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Making the Most of Your Group Health Benefits

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Understand What You Have

Get your plan's summary plan description (SPD) from your plan administrator. It gives a detailed summary of your plan—how it works, the benefits it provides, and how those benefits may be obtained or lost. Look for information on:

- Physician choice
- Accessibility of doctor's offices
- Deductibles
- Co-payment requirements
- Maximum out-of-pocket expenses
- Lifetime benefits
- Incentives for using the plan's network of providers
- Exclusions
- Waiting periods
- Prescription benefits
- Maternity benefits

- Dental and vision benefits
- Preventive care programs
- Member rights, including the right to appeal
- Quality reports and ratings from member-satisfaction surveys

Ask Before You Need It

Don't wait for a serious illness or injury to learn what to expect from your group health plan. Now is the time to find out. Take the time to learn the answers to the following questions:

- Do you need prior approval to visit a specialist?
- How does the plan define emergency care?
- How do you get care if you are outside the area?
- What hospitals are in the plan's network?
- Is there a time limit on hospital stays?
- Who decides when you will be discharged?
- Will the plan pay for follow-up care, such as nursing home care or home health care?
- If you have a serious medical problem, will the plan provide someone to oversee care and make sure your needs are met?
- Are second opinions required for surgery? If so, who pays?
- How do you get ambulance service?
- Is there an advice hot line to help decide how to handle a problem that may not require a doctor's visit?

Be Proactive

Don't be afraid to ask your doctor questions, and insist on clear answers. If you're concerned that you won't be able to understand or follow a doctor's instructions, bring someone with you or take notes. Take responsibility for your own care. Consider:

- Lifestyle choices and changes you can make to lower your risks or prevent illness (e.g., losing weight)
- The risks and benefits of any tests or treatments
- How you would go about obtaining care after hours

What Happens When You Lose Coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) allows you to purchase health coverage under your employer's plan if you lose your job, change jobs, get divorced, or upon the occurrence of other qualifying events. Coverage that you obtain under COBRA can last from 18 to 36 months, depending on your situation.

COBRA applies to most employers with 20 or more workers and requires your plan to notify you of your rights. Most plans require you to make an election for coverage under COBRA within 60 days of the plan notifying you. Follow up with your plan administrator if you don't get a notice, and make sure that you reply within the allowed time.

When you buy the insurance under COBRA, you must pay the full premium amount, plus administrative costs of up to 2 percent. If you were accustomed to sharing health insurance premiums with your employer, you may be in for a shock. However, if you or any family member have pre-existing conditions, you may not have any other choice, at least until you get into a new group plan. You must remember to pay your premiums on time, or you will lose your coverage.

The medical coverage under COBRA must be identical to the coverage you had before. However, employers may drop benefits such as dental care and vision care.

As Your Lifestyle Changes, So Do Your Insurance Needs

Review your group health insurance benefits and options when you:

- Get married
- Get divorced
- Have a new child
- Have a child who is no longer dependent on you
- Suffer the loss of your spouse

The information provided by your employer should tell you how you can change benefits or switch plans if needed.

Planning for Retirement

Find out what benefits are available during retirement. Ask your employer's human resources office, union, and plan administrator. Check your SPD. Make sure that all sources agree about the benefits you will receive and if they can be changed or lost. After you have this information, you can make other important choices, such as finding out if you are eligible for Medicare insurance coverage.

What Can You Do If a Claim Is Denied?

Your plan administrator has a limited time after you file a claim to tell you if you will receive the benefits. If that is not enough time, you must be notified within a specified time why more time is needed and the date you can expect a decision. Many states regulate claims processing and denial notification to members, so be sure to find out your insurance company's time frames for processing claims, issuing denials, and resolving appeals.

If your claim is denied, you must be notified in writing and given specific reasons why it was denied. If you have no answer in the allotted time, the claim is considered a denial, and you can use the plan's rules for appealing the denial. If you disagree with any claims decision or preauthorization denial, you can request an appeal.

It's important to understand how your plan handles complaints. Check your health benefits package and your SPD to determine who is responsible for handling problems with benefit claims. Keep records and copies of all correspondence.

What If You Are Unhappy with Your Health Care?

If you are in a managed care plan, you can change your primary care doctor if you are unhappy with the relationship. If the plan itself does not satisfy you, you may be able to switch plans. If you are dissatisfied with the managed care plan but prefer to remain in the plan because you want to remain with your physician, file a complaint. You have the right to a fair and timely process for resolving your complaint. If you are still unhappy, speak to your employee benefits manager to help you match your needs with the available plans.

Stay Informed

- Ask for a copy of the member handbook, sometimes called the evidence of insurance or evidence of coverage, to review coverage policies.
- Check to see if your plan has a right-to-privacy policy. Make sure that the plan requires your consent to release any medical information about you to outside agencies not involved with your direct health care or the administration of your health policy, especially your employer.
- Does your plan have a magazine or newsletter? Such a publication can give information on how the plan works and on rules that affect your care.
- Ask how you will be notified of changes in the plan's medical providers or covered services and prescriptions.

- Talk to your plan administrator to learn more about your policy.

The more information you have, the easier it will be for you to make quality healthcare decisions.

Have questions? Need help? Call the CAPTRUST Advice Desk at 800.967.9948, or schedule an appointment with a retirement counselor today.

Source: Broadridge Investor Communication Solutions, Inc.