

## Choose the right health benefits

By Lynn Brenner; Parade ~ Sep 23, 2007

For Americans lucky enough to have health insurance through their employer, fall is open enrollment season: time to choose your health coverage for 2008. Don't miss this opportunity! Picking the right plan can save your family hundreds, even thousands, of dollars next year. The process can be confusing, so here's a guide to make the job easier.

**Assess the situation.** First, find out what you currently spend on health care. Go through your canceled checks and pay stubs, then add up your 2007 premiums, co-payments, coinsurance and deductibles. (See box.) Jot down the names of your doctors too. Finally, think about whether your needs are likely to change in 2008. Do you have a new baby, for example? Do you have a recently diagnosed condition that may require a specialist's care? You'll want to consider these changes as you weigh your 2008 options.

**Know your choices.** Many big employers offer two or more health plans. The options usually include a high-cost and a lower-cost Preferred Provider Organization (PPO), or a choice between a PPO and a Health Maintenance Organization (HMO). At a small company, only one plan may be offered—usually a PPO with in-network and out-of-network options.

Time out! What's the difference between an HMO and a PPO?

In an HMO, you're required to use participating doctors and hospitals—that is, "in-network" providers—for all services. HMOs typically don't cover out-of-network care, with some exceptions for emergencies. PPOs also have in-network doctors and hospitals, but you're not required to use them. The downside: If you go out of network, your coverage is substantially reduced.

Compare the plans. Many working couples have access to two health plans. Always compare your spouse's plan with yours to see which makes the most sense for your family, advises Tom Billet, a senior benefits consultant at Watson Wyatt Worldwide.

Look at what each plan charges for premiums, deductibles, co-payments and coinsurance, and consider what your maximum out-of-pocket expense will be.

Also check whether your doctors are in the plan's network. If not, what are the restrictions on out-of-network care? People often underestimate the cost of going out of network, says Billet. If a health plan provides 70% out-of-network coverage, that doesn't mean you're covered for 70% of the bill. It means you'll be reimbursed for 70% of the insurer's "allowable" charge. Typically, the allowable charge is the in-network provider's fee for the same service. Let's say you visit an out-of-network doctor who charges \$200 for an appointment.

If in-network doctors charge \$100, you'll be reimbursed for only 70-70% of the \$100 allowable charge.

Weigh the trade-offs. Don't automatically opt for the broadest, costliest coverage. Remember, if you accept a higher deductible, your premiums will be lower. If you can really afford a \$500 deductible, for example, it's foolish to pay a substantially higher premium for a \$100 deductible plan. On the other hand, don't take a less-expensive, higher-deductible plan unless you're sure you can pay the deductible. And, of course, make sure you can live with the plan's out-of-pocket maximum.

Beware of limited benefits. If you're ineligible for a comprehensive health plan, you may be offered the chance to buy "limited-benefit" medical insurance. But don't get excited: This is truly bare-bones coverage. These plans typically don't cover most hospitalization and surgery costs. They can cap total benefits at as little as \$2,000 a year and restrict you to four or five annual doctor visits. And some plans limit or delay coverage of pre-existing conditions.

Should you buy one? It's a tough call. Before deciding, compare what the policy costs with the maximum it would pay you. You might be better off saving the premiums in the bank.

### **Decoding Your Coverage**

Is your health plan written in a foreign language? Here's how to translate a few key phrases:

**Premiums** are the amount you pay for your insurance policy, often deducted directly from your paycheck.

**Deductibles** are paid out of pocket each year before insurance kicks in. Each family member usually has a separate deductible.

**Co-payments** are flat fees charged each time you visit the doctor or use any medical service, regardless of the cost of the procedure.

**Coinsurance** requires you to pay a percentage of the total cost of care. Many plans require either coinsurance or co-pay, but some charge both.

**Maximum** out-of-pocket expense is the most you'll have to spend before all of your medical bills are covered.