Best of Benefits 101

DMA BENEFITS

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Have You Visited the Doctor This Year?

Visiting your primary care doctor at least once a year is essential to keeping your health on the right track. In fact, those who take preventive care seriously tend to be healthier and lead more productive lives. Take a look at the following three ways you can benefit from scheduling your annual checkup:

1

Control Chronic Diseases

Visiting your doctor for an annual checkup can help you detect and receive treatment for chronic conditions before they cause serious health problems.

2

Establish a Baseline

If you schedule annual checkups, your doctor will likely be more familiar with your personal health history. This knowledge will help create a health baseline, allowing your doctor to detect any unusual or abnormal health concerns before they become a more serious issue.

3

Form a Relationship

Research shows that patients who have a good relationship with their doctor receive better care and are happier with the care they receive. Going to your annual checkup will help strengthen the relationship between the two of you, increasing your trust and comfort in the care you receive.

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The Importance of Preventive Care

According to the U.S. Centers for Disease Control and Prevention (CDC), 7 out of 10 Americans die each year from chronic diseases, many of which are preventable. When preventive care is used and illnesses and diseases are caught early enough, individuals can avoid or better control their health problems.

What Is Preventive Care?

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. Preventive care occurs before you feel sick or notice any symptoms and is designed to prevent or delay the onset of illness and disease. The CDC asserts that treatment for chronic diseases works best when they are detected early.

In its broadest definition, prevention includes a healthy lifestyle, exercise, diet and other similar efforts. Preventive care in a medical setting includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations. Regular health evaluations will help keep you healthy and prevent more serious problems later.

Why Use Preventive Care?

Preventive care is important because it helps you stay healthy and access prompt treatment when necessary, and it can also help reduce your overall medical expenses.

- Stay healthier and get more effective treatment – Many types of screenings and tests can catch a disease before it starts; for example, diabetes screenings can tell you whether you're pre-diabetic, or whether you already have diabetes without being aware of it.

  Starting treatment or lifestyle changes before a disease starts or while it is still in its early stages will help you stay healthier or recover more quickly.

- Pay less for medical expenses – Preventive care saves you money in two ways.

  - First, preventive care helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

  - Second, many preventive services are now covered in full by insurance due to the Affordable Care Act (ACA), which means they are free for you if you have health insurance. The ACA requires certain preventive services to be covered with no cost-sharing—this means that for many preventive care services, you will not have to pay a deductible, copay, coinsurance or other out-of-pocket expenses.

The U.S. Department of Health and Human Services has provided lists of preventive services that must be covered by most health insurance plans. Lists are available for adults, women and children, as covered services depend on age and gender. Click here for the lists of covered preventive care services.

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For adults, services such as blood pressure and cholesterol checks and screenings for depression are covered. Women may have folic acid supplements and anemia screenings covered if they are pregnant. Children's covered preventive services include autism screenings for children at ages 18 and 24 months and alcohol and drug use assessments for adolescents.

When preventive care services are combined with a lifestyle that is focused on wellness, significant savings can be realized. Ultimately, preventive care provides the benefit of saving lives and improving the quality of your health for years to come.

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Health Insurance Terms You Need To Know

The health care system in the United States can be confusing. In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, the government, health plans and health care providers. This way, you can make better decisions and ultimately receive better care.

Advance Premium Tax Credit – A new tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit to apply to your premiums each month, up to a maximum amount. If your advance payments for the year are less than the credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments are more than the amount of your credit, you must repay the excess with your tax return. Also called premium tax credit.

Affordable Care Act (ACA) – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Ambulatory Care – Health care services that do not require a hospital stay, such as those provided in a doctor's office, clinic or day surgery center.

Annual Limit – A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services, such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Assignment of Benefits – A document you sign that allows your hospital or doctor to collect your health insurance benefits directly from your health carrier. Otherwise, you pay for treatment and the insurance company reimburses you.

Benefits – The amount of money payable by an insurance company to a claimant under the insurance policy.

Brand-name Drugs – Prescription drugs sold by a drug company under a specific name or trademark and protected by a patent. Brand-name drugs may be available by prescription or over the counter.

Broker – An independent insurance agent who works with many insurance companies to find insurance policies for his or her clients.

Cafeteria Plans – Benefit programs that help employees pay for certain expenses, such as life insurance, disability benefits, medical expenses and child care, with pre-tax dollars. Employers select the benefits that will be offered (only certain benefits can be provided), and employees use pre-tax dollars to buy the benefits they want. Employers can also make contributions to subsidize benefits. Cafeteria plans are also known as flexible benefit plans or IRS 125 Plans.

Capitation – A set dollar limit that a health maintenance organization (HMO) pays to your primary care physician for providing medical treatment to you and your dependents. The fee is usually paid to the physician on a monthly basis.

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The physician gets no more or less than this set fee, no matter how much or how little you use his or her services.

Case Management – A technique that insurance companies and HMOs use to ensure that individuals receive appropriate, timely and reasonable health care services.

Children's Health Insurance Program (CHIP) – A government insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women in families that earn too much income to qualify for Medicaid but can't afford to purchase private health insurance coverage.

Claim – A request by an individual (or his or her provider) for the insurance company to pay for services obtained.

Coinsurance – The money that an individual is required to pay for services after the deductible has been met. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event.

Copayment – An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. Copayments are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.

Deductible – A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.

Denial of claim – Refusal by an insurance company to pay a submitted request for health care services obtained.

Dental Insurance – Insurance that helps pay for dental care and usually includes regular checkups, cleanings, X-rays and certain services required to promote general dental health. Some plans will provide broader coverage than others, and some will require a greater financial contribution from you when services are rendered. Some plans may also provide coverage for certain types of oral surgery, dental implants or orthodontia.

Dependent – Any individual, adult or minor whom a parent, relative or other person may choose to cover on his or her insurance plan.

Employee Assistance Program (EAP) – Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to pay directly for EAP services provided.

Essential Health Benefits – A set of health care service categories that must be covered by certain plans.

Exclusions and Limitations – Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).

Exclusive Provider Organization (EPO) – Health care plans similar to preferred provider organizations (PPOs), with the main difference being that services are covered only if you go to doctors, specialists or hospitals in the plan's network, although there are exceptions for emergencies.

Fee-for-service Plans (FFS) – A type of coverage where insurers pay for health care services provided to plan participants. With this type of coverage, you can choose any doctor you wish and change doctors any time or go to any hospital in any part of the country. These plans existed primarily before the rise of HMOs and PPOs.

Flexible Spending Account (FSA) – An individual arrangement set up through employers to pay for many of out-of-pocket medical expenses with tax-free dollars. The FSA account holder sets aside a pre-tax dollar amount for the year which he or she can use to pay medical expenses. Unused FSA funds can expire, depending on the policy of the account holder's employer.

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Generic Drugs – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Grandfathered Health Plan – A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010, and is exempt from many, but not all, provisions of the ACA.

Group Health Plan – A health plan offered by an employer or employee organization that provides health coverage to a large group of people at a discounted rate.

Health Insurance – A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Health Insurance Marketplace (Marketplace) – A state or federal resource where individuals, families, and small businesses can shop for health insurance plans based on costs, benefits and other important features, and enroll in coverage. Individuals who enroll in a health insurance plan through the Marketplace may be eligible for Advance Premium Tax Credits and other assistance in paying for coverage. Also known as Exchanges.

Health Maintenance Organization (HMO) – Prepaid, or capitated, health care plans in which individuals pay a small monthly fee to be a member of the HMO, as well as small fees or copayments for specified health care services. Services are provided by physicians and allied health care personnel who are employed by or under contract with the HMO. HMOs are available to both individuals and employer groups.

Health Reimbursement Arrangement (HRA) – Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses. Like health savings accounts (HSAs), unused amounts may be rolled over to be used in subsequent years. Unlike HSAs, the employer funds and owns HRA accounts. The employer sets up the HRA, determines the amount of money available in each employee's HRA for the coverage period and establishes the types of expenses the funds can be used for.

Health Savings Account (HSA) – A medical savings account available to people who are enrolled in an HSA-compliant high-deductible health plan. The account is employee-owned, and money may be contributed by both the employer and employee. If the employee leaves the company, he or she remains in control of the account. The funds contributed to the account are pre-tax, which means they aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses; there is a heavy tax penalty for using HSA funds for non-qualified expenses. Funds roll over year to year if you don't spend them, and can accumulate a significant balance. There is a limit to how much money can be put into an HSA every year, but no cap on how much money can be in the account.

High Deductible Health Plan (HDHP) – A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with an HSA or an HRA to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Independent Practice Association (IPA) – A group of independent practicing physicians who band together for the purpose of contracting with HMOs, PPOs and insurance companies for their services.

Individual Mandate – The ACA requirement that most individuals obtain acceptable health insurance coverage for themselves and their family members or pay a penalty. There is a graduated tax penalty, or fee, for individuals who do not obtain health insurance by the time they file their taxes for 2014. **Note:** Effective for plan years beginning Jan. 1, 2019, the individual mandate is no longer applicable.

In-network –Typically refers to physicians, hospitals or other health care providers who contract with an insurance plan (usually an HMO or PPO) to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

Lifetime Limit – A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits or limits

on specific benefits, or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Long-term Care Insurance – Insurance policies that cover the costs of providing nursing care, home health care services and custodial care for the aged and infirm.

Managed Care – A system of health care delivery that is characterized by arrangements with selected providers, ongoing quality control and utilization review programs, and financial incentives for members to use providers and procedures covered by the plan.

Maximum Benefit – The maximum dollar amount that an insurance company will pay for claims, either for a specific procedure or service or during a specified period of time.

Medicaid – A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and, in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, so Medicaid varies state by state and may have a different name in your state.

Medical Loss Ratio (MLR) – A basic financial measurement used in the ACA to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has an MLR of 80%. With an 80% MLR, the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs and agent commissions. The ACA sets minimum MLRs for different markets, as do some state laws.

Medically Necessary – A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.

Medicare – A federal health insurance program for people who are age 65 or older and for certain younger people with disabilities. It also covers people with End-stage Renal Disease (ERSD)—permanent kidney failure requiring dialysis or a transplant.

Medicare Part D – A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Minimum Essential Coverage – The type of coverage an individual needs to have to meet the individual responsibility requirement under the ACA. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Open Enrollment Period – A period of time, usually but not always occurring once per year, when employees of companies and organizations may make changes to their health insurance and other benefit options. The term also applies to the annual period in which individuals may buy health insurance plans through the Marketplace.

Out-of-network – Typically refers to physicians, hospitals or other health care providers who do not contract with an insurance plan to provide services to its members. Depending on the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

Out-of-pocket Maximum (OOPM) – The total amount paid each year by the member for the deductible, coinsurance, copayments and other health care expenses, excluding the premium. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.

Point-of-service Plan (POS) – A type of HMO that allows the patient to see either in-network or out-of-network

providers. However, the patient pays more out of pocket when using an out-of-network provider.

Pre-admission Certification –Approval granted by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or inpatient facility before admittance. The goal is to ensure that individuals are not exposed to inappropriate health care services, or services that are not medically necessary. Also called "precertification" or "pre-admission review."

Pre-existing Condition – Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.

Preferred Provider Organization (PPO) – A type of managed care plan in which health care providers and insurers agree to offer substantially discounted fees for covered health care services and to lower copays and deductibles for in-network services. The plan's payment ratio (what your insurance company pays compared to what you pay) may be high—for example, it could be 90/10, with the insurance company paying 90% of medical costs and you paying 10% after the copay and deductible.

Premium – The amount of money charged by an insurance company for coverage.

Prescription Insurance – Insurance that helps pay for prescription drugs and medications. Prescription insurance is often offered as part a larger health insurance plan, though this is not always the case. Stand-alone individual prescription insurance may be available for people who are not offered prescription drug coverage or who have no health insurance. Eligibility for specific medications and the cost of insurance varies among health plans. Also known as drug coverage.

Preventive Care – Any medical checkup, test, immunization, or counseling service used to prevent chronic illnesses from occurring.

Primary Care Physician (PCP) – A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a gatekeeper for an individual's medical care, referring him or her to specialists and admitting him or her to hospitals when needed.

Qualified Health Plan – An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Qualified Medical Expense – The costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.

Reasonable and Customary Charges – The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges are the responsibility of the patient.

Self-insured – A health benefits plan in which the employer is responsible for the cost of its employees' health care. Typically, a third party provides administrative services for the plan to the employer group.

Summary of Benefits and Coverage (SBC) – An outline of a health insurance plan that allows somebody to evaluate costs and coverage and compare against other health plans.

TRICARE – A health care program for active-duty and retired uniformed services members and their families.

Vision Insurance – Insurance that covers specific eye care benefits defined in the policy. Vision insurance policies typically cover routine eye exams and other procedures, and provide specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. Some vision insurance policies also offer discounts on refractive surgery.

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Waiting Period – A period of time in which your health plan does not provide coverage for a particular pre-existing condition.

Waiver – A rider or amendment to a policy that restricts benefits by excluding certain medical conditions from coverage.

Wellness Program – A program intended to improve and promote health and fitness, usually offered through the workplace, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs and preventive health screenings.

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Medicare 101

If you're nearing retirement age, or are over 65 and still working, you may have questions about Medicare. Read on for the information you need to know.

What Is Medicare?

Medicare is health insurance for people who are age 65 or older, under 65 with certain disabilities, or any age with End-stage Renal Disease (permanent kidney failure).

Types of Medicare

There are four types of Medicare. *Medicare Part A* helps cover inpatient care in hospitals, skilled nursing facilities, and hospice and home health care. Generally, there is no monthly premium if you qualify and paid Medicare taxes while working.

Medicare Part B helps cover medical services like doctors' services, outpatient care and other medically necessary services that Part A doesn't cover. You need to enroll in Medicare Part B and pay a monthly premium determined by your income, along with a deductible.

Many people also purchase a supplemental insurance policy, such as a Medigap plan, to handle any Part A and B coverage gaps.

Medicare Advantage Plans, also known as *Medicare Part C*, are combination plans managed by private insurance companies approved by Medicare. They typically are a combination of Part A, Part B and sometimes Part D coverage, but must cover medically necessary services. These plans have discretion to assign their own copays, deductibles and coinsurance.

Medicare Part D is prescription drug coverage and is available to everyone with Medicare. It is a separate plan provided by private Medicare-approved companies, and you must pay a monthly premium.

Getting Started

Medicare sends you a questionnaire about three months before you're entitled to Medicare coverage. Your answers to these questions, including whether you have group health insurance through an employer or family member, help Medicare set up your file and make sure your claims are paid correctly.

If your health insurance or coverage changes at any time after submitting the questionnaire, call the Medicare Coordination of Benefits Contractor at 855-798-2627 to update your file.

Once you start Medicare, you should schedule a free preventive visit within the first 12 months to assess your current health status and provide a health roadmap for the future.

Also, create an account on Medicare.gov to access your information and keep track of claims. If you want your family or friends to be able to call Medicare on your behalf, fill out an Authorization Form to allow them to do so.

Coordination of Coverage

If you have Medicare and another type of insurance, the question of who should pay or who should pay first can be tricky. For example, generally a group health plan would pay before Medicare, but there are several exceptions. Contact the number above for specific answers for your situation, or visit www.medicare.gov for additional information.

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10 Easy Ways to Stretch Your Health Care Dollars

You've no doubt noticed that each year, your health care costs go up. This continuing trend can significantly impact your budget. While it's difficult to control all the factors that contribute to rising health care costs, stretching your health care dollars is easier than you think with these 10 easy ways to get the most bang for your buck.

1. Understand how your health plan works.

This is the first and probably most important step. You need to know what is and what is not covered, what procedures you need to follow to ensure your claims are paid, and which providers and facilities to use to get the most cost-effective care. Know the deductibles, copayments and other out-of-pocket costs you are responsible for paying before you use medical products or services or get a prescription filled.

2. Use in-network providers.

Participating providers (doctors, hospitals, and others in your plan's network) generally charge discounted rates for plan members. When you go to a non-participating provider you will likely pay a higher coinsurance percentage (for example, 30% out-of-network versus 10% in-network). And, you will likely have to pay the difference in price between the participating provider's discounted fee and the non-participating provider's "regular" fee.

3. Look into freestanding surgical and diagnostic centers.

If you need surgery, you might save money by having it performed at an ambulatory surgical center (a clinic that is not associated with a hospital.) These sites usually charge less than hospitals or their outpatient surgical centers. Freestanding diagnostic centers are also available and tend to charge less for certain tests like MRIs, CAT scans, X-rays and bone density scans. But before you go, make sure the facility is in your plan's network and that your plan's benefits cover the service. As always, talk to your doctor to be sure this course of action is appropriate for you.

4. Ask your doctor about home testing and monitoring devices.

Home tests for blood pressure, diabetes and other conditions can help ensure you are following your doctor's orders and that prescribed treatments are working. These tests will usually cost less than in-office testing. Check with your doctor to be sure in-home testing is appropriate, report your results regularly and call your doctor if you notice anything unusual.

5. Only go to the hospital emergency room for true emergencies.

If you need medical care when your regular doctor is not available, think about going to an urgent care center rather than a hospital emergency room. This can often be a tough call, but avoiding the ER will probably save you money for two reasons: 1) the copayment is usually lower for a doctor visit or an urgent care visit, and 2) your insurer might make you pay for the full cost of care if you use an emergency room for a non-emergency. Plus, getting care at an urgent care center will likely be faster than at the ER. Call your plan's health hotline, if available, to get advice on how, when and where to seek care in a non-emergency situation.

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6. Carefully check all medical bills.

Insurance companies and hospitals are not exempt from making billing errors. Insurers often miscalculate the family deductible, so keep a careful tally of individual as well as total family payments to be sure you don't overpay. If you have a hospital stay, try to keep a log of all the services, medications and supplies you are given, so when you get a bill you can be sure you were not charged for procedures you didn't have or items you didn't use. Ask for an itemized bill.

7. Use any additional programs or discounts provided by your employer or health plan.

Many health plans provide access to free disease management programs for chronic conditions like asthma, diabetes and heart disease. These programs can help you stay healthy and manage your condition, and can possibly save you money in the long run. In addition, many employers offer complementary programs that are designed to prevent illness and lower health costs over the long run. These programs may include smoking cessation and weight loss programs, or discounts on fitness clubs or other items that help you live a healthy lifestyle.

8. Live a healthy lifestyle.

Healthy habits like exercising regularly, eating well and not smoking can increase your stamina, improve your mood and lower your risk for certain diseases. Aside from the physical and psychological benefits, healthy living can also offer financial rewards, such as lower premiums for non-smokers and fewer doctor visits for those with low blood pressure.

9. Make careful decisions about prescription drugs.

Prescription drugs are the fastest rising area of health care costs and one of the biggest reasons behind dramatic increases in health care costs nationwide. Here are some ways you can reduce your prescription drug costs:

- **Use generic drugs whenever possible, even for over-the-counter medications.** Remember, the most expensive drug doesn't mean it's the best. There are usually generic equivalents that are less expensive than the drugs you see advertised on TV. Before your physician writes you a prescription, ask about generic equivalents, lower-cost brand name drugs to treat the same condition and even over-the-counter options.
- **Know how your drug plan works.** Check your copayments and know the maximum amount your plan will pay for in one year. Find out if your plan has a formulary (a list of preferred drugs that are covered). A health plan with a closed formulary pays only for certain pre-approved drugs. A plan with an open formulary will cover most drugs but at varying prices.
- **Use a mail order pharmacy if one is available.** Ordering prescriptions by mail can save 10–15% and is ideal for patients who take medication on an ongoing basis and can place orders in advance.
- **Talk to your doctor.** Make sure your physician knows if you have to pay for prescriptions out of your own pocket. Often there are less expensive but equally effective treatment options.
- **Compare prices.** Shop around for the pharmacy that offers the best value for your needs. You may even need to get different medications from different pharmacies depending on which offers a better price.
- **Consider pill-splitting.** Some medications can be obtained at double the prescribed dose, and then split in half. This practice can result in 50% savings. You must be sure your medication is appropriate for splitting, so talk to your doctor first. Some medications require very precise dosing, and others simply cannot be split effectively or accurately.
- **Look into manufacturer aid programs.** Most major drug manufacturers have programs to subsidize patients who are not able to pay for medications they need. All of these programs require your doctor to apply for you.

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- **Take all medications as prescribed.** Not refilling your prescription might seem like a good way to save money, but it may in fact cost you more money in the long run. Many drugs, when taken as directed, can help prevent expensive medical care or hospitalization in the future.

10. Use a health care spending account to pay for medical expenses with pre-tax money.

If your employer provides you access to a flexible spending account (FSA) or health savings account (HSA), use it. These accounts let you set aside pre-tax money from your paycheck to pay for eligible items like prescription drugs, deductibles, coinsurance, dental expenses and vision care. You get to save for these expenses gradually, rather than having the money in your checking account when the need arises. And, because you don't pay taxes on the money, you are actually getting a "percent off" or a discount on everything you purchase with your saved money. For example, assuming the government takes 20% of your income, and you put $500 in your health care spending account, you save about $100 in taxes.

Health care costs are tied directly to utilization; when you use your health plan more, there are more claims. And the higher the claims, the more you and your employer must contribute to pay for these claims. Don't forget that the most cost effective way to reduce the cost of health care is to make better decisions about the way you live, including the way you eat, exercise and spend your health care dollars.

Know Your Benefits

How to Be a Wise Health Care Consumer

With health care costs continuing to rise, it's more important than ever to take responsibility for your medical care choices. Asking questions and researching your options are good ways to start taking control of how much you spend on health care.

Consider Your Plan Options

Making careful health care decisions is vital for keeping your health care costs down. You can control your out-of-pocket costs by carefully reviewing your health insurance plan options and choosing the one that best fits your needs. For example, if you have many medical problems or recurring medication, you might want to pay a higher premium for more coverage and a lower deductible. If you are generally healthy and rarely need to visit the doctor, a high deductible health plan (HDHP) with lower monthly premiums might be the most cost-effective option.

Ask Your Doctor

Patients often accept their doctors' advice without truly understanding what treatment alternatives are available, and what—if any—differences there are in cost and effectiveness among those alternatives. A few simple questions can help you decide what treatment plan is best for both your health and your wallet. Ask questions such as:

- How much will my treatment cost?
- Can I be treated another way that is equally effective but less costly?
- What are the risks?
- What are the side effects?

Having a conversation with your physician can help you better understand how his or her care and recommendations affect your health and your plan costs.

Make Careful Decisions About Prescription Drugs

Many people incorrectly think that there is a significant difference between generic and brand name prescription drugs. However, generic drugs are only approved by the Food and Drug Administration (FDA) if they have the same active ingredient, strength, dosage form and route of administration as the brand name drug.

Generic drugs may contain different inactive ingredients, but the primary difference between generic and brand name medications lies in the name of the drug and the cost. Generic drugs cost less but still provide the same health benefits as name brand drugs.

The next time your doctor writes you a prescription, ask if a generic equivalent is available. Your physician can instruct your pharmacist to use a generic substitute.

Choose In-network Providers When Possible

Seeing doctors who are in your insurance plan's network is typically much less expensive than out-of-network health care providers. When you choose a plan, make sure that you have access to the doctors and hospitals you will want to visit when you need care.

Seek Outpatient Care

Outpatient care is often a less expensive alternative to inpatient care, and it does not necessarily sacrifice the quality of care. If you need to have surgery, ask your doctor if laboratory tests can be done in a clinic rather than in a hospital. In addition, the surgery itself can sometimes be performed in a clinic or an outpatient surgical facility, giving you the ability to recover in the comfort of your home instead of in a hospital. If outpatient care is a reasonable alternative for the specific care you need, it can help you save on out-of-pocket expenses.

Know Your Benefits

Review Benefits and Bills

When you need medical care or medications, review your insurance coverage to understand what costs you will be responsible for. Then, when you receive the bill and Explanation of Benefits (EOB), carefully look it over to ensure that you were charged correctly. Errors can occur in medical billing codes and in coverage, so taking a few minutes to read through the bill could save you money by catching potentially costly mistakes.

In general, being a wise health care consumer means taking the time to learn about your insurance and medical care options, choosing the plan and treatments that are best for you, and reviewing medical bills to ensure the charges are correct.

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Open Enrollment Glossary of Terms

Open enrollment is the time of year reserved for you to make changes to your benefit elections, and unfamiliar terms can make this process confusing. Use these definitions of common open enrollment terms to help you navigate your benefits options.

Coinsurance—The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Consumer Driven Health Care (CDHC)—Health insurance programs and plans that are intended to give you more control over your health care expenses. Under CDHC plans, you can use health care services more effectively and have more control over your health care dollars. CDHC plans are designed to be more affordable because they offer reduced premium costs in exchange for higher deductibles. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are common examples of CDHC plans.

Copayment—A flat fee that you pay toward the cost of covered medical services.

Covered Expenses—Health care expenses that are covered under your health plan.

Deductible—A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependent—Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Flexible Spending Account (FSA)—An account that allows you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year. Most funds must be used by the end of the year, as there is only a limited carryover amount.

Health Management Organization (HMO)—A type of health insurance plan that usually limits coverage to care from doctors who work for or contract within a specified network. Premiums are paid monthly, and a small copay is due for each office visit and hospital stay. HMOs require that you select a primary care physician who is responsible for managing and coordinating all of your health care.

Health Reimbursement Arrangement (HRA)—An employer-owned medical savings account in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account as reimbursement for qualified health care expenses.

Health Savings Account (HSA)—An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high-deductible health plans (HDHP).

High Deductible Health Plan (HDHP)—A qualified health plan that combines very low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

In-network—Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

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Inpatient—A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary (or medical necessity)—Services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Medicare—An insurance program administered by the federal government to provide health coverage to individuals aged 65 and older, or who have certain disabilities or illnesses.

Member—You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Out-of-network—Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket Expense—Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-pocket Maximum (OOPM)—The highest out-of-pocket amount paid for covered services during a benefit period.

Preferred Provider Organization (PPO)—A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Premium—The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Primary Care Physician (PCP)—A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance—The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances.

COST COMPARISON: ER vs. URGENT CARE

Billions of dollars are wasted each year because patients visit the wrong health care centers during non-emergencies. Perhaps individuals are unaware of the cost differences, or maybe they simply don't know where to go at the time. The following illustration is an estimation of some common illnesses. It provides a comparison between emergency room (ER) and urgent care costs.