what's this bill?

know how your open enrollment choices may affect your finances

If you're one of the millions of Americans who once signed up for health insurance every year and then forgot about it, these last few years have probably been frustrating.

You're not alone.

i didn't pay for this before

74%

OF AMERICANS HAVE SEEN THEIR HEALTHCARE COSTS RISE

64%

WANT TO DECREASE COSTS BUT DON'T KNOW HOW

55%

HAVE RECEIVED A MEDICAL BILL THEY COULDN'T AFFORD

SOURCE: HEALTH INFORMATION FIRM AMINO

take back control

When it comes to health insurance, it's important to consider how much money comes out of your paycheck. However, if you're only focused on monthly paycheck deductions, you may miss the chance to save money or better prepare for the unexpected.

Know how your insurance choices will affect your wallet, and whether you're selecting the right amount of coverage for your (and you're family's) needs.

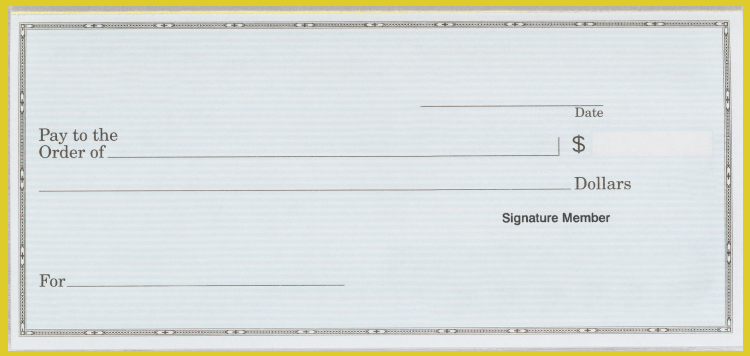
If your Open Enrollment is coming up, use this eBook to:

- Understand the difference between your various health insurance costs
- Prepare for those unexpected bills
- Know if you have other options
- Find a balance between tolerable risk (what if the worst happens) and potential savings (what if you're healthy all year)

know these terms

1. PREMIUM
2. DEDUCTIBLE
3. CO-PAY
4. CO-INSURANCE
5. MAXIMUM OUT OF POCKET
6. PREVENTATIVE CARE
7. FLEXIBLE SPENDING ACCOUNTS
8. HEALTH SAVINGS ACCOUNTS

01 think premium, think paycheck



You probably know about premiums. It's the amount of money the insurance company charges monthly for a plan. If you have insurance through work, a portion of the premium comes out of every paycheck (pretax) and the rest is paid by your employer. If you've never asked or looked at how much your employer pays for your insurance, you should. Chances are, they too have felt the increases, and have picked up a sizable chunk of your monthly premium.

However, the premium isn't the only thing that could come out of your paycheck. Depending on your plan, you may want to consider contributing to special savings accounts (see Flex Spending and Health Savings accounts) that can help you plan for other costs – such as a high deductible or coinsurance.

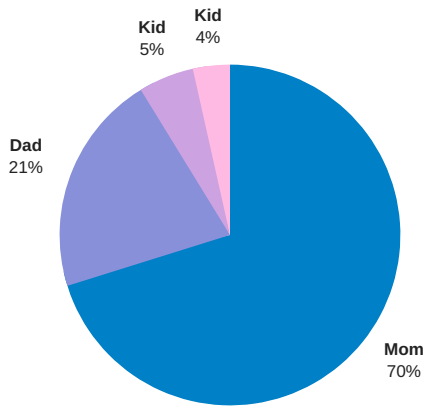
02 plan for your deductible

The deductible is one of the reasons you might get that unexpected medical bill. It's the amount you pay (in addition to your premiums) before your insurance will cover a claim or a prescription.

Other types of insurance – like car or home – use deductibles. Until recently, however, you may not have had a deductible over a few hundred dollars in your health plan. Health insurance deductibles have been climbing for years, and you may pay thousands before your insurance covers anything (other than preventive care).

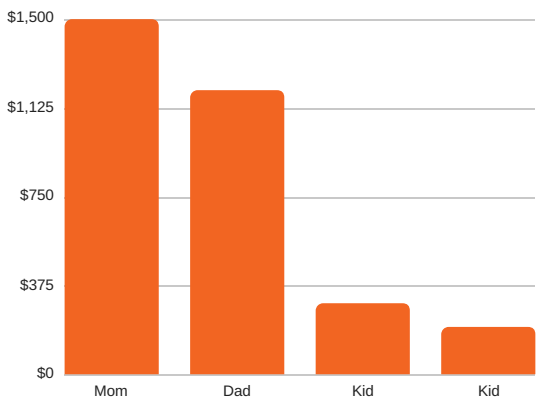
You'll also need to know that there's a big difference between embedded and non-embedded deductibles.

how you reach your deductible matters



non-embedded - aggregate

With a non-embedded deductible, claims for everyone on the plan are applied until the deductible is met. For example, a family of 4 has a $6000 deductible. Mom has to have $4000 worth of tests, then the children have $500 (total) in sick visits, and dad has a monthly prescription that costs $100. As soon as those combined costs reach $6000, the deductible is met and future costs are covered by the insurance plan terms. However, in this situation, the deductible is never met. The family pays $5700 out of pocket, in addition to their monthly premiums.



embedded - individual

An embedded deductible is split so each person on the plan reaches a portion of the total. For example, let's say our family opts for the same $6000 deductible plan, but it's broken into $1500 individual deductibles. Mom now pays $1500 for her deductible and the remaining $2500 of her tests are covered under the terms of the plan. The rest of the family still must continue to meet the remainder of the balance, but the family's out of pocket is reduced to $3200, plus their monthly premiums and any co-pays or co-insurance that kick in after the deductible is met (more on that in a minute).

SOURCE: GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

TIP

the higher the deductible, the lower the premium

High deductible plans are often attractive to healthy people who don't expect to often use health insurance. Why? Because you're guaranteed to pay premiums every month, but you may never reach your deductible. You may be able to save money monthly if you go with a plan with lower premiums and only have to pay a fraction of your high deductible.

TIP

embedded deductibles help if one person in the family expects higher claims

If the claims for one person in the family can be anticipated and are expected to be high (think pregnancy, chronic conditions, surgeries, expensive monthly prescriptions), but the rest of the family is healthy, find out if embedded deductibles are available and consider whether selecting a plan with one could save you and your family money.

when C comes after D: copays can come after the deductible

Copays are still common, but far fewer plans use the formula, "just pay your monthly premium and a $20 copay every time you go to the doctor." Increasingly, copays are associated with high deductible plans, and when a high deductible plan has a copay, it might be confusing. Say you regularly see a specialist, and at the start of your plan year, the doctor invoices you for the full amount of your visit (because you haven't met your deductible). For months, every time you visit your doctor, there's no copay, but you do get a sizable bill several weeks later. Then you hit your deductible, and your next visit, you're told there's a $50 co-pay.

This happens when copays kick in only after your deductible has been met. The new normal is no copays and high bills followed by copays and low bills.

TIP

if you expect to meet your deductible, look closely at copays

It's rare that a plan has the exact same copays for every type of treatment. Here are a few reasons to know your copays after deductible:

- **If you have monthly prescriptions**, check the copays on the generic and specialty prescriptions and review the plan formulary to make sure your script is covered.
- **If you have a condition that requires regular visits to a specialist**, check the specialist copays.
- **If you're anticipating multiple procedures or a hospitalization,** see if there's a daily copay and maximum for hospitalizations.
- **Finally, if you tend to use an urgent care facility for sick visits** instead of your doctor, check the cost difference.

04 don't confuse the "co's" : coinsurance is different

With a copay, you're on the hook for a flat payment based on the type of medical claim. With coinsurance you're paying a percent of the claim. Here's how that can work:

Our same family of 4 hits their $6000 deductible half way through the year, and their plan has 10% coinsurance instead of a copay. Child #1 has an emergency appendectomy, which costs $35,000. They will have to pay $3500 out of pocket for the surgery.

Coinsurance can become particularly costly if you go out of network. Some plans have 0% coinsurance in network, but may have a 20% or higher for going out of network.

SOURCE: HEALTHCARE.GOV

TIP

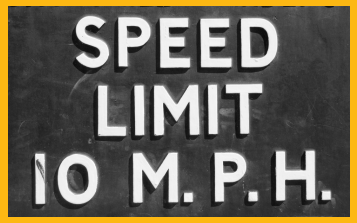
hospitals and providers must be in network to avoid a surprise coinsurance bill

You use an in-network hospital and schedule an appointment with an in-network specialist who has privileges there. You have an out-patient procedure, only to discover a month later that you have an unexpected bill because of a 20% out of network coinsurance (or worse, a full bill). Why? The anesthesiologist wasn't in network.

This situation can't be completely avoided during open enrollment, but knowing it's a possibility may influence your decision to choose a plan with a coinsurance. Alternatively, you may want to accept such a plan to keep your premiums lower and will make a mental note to tell your providers and your hospital you only want in network doctors.

SOURCE: WASHINGTON POST

05 maximum out of pockets limit the financial pain



Between monthly premiums, a high deductible and coinsurance, our family is one emergency from a financial crisis. Ten percent of a stay in an ICU, a premature birth, or cancer diagnosis would wipe out their net worth. Enter maximum out of pockets.

The maximum out of pocket is the most money you would pay for covered treatments in a year, regardless of how expensive your claims get. If our family's plan has a $10,000 maximum out of pocket, they would be just $800 from hitting it. If Child #1's emergency appendectomy has complications that result in an extended hospital stay, the additional $25,000 is almost entirely covered.

NOTE: Max out of pockets do not include your total spend on your monthly premiums or treatments not covered by your plan, i.e. you pay your premiums PLUS a max out of pocket.

TIP

maximum out of pockets mitigate coinsurance and high deductibles

Politics and opinions about the insurance industry aside, many things affect the rising cost of health care, but patient decisions can directly impact three of them:

1) Unnecessary tests and procedures
2) Not paying attention to what medical providers charge
3) Epidemics of chronic disease and unhealthy lifestyles

Insurance companies have changed their plans – like higher deductibles, coinsurance and / or higher premiums – to create financial incentive for patients to become more cost and health aware. The idea is that for elective and non-emergent care, patients should consider their options or shop for the best price. However, if faced with chronic conditions that cannot be changed by lifestyle, or an unexpected health crisis, they would never forgo treatment because there was no limit to what they'd pay out of pocket. ***In short – if you already (or are prepared to) manage your health finances and lifestyle proactively, max out of pockets should make it less terrifying to choose a plan with slightly more financial exposure in exchange for the opportunity to save money on your monthly premiums.***

SOURCE: GOVERNMENT FINANCIAL OFFICERS ASSOCIATION

06 be sure preventive care is always there

Preventive care typically includes your annual physical, kids' well visits, vaccinations, and standard blood work. Because it's far less expensive to catch a condition or a disease early and manage it proactively than to wait until it lands you in the emergency room, **many insurance plans fully cover preventive care, no matter what you've paid towards your deductible.**

Most Americans use preventive care at about half the recommended rate, a decision with substantial personal consequences and national economic implications.

According to the CDC, "Opportunities for prevention impact all Americans, regardless of age, income, or perceived health status. Each year, potentially preventable chronic diseases (e.g., heart disease, cancer, diabetes) are responsible for millions of premature deaths among Americans... Because health problems impact productivity, health problems are a major drain on the economy, resulting in 69 million workers reporting missed days due to illness each year. This loss of productivity reduces economic output by $260 billion per year."

TIP

treat preventive care as the cost of entry

Preventive care is good for your wallet and your health; it helps your doctor treat you more effectively; it benefits your employer financially; it may play a role in slowing the costs of rising health care; and reduces the likelihood of higher insurance claims. If ever there was cause to use #winning in healthcare, it would be with preventive care.

If you're considering a plan with potentially higher financial exposure, see if preventive care is fully covered regardless of what you pay towards your deductible. Some plans even include tests like mammograms, so be sure to look at everything the plan covers under preventive care – you may be surprised.

Knowing you can check on your health without incurring unwanted bills will make any plan more attractive.

07 & 08

special savings accounts can help you manage your expenses:

know if a flexible spending (fsa) or health spending (hsa) account can work for you

07 use or lose your flex spending account

A few things to know about an FSA:

- FSAs are pretax savings accounts where the money can be used towards medical expenses not paid by insurance.
- You choose how much you want to put into the account monthly and it's taken out of your paycheck.
- The entire amount of your planned contributions is usually available to you the first day of the plan year.
- If you leave your company and have spent more than you've paid into it, you don't have to pay it back (for real).
- BUT if there's money left in the account at the end of the year or when you leave your company, you lose it. However, some plans have a rollover feature or a three month grace period.

08

your hsa follows you around like a puppy

At first, the HSA may sound similar to the FSA, but once you start using them, you'll notice some very clear differences:

- HSAs are also are pretax savings accounts where the money can be used towards medical expenses not paid by insurance.
- You choose how much you want to put into the account monthly and it's taken out of your paycheck. If your employer allows it, you may be able to change your contributions throughout the year.
- You can only access what's already been deposited into the account.
- If you leave your company, you can still access the account.
- The money in the account can be invested and if it goes unused, you can withdraw it in retirement without penalty.

TIP

whether you go with an hsa, fsa (or both), check the IRS

HSAs and FSAs are great tools for planning for the unexpected and proactively managing your health costs. However, understand exactly how they work with your chosen insurance plans or you could end up paying at tax time. Here are some common situations and what to avoid:

- You and your spouse are both offered FSAs / HSAs through your respective jobs: The IRS sets annual limits for individuals and / or families on both types of accounts. If you and your spouse both make high contributions and exceed the limits, you'll owe taxes on the amount you go over.
- Your company offers an FSA and an HSA: There's no double dipping. You cannot use an FSA on the same medical expenses you pay with an HSA. For example, if you have a high deductible plan with an HSA, you can't use the FSA on any medical expenses. However, you could use the FSA on other expenses like dental or vision. It may make sense to have both if you usually meet your deductible and your entire family wears glasses or a child will be getting braces.
- You use an account with a debit card: Many of these accounts come with a debit card for convenience. Often the HSA / FSA administrator will recognize whether the payment made is to a legitimate healthcare provider. However, they may also require receipts and will freeze your account if they don't receive them.

SOURCE: SHRM

ways to potentially save money

1. if you don't anticipate major medical expenses, consider plans with lower premiums and a higher deductible.

2. model your best case scenario, worst case scenario and a typical year. do potential savings in your best case outweigh the risk in your worst?

3. if available to you, put at least enough in an HSA or FSA to cover what you expect to spend on your deductible.

4. if one person in your family has higher claims than the rest, consider an embedded deductible.

ways to potentially save money

5. if your plan has a high deductible and a coinsurance, learn how to price shop for tests and procedures.

6. review what you spent on prescriptions last year and what they will cost on your new plan formulary. see if RX mail service is an option. talk to your doctor about whether generics can work for you.

7. look at your lifestyle. are your lifestyle choices affecting your medical expenses?ask your doctor if diet, exercise or stopping smoking reduce your medical bills.

8. take advantage of preventive care to reduce the likelihood of a major medical event and catch chronic conditions and diseases early.

ask your employer about using SentricWorkforce to bring open enrollment online

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