

Healthcare Consumerism

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Contents

Introduction 3

Understanding the Basics of Your Health Plan 4

The Importance of Healthcare Literacy 6

How to Choose the Right Plan 9

How to Wisely Use Your Health Dollars 11

Knowing Where to Go for Care 13

How to Make Smart Healthcare Decisions 15

Understanding Costs and Avoiding Surprises 17

The Power of Preventive Care 19

Tools and Resources to Navigate Healthcare 21

Becoming a Confident Healthcare Consumer 23

Introduction

Healthcare consumerism refers to taking an active and informed role in choosing, using and managing your healthcare. Rather than approaching healthcare as something that happens to you, consumerism encourages you to understand your options and make deliberate decisions, much like you would when selecting a home, a financial product or a major purchase. This includes knowing how your health plan works, understanding the care you receive and considering cost, quality and convenience when making decisions for yourself and your family.

This approach matters more than ever for everyday employees, as healthcare costs continue to rise and individuals are directly responsible for a larger share of those costs through premiums, deductibles, copayments and coinsurance. The choices you make, such as which health plan to enroll in, where to go for care and how services are used, can significantly affect both out-of-pocket spending and overall financial well-being. Healthcare consumerism can help you move from reacting to bills and decisions toward having greater control over your healthcare experience and expenses.

Being an informed healthcare consumer has several advantages. Understanding your benefits and comparing care options can help lower unnecessary spending while still ensuring access to quality care. Active participation in healthcare decisions is also associated with better outcomes, as individuals are more likely to seek preventive care, ask questions and follow treatment plans that fit their needs. Just as importantly, consumerism can reduce stress by minimizing confusion, avoiding surprise costs and increasing confidence when navigating a complex system.

This guide is designed to help you build that confidence. It walks you through the basics of how health plans work and how to choose the coverage that best fits your situation. You will learn how to use your healthcare dollars wisely, identify the right place to go for different types of care and make informed decisions that balance cost and quality. The guide also explains how to understand healthcare costs better, avoid unexpected bills, take advantage of preventive care, and use available tools and resources to navigate the healthcare system more effectively. By applying these principles, you can take greater control of your health, your finances and your overall well-being.



Understanding the Basics of Your Health Plan

Understanding how your health plan works is an important step in becoming a confident healthcare consumer. While health insurance can feel complex, most plans follow similar rules and use common terminology. Learning these basics helps you better anticipate costs, choose appropriate care and avoid surprises when you receive medical bills.

Key Health Insurance Terms Explained

Health plans use specific terms to describe how costs are shared between you and your insurance provider. Understanding these terms can help you estimate expenses and make smarter choices.

- **Premium** is the amount you pay to maintain your health insurance coverage, usually deducted according to your payroll cycle, typically weekly, biweekly or monthly, regardless of how often you use care.
- **Deductible** is the amount you must pay out of pocket for covered services before your health plan begins to share costs.
- **Copayment (or copay)** is a fixed dollar amount you pay for certain services, such as a doctor's visit, a prescription or an urgent care visit.
- **Coinsurance** is your share of the cost of covered services after you meet your deductible, typically expressed as a percentage.
- **Out of pocket maximum (OOPM)** is the most you will pay during a plan year for covered services. Once you reach this limit, your health plan pays 100% of eligible costs for the remainder of the year.

- **In-network** means the doctors, hospitals and other providers who have a contract with your health plan to provide services at negotiated rates. Using in-network providers typically means lower out-of-pocket costs.
- **Out-of-network** means the providers who do not have a contract with your health plan. Care from out-of-network providers usually costs more, and some plans may not cover it at all except in emergencies.
- **Prior authorization** is approval from your health plan that's required before certain services, procedures or medications are covered. Without it, the plan may deny the claim even if the care would otherwise be covered.
- **Step therapy** is a requirement to try a lower-cost or preferred treatment first before your plan covers a more expensive or specialized alternative.

Common Types of Health Plans

Most employer-sponsored health plans fall into the following categories:

- **Preferred provider organization (PPO)** plans typically offer the greatest flexibility. You can see specialists without a referral and use both in network and out of network providers, though out of network care usually costs more.
- **Health maintenance organization (HMO)** plans generally require you to choose a primary care provider and obtain referrals to see specialists. These plans often have lower premiums and more predictable costs, but less flexibility.
- **Exclusive provider organization (EPO)** plans blend features of PPOs and HMOs. They typically do not require referrals, but coverage is limited to in network providers except in emergencies.
- **High deductible health plans (HDHPs)** feature lower premiums and higher deductibles. They typically allow for contributions to a health savings account (HSA), which allows you to save and pay for qualified healthcare expenses on a tax advantaged basis. These plans work best for individuals who want more control over healthcare spending and are comfortable managing costs.

A Day in the Life of a Healthcare Consumer

Consider a typical scenario. A healthcare consumer schedules a routine doctor visit and confirms the provider is in-network, knowing this affects out-of-pocket costs. At the appointment, you pay a copay, then review the explanation of benefits (EOB) to understand how the claim was processed. Later in the year, when a minor illness arises, you choose an urgent care center instead of the emergency room, saving time and money. During open enrollment, you reflect on healthcare usage, total costs and whether a different plan option might be a better fit for the upcoming year.

These everyday decisions illustrate healthcare consumerism in action. By understanding the basics of the plan, key terms and available options, you are better positioned to manage costs, reduce uncertainty and make informed choices that support both financial well-being and long-term health.



The Importance of Healthcare Literacy

Healthcare literacy plays a central role in how confidently and effectively individuals navigate the healthcare system. It refers to a person's ability to find, understand, evaluate and use health related information to make appropriate decisions about care, coverage and costs. Strong healthcare literacy supports better health outcomes, lower stress and more informed financial decisions, while limited literacy can lead to confusion, delayed care and unexpected expenses.

In today's healthcare system, healthcare consumers are often expected to interpret plan materials, compare coverage options, understand medical advice and evaluate costs, all while managing busy lives. Healthcare consumerism depends heavily on literacy: The more clearly individuals understand their benefits and care options, the more effectively they can take control of their healthcare experience.

The 4 Levels of Healthcare Literacy

The National Assessment of Adult Literacy identifies the following four levels of health literacy:

1. **Proficient**—People with proficient health literacy have the least difficulty navigating the healthcare system because they have the necessary skills to perform complex and challenging literacy tasks. This group is typically effective at choosing appropriate treatment, following health instructions and adhering to treatment plans.
2. **Intermediate**—Individuals at this level can read and understand moderately complex healthcare documents, extract relevant information and draw reasonable conclusions. These individuals can generally navigate the healthcare environment.

3. **Basic—**Those at the basic level can handle simple, everyday literacy tasks like reading, understanding and using information from short health articles, brochures and medical pamphlets. However, these individuals may struggle to navigate more complex healthcare concepts and certain treatment plans.
4. **Below basic—**Individuals at this level have limited literacy skills; they may be illiterate or able to locate information in basic documents like hospital forms and medical pamphlets. However, this level of literacy is significantly lower than what is necessary to navigate healthcare.

Common Challenges and Misconceptions

Healthcare literacy challenges are common and not a reflection of intelligence or effort. Insurance language, medical terminology and billing processes are inherently complex. Technology or electronic health (eHealth) literacy is another challenge many face, as accessing portals, apps and online tools to manage benefits can add an extra layer of difficulty. Stress, illness or time pressure can further reduce understanding, even for individuals who typically feel confident navigating benefits.

Many people assume they should already understand how healthcare works, which can discourage them from asking questions. In reality, questions are one of the most effective tools for improving literacy and making better decisions.

Some of the most common challenges and misconceptions include:

- **Deductibles differ from the out-of-pocket maximum.** The deductible is paid before insurance shares costs; the out-of-pocket maximum is the most you'll pay before your plan covers 100%.
- **HSA and flexible spending account (FSA) funds have limitations.** HSA and FSA funds only cover eligible expenses as defined by the IRS. Using them for other purposes can trigger taxes and penalties.
- **Higher premiums don't mean better coverage.** Premiums reflect how costs are split, not the quality of coverage. A lower-premium HDHP with an HSA may cost less overall for light plan users.
- **FSA funds aren't always forfeited.** Some plans allow a grace period or limited rollover. Check your plan before assuming.
- **Network status affects cost significantly.** Out-of-network care is often billed at a higher rate or not covered.
- **Asking questions is expected, not a weakness.** Rules and plans change often, so checking with HR or your insurer is normal.
- **Enrollment isn't locked in for the year.** Qualifying life events (new dependent, job change, diagnosis) can open a window to adjust coverage.

Why Healthcare Literacy Matters

Higher healthcare literacy supports stronger consumerism by enabling individuals to:

- Choose health plans that align with their needs and budgets.
- Understand when and where to seek care.
- Manage out of pocket costs more effectively.
- Follow treatment and preventive care recommendations.
- Avoid billing errors and unexpected expenses.

From a healthcare consumer's perspective, improved healthcare literacy leads to greater confidence, reduced stress and better engagement with benefits throughout the year—not just during open enrollment.

Building Healthcare Literacy Over Time

Healthcare literacy is not fixed; it grows with experience, education and access to the right resources. Understanding can improve over time through simple actions, including reviewing plan materials, using employer tools, maintaining personal records, and seeking clarification from providers or benefits teams. In fact, this guide itself is designed to support that growth by breaking complex topics into manageable, practical information.

Improving healthcare literacy can empower you to take an active role in your care, make informed choices and navigate the healthcare system with confidence. It is a foundational element of healthcare consumerism, and a key driver of better health and financial outcomes.



How to Choose the Right Plan

Choosing a health plan is one of the most important benefits decisions you make each year. The right plan balances cost, coverage and access to care to fit your health needs and financial situation. While there is no one-size-fits-all option, understanding what to compare and how to evaluate your needs can make the decision far more manageable.

Factors to Compare When Reviewing Health Plans

When comparing health plan options, it is important to look beyond the monthly premium and consider each plan's total cost and coverage structure.

- **Costs**—Compare premiums, deductibles, copays, coinsurance and out-of-pocket maximums. A plan with a lower premium may result in higher costs when care is needed, while a higher-premium plan may offer more predictable expenses.
- **Provider networks**—Check whether your preferred doctors, specialists, hospitals and pharmacies are in-network. Staying in-network typically results in lower out-of-pocket costs and smoother claim processing.
- **Coverage and benefits**—Review what services are covered, including preventive care, mental health services, maternity care and specialty treatments. Pay attention to coverage limits, referral requirements and prior authorization rules.

Key Decision Drivers to Consider

Your personal circumstances play a major role in determining which plan is the best fit. Evaluating the following factors can help guide your choice:

- **Health needs—**Consider how often you typically seek care. Individuals who expect frequent doctor visits, ongoing treatment or specialist care may benefit from plans with lower deductibles and copays. Those who primarily use preventive care may prefer lower-premium options.
- **Prescription use—**Review the plan's prescription drug coverage, including formularies, tier levels and pharmacy networks. Tier groups medications by cost, typically starting with the lowest-cost generics (Tier 1), moving up to preferred and nonpreferred brand-name drugs, and ending with the highest-cost specialty medications. The higher the tier, the more you'll likely pay in copay or coinsurance. If you take regular medications, understanding copays or coinsurance for those drugs is critical.
- **Anticipated life events—**Think about any upcoming changes, such as having a baby, planning a surgery, managing a new diagnosis or adding dependents. These events can significantly affect healthcare usage and costs.

How to Compare Plans During Open Enrollment

Open enrollment is your annual opportunity to review and change your health coverage. Taking a structured approach can help ensure you choose the plan that best meets your needs. Follow these steps to help compare your options:

1. **Review last year's healthcare usage.** Consider how often you visited doctors, filled prescriptions, or needed urgent or specialty care, as well as what you paid out of pocket.
2. **Identify what matters most to you.** Decide whether your priority is lower monthly costs, predictable expenses, access to specific providers or flexibility in choosing care.
3. **Compare total anticipated costs.** Look beyond premiums and estimate your potential total spending under each plan, including deductibles, copays, coinsurance and out of pocket maximums.
4. **Confirm network coverage.** Ensure the providers and pharmacies you prefer are covered under the plan options you are considering.
5. **Evaluate additional features and tools.** Consider access to telehealth, HSAs, wellness programs, and decision support resources that can simplify care and lower costs.
6. **Make a confident selection.** Choose the plan that best aligns with your expected needs, budget, and comfort level by managing healthcare expenses.
7. **Check for changes.** Comparing this year's plan details, contribution limits and benefit offerings against the prior year can help prevent unexpected outcomes, such as a higher-than-anticipated deductible, the loss of a previously available benefit or unused tax-advantaged savings opportunities.

Selecting the right health plan is not about predicting every possible healthcare need; it is about making an informed choice based on the best information available. By comparing plans thoughtfully and considering your personal priorities, you can choose coverage that supports both your health and your financial well being throughout the year.



How to Wisely Use Your Health Dollars

Healthcare costs extend beyond monthly premiums, which is why understanding how to manage and pay for expenses is a key part of being an effective healthcare consumer. Many employers offer tax-advantaged accounts that help you pay for medical expenses more efficiently. When used correctly, these accounts can significantly stretch healthcare dollars and reduce overall costs.

Types of Health Savings and Spending Accounts

Different health accounts serve different purposes, and eligibility depends on the type of health plan you select and your employer's offerings.

- **Health savings account (HSA)—**HSAs are available to individuals enrolled in a qualified HDHP. You can contribute pre-tax dollars, your employer may contribute, and the funds belong to you, even if you change jobs or retire. Unused balances roll over year to year and can be invested for future health expenses. HSAs are well suited for individuals who want flexibility, long term savings and control over how funds are used.
- **Flexible spending account (FSA)—**FSAs allow you to set aside pre-tax dollars to pay for eligible healthcare expenses. These accounts are employer-sponsored, and funds must generally be used within the plan year, though some plans allow a limited rollover or a grace period. FSAs are best for predictable expenses. FSAs are ideal when you can reasonably estimate expenses such as prescriptions, routine visits or planned procedures.

- **Health reimbursement arrangement (HRA)—**An HRA is funded entirely by the employer and reimburses employees for eligible medical expenses. The employer determines how much is available and what expenses are covered. These funds typically do not move with you if you leave the company. HRAs can help offset medical costs when available, but typically work as a supplement rather than a primary savings tool.
- **Dependent care FSA (DFFSA)—**DCFSAs let you set aside pre-tax dollars to pay for eligible dependent care expenses, such as daycare, preschool, before/after-school care, or care for an elderly or disabled dependent, so you or your spouse can work or look for work. Like a healthcare FSA, funds are employer-sponsored and generally must be used within the plan year, subject to any grace period or carryover your plan allows. DCFSAs are separate from healthcare FSAs and have their own contribution limit. They're a good fit if you have regular, predictable dependent care costs.

How Tax-advantaged Accounts Save You Money

HSAs and FSAs allow you to pay for eligible healthcare expenses using pre-tax dollars, which lowers your taxable income and increases your purchasing power. An HSA offers additional long-term savings advantages, as contributions grow tax-free and withdrawals for qualified medical expenses are also tax-free. Using these accounts effectively means paying less overall for the same care.

HRAs also help reduce out-of-pocket costs by reimbursing eligible expenses, even though the employer provides the funds. Understanding which expenses are eligible under your specific account helps ensure you receive the full benefit.

Tips for Stretching Your Healthcare Dollars

Using your healthcare dollars wisely goes beyond choosing the right account. Small decisions can lead to meaningful savings over time. Consider these tips:

- **Use generic medications when available,** which often cost significantly less than brand-name drugs and are equally effective.
- **Take advantage of preventive care,** which is typically covered at no cost and can help prevent more serious and expensive health issues.
- **Choose the right care setting,** such as urgent care or virtual visits, instead of emergency rooms for nonemergency needs.
- **Monitor your spending and review explanations of benefits** to ensure services are billed correctly and covered as expected.
- **Plan for known expenses** so you can use tax-advantaged funds efficiently.

By understanding how healthcare-related accounts work and making thoughtful spending choices, you can maximize the value of your benefits, reduce unnecessary costs and gain greater control over your healthcare finances.



Knowing Where to Go for Care

One of the most impactful decisions you can make as a healthcare consumer is choosing the right place to receive care. The "site of care" you select affects not only how quickly you are seen, but also how much you pay. Many services can be delivered in more than one setting, and understanding your options can help you receive appropriate care while managing costs and convenience.

Choosing the Right Type of Care

Different care settings are designed for different levels of medical need. Knowing when to use each option can make healthcare simpler and more affordable:

- **Primary care provider (PCP)—**Your PCP should be your first stop for routine care, preventive services, chronic condition management and nonurgent concerns. PCPs know your medical history and can coordinate care with specialists when needed.
- **Urgent care—**Urgent care centers are appropriate for non-life-threatening issues that need attention sooner than a regular office visit, such as minor fractures, infections or sprains. They typically offer extended hours and shorter wait times than emergency rooms.
- **Emergency room (ER)—**ERs are designed for serious or life-threatening conditions such as chest pain, difficulty breathing, severe bleeding or major trauma. ERs provide critical care but incur the highest costs and have the longest wait times.
- **Virtual care (or telehealth)—**Virtual visits are often suitable for minor illnesses, follow up appointments, mental health visits or prescription refills. Telehealth offers convenience, faster access and lower costs for many common needs.

Why Site of Care Matters

Choosing the appropriate care setting can significantly affect both cost and convenience. Emergency rooms require specialized staff and equipment, which makes them expensive even when the condition is not severe. Urgent care and virtual visits usually cost far less and often provide faster service for minor issues. Primary care visits support continuity of care and can help prevent health problems before they become more serious.

Using the right site of care helps ensure that emergency resources are available for true emergencies while allowing you to receive timely, cost-effective treatment for everyday health needs.

Understanding Cost Differences in Simple Terms

The same medical issue can result in very different costs depending on where you go for care. For example, treating a minor illness might cost a small copay through a virtual visit, more through an urgent care visit, and significantly more in an emergency room. Even when insurance covers part of the cost, your out-of-pocket responsibility often increases with higher-cost care settings.

Understanding these differences allows you to weigh urgency, severity and cost before making a decision, when it is safe to do so.

Finding In-network Providers

Staying within your plan's network is one of the easiest ways to manage healthcare costs. In-network providers have contracted rates with your insurance plan, which typically results in lower out-of-pocket expenses.

To find in-network providers:

- Use your insurance company's online provider directory or mobile app.
- Confirm network status when scheduling an appointment, as networks can change.
- Ask your PCP for in-network referrals when seeing a specialist.
- Check whether telehealth services are included in your plan benefits.

Knowing where to go for care and how to find covered providers can help you take control of your healthcare experience. With the right knowledge, you can receive appropriate care, save time and avoid unnecessary costs while maintaining access to quality services.



How to Make Smart Healthcare Decisions

Being a smart healthcare consumer means going beyond where you receive care to understanding who provides that care and what options are available. Many medical decisions offer multiple paths forward, with differences in cost, quality and outcomes. Taking the time to compare options and ask the right questions helps ensure that your care aligns with your health goals, values and financial considerations.

Comparing Providers, Hospitals and Treatment Options

Not all providers or facilities deliver care in the same way or at the same cost. It is helpful to compare options before scheduling care.

When evaluating providers or hospitals, consider factors such as experience, specialty focus, patient outcomes, convenience and whether the provider is in-network. Treatment options may also vary, each with different risks, benefits, recovery times and costs. Whenever appropriate, ask about alternatives and what might happen if you choose one option over another.

Cost transparency tools, provider directories and employer sponsored resources can help you understand both financial and quality differences before making a decision.

Understanding Quality Ratings

Quality ratings are designed to help consumers assess how well providers and facilities perform. These ratings may reflect patient satisfaction, safety measures, outcomes and adherence to best practices. While no rating system is perfect, they can provide valuable insight when comparing options.

Quality information can often be found through health plan websites, hospital systems, government supported tools and reputable third-party organizations. When reviewing ratings, look for patterns rather than focusing on a single score, and consider how quality measures relate to your specific health needs.

Questions Every Healthcare Consumer Should Ask

Asking questions is one of the most effective ways to participate in your care. Consider asking your provider:

- *What are my treatment options, and what happens if I choose not to treat this right away?*
- *What are the benefits and risks of each option?*
- *How will this treatment affect my daily life or ability to work?*
- *Are there lower cost or less invasive alternatives?*
- *What follow up care will be required?*
- *Is this provider or facility in my plan's network?*

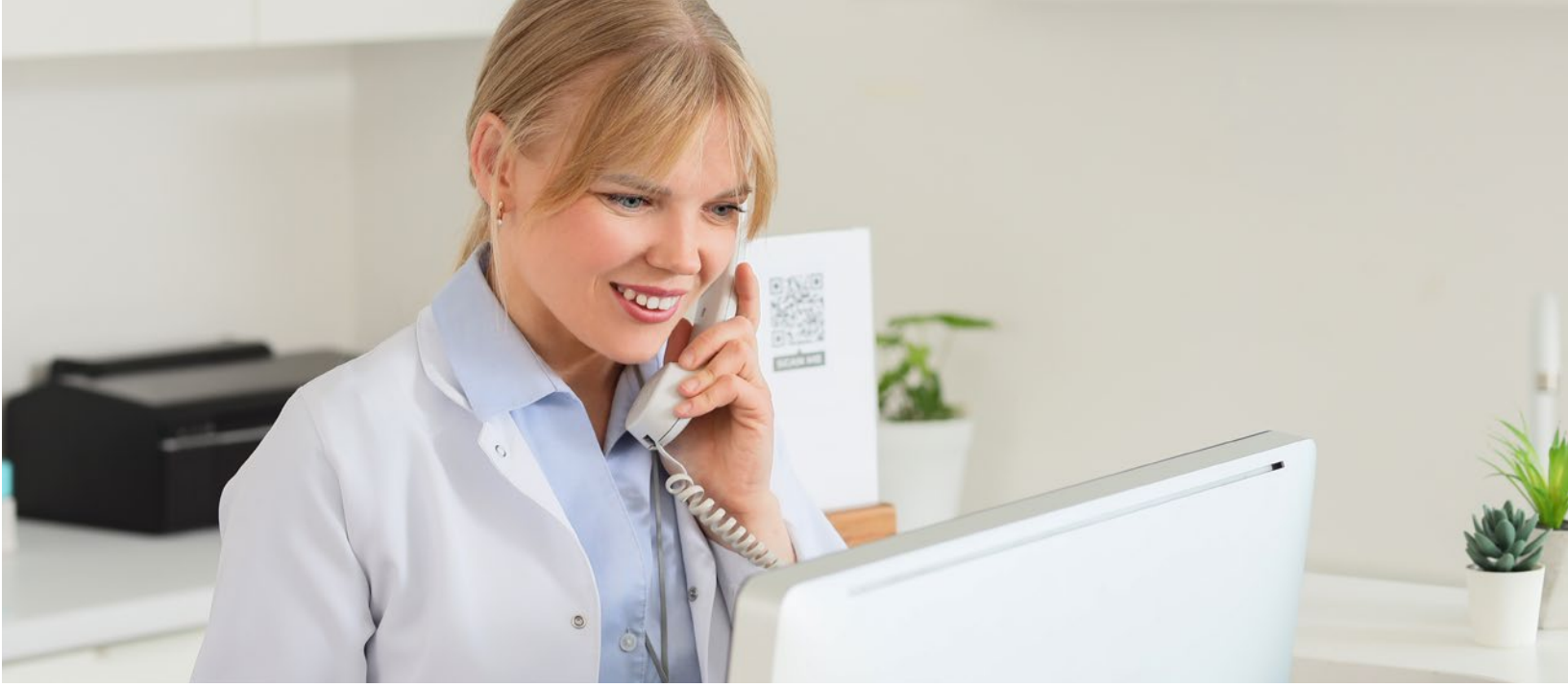
These questions help ensure you understand both the medical and financial aspects of your care.

What Is Shared Decision-Making?

Shared decision-making is a collaborative approach in which you and your provider work together to make healthcare decisions. Your provider brings medical expertise, while you bring your personal preferences, lifestyle needs and priorities. Together, you weigh the available options and choose the path that best fits your situation.

This approach leads to more personalized care, greater satisfaction and often better outcomes. Shared decision making recognizes that the "right" choice is not always the same for everyone and that informed patients are better equipped to make decisions that support their long term health.

Making smart healthcare decisions is not about having all the answers; it is about asking thoughtful questions, understanding your options and partnering with your providers. With the right information and a proactive mindset, you can make choices that support both your health and your overall well-being.



Understanding Costs and Avoiding Surprises

Even with health insurance, medical costs can feel unpredictable. Many unexpected expenses result not from the care itself, but from a lack of information before services are received or after bills arrive. Understanding how healthcare pricing works and taking a few proactive steps can greatly reduce the risk of surprise costs.

How to Estimate Costs Before Getting Care

Estimating costs in advance is one of the most effective ways to manage healthcare expenses. Your health plan and provider can often offer helpful information before treatment is given.

You may be able to estimate costs by:

- Using your health plan's cost estimator or member portal
- Calling your insurance company to ask how a service is covered
- Asking the provider's office for an estimate or "good faith" cost
- Confirming whether deductibles or coinsurance will apply

While estimates are not always exact, they offer a clearer picture of potential out-of-pocket costs and allow you to compare options when appropriate.

Key Cost Terms to Know

The following healthcare billing terms are especially important when it comes to avoiding surprises:

- **Allowed amount—**This is the maximum amount your insurance plan agrees to pay for a covered service. In network providers accept this amount, while out of network providers may charge more.
- **Balance billing—**This is when you are billed for the difference between a provider's charge and your plan's allowed amount. This most commonly occurs with out of network care and can result in higher unexpected costs.
- **Surprise billing—**These are unexpected charges that occur when you unknowingly receive care from an out of network provider, often during emergencies or hospital visits. Understanding network status and coverage protections can help reduce this risk.

Practical Tips to Avoid Unexpected Costs

Taking a few simple steps before and after receiving care can significantly reduce confusion and unexpected expenses:

- **Get cost estimates when possible.** Ask for pricing information in advance, especially for planned services, imaging or procedures.
- **Confirm network status.** Verify that providers, facilities, specialists, labs and anesthesiologists are in-network, even when using an in-network hospital.
- **Understand your coverage.** Know whether a service applies to your deductible, uses a copay, or requires coinsurance.
- **Review bills and explanations of benefits (EOBs).** Compare provider bills with your EOB to ensure services were processed correctly and charges match your plan's coverage.
- **Ask questions and follow up.** If something does not look right, contact your provider or insurance company for clarification or correction.

Understanding healthcare costs takes awareness and preparation, but it does not require expert knowledge. By estimating costs, learning key billing terms and carefully reviewing statements, you can reduce surprises, catch errors early and make more informed financial decisions about your care.



The Power of Preventive Care

Preventive care focuses on helping you stay healthy rather than treating problems after they become serious. From a healthcare consumer perspective, prevention is often the most cost-effective form of care. Identifying health risks early and adopting healthy habits can reduce the need for expensive treatments, medications and hospital visits later. Preventive care also supports long-term well-being and can help you stay productive and engaged at work.

Why Preventive Care Is the Least Expensive Care

Preventive services are designed to detect potential issues early or prevent them altogether. Many health plans cover preventive care at little to no cost to you because keeping people healthy lowers overall healthcare spending. In fact, under most plans, your annual physical is completely covered, meaning you typically pay nothing out of pocket for this visit. Routine screenings, vaccinations and wellness visits can help catch conditions such as high blood pressure, diabetes or cancer in earlier, often more manageable stages.

Skipping preventive care may seem like a cost saving choice in the short term, but it can lead to higher expenses and more complicated treatments over time. Staying current on recommended preventive services is one of the simplest ways to protect both your health and your budget.

Common Preventive Services You May Have Access To

While coverage varies by plan, preventive services often include a wide range of routine and wellness-focused care, such as:

- Annual wellness or physical exams

- Routine screenings (e.g., blood pressure, cholesterol and certain cancer screenings)
- Immunizations and vaccines
- Preventive care for children, including well child visits
- Certain counseling services related to lifestyle and well being

Review your plan materials to understand which preventive services are available to you and how often they are recommended.

Everyday Wellness Strategies That Make a Difference

Staying healthy is not only about doctor visits; everyday habits play a major role in overall well being and healthcare costs. This can include the following:

- **Sleep—**Getting adequate, quality sleep supports immune function, mental health and energy levels. Poor sleep is linked to increased health risks and higher medical costs.
- **Nutrition—**Balanced nutrition helps maintain a healthy weight, manage chronic conditions and reduce the risk of illness. Small improvements in daily food choices can lead to meaningful long term benefits.
- **Stress management—**Chronic stress can contribute to physical and mental health conditions. Techniques such as mindfulness, breaks during the workday, social connection and mental health support can improve resilience and well being.
- **Exercise—**Regular physical activity helps prevent chronic disease, boosts mood and improves overall health. Even moderate movement, such as walking or stretching, can have positive effects.

The Connection Between Well being and Lower Healthcare Costs

There is a strong link between overall well-being and healthcare spending. Individuals who prioritize preventive care and healthy habits are more likely to experience fewer medical complications, reduced reliance on medications, and fewer urgent health incidents. Over time, this leads to lower out-of-pocket costs and greater stability in healthcare usage.

Preventive care and everyday wellness are not about perfection; they are about consistency and making informed choices. By taking advantage of preventive services and focusing on daily health habits, you can support your long-term health while also managing healthcare costs more effectively.



Tools and Resources to Navigate Healthcare

Navigating the healthcare system can feel overwhelming, but you do not have to do it alone. Many tools and resources are designed to help you understand benefits, compare options, find care and make informed decisions. Knowing what tools are available and how to use them can save time, reduce stress and help you get the most value from your health plan.

Employer-provided Apps and Support Tools

Many employers and health plans offer digital tools and services to make healthcare easier to manage. While offerings vary, common tools include:

- **Cost calculators and transparency tools** that help estimate out of pocket costs for common services or procedures.
- **Telehealth platforms** that provide convenient access to virtual medical or mental health visits.
- **Nurse advice lines** that offer 24/7 guidance on symptoms, treatment options and whether care is needed.
- **Mobile apps or member portals** that allow you to view claims, track deductibles, find providers, and manage prescriptions.

Using these tools before scheduling care can help you choose cost effective options and avoid unnecessary visits or expenses.

National Healthcare Resources

In addition to employer resources, there are well established national tools that provide reliable health information and provider data. Provider directories from insurance carriers can help you confirm

network status and locate in network doctors, hospitals and pharmacies. Evidence based health information from reputable medical organizations and government health agencies can help you understand conditions, treatments and preventive care recommendations.

- MedlinePlus (U.S. National Library of Medicine)—Consumer-friendly information on conditions, medications and treatments, backed by the National Institutes of Health
- CDC (Centers for Disease Control and Prevention)—Guidance on preventive care, vaccinations, screenings and public health topics
- Mayo Clinic—Patient education content on symptoms, conditions and treatment options from a nonprofit medical center
- HealthCare.gov—Federal resource for understanding health insurance terms, coverage options and Marketplace plans
- Medicare.gov—Official U.S. government resource for Medicare coverage, plan comparisons and provider lookup tool

When researching medical topics or providers, look for transparent, regularly updated sources focused on patient education rather than promotion.

Personal Health Records and Benefits Usage

Maintaining your own healthcare records can make managing care easier, especially if you see multiple providers or change plans. Keeping copies of visit summaries, test results, prescriptions, and explanations of benefits allows you to track your history and reference past care when needed.

Tracking how you use your benefits throughout the year can also help you make better decisions during open enrollment. Reviewing claims, out of pocket spending and account balances gives you a clearer picture of which plan features you use most and what coverage may work best in the future.

How to Spot Reliable Health Information

Not all health information found online is accurate or trustworthy. Reliable health information generally comes from credible medical sources, cites evidence or research, and avoids exaggerated claims or quick fixes. Be cautious of websites or social media content that promote miracle treatments, discourage seeking professional medical advice or rely heavily on testimonials rather than facts.

When in doubt, compare information across multiple reputable sources and discuss questions with a healthcare professional. Using trusted information supports better decision making and helps you avoid unnecessary worry or harmful choices.

Knowing how to access the right tools and resources is a key part of healthcare consumerism. With the support available through your employer, your health plan and trusted public resources, you can navigate healthcare more confidently, make informed decisions, and take an active role in managing your health and benefits.



Becoming a Confident Healthcare Consumer

Healthcare consumerism is not about mastering every detail of the healthcare system; it is about making informed, intentional choices. By understanding the basics of your health plan, knowing where to go for care, and using available tools and resources, you can take greater control of both your health and your healthcare spending. The following takeaways are designed to help you put what you've learned into action.

Quick-start Checklist for Healthcare Consumerism

Use this checklist as a simple way to stay engaged and informed throughout the year:

- ☐ Know your health plan type and key terms (premium, deductible, copays, out-of-pocket maximum).
- ☐ Use in-network providers whenever possible.
- ☐ Choose the right site to care for your needs.
- ☐ Ask questions and participate in decisions about your care.
- ☐ Review explanations of benefits and medical bills.
- ☐ Take advantage of preventive care and wellness services.
- ☐ Use employer tools such as cost estimators, telehealth and nurse advice lines.
- ☐ Keep basic records of your healthcare visits and expenses.

Top Money-saving Behaviors

Small, consistent decisions often lead to the biggest savings over time. Money-saving behaviors include:

- Use preventive care to catch issues early.
- Choose virtual visits or urgent care instead of emergency rooms for nonemergencies.
- Ask about generic medications or alternative treatments.
- Stay in-network and confirm coverage before care.
- Use HSAs, FSAs or HRAs for eligible expenses.
- Compare costs when scheduling planned services.
- Review bills and follow up on errors or unclear charges.

How to Prepare for Open Enrollment Each Year

Open enrollment is your annual opportunity to adjust coverage based on your needs. Preparing in advance can make selecting a plan easier and more effective.

Before open enrollment:

- Review how often you use healthcare and what you pay out of pocket.
- Look at prescription use, major services or changes in health needs.
- Consider upcoming life events that may affect coverage needs.
- Compare total potential costs, not just premiums.
- Review provider network changes and available tools.

Being a confident healthcare consumer is an ongoing process, not a one-time decision. With awareness, planning and the right resources, you can navigate the healthcare system with greater confidence, reduce unnecessary costs and make informed choices that support your well-being. This guide is a starting point to help you take control of your healthcare today and in the future.