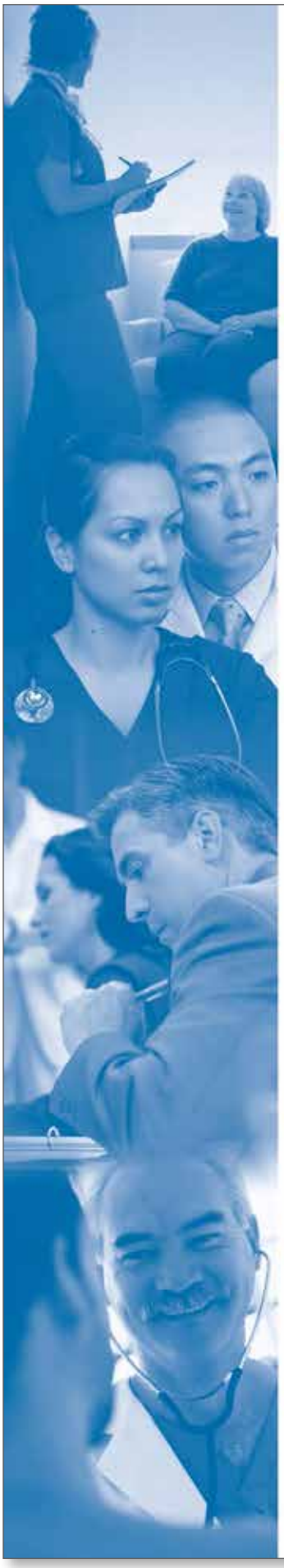

Employee Information

Understanding Your Healthcare Options

There are many different types of health benefit plans. The more informed you are, the better your healthcare decisions will be. Ask your Human Resource Manager to provide information to help you match your needs and preferences with the available plans.

Review the Benefits Available

Do the plans offered cover preventive care, well-baby care, vision or dental care? Are there deductibles? How are pre-existing conditions handled? Answers to these questions can help determine the out-of-pocket expenses you may face. Matching your needs and those of your family members will result in the best possible benefits.

Affordable Care Act

Under the Affordable Care Act (ACA), you may have additional health coverage options through the Health Insurance Marketplace (or "Marketplace"). On January 1, 2014, you could use the Marketplace to buy coverage, determine your eligibility to lower your monthly premiums, and to find out what your premium, deductibles, and out-of-pocket costs were before you made a decision to enroll. Beginning Oct 1, 2013, all employers subject to the Fair Labor Standards Act (FLSA) were required to provide a notice informing all employees of the Health Insurance Marketplace. Ask your HR manager for your copy of the notice if you joined after this date.

Who Is Eligible for Coverage?

Some plans will cover not only the employee, but also family members. Assess who can be covered and the costs associated with each option. Ask questions such as: At what age are dependents no longer covered? Are spouses who work full time eligible for coverage? Are same-sex partners eligible for coverage?

Research HMO vs. PPO

Find out if your plan offers a choice of HMO or PPO and analyze which one best fits your situation. With a health maintenance organization (HMO) you will need to receive most or all of your health care from a network provider. You are required to select a primary care physician who will provide all your basic healthcare services and when needed, refer you to a specialist. There are minimal co-payments required under HMOs.

A preferred provider organization (PPO) is a health plan that has contracts with a network of "preferred" providers from which you can choose. You do not need to select a PCP and you do not need referrals to see other providers in the network. While there is more flexibility with which doctors you can see, co-payments for services are generally more than that for an HMO.

Verify that Your Doctors Participate in the Plan

If you have specific doctors that you prefer or specialists that provide treatment, ask to see your healthcare provider's Physician Directory to see if your doctor is covered under the plan. This information may assist in deciding whether or not to choose an HMO or PPO. In the case of an HMO, it will be necessary to choose a doctor as your Primary Care Physician (PCP).

Flex Spending Options May Help Cover Costs

Some companies offer Flex Benefits which acts as an expense account to help cover costs for qualified medical expenses or child or dependent care. Money is automatically set aside from your salary and is not taxed, saving you up to 40%. Expenses can be paid with a benefit debit card or money can be refunded with a check or direct deposit.

Assess Your Benefit Coverage as Your Family Status Changes

Marriage, divorce, childbirth or adoption, or the death of a spouse are life events that may signal a need to change your health benefits. You, your spouse, and dependent children may be eligible for a special enrollment period under provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Be Aware that Changing Jobs and Other Life Events can Affect Your Health Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) you, your covered spouse, and your dependent children may be eligible to purchase extended health coverage under your employer's plan if you lose your job, change employers, get divorced, or upon occurrence of other events. Federal COBRA law applies to most employers with 20 or more workers and requires your plan to notify you of your rights; employers in states with "mini-COBRA" laws (affecting those with less than 20 workers) must also provide such notice. Most plans require eligible individuals to make their COBRA election within 30 days of the plan's notice.

If you're changing jobs, HIPAA generally limits pre-existing condition exclusions to a maximum of 12 months (18 months for late enrollees). HIPAA also requires this maximum period to be reduced by the length of time you had prior creditable coverage. You should receive a certificate documenting your prior creditable coverage from your old plan when coverage ends.

Look for Wellness Programs

More and more employers are establishing wellness programs that encourage employees to work out, stop smoking, and generally adopt healthier lifestyles. HIPAA encourages group health plans to adopt wellness programs but also includes protections for employees and dependents from impermissible discrimination based on a health factor. These programs often provide rewards such as cost savings as well as promoting good health.

Read Your Plan's Summary Plan Description (SPD)... It's a Wealth of Information

Your health plan administrator should provide a copy of its SPD. It outlines your benefits and your legal rights under the Employee Retirement Income Security Act (ERISA), the federal law that protects your health benefits. It should contain information about the coverage of dependents, what services will require a co-pay, and the circumstances under which your employer can change or terminate a health benefits plan. Save the SPD and all other heath plan brochures and documents, along with memos or correspondence from your employer relating to health benefits.

Plan for Retirement

Before you retire, find out what health benefits, if any, extend to you and your spouse during your retirement years. Consult with your employer's human resources office, your union, the plan administrator, and check your SPD. Make sure there is no conflicting information among these sources about the benefits you will receive or the circumstances under which they can change or be eliminated. With this information in hand, you can make other important choices, like finding out if you are eligible for Medicare and Medigap insurance coverage.

Know How to File an Appeal If Your Health Benefits Claim Is Denied

Understand how your plan handles grievances and where to make appeals of the plan's decisions. Keep records and copies of correspondence. Check your health benefits package and your SPD to determine who is responsible for handling problems with benefit claims. Contact the Employee Benefits Security Administration (EBSA) for customer service assistance if you are unable to obtain a response to your complaint.

Cover Your Mental Health

Many health care plans include an Employee Assistance Program (EAP) which offers employees confidential care with a mental health professional should the need arise. In most cases, this benefit extends to an employee's family members as well.

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