Navigating Your Health Benefits FOR DUMMIES®

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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

Navigating Your Health Benefits For Dummies guides you through the twists and turns on the road to health benefits. Signs posted along the route point to avenues you need to visit and side trips you may want to explore. 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 benefits and have a right to know how they work. This book gives you that knowledge.

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 six chapters each focus on one aspect of the health benefits landscape:

- **Chapter 1, Choosing Your Health Benefits,** takes you through the process of understanding the need for benefits to deciding which benefits you need and finding a plan that meets those needs. This chapter also offers info on dealing with the once-a-year Open Enrollment opportunity to make changes to your benefits.
- **Chapter 2, 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 having tests run.
- **Chapter 3, 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 4, 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 5, Speaking Up,** suggests ways to communicate with your health plan and offers pointers on how to file a claim and appeal a decision.
- **Chapter 6, 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 **Ten Tips for Managing Your Health Benefits** cheat sheet chock-full of ways to, well, manage 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. Here are the icons in this book:

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

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

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

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

Choosing Your Health Benefits

In This Chapter

- Understanding the need for insurance
- 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 — but 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.

Realizing Why You Need Health Insurance

Everyone expects to remain healthy over the years, but accidents do happen. And you just can't plan for illness, whether it's a common cold or a potentially fatal disease.

Valuing your benefits

Health benefits are designed to help safeguard you from the considerable costs of hospital stays, surgical procedures, visits to the doctor, prescription drugs, and routine preventive care. And with medical costs rocketing ever higher, you need as strong a shield as you can get.

Your overall financial picture benefits from the security of your health-benefits plan. A health plan defends your major financial assets from major assaults.

Your health plan makes the bite of everyday medical costs bearable and the specter of major medical problems a bit less threatening from a financial viewpoint.

In return for paying a *premium,* basically the price of the health plan, you gain protection from the potentially high cost of medical care — especially for serious illness and injury. 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 costs, 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 — you don't have to do any haggling yourself.

Plus, a health plan can offer you a world of information to help you make the best decisions about your health and the health of your family. A health plan can provide data to help you choose a doctor, and it can offer numerous ways to help make you healthy and keep you well. Now, that's value!

Being uninsured is hazardous to your health and your finances

Groups who have looked at such things, including the National Coalition on Health Care, 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, if you're diagnosed with cancer, for example, a later diagnosis may limit your treatment options if the disease is discovered at a later stage.
- You are 30 to 50 percent more likely to end up in the hospital for an avoidable condition.

Put these all together and it's easy to see that going without health benefits, even for a short time, puts you and your family at serious health and financial risk.

Picking Up the Basics of Benefits Plans

Health benefits abound with acronyms 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 limited to 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 or partner's job), in which case your employer may pay all or part of the *premium,* which is the cost of an insurance policy. You can also purchase coverage on your own (see the upcoming section, "Buying your own health benefits").

Many states offer health coverage 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.

If you're new to a plan, confirm when you become eligible for benefits and when your coverage starts.

Expanding on the plans

If you have health benefits through your employer, your employer selects the options and coverage available through your health plan. If you want coverage of something you don't have — massage, for example — talk to your health benefits or human resources director.

Your company may offer more than one type of 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 prescription drugs, dental, and behavioral/mental health benefits.

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), 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,* your medical professionals are paid a fee for each service they provide to you.

The upside is that you get to choose your doctors, regardless of whether they're in a 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 are low; 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 choose from doctors within your network, but you don't have to designate one doctor as your PCP. PPOs 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, 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 or *consumer-choice health plans (CDHP)* are relatively new types of health plans designed to give you more control over your health-care spending.

These acronym-heavy plans combine a *high-deductible health plan* (typically $1,000 to $2,000 for an individual and $2,000 to $5,000 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 and who contributes to the account.

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 dollars wisely.

CDHPs have many of the features of traditional plans (see the previous "Honoring traditional plans" section) but also include an account you manage yourself. The current choices include:

- **Flexible Spending Account (FSA):** With an FSA, money is taken from your paycheck before taxes and put into an account. You can use that money to pay for health-care-related services and products as well as certain expenses for your dependents, such as day-care costs. The IRS determines which expenses are covered, so check to see what's allowable either through your plan administrator or through the IRS Web site at `www.irs.gov/publications/p502/index.html`.

  The list of covered expenses is quite extensive. Set aside a folder or basket to collect drugstore receipts — allergy medicine and bandages are approved items, and you may as well use your 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. You know what they say: You can't take it with you. It's only too true when it comes to FSAs.

- **Health Savings Account (HSA):** To open an HSA, your health plan has to qualify as high-deductible. The good news is that if it is, 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 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.

No rule exists that says you have to spend HSA dollars for health-care costs. You can usually withdraw cash from your account; although if you spend the money on nonqualified expenses, it's taxable, and you may have to pay additional penalties. 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.

  A version of this fund, a Retiree Reimbursement Account (RRA), is available, aptly enough, to retirees.

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 the 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 is right for you and your family.

Determining 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 overall cost of the plan to deductibles to the *copayment* 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.

- **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 access to 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.

Measuring the impact on 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 4 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, paying out-of-network fees, and chipping in for coinsurance costs. 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 available discounts for living healthy. See whether following an exercise program or being a nonsmoker can benefit your pocketbook as well as your health.
- 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.

- Consider lowering your premium by opting for a plan with a high deductible.

The Health Expense Calculator at www.PlanForYourHealth.com can help you estimate annual health-care costs.

Working the Internet

If you have the luxury of choice in your health plan, you can turn to the Internet to help you research plans and companies to your heart's content.

If you have a choice in health plans, check the Web sites of the plans you are considering. 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 plans and policies.
- 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: Healthfinder is the Department of Health and Human Services gateway to health information resources.
- www.intelihealth.com: Aetna InteliHealth is a resource for health information from trusted sources including Harvard Medical School.

- www.jointcommission.org: The Joint Commission on Accreditation of Healthcare Organizations is an independent group that accredits certain organizations.
- www.ncqa.org: The National Committee for Quality Assurance is also an independent group that accredits certain health plans.

Buying your own health 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 COBRA (Consolidated Omnibus Budget Reconciliation Act) provisions to stay insured temporarily through your previous employer. Visit www.cobrainsurance.net or talk to your old boss about this program. Keep in mind that the election period may have time limits.
- Purchasing an individual health plan. More and more people – nearly 18 million to be specific – purchase their own health benefits. This trend is likely to continue as fewer employers offer health plans.

  Depending on where you live, you may have to fill out a health questionnaire and your answers can affect the price of the plan.

  

  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.
- Contacting your state's insurance or health department. You can find a guide to your state's health consumer regulations at www.HealthInsuranceInfo.net, a Web site designed to help you get and keep health insurance.

- 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.)

  Your state may also help if you have a medical condition that makes you ineligible for an individual plan. The cost of a state plan 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.

- 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. You may qualify for group coverage through them.

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 and enticements. 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 plan — 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 plans 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 and copayments: 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.

If you're confused by a term or two (or 20!), check the glossary at www.PlanForYourHealth.com. Your benefits administrator at work can help as well.

Seeing what you will need

Anticipating major life events during Open Enrollment is 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; if you're taking an extended trip to some exotic destination, book a plan that travels well (see Chapter 3). 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. You may need to strike a balance between your ideal plan and the plan you can afford.

Chapter 2

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 as is until Open Enrollment season hits, but 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 when you have either type of expense.

Your benefits book or online resource is a certain source of information that 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. Children whose parents are divorced and seniors who draw Medicare benefits may have supplemental insurance and health-care 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 with 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 office, lab, or pharmacy (though you may have to present a check or cash as a copayment as well).

Your plan may require pre-authorization before you consult a specialist or undergo certain procedures. Be sure you understand whether you need authorization and how to get it.

Health plans have a lot of specific information 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!) The next best 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 information provided by 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.

Once you actually have a doctor and an appointment, to cut down on the time you spend in the aptly named "waiting room," try to book 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, 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 don'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.

When you have questions about your health-care coverage, contact your health plan. For questions about your health, talk to your doctor about the most appropriate treatment options for you.

Exploring your options

If at all possible, choose a PCP who's part of your insurer's network. 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`.

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, 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 1).

Making your choice

You have several candidates, all in your network, and you can't decide among them. Use your own criteria to narrow the field, but some common questions include the following:

- **Affiliations:** What hospital is the doctor affiliated with? Does the doctor belong to a medical group you can tap into if you need to?
- **Appointments:** How easily and quickly can you get an appointment? Can you get an appointment before or after your work hours or on Saturday?
- **Availability:** Can you reach the doctor by phone or via e-mail to answer questions? If you can't talk to the doctor, is there a nurse or physician's assistant ready to help?
- **Board certification:** Is the doctor board certified? Check `www.abms.org` or call toll-free 866-ASK-ABMS to find out.
- **Satisfaction ratings:** Some health plans may offer members the opportunity to rate a health-care provider based on their satisfaction level. These ratings are likely offered on the health plan's Web site.
- **Specialty:** Does the doctor have expertise relevant to your needs? If you have young children, you may want a pediatrician or family physician; if your elderly mother is part of the family, you want your PCP to have experience in geriatric issues.

In the end, the best PCP for you is someone you trust and can communicate with easily.

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 make sure any specialist you consult is approved by your plan.

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. Examples include the American Academy of Pediatrics at `www.aap.org` and the American Academy of Family Physicians at `www.aafp.org`.
- Check the National Committee for Quality Assurance's Web site at `www.ncqa.org` to find out whether your physician has received any recognition.

If you have trouble getting an appointment with a specialist, your PCP may be able to help.

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 you can replace a crown or bridge. Check with your benefits book or your health plan for details.

Dental plans often are structured the same way as health-care plans — you'll find that traditional plans, managed-care plans,

PPOs, and dental costs generally are qualified expenses for a tax-advantaged health savings account. All these options are explained in Chapter 1.

Likewise, 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.

The deductible, copayment, and co-insurance amounts of your behavioral health benefits may be higher than those for your medical coverage. You also may be limited in the number of visits covered.

Often, employers offer an *Employee Assistance Program (EAP)* for health concerns ranging from caring for your children or parents to alcohol and drug abuse treatment. Through your EAP, you have access to professionals who provide confidential assessment and short-term counseling. If your marriage is ending — or your parents' 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 brings you more joy than just about anyone else in your life, 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 1).

Filling Prescriptions

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

Consider getting your prescriptions through the mail. If you opt for the convenience and lower cost of mail-order prescription services, see whether you can call and speak to a pharmacist. At the least, get the number for the customer service department.

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 with its formulary, based on how expensive the drug is, how well it works, and so on. The different levels of coverage often translate into different copay amounts for you.

Your health plan may require preapproval 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 their customer service department.

Going generic or brand-name

A *generic drug* is a chemically equivalent version of a brand-name drug for which the patent has expired. The Food and Drug Administration ensures the quality of generic drugs.

Typically generic drugs are less expensive than branded drugs, but isn't that always the way?

Get into the habit of asking your doctor to approve generic equivalents for your prescriptions. Doing so saves 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 a valid choice. Ask your doctor if you're unsure.

You can pay for many of these drugs with money from your Flexible Spending Account (refer to Chapter 1).

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 you should get, and when. You're wise to take advantage of your plan's benefits and go get these tests. Don't delay!

And, if you actually break a limb, have a baby, or get your gall bladder removed, you'll probably see the inside of a hospital.

As with accessing the 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 discover whether your plan covers the tests your doctor wants you to have. And, if you have to go to an outside lab, 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.

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, what after-hours care your doctor offers (if any), and which area hospitals are in your network. Virtually all states require that health plans provide some coverage for emergency services.

Some plans offer a 24-hour hotline or nurse help line 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 functions of your health-benefits plan is to keep you healthy. In fact, many plans offer incentives to do just that. Check to see if your plan offers:

- Coverage for check-ups, well-woman and well-child visits, and flu shots.
- Coverage or discounts for weight-loss and fitness programs, smoking-cessation programs, and alternative medicine.

Facing a natural disaster

Natural disasters can strike quickly and without warning. Should you be affected by Mother Earth's less benevolent side, you may be dealing with a whole lot all at once. Having your health and financial affairs in order beforehand can ease the uncertainties during a chaotic time. Use these tips:

- **Know what's covered:** If you or a family member is injured or becomes ill, health benefits can quickly become your most important asset. Review your benefits for the amount and extent of coverage, with an emphasis on how to handle catastrophic or long-term injuries. Look at coverage for rehabilitation and the lifetime maximum the policy will pay.
- **Have information at the ready:** Always carry a medical information card or wear a medical alert bracelet that informs medical personnel of any special conditions, medications, and allergies.
- **Assemble a health-benefits kit:** Gather your family's health records and health benefits information and keep it where you can easily grab it if you have to evacuate. Chapter 6 tells you how to compile this info, and you can download and print a personal health information record at `www.PlanForYourHealth.com`.
- **Stay in touch with your health plan:** If you or a family member needs medical attention, seek care immediately. Call your health plan as soon afterwards as possible to find out what to do and what information to provide to make a claim.
- **Keep your boss in the loop:** Notify your employer immediately if you're affected by circumstances beyond your control.
- **Save your receipts:** Save any medical or prescription receipts to submit for reimbursements. Even if your plan is generally by-the-book, restrictions may be lifted in the face of a regional disaster.
- **Enlist your doctor's help:** If you're injured, ask your doctor to keep records detailing your treatment and progress. Your insurance company may require details of your rehabilitation plan to provide coverage.
- **Be prepared to be flexible:** Understand your own health needs and risks, and have a plan for getting the care you need if you're temporarily cut off from your regular medical services.

Chapter 3

Meeting Life Head-On

In This Chapter

- Working life
- Married life
- Family life
- Single life
- Retired life

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 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. 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 or 36 months — which may be all you need to tide you over until you find your own plan. You may want to invest in a short-term, supplemental policy to ensure that you're covered while you're waiting to be eligible for your employer-sponsored plan. Make it your business to find out what's available.

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.

If you don't have access to benefits through your employer, try professional and alumni associations and check Chapter 1 for advice on finding a plan on your own.

Accepting an offer

In today's job market, the benefits package an employer offers can be a determining factor as to whether you accept an offer from a company. And health benefits are a major portion of a package that 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 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 Flexible Spending Accounts 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 better for you than COBRA, so be sure to compare.

Getting an invisible bonus

Your employer already realizes that the benefits you're paid can add significantly to your annual salary. Table 3-1 shows that for someone making $25,000, the benefits can add up to an additional $8,727, raising total compensation to $33,727 — it's sort of like getting a bonus they don't tell you about.

Table 3-1 Typical Benefits Costs

Benefit	*Cost to Employer*
401(k) plan	$ 750
Dental insurance	$ 120
Disability	$ 300
Health insurance	$3,034*
Life insurance	$ 75
Social Security/Medicare	$1,913
Three paid personal days	$ 289
Two weeks paid vacation	$ 962
Unemployment compensation	$ 784
Workers' compensation	$ 500
TOTAL	**$8,727**

Source: A. Foster Higgins and Co.

**Family Health Insurance — $8,167. Source: Kaiser Family Foundation.*

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

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 covers you for up to three months if you're unable to work due to an injury, illness, or health event. Long-term disability lasts for three months or longer. Check with your human resources department to find out what type of disability coverage is available.

Striking 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 to 36 months. The folks in your old human resource department can help you find out.

If you need to find health benefits on your own, Chapter 1 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 if 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 (swinging or otherwise) 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 1 has an exercise to help.

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.

Use Table 3-2 to compare your benefits, using the blank columns either to record comments or to indicate the plan with the better benefit.

Table 3-2 Comparing Benefits Plans

Benefit	*Bride's Plan*	*Groom's Plan*
Size of network		
Monthly premium		
Copayment		
Deductible		
Prescription cost		
Mental health coverage		
Vision coverage		
Dental coverage		
Discount opportunities		
Alternative treatment coverage		
Access to specialists		
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, 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 1 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, not everyone is so rude and there are some folks an expectant mother actually encourages to touch her. These health-care and child-care specialists may include:

- **Obstetrician:** A doctor whose specialty is guiding mothers-to-be through pregnancy and helping deliver the baby.
- **Midwife:** A person trained to help deliver babies and who offers support and advice throughout pregnancy.

- **Doula:** A woman experienced in childbirth who provides physical, emotional, and informational assistance before, during, or after childbirth.
- **Lactation consultant:** A person who offers information and guidance to help new moms and their newborns get off to a nutritious start.

Your health-benefits plan may not cover the services of all these professionals, so check with your health plan before making an appointment.

Consider whether you want to expand your family when selecting your plan and your Flexible Spending Account contribution during Open Enrollment.

Finding a stork to deliver your bundle

If you already have an obstetrician and/or a midwife you trust, you're well ahead of the game. Just make sure their services are covered by your health benefits.

Getting a referral from family or friends is one method for finding a new medical professional, so ask around if you don't know a baby-delivery professional. Another good source for information is your health plan's network. Narrow your choices by using criteria important to you, such as office location, appointment hours, hospital affiliation, education, gender, or ethnicity.

Many obstetricians and midwives welcome a preliminary visit before you become a patient, but find out before you go what the charge is — if any — and whether your health plan will pay for it.

Anticipating 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.

According to HealthDecisions.org, a resource provided by America's Health Insurance Plans, the average cost of a normal, uncomplicated vaginal delivery at a hospital can range from $5,000 to $8,000. Being able to anticipate what your payments may be can make your baby's arrival a tiny bit less stressful.

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, health-care 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.

Time of firsts: Finding your child's first doctor

Now that your obstetrician 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 as 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 benefits customer service representative for a list.

Your family physician or pediatrician plays an important role in your family's life for years to come. Don't be shy about scouting for the perfect person. You (and your partner, if available) need to decide the most important qualities you want your pediatrician to have. 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.

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 get to decide which plan to use, 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.

Other things to think about include:

- **Your life insurance coverage:** Your child will have financial needs throughout his or her childhood. You may want to increase coverage for both parents just in case.
- **Child-care costs:** Even if Grandma watches the young ones while you're at work, you have to pay her something. You may want to start a tax-advantaged health-care account to draw on for child-care expenses.
- **College costs:** Today onesies, tomorrow cap and gown? Sometimes it feels just that quick, so the sooner you start preparing for education expenses, the less the sticker shock.

- **Consumer-directed health-care options:** Adding to your family is an opportunity to explore the advantages of options such as Flexible Spending Accounts, Health Savings Accounts, and more. Chapter 1 explains those options.

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

Table 3-3 Childhood Benefits Milestones

Milestone	*Benefits Check*
Being born	Add baby to plan within 30 days; begin appropriate immunizations and well-baby check-ups
Starting school	Make sure your health plan covers immunizations; start a college fund if you haven't
Becoming a pre-teen	Consider adding an orthodontic component to your dental plan; see if your plan covers physical therapy for potential sports injuries
Graduating high school/ Heading to college	Discover how long your benefits cover your children and how to extend benefits for full-time students; see what employer- or state-sponsored plans are available if your young adult works part- or full-time; explore health plans offered by the college or university
Graduating college	Consider individual coverage if your child doesn't yet have a job or isn't eligible for employer-sponsored benefits

Starting Over: Single Again

Becoming single again can be challenging — you've lost a spouse 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 temporary continuation of health coverage under your former spouse's employer.

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 before you 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 help.

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.

Looking at long-term care

As Americans age — baby boomers are now entering 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 a free, long-term care planning brochure at `www.fpanet.org/public/tools/healthcare.cfm`.

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 human resources department or the plan'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 1 for tips on doing so.

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.

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

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).

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)* professional. A CFP professional is someone who 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 1) 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 to find out if and when you qualify for Medicare. Be ready to provide your Social Security number and date of birth when you call.

Medicare has several parts, each with a different function:

- **Part A** provides hospitalization benefits. You get this service at no charge just for being older than 64 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 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 a copay for each prescription 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.

Passport to healthy globetrotting

Traveling should be all fun and no hassles. To help keep it that way, use the tips here to make your trip free of concerns about your health benefits.

- **Never leave home without it:** Make sure that you have your insurance identification card and emergency contact information with you.
- **Read the fine print:** Review your current health benefits to see what your options are if you need medical care when you're away from home. Your destination — whether domestic or international — and how long you're staying may impact your coverage. Contact your plan to discuss your options, and be aware that Medicare does not normally cover expenses outside the United States.
- **Make sure you can follow your routine:** Schedule a routine check-up before, rather than after, your trip and get any recommended vaccinations. If you need regular blood tests, get allergy shots, or receive ongoing therapy, find out how to access those services when you're on the road.
- **Get set for emergencies:** Your plan may not fully reimburse you for services you receive from out-of-network providers, even in an emergency. So, be that extra bit prepared and know the name and location of in-network hospitals and emergency-care facilities at your destination.
- **Consider short-term insurance:** A supplemental health benefits plan as well as medical evacuation insurance can be a real benefit. If you're planning exotic doings in exotic locations, such as scuba diving in the Great Barrier Reef, look into coverage specific to your needs.
- **Make sure you get your meds:** Stow your prescriptions in your carry-on bag in the original packaging along with a list of your medications. Take an emergency refill prescription with you and find out what your options are if you need a refill when you're away from home.
- **Take care of the kids:** Your children are more likely to get sick than you are — their immune system is still developing and they may not wash their hands as often as you tell them to. Make sure that their coverage under your policy is up-to-date, and take their health information (immunizations, allergies, and current medications) with you.

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.

Chapter 4

Paying Up

In This Chapter

- Looking at health-care costs
- Explaining your "Explanation of Benefits"
- Savings opportunities

Low-cost doctor visits, a $10 copay for a $90 prescription, that handy refrigerator magnet with your health plan's contact info — these things don't come cheap. This is the chapter that tells you what you have to pay and to whom.

Knowing What You're Paying For and How

Don't take the *and How* in the heading to mean that we think you pay more than you should for health-care benefits. Just the opposite is true if you have group coverage through your employer. If that's the case for you, your employer may pay at least part of your benefits premium for you.

What these sections explore is 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:** An upper limit on costs or services covered by a plan. For example, a plan may limit you to 60 days of occupational therapy or put a ceiling on the dollar amount of coverage it will provide over your lifetime. Some plans have limits; some don't, so check your policy.
- **Copayment (copay) or co-insurance:** 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 co-insurance kicks in.

- **Deductible:** The amount you have to pay for covered medical services before your health plan starts chipping in. Your deductible amount may be very, very small or really quite large. What size it is depends partly on you: You can trade off the costs of a high deductible with a lower premium, and if you're young, healthy, and don't have dependents, this may be the way to go.

  Some employers have plans that don't have a deductible and pay for covered benefits from the first dollar you spend. Oddly enough, they're called *first-dollar plans.* The term may also describe a plan that has a deductible but also has a benefits account you can use to pay for medical services such as your annual physical before the deductible is met.

- **Exclusion:** A health condition or circumstance not eligible for coverage under your health plan. What your plan doesn't cover is listed in the Certificate of Coverage for your benefits. Call your plan's customer service number to get a copy of your Certificate of Coverage.

  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 and copayments.

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. If you have the chance, you may want to start a health savings account if you expect high out-of-pocket costs.

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 an insurance plan. Your employer may pay part of your premium if you get your health benefits through your company.

  Pay attention to what your premiums run — your employer's contribution is part of your compensation package. You can find this amount on your paycheck stub.

- **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. For example, your doctor may charge $60 to remove that pesky wart, but your health plan pays just $40. You may have to pay the difference. On the other hand, your health plan may negotiate the doctor's fees in advance, including an agreement that prevents your doctor from billing you for the remaining $20.

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 pre-tax 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 and copays goes directly from your hand to the medical service professional, whether that's your doctor, pharmacist, or ophthalmologist.

What form of payment each accepts — check, cash, or charge — is information you should find out ahead of time. While you're asking those questions, find out whether you should be prepared to pay for each visit, whether the office handles billing your insurance and filing claims for you, or whether you have to do the paperwork yourself.

If you're the one getting reimbursed, make sure to check the appropriate box on the claim form, and be sure you 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 is usually mailed to you, but 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 (this, however, is sometimes hard to discern as it may be literally in code numbers or abbreviations)
- The claim amount
- The agreed-upon amount paid by your plan
- The amount you're responsible for paying

Health benefits reminders for whatever life brings!

You can't plan for illness or accidents, but the unexpected does happen. That's why going without health benefits, even for a short time, puts you and your family at serious financial risk. If you're between jobs, or between insurance plans, look into temporary coverage. Make use of the following tips as well:

- Set up a health savings account (HSA) if you're eligible. You can set aside money tax-free to use as a retirement account or to pay health expenses should you get sick.
- Join a prescription drug discount program. Some pharmaceutical companies have patient assistance programs that allow you to buy drugs at a discount. You also can look for a mail-order program or ask your local pharmacist for options.
- Maintain your health. You know what it takes — eating right and exercising. Living a healthy lifestyle improves your health and may reduce your risk of getting cancer and other chronic diseases.
- Get routine health screenings. When problems are found early, your chances for treatment are better. Look to local agencies for free or low-cost programs.

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

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 just 30 days to let your insurance carrier know that you disagree. Chapter 5 takes you through the appeals process.

Saving with Discounts

Discounts, though no substitute for health insurance, are useful not only for services your health plan doesn't include but for circumstances such as being employed part-time without access to an employer-sponsored health plan, or any

situation in which traditional coverage isn't available. Some of the myriad discounts for health-related items include

- Discounts for vision and dental care.
- Wellness discounts, which can take the form of discounted gym or health club memberships, discounts on exercise programs and equipment, stop-smoking classes, and discounts for flu shots.
- Discounts for services such as acupuncture, nutritional supplements, and massage therapy.

You may be able to save money on items and services you already use.

Chapter 5

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-care plan provider. 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 do have a question about a payment or disagree with a decision about a claim, however, it's good to know who to turn to. This chapter tells you how to find that information.

Checking Your Claim Status

Often you go to the doctor, shell out cash for the copay amount, go home, and blithely ignore all the paperwork generated from your visit. But, because your health plan is paying attention, it makes sense for you to pay attention as well.

Whether you submit claims yourself or the office, lab, or pharmacy does it for you, staying on top of your claims and charges is good for both your mental and financial health. 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 4.

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, and when your payment is due.

If your health plan is very techno-savvy, your plan 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. The next sections offer pointers for when you're actually in contact.

Choosing a method

Your plan's customer service department may well be a thing of many parts. You can often 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.

Which method you use may hinge upon what you want to accomplish. And different methods have different strengths:

- IVR's 24/7, always-available feature 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 a customer service representative

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. That old saying about attracting more flies with honey works to this day (though why anyone wants to attract flies is beyond us). 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. No one but you could provide the details asked for, and anyone who doesn't provide them is going to 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. You'd think everyone would call during lunch, but that's not the case, so you may want to try it yourself.

Appealing a Decision

Stories of tussles with health plans are legion and legendary. And, though it's true that insurance companies are businesses, they're in the business of serving their customers — which means you. They're actually trying to make your experience with them as painless as possible — no one wants to make things more difficult for you when you're already ill or injured.

Sometimes, however, what you think your health plan should pay for and what your policy 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 30 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. You can 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 6

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 have health benefits through an employer's plan. Helping you figure out what changes to make, if any, is the goal of this chapter.

Looking at This Year's Expenses

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

You keep track of your health care and finances, right? Well, if you haven't been, now's your chance to set up a system.

Your system doesn't have to be elaborate, you just need two file folders — or baskets or drawers or stacks. 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.

Always carry a medical information card that informs medical personnel of any special conditions, medications, and allergies.

- **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, including copayments.
- **Statements** from your Health Savings Account (HSA), Flexible Spending Account (FSA), or similar plan. (Chapter 1 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.
- **Insurance policies** of all descriptions — health, life, disability, and the canine-care policy you took out for Fido. On second thought, maybe that one should be in the file marked *Fido.*

Keeping this active file, along with photos of each family member, in a fire- and waterproof carrier makes grabbing the file easy in case you have to evacuate your home for any reason. Tell someone else where your files are in case of an emergency.

Into the second file goes reference-type information you want to have around but don't need to do anything with. This inactive file holds

- **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.

The Personal Health Information Record at `www.PlanForYourHealth.com/prepare` can help you assemble your family health record.

Don't forget to list the name and contact information for each doctor and to update the list every year.

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. And, sorry, even though that shopping spree was vital to your mental health, it doesn't qualify as an allowable expense.

Then, check the balance in any tax-free health savings accounts you have. Often, you can roll over excess funds and spend them next year, but if you didn't contribute enough to cover all your allowable expenses, you may want to consider upping your ante, so to speak.

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, in which case you consider your options and try to appreciate the break in the monotony.

However, if you see LASIK eye surgery in your future, hear wedding bells, or feel a change in the air at your job, you can adjust your benefits program to anticipate your needs for the upcoming year. Table 6-1 lists some situations and the health benefits and financial moves you can make to accommodate them.

Table 6-1 Anticipating Plan Adjustments

Event	*Possible Plan Adjustments*
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 child care or day-to-day expenses such as diapers; start a college savings plan; increase your life insurance

(continued)

Table 6-1 *(continued)*

Event	*Possible Plan Adjustments*
Graduating from college	Investigate and enroll in a health benefits plan offered by your new employer, or consider individual coverage or COBRA
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
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 3)
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 3 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 benefits plans and compare plans through the plans' 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 Tips for Managing Your Health Benefits

Take Time for Open Enrollment

If you're really pressed for time during Open Enrollment — the period when you have a chance to alter your health benefits options, if options you have — try these time-efficient tips:

- **If you have 5 minutes,** visit `www.PlanforYourHealth.com` and check out the Health Benefits Priorities Tool.
- **If you have 10 minutes,** visit your health plan's Web site or your employer's intranet site for information specific to you and your needs.
- **If you have 15 minutes,** estimate your health expenses for the year using the calculator on `www.PlanforYourHealth.com` and review the related articles there.
- **If you have 45 minutes,** look at your health-care spending over the past year and use the information to plan your family health budget for next year.

Chapter 1 explains the ins and outs of Open Enrollment.

Find the Plan That Suits You

Do some detective work to make sure you're picking a plan that meets your health-care needs and fits into your overall financial budget. Common health-care essentials include a prescription drug plan and coverage for prenatal, well-woman, and well-child visits, as well as physicals (even men need check-ups, too). Chapter 1 has a tool to help you with your priorities plus info on plan options.

Use All Your Plan Has to Offer

If you're paying for a vision care benefit, go get that spare set of glasses. If you can join a tax-advantaged savings plan such as an HSA or FSA — and if doing so makes financial sense — sign up.

Take advantage of the freebies your plan pays for — check-ups, for example, and preventative care like screenings and flu shots.

If you can visit an acupuncturist at a discounted price, see whether having needles stuck in your back can help with your migraines. (Chapter 4 talks about discounts.)

Go for a Tax-Advantaged Account

When you — or, even better, your employer — can contribute to a tax-free health account such as a Health Savings Account, it generally makes good sense to go for it. (Turn to Chapter 1 for a full explanation of consumer-driven accounts.)

Ten Tips for Managing Your Health Benefits

Don't Leave Money on the Table

If your employer offers benefits dollars in proportion to your salary, explore ways to get the most health-benefits bang for your buck. Your human resources person can probably help.

If you have a Flexible Spending Account, make sure you use it up each year; funds left at the end of the year are gone much faster than 60 seconds.

Track Your Spending

Keeping your receipts for health-care costs, including premiums and deductible costs, from both a family-budget perspective and a health-costs perspective just makes good sense. Plus, if you know what you spent this year, anticipating your costs for next year is easier. Chapter 6 offers tips on what to save and how to use it.

Make Use of Information Offered

Your employer and your health plan offer a whole host of tools they're only too willing to share. The info is there for the asking, so ask!

You can access tools that help you compare different options, calculators that help you plan your contribution to your Flexible Spending Account or Health Savings Account, and online health-plan tutorials. You may also be invited to health-benefits or retirement-planning seminars periodically.

Re-evaluate during Life Events

You know that big changes in your life have many repercussions; you just may not realize their effects on your health benefits and finances. But, whether you're getting hitched, hitting the road, raising a family, or facing retirement, you need to take your shifting benefits needs into consideration at every major juncture in your life, and some of the minor ones as well. Check Chapter 3 for a rundown of points to ponder along the road of life.

Pursue Special Discounts

Your health benefits may offer discounts at gyms so that you can stay healthy, with massage therapists so that you can feel wonderful, and for stop-smoking classes so that you can breathe freely. You may also get reduced rates for mother-and-baby check-ups and other wellness benefits. Check your policy, check with your health plan, and check out Chapter 4.

Speak Up about Your Claims

If you don't speak up for yourself when you disagree with a claim statement, no one else will. You have to stay on top of your Explanation of Benefits statements, compare them with your receipts, and be ready to make a phone call if things don't match. Chapter 5 elaborates on this topic.