous relationship to consider as well.

Talk about what each of you holds valuable in the health-care realm. Chapter 2 offers tips to help you prioritize.

Compare rankings and work out any major differences — rock, paper, scissors works for us — before coming up with your blended list of health-benefits priorities.

Checking out your mate's, uh, benefits package (wink, wink)

Along with scoping out your spouse's peanut butter preference and sock drawer, you should examine his or her admittedly less interesting health plan. Assuming you both currently have health benefits, you need to look at each of them and decide whether to keep separate benefits or have one of you switch to the other's health plan. Of course, if only one of you is insured now, your choice is simpler — check to make sure you can add the uninsured partner to the existing plan.



The old adage that two can live as cheaply as one was probably never true, and it certainly isn't the case when it comes to buying health benefits. However, health benefits may be less expensive for you as a couple than for each of you separately. Deciding whether you should merge your health plans as well

as your lives only makes sense. And keep in mind that you both may be able to be covered under both plans. Check with your respective employers to see whether this is a possibility.

Some insurers offer individual “child only” plans. So, if you or your mate is a parent and your employer’s health plan doesn’t cover dependents, consider looking into an individual plan for your offspring. (See Chapter 2 for more on individual plans.)

Use Table 4-2 to compare your benefits, using the blank columns either to record comments or to indicate the plan with the better benefit.

Table 4-2 Comparing Benefits Plans		
<i>Benefit</i>	<i>Bride’s Plan</i>	<i>Groom’s Plan</i>
Size of network		
Doctors in network		
Monthly premium		
Copayment		
Coinsurance		
Deductible		
Out-of-pocket maximum		
Prescription cost		
Behavioral/mental health coverage		
Vision coverage		
Dental coverage		
Discount opportunities		
Alternative treatment coverage		
Access to specialists		
Participating hospitals		
Savings options (HSA/FSA)		



If you plan to switch to your mate’s health plan, make the move sooner rather than later. Many plans offer a 30-day — or somewhat longer — window after your wedding during which you can join your spouse’s plan without offering proof of insurability. In other words, you get a grace period

during which the health-benefits provider accepts you with no questions asked — possibly the only time an employer embraces you as willingly as your mate does.

Anticipating a Very Special Delivery

Adding to your family is exciting, nerve-wracking, joyous, fulfilling, exhausting, and every other emotion all tied up in one small bundle of joy. You read baby books, plan the nursery, and shop for cribs, car seats, and cuddly toys. However, if you're like the majority of expectant parents, you spend little or no time reviewing your health benefits.

Aside from checking what your policy offers in the way of adoption services, maternity benefits, and traditional pre- and post-pregnancy care, you may want to find out whether a midwife's services are covered and what your health plan pays for in the realm of genetics counseling, infertility treatment, and other cutting-edge procedures.



Whether you're adopting or pregnant, enlarging your family is the perfect opportunity to review health benefits. Use the priorities checklist in Chapter 2 to determine which benefits are most important to you.

Expecting increases

As mom's belly grows, so do her health-care needs. A pregnant woman (and cheers if that description fits you) has additional health-care needs. Check your health-benefits package to see what's covered and how to make the most of the benefits you have.

Pregnant women have a lot of people wanting to touch their bellies. Every mother-to-be gets a fair number of perfect strangers coming up unexpected and uninvited and touching her rounded stomach. Fortunately, there are some folks an expectant mother actually likes to interact with. Make sure you check with your health-benefits plan to see whether they cover the services of various maternity-related professionals, such as midwives, doulas, and lactation consultants.



Think about whether you expect to expand your family when selecting your plan and your Flexible Spending Account contribution during Open Enrollment.

Predicting prenatal costs

As a parent, you're in prenatal mode from the moment you know you're expecting until the moment the baby arrives. (Okay, to be honest, the delivery process usually takes *several* moments.) You see your physician or midwife for prenatal checkups; you attend prenatal birthing classes. All these anticipatory activities can add up, cost-wise, so it pays to find out how to make the most of your prenatal benefits.



The Baby Expense Calculator at www.PlanforYourHealth.com helps you estimate the cost of pregnancy and your new baby during the first year, including out-of-pocket costs, premiums, copays, and deductibles.

Bringing home baby

Your new addition is coming home from the hospital or arriving via the adoption service. The reality of parenting is upon you. A little planning at the start can make for a slightly less bumpy ride down the road.

Finding your child's first doctor

After your obstetrician's or midwife's job is done, you need the services of a *pediatrician* (a doctor who specializes in caring for children) or a family physician. Finding a doctor before you give birth can set your mind at ease, especially because the doctor may visit your baby for the first time before you leave the hospital. Check your health plan's Web site for participating pediatricians, or ask your insurance company's customer service area for a list.

It goes without saying that the doctor you choose should be knowledgeable and personable, but you may want to consider other factors as well:

- ✓ **Areas of expertise:** If your child has a serious health problem, you want a pediatrician who is an expert in that area. And, even if your child has no problems now, it's good to know what your family physician or pediatrician is especially good at.

Note: Some pediatricians specialize in caring for adopted children.

- ✓ **Convenience:** Location can play a major role in making the doctor easy to see. Whether the doctor has late office hours or weekend hours can make a big difference in your life.
- ✓ **Cultural or ethnic background or language:** Sometimes, having a doctor who shares your history and values makes an enormous difference.
- ✓ **Quality of stickers:** If your little guy is into Batman, but the only stickers offered are Spiderman, there may be comic consequences.

See Chapter 3 for tips on talking with your doctor to make the most of your visit.



Set up well-baby visits to the pediatrician soon after your baby is born so that your child gets routine immunizations and screening tests.

Baby-proofing your benefits

If your child is lucky enough to have two parents with two health plans, you're in the enviable position of being able to choose which plan is better for your growing family. Even if you don't have more than one plan to choose from, you may have options as far as coverage.



Add your child to your health plan as soon as possible. Most employers allow for these types of life changes outside of annual Open Enrollment periods. But pay attention; you don't want to miss a deadline (often just 30 days after birth) and leave your little one uninsured.

Changing benefits needs as your children grow

Between welcoming a wee bundle into your heart and feeling that same heart crumble a bit as your baby leaves the nest, you have numerous opportunities and, frankly, obligations to fit your benefits to your children's changing needs.

Table 4-3 suggests some milestones and corresponding benefits adjustments to consider as your children grow.

Table 4-3 **Childhood Benefits Milestones**

<i>Milestone</i>	<i>Benefits Check</i>
Being born	Add baby to plan within 30 days; begin appropriate immunizations and well-baby checkups.
Starting school	Make sure your health plan covers immunizations; start a college fund if you haven't already.
Becoming a preteen	Consider adding an orthodontic component to your dental plan; see whether your plan covers physical therapy for potential sports injuries.
Graduating high school/ heading to college	If your plan covers dependents, they can be on your plan until age 26 regardless of student status.
Graduating college	Consider individual coverage if your child doesn't yet have a job or isn't eligible for employer-sponsored benefits, or if your child doesn't have a job or can't afford employer-sponsored coverage, consider leaving your child up to age 26 on your plan (which is permitted with limited exceptions even when a child is eligible for employer-sponsored coverage).

Starting Over: Single Again

Becoming single again can be challenging — you've lost a mate either to divorce or death. But, there's no time like the present to take a hard look at your benefits situation and make any necessary changes. If you put off making the decisions too long, you may have fewer choices when you get around to it.

After a divorce

If you don't have coverage through your employer, you may be eligible to continue group insurance on your ex-spouse's plan, though check the policy rules to be sure. You also

may be able to make use of federal COBRA provisions that allow for continuation of health coverage under your former spouse's employer for a period of 36 months.

If children are in the picture, it's most important that their health benefits continue uninterrupted. So work out with your ex which of you will list the children on your health plan. You may want to do as others have done and list your children on both policies — one serving as primary and one as secondary.



Spouses paying child support need to have enough life insurance for themselves to cover any court-required payments as well as college expenses.

After a death

Enduring the death of a mate is one of life's hardest experiences. Adjusting to your new circumstances takes time and strength. If you're fortunate enough to have family or friends willing to help you manage some of the hard decisions, accept their assistance.

A willing and trusted helper can notify employers, financial institutions, the Social Security Administration, and the Veterans Administration, if applicable. An aide can help organize your financial records and collect documents pertaining to finances and the settlement of the estate.



Women are more likely to be the surviving spouse and more likely to face losing health benefits.

If you're in this situation and were covered under your spouse's health plan through work, you need to switch to your own employer's plan. If you're not employed or can't get health benefits through your job, you and your dependent children can continue under your spouse's benefits for up to 36 months (provided you pay the premiums) through COBRA provisions. Get in touch with the employer's human resources department or the health insurance company's customer service department even if you weren't covered under your spouse's benefits because you may be able to buy into the group health plan. Some life insurance plans provide health benefits for beneficiaries.

If you have to find health benefits for you and your children, turn to Chapter 2 for tips on doing so.

Looking at long-term care

As Americans age — the oldest baby boomers are now well into their sixties — and as medical advancements spawn longer lives, the need for long-term care is skyrocketing. Half of all Americans will need some form of long-term care.

Long-term care insurance covers costs for nursing homes, assisted-living centers, and in-home caretakers, who help with everyday tasks such as bathing and dressing. Though costs vary widely from state to state, the average price tag for a private room in a nursing home can be upwards of \$70,000 per

year. Generally, these services are not covered by Medicare or retiree health insurance. You can check with your current plan, your human resources department, or a financial planner, or contact your state's health department to find out about Medicaid options for long-term care. (Read more about Medicare and Medicaid in the section "Planning for Retirement.")

Check out the free *Planning for Long-Term Health Care* brochure at www.fpaforfinancialplanning.org. The Brochures link is under the Tools & Resources menu.

Planning for Retirement

It's never too early to start planning for your retirement. On the other hand, just because you haven't thought about it yet doesn't mean it's too late to start.

Half the population just guesses what their retirement needs will be. You can easily be above average simply by taking the time to plan a secure future for yourself and your loved ones.



Make use of the Healthy Retirement Readiness Tool at www.PlanforYourHealth.com to figure out how to prepare for your prime years.

Traditional retirement age is 65. That's when you can get benefits through Medicare, a government program that provides health-care insurance to people aged 65 years or older as well as certain disabled individuals (you hear more about Medicare later in the chapter). You can start drawing Social Security benefits when you turn 62 (doing so that early isn't always your best choice, though, as you get a smaller monthly amount than you would if you waited).

Investigating life insurance

Life insurance is a way to protect the financial and emotional health of loved ones. The financial benefits can cover funeral expenses, pay off a mortgage, and ensure your child's education, among other things. The emotional benefits come from having access to expert resources to help build legal and financial plans for your future needs.

How much life insurance to buy hinges on your family situation, how old you are, how old your spouse and children are, and what kind of lifestyle your family maintains.

Talk to a certified financial planner to make sure you set up your policy to best benefit your family.

You may be able to retire when you're 63½ and get benefits for the 18-month gap before your 65th birthday through your former employer's benefits under the federal COBRA program. Not since you insisted, "No, I'm six-and-a-half!" does half a year matter so much.



If you're retiring early but your spouse is still working, look into signing on to your mate's health plan. Alternately, consider a part-time job with a company that offers health benefits to employees who work a minimum number of hours.

Whatever your decision, make sure that you consider all the implications for your overall financial and health-benefits picture.

Readying your retirement account

For help preparing your retirement account, consult a *Certified Financial Planner (CFP)*. A CFP professional is qualified to assist you with your financial planning — sorta like the title implies, huh? A CFP professional has to have experience and knowledge and ethics and stay on top of new resources in order to earn the title, so you can bet that he or she can help you out. Find one to meet your needs at www.PlannerSearch.org.

Focusing on health benefits

You know the old saying: If you have your health, you have everything. Okay, it may not be literally true, but it's an undeniable fact that taking good care of your health is the best long-term investment you can make for your future.



When you're planning for retirement, don't focus exclusively on your financial needs; you need health-care coverage as well. Your health benefits are worth thousands of dollars. They protect you against financial risk in case of illness or accident.

If you're used to having health benefits through work, it's easy to forget that most plans don't follow you into retirement, though you should, of course, check with your employer to see what options you have. You or your spouse may be one of the lucky few who work for a company that offers retiree benefits. However, you're likely to need to figure out how to cover the costs of premiums, copayments, and other health-care expenses on your own.



Check whether any professional or alumni associations you belong to, such as the Chamber of Commerce, offer group health or dental benefits. Also, consider looking into individual plan options (refer to Chapter 2) or discount programs.

Weighing your Medicare options

You know the federal Medicare program; you've contributed to it through your payroll taxes your entire working life. You're probably aware that Medicare provides basic health benefits to people 65 years or older and to certain disabled individuals.

You may or may not know that Medicare doesn't cover all your medical costs, so you're still on the hook for considering additional coverage.

Call the Social Security Administration at 800-772-1213 or visit www.Medicare.gov to find out if and when you qualify for Medicare. Be ready to provide your Social Security number and date of birth.

Medicare has several parts, each with a different function:

- ✓ **Part A** provides hospitalization benefits. You get this service at no charge when you turn 65, and if you're like most people, you don't have to do anything to enroll in the program.

If you or your spouse didn't pay into the Medicare system, you may be able to pay a monthly premium to get coverage.

- ✓ **Part B** covers doctor services and some outpatient care such as physical therapy and home health care. You have to enroll and pay a monthly premium for this part if you want it.

- ✓ **Part C** is known as Medicare Advantage. It combines the benefits of Parts A and B and may include the Part D prescription drug benefit. Medicare Advantage plans are offered by private health plans that contract with the federal government.

- ✓ **Part D** is a prescription drug benefit added in 2006. It is available from a variety of prescription drug plans that vary as to drugs covered, costs, and pharmacies you can use. You pay a premium to a private health plan contracting with the government and generally pay a copay for most prescriptions you fill under the plan.



Sign up for Part D coverage as soon as you're eligible — three months before and after your 65th birthday. Late fees may apply if you miss an enrollment deadline.

The variety of prescription drug plans can be confusing. You may need help to figure out which plan is best for you. Visit www.Medicare.gov or call 1-800-Medicare for help.

Using Medicaid

If you cannot afford health insurance or if your health-care costs deplete your savings, you may qualify for help through Medicaid, a joint federal/state program that provides a crucial safety net for many Americans. Medicaid is generally available to those under a certain income level who have little in the way of assets, although your state may offer additional programs with different eligibility rules for families and children. State Medicaid plans vary; in some locations, you may have a choice of plans. Get in touch with your state's Medicaid office, department of social services, or health department to find out more about Medicaid provisions in your state.



The state-by-state resource guide at www.PlanforYourHealth.com/insure/ provides specific information on resources for free or low-cost health-care coverage.

Chapter 5

Paying Up

In This Chapter

- ▶ Looking at health-care costs
- ▶ Explaining your “Explanation of Benefits”
- ▶ Savings opportunities

The benefits you enjoy from belonging to your health plan don’t come cheap. This chapter tells you what you have to pay and to whom.

Following the Money

Copays, coinsurance, premiums, and deductibles are some of the costs associated with your health-care benefits that you may be responsible for paying. The next sections explore what you have to pay and the methods you can use to do so.

Understanding what you pay for

The following list describes various terms associated with the costs of health plans. Some or all may apply to you.

- ✓ **Annual or lifetime maximum:** Lifetime dollar limits on coverage of essential services are prohibited after Health Care Reform. Annual dollar limits will also be prohibited on coverage of essential services in 2014, but until then, restricted annual limits on essential services are permitted. Plans may also have dollar limits on non-essential services.



- ✓ **Copayment (copay) or coinsurance:** A dollar amount or percentage you're responsible for paying for your covered health-care services. You may have to pay a set amount every time you make an office visit, a different amount for lab work, and various amounts for different types of prescription drugs.

You may have to meet a deductible before your copay or coinsurance kicks in.

- ✓ **Deductible:** The amount you have to pay for covered medical services (generally each year, although some plans have a separate hospital deductible for each hospital admission) before your health plan starts chipping in. Your deductible amount may be very small or quite large, depending partly on you: You usually can get a plan with a high deductible for a lower premium, and if you're young, healthy, and childless, this may be the way to go.

First-dollar plans don't have a deductible and pay for covered benefits from, you guessed it, the first dollar you spend. The term first-dollar plan may also describe a plan with a deductible that also has a benefits account you can use to pay for medical services before you meet the deductible.

- ✓ **Exclusion:** A health condition or service not eligible for coverage under your health plan. What your plan doesn't cover is listed in your coverage document (sometimes called a Certificate of Coverage or Summary Plan Description). Call your plan's customer service number to get a copy of this document.



If you have a chronic or unusual condition, check the exclusions carefully before choosing a plan.

- ✓ **Out-of-pocket:** Money you pay toward the cost of health-care services. It's essentially money you have to dig out of your own pocket, so it's aptly named, isn't it? Out-of-pocket expenses include deductibles, copayments, and coinsurance. Sometimes, what you pay for services not covered by your plan is considered out-of-pocket as well.

Plans vary widely in the amount of out-of-pocket costs you pay. A health savings account can help your budget. (Chapter 2 has more info on HSAs.)

Some plans put a cap on your out-of-pocket expenses. After you reach the out-of-pocket limit, the health plan pays all your covered costs.

✓ **Premium:** The cost of a health plan. Your employer may pay part of your premium if you get your health benefits through your company.

✓ **Reimbursement:** A payment either to you or a health-care professional for covered medical services.

A fee-for-service plan may reimburse you or your doctor a set amount or maximum amount for specific services. This system can lead to larger out-of-pocket costs for you when you have to pay the difference between what your doctor charges and what your plan pays. However, your health plan may negotiate fees in advance so your doctor can't bill you for the balance.

Paying for what you get

Typically your largest all-at-once cost is your premium, even though it's actually spread out into monthly or quarterly payments. If you get health benefits through your job, paying that premium is a no-brainer on your part because the amount is deducted pretax from your paycheck before you even see it.

Your premium, however, is generally the only health-care money you don't see fly out of your bank account. The money it takes to meet your deductible, copays, and coinsurance goes directly from your hand to the medical service provider.

Find out ahead of time what form of payment your health-care professionals accept and ask whether you should be prepared to pay for each visit, whether the office bills your insurance and files claims for you, or whether you have to do the paperwork yourself.



If you're the one getting reimbursed, be sure to check the appropriate box on the claim form and get the proper documentation from your medical service provider.

Reading Through Your Explanation of Benefits

Every time you or your doctor files a claim with your insurance company, you get an *Explanation of Benefits*, also known as an *EOB* or *claims statement*. This form may be mailed to you, or it may be available on your insurance company's Web site, guarded by your own personal password, or on your own personal Web page.

The EOB explains how your health-benefits claim was processed. As well as your name and policy information, the form usually includes

- ✓ Date of service
- ✓ Who provided the service
- ✓ The service provided
- ✓ The claim amount
- ✓ The agreed-upon amount paid by your plan
- ✓ The amount you're responsible for paying



If you have questions about any information on the form, call your plan. If you believe a claim was denied or paid incorrectly, move to appeal the claim quickly. You may have up to 180 days to let your insurance carrier know that you disagree. Chapter 6 takes you through the appeals process.

Chapter 6

Speaking Up

In This Chapter

- ▶ Considering claims
- ▶ Reaching out to customer service
- ▶ Disagreeing with a decision

Along with your right to pay premiums and make claims, you have the right to communicate with your health insurer. Of course, that's not a right you're going to make use of every day — they're very nice people, but you have a life to enjoy after all.

When you have a question about a payment or disagree with a decision about a claim, it's good to know where to turn — information this chapter tells you how to find.

Checking Your Claim Status

Often you go to the doctor and just ignore all the paperwork generated from your visit. But, because your health plan pays attention, you should pay attention too.



Whether you submit claims yourself or the office, lab, or pharmacy does it for you, it makes sense to stay on top of your claims and charges. And, just to be clear, a *claim* is information either you or your doctor submits to your health plan requesting payment for medical services. Submitting claims yourself naturally leads you to pay close attention to the process. You should receive notice of payment of your claim, usually in the form of an Explanation of Benefits (EOB), which is explained in Chapter 5.



Your EOB is the jumping-off point for any further action on your claim, so make sure it reflects your understanding of the situation, especially when it comes to who's paying how much to whom. If you disagree with a decision about your claim, see "Appealing a Decision" later in this chapter for advice on how to proceed.

Health plans usually have a toll-free number and most have a Web site. You can use either avenue to check on your claim and find out how much you owe, if anything.

If your health plan is very techno savvy, it may even offer you your own, personalized Web page that lists all your benefits information in one, password-protected place.

Contacting Customer Service

Finding out how to get in touch with your benefit plan's customer service department is as easy as looking at your membership card, which usually has both a toll-free phone number and the company's Web site. Read on for pointers for when you're actually in contact.

Choosing a method

Your plan's customer service department may let you choose whether you want to talk to a live person, use the interactive voice response (IVR) system, or visit the company's secure member Web site.

The method you use may hinge upon what you want to accomplish; different methods have different strengths:



- ✓ The always-available feature of IVR is quite handy when you have a simple, general question.

You may want to research how easily you can transfer from IVR to a live person when you're comparing health plans.

- ✓ If you have a question about a specific claim or want help interpreting your circumstances, you may need to talk to a live person.

- ✓ A member Web page dedicated solely to you is not only flattering but useful for finding information about your policy and claims.

Talking to an actual person

Before you get on the phone, gather your policy ID card and relevant claims documents to have them close at hand. In addition, make sure you know the date of service and the name of the doctor in question if you're calling about a claim.



Even if you're frustrated, be polite to your customer service rep. It's hard to get really good service from someone you're screaming at.

Customer service representatives usually have to ask you to validate a lot of personal information. And although you may be hesitant to give out so many personal details, collecting this information is one method your health plan uses to protect you. Anyone who can't provide these details will be stopped cold in any attempt to horn in on your benefits or personal information.

Timing is everything, as usual. Try to avoid calling during peak days — generally Mondays — and peak hours, which surprisingly enough are mid-morning and mid-afternoon. Everyone *doesn't* call during lunch, so you may want to try it yourself.

Appealing a Decision

Stories of tussles with health plans are legion and legendary. And, although it's true that insurance companies are businesses, they're in the business of serving their customers — which means you.

Sometimes, what you think your health plan should pay for and what your policy actually covers don't exactly match up. Fear not. If all or part of a claim is denied when you think it shouldn't be, you can take some steps.

The first thing to do is make sure the procedure in question is covered by your plan. Just because you have benefits, doesn't mean they cover everything. For example, some plans put limits on the number of physical therapy visits you can have.

If you think a procedure should be covered, contact your plan. They may have denied your claim simply because they didn't receive all the documents they needed, or they may be waiting for coverage to be determined under another plan. (Your spouse's plan may pay first.)

If that isn't the problem, you can appeal the decision. The appeals process starts with a review of your claim. You get an opportunity to tell your side of the story and provide further information about your care. You can also review all the information the plan relied on in making its claim decision. Appeals can be requested over the phone, and plans are required to respond within 60 days (or less for urgent matters).



Your doctor may be able to help you appeal a claim by writing or calling your health plan to explain why you needed care. Alternative helpers may include a hospital social worker, your state insurance department, or your state health department. Most state insurance departments have a consumer help line that is staffed by knowledgeable advocates who can talk to your plan and help you to understand your rights.

In some cases, you may be entitled to an external review of your claim — an objective process outside your plan. Get the particulars about your plan's appeals process by calling the toll-free number on your ID card or visiting the plan's Web site. Often a description of the appeals process is included on your Explanation of Benefits.



Appeals have time restrictions, so make sure to check your claims and file any appeal before the deadline.

Chapter 7

Tracking Needs for Next Year

In This Chapter

- ▶ Reviewing this year
- ▶ Predicting the future
- ▶ Making use of the Web

During Open Enrollment each year, you get a chance to make adjustments to your benefits coverage if you're covered through an employer's plan. This chapter can help you figure out what changes to make, if any.

Starting with This Year

The first step in figuring out what your benefits package should look like next year is reviewing how well your benefits served you this year.

Having a system

If you haven't been keeping track of your health care and finances, now's your chance to set up a system. It doesn't have to be elaborate, you just need two file folders. Into one, you put information you may need to look at within the year or at tax time, such as:

- ✓ **Contact information** for your doctors and your health plan, updated every year at least.



Always carry a medical information card that informs medical personnel of any special conditions, medications, and allergies. With some health plans, you can print out an emergency card to keep in your wallet.

- ✓ **Bills and receipts**, including the Explanation of Benefits (EOB) pages you get from your insurance company, no matter who paid. Receipts for out-of-pocket costs for equipment or therapies go here as do records of the premiums and deductible amounts you paid, as well as copayments and coinsurance.
- ✓ **Statements** from your Health Savings Account (HSA), Flexible Spending Account (FSA), or similar plan. (Chapter 2 discusses these plans.)
- ✓ **Family health records** for this year and last year, including information on pre-existing conditions, medications you're taking and the dosage, allergies, immunizations, blood type, and name and contact information for your family physician. A printout of your Personal Health Record (PHR) would be a perfect addition. (We discuss PHRs in Chapter 2.)
- ✓ **Insurance policies** of all descriptions — health, life, disability.



Keep this active file, along with photos of each family member, in a fire- and waterproof carrier that you can quickly grab in case you have to evacuate your home for any reason.

Into the second file goes information you want to have around but don't need to do anything with, such as:

- ✓ **Old bills and receipts:** Medical information more than two years old is good to hang onto.
- ✓ **Health history records:** Create a record for each family member that includes records of any hospital and clinic stays and details of illnesses and injuries.



If you don't have access to a PHR, you can download a Personal Health Information Record at www.PlanforYourHealth.com. Just type **phr** into the Search box.

Working your system

Having a filing system makes reviewing your health expenses and experiences a piece of cake. You simply pull out your

active health file and tally up your health-care costs for the past year, adding up how much you spent on premiums, deductibles, copays, and out-of-pocket expenses.

Then, check the balance in any tax-free health savings accounts you have. If you didn't contribute enough to cover all your allowable expenses, you may want to consider upping your ante, so to speak, for next year.

Evaluating Future Needs

If you think your health and financial life next year will turn out to be pretty similar to what it was this year and your current benefits package worked for you, you can probably just keep on keeping on with the setup you have. Sometimes, though, the plans themselves change, so you need to consider your options.

However, if you foresee changes to your health, job, or life situation, you can adjust your benefits program to anticipate your needs for the upcoming year. Table 7-1 lists some situations and the health benefits and financial moves you can make to accommodate them.

Table 7-1	Anticipating Plan Adjustments
<i>Event</i>	<i>Possible Plan Adjustments</i>
Anticipating LASIK surgery, a root canal, or new glasses	Start or increase a health savings plan (such as an HSA or FSA)
Adding a baby	Put the wee one on your health-benefits plan; consider an FSA for eligible child care or day-to-day expenses; start a college savings plan; increase your life insurance
Graduating from college	Investigate and enroll in a health-benefits plan offered by your new employer, consider individual coverage or COBRA, or staying on a parent's plan up to age 26
Getting married	Evaluate whether one of you should switch to the other's health plan; get life insurance; start or add to separate retirement accounts

(continued)

Table 7-1 (continued)

<i>Event</i>	<i>Possible Plan Adjustments</i>
Getting divorced	Adjust health plan and finances as agreed upon; consider COBRA or other options for yourself and your children if you're losing coverage
Changing jobs	Check which current benefits transfer to your new plan (you may be able to roll over health savings accounts and retirement plans); arrange for gap insurance if you aren't immediately eligible for benefits with your new employer (one option may be COBRA coverage, explained in Chapter 4)
Adjusting to an empty nest	Look at adjusting your child's health benefits; if educational costs are already covered, switch extra money into your retirement plan
Caring for parents	Help evaluate their health plan needs, including long-term care policies; look at Medicare options, including Part C and Part D coverage; consider purchasing supplemental insurance
Looking forward to retirement	Estimate your likely health-care costs; review the health benefits your employer offers after you retire; consider starting an HSA or other savings account; buy supplemental health insurance and think about long-term care insurance; find out how to draw from pension and other retirement accounts



Turn to Chapter 4 for complete information on what to consider during all your major life events.

Leveraging the Internet



The tools and calculators at www.PlanforYourHealth.com are useful in helping you figure your current expenses and future needs, so make use of them. You may be able to find the costs of health benefits and compare plans through the insurers' Web sites.

Your health plan, your Certified Financial Planner professional, and your employer all may have Web sites full of helpful information, so don't be shy about asking about them and making use of them.

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Ten (Or So) Important Points to Remember

Health Care Reform

We've simplified key elements of the Health Care Reform law passed by Congress in March 2010. A snapshot of the changes follows.

Manage Your Health

These new regulations:

- ✓ Eliminate lifetime dollar limits on essential benefits and phase out annual dollar limits on essential benefits as well
- ✓ Create state-run insurance exchanges rolling out in 2014 to help people who do not have health-care coverage
- ✓ Help to make health-care coverage available to people ages 55 to 65 who are not yet retired — so before they're eligible for Medicare — through the temporary Early Retirement Reinsurance Program

Live Well

Keep these points in mind to live well.

- ✓ The new regulations require all new plans to cover certain preventive health screenings provided in-network, such as mammograms and colonoscopies, without charging a deductible, copay, or coinsurance. This change affects most new plans and existing plans as they renew.
- ✓ The law allows states to establish temporary high-risk pools to provide access to coverage for anyone who doesn't have insurance for six months due to a pre-existing condition.
- ✓ The new regulations only allow insurance companies to cancel health plans in cases of fraud or misrepresentation.

Keep Family Benefits in Check

The new regulations for family benefits:

- ✓ Require that health-care plans offer coverage to people under the age of 19, regardless of pre-existing conditions. **Note:** Starting in 2014, all Americans will be able to get health-care coverage, even with pre-existing medical conditions.
- ✓ Allow children under age 26 to stay on their parents' plan.
- ✓ Mandate that all new health benefit plans include certain preventive health-care services, such as checkups and immunizations for children.

Ten (Or So) Important Points to Remember



Money-Saving Tips

In addition, in unsettled financial times, it only makes sense to save money wherever you can — and your health benefits are no exception. Check out the following four worthwhile tips.

Use All Your Plan Has to Offer

If you're paying for a vision care benefit, go get that spare set of glasses. Take advantage of the freebies your plan pays for — such as checkups and preventive care like screenings and flu shots. Your plan may offer you a wealth of information — you just need to check out its Web site. If your plan offers a Personal Health Record (PHR), be sure to personalize it.

Get Paid to Get Fit

Many health insurance companies, and increasingly employers as well, are offering wellness incentives — rewards for living a healthy lifestyle. You may be eligible to get money in your pocket for exercising and eating right, and feel better to boot! Talk to your employer or insurer about these programs.

See Network Doctors

Make sure your doctor is in your health plan's network of medical providers. Even if your plan has out-of-network benefits, it usually costs considerably less to use an in-network physician. And these days, it may be possible to have a "virtual" doctor's appointment — see if your plan and your doctor offer online consultations, which can save precious time — and fuel.

Stay Well!

Never underestimate the value of wellness. Maintaining your health by living a healthy lifestyle that includes eating right and exercising may reduce your risk of getting cancer or chronic diseases. Balancing work, home, and play is important. Be sure to get enough sleep as well. You'll be glad you did.

About the Authors

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