Tools to Reach Your Personal Goals

Certain financial goals are universal, or nearly so. Among them are providing for the well-being of your family. Once you have your objectives in mind, you can choose the right insurance and investments to fit your family's needs.

Fast Facts

- *If you have young children in daycare, make sure to sign up for a Flexible Spending Account through your company or your spouse's. Up to $5,000 can be contributed to the FSA and used to pay for dependent care expenses with pretax dollars. If you are in a top 35% income tax bracket, that saves you $1,750—35% of $5,000.* *Page 77.*
- *Think you may want long-term care insurance for yourself or your parents? The perfect age to purchase is between 50 and 62. After age 70, rates go up considerably.* *Page 84.*
- *When deciding between a Roth and a traditional IRA, consider your tax bracket now and the state in which you plan to retire. These may help you decide whether to take the tax break now or in the future.* *Page 87.*

If there are people who depend upon your income, you must consider what will happen if that income stops. When you have children, therefore, it's time to think—and to act—about life insurance. There are two types of life insurance:

- **Term insurance**. These policies provide coverage for a specified amount of time, often 10 or 20 years. You may have the ability to renew the policy when the term expires. If you die within the term, the insurer pays the beneficiary the face value

PRESCRIBE LUNESTA FIRST-LINE—FOR A FULL 7 TO 8 HOURS OF SLEEP

LUNESTA has been studied in large, well-controlled clinical trials in **all** of the following patient types:

- ✓ Patients With Insomnia Comorbid With Major Depressive Disorder
- ✓ Patients With Insomnia Comorbid With Generalized Anxiety Disorder
- ✓ Patients With Insomnia Comorbid With Rheumatoid Arthritis
- ✓ Patients With Insomnia Comorbid With Menopause

The failure of insomnia to remit after 7 to 10 days of treatment should be medically evaluated.

Any night or every night

Leave the rest to...

Lunesta® (eszopiclone) ℂ
1, 2 AND 3 MG TABLETS

LUNESTA is indicated for the treatment of insomnia. In controlled outpatient and sleep laboratory studies, LUNESTA administered at bedtime decreased sleep latency and improved sleep maintenance. LUNESTA is not indicated for the treatment of depression, generalized anxiety disorder, rheumatoid arthritis, or menopause.

Important Safety Information

LUNESTA, like other hypnotics, has CNS-depressant effects. Because of the rapid onset of action, LUNESTA should only be ingested immediately prior to going to bed or after the patient has gone to bed and has experienced difficulty falling asleep. Patients should not take LUNESTA unless they are prepared to get a full night's sleep. As with other hypnotics, patients receiving LUNESTA should be cautioned against engaging in hazardous occupations requiring complete mental alertness or motor coordination (eg, operating machinery or driving a motor vehicle) after ingesting the drug, including potential impairment of the performance of such activities that may occur the day following ingestion of LUNESTA. In clinical trials, the most common adverse events associated with LUNESTA were unpleasant taste, headache, somnolence, dizziness, dry mouth, infection, and pain.

LUNESTA has been classified as a Schedule IV controlled substance. Sedative hypnotics have produced withdrawal signs and symptoms following abrupt discontinuation. The risk of abuse and dependence increases with the dose and duration of treatment and concomitant use of other psychoactive drugs. The risk is also greater for patients who have a history of alcohol or drug abuse or history of psychiatric disorders. These patients should be under careful surveillance when receiving LUNESTA or any other hypnotic. Sedative/hypnotic drugs should be administered with caution to patients exhibiting signs and symptoms of depression. Suicidal tendencies may be present in such patients, and protective measures may be required. Intentional overdose is more common in this group of patients; therefore, the least amount of drug that is feasible should be prescribed for the patient at any one time.

LUNESTA, like other hypnotics, may produce additive CNS-depressant effects when coadministered with other psychotropic medications, anticonvulsants, antihistamines, ethanol, and other drugs that themselves produce CNS depression. LUNESTA should not be taken with alcohol. Dosage adjustment may be necessary when LUNESTA is administered with other CNS-depressant agents because of the potentially additive effects.

Impaired motor and/or cognitive performance after repeated exposure or unusual sensitivity to sedative/hypnotic drugs is a concern in the treatment of elderly and/or debilitated patients. See dosage and administration in complete prescribing information.

Please see brief summary of complete prescribing information.

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Lunesta®
(eszopiclone) CIV
1, 2 AND 3 MG TABLETS

BRIEF SUMMARY

INDICATIONS AND USAGE

LUNESTA is indicated for the treatment of insomnia. In controlled outpatient and sleep laboratory studies, LUNESTA administered at bedtime decreased sleep latency and improved sleep maintenance.

CONTRAINDICATIONS

None known.

WARNINGS

Because sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. Worsening of insomnia or the emergence of new thinking or behavior abnormalities may be the consequence of an unrecognized psychiatric or physical disorder. Such findings have emerged during the course of treatment with sedative/hypnotic drugs, including LUNESTA. Because some of the important adverse effects of LUNESTA appear to be dose-related, it is important to use the lowest possible effective dose, especially in the elderly (see **DOSAGE AND ADMINISTRATION in the Full Prescribing Information**).

A variety of abnormal thinking and behavior changes have been reported to occur in association with the use of sedative/hypnotics. Some of these changes may be characterized by decreased inhibition (e.g., aggressiveness and extroversion that seem out of character), similar to effects produced by alcohol and other CNS depressants. Other reported behavioral changes have included bizarre behavior, agitation, hallucinations, and depersonalization. Amnesia and other neuropsychiatric symptoms may occur unpredictably. In primarily depressed patients, worsening of depression, including suicidal thinking, has been reported in association with the use of sedative/hypnotics.

It can rarely be determined with certainty whether a particular instance of the abnormal behaviors listed above are drug-induced, spontaneous in origin, or a result of an underlying psychiatric or physical disorder. Nonetheless, the emergence of any new behavioral sign or symptom of concern requires careful and immediate evaluation.

Following rapid dose decrease or abrupt discontinuation of the use of sedative/hypnotics, there have been reports of signs and symptoms similar to those associated with withdrawal from other CNS-depressant drugs (see **DRUG ABUSE AND DEPENDENCE**).

LUNESTA, like other hypnotics, has CNS-depressant effects. Because of the rapid onset of action, LUNESTA should only be ingested immediately prior to going to bed or after the patient has gone to bed and has experienced difficulty falling asleep. Patients receiving LUNESTA should be cautioned against engaging in hazardous occupations requiring complete mental alertness or motor coordination (e.g., operating machinery or driving a motor vehicle) after ingesting the drug, and be cautioned about potential impairment of the performance of such activities on the day following ingestion of LUNESTA. LUNESTA, like other hypnotics, may produce additive CNS-depressant effects when coadministered with other psychotropic medications, anticonvulsants, antihistamines, ethanol, and other drugs that themselves produce CNS depression. LUNESTA should not be taken with alcohol. Dose adjustment may be necessary when LUNESTA is administered with other CNS-depressant agents, because of the potentially additive effects.

PRECAUTIONS

General

Timing Of Drug Administration: LUNESTA should be taken immediately before bedtime. Taking a sedative/hypnotic while still up and about may result in short-term memory impairment, hallucinations, impaired coordination, dizziness, and lightheadedness.

Use In The Elderly And/Or Debilitated Patients: Impaired motor and/or cognitive performance after repeated exposure or unusual sensitivity to sedative/hypnotic drugs is a concern in the treatment of elderly and/or debilitated patients. The recommended starting dose of LUNESTA for these patients is 1 mg (see **DOSAGE AND ADMINISTRATION in the Full Prescribing Information**).

Use In Patients With Concomitant Illness: Clinical experience with eszopiclone in patients with concomitant illness is limited. Eszopiclone should be used with caution in patients with diseases or conditions that could affect metabolism or hemodynamic responses.

A study in healthy volunteers did not reveal respiratory-depressant effects at doses 2.5-fold higher (7 mg) than the recommended dose of eszopiclone. Caution is advised, however, if LUNESTA is prescribed to patients with compromised respiratory function.

The dose of LUNESTA should be reduced to 1 mg in patients with severe hepatic impairment, because systemic exposure is doubled in such subjects. No dose adjustment appears necessary for subjects with mild or moderate hepatic impairment. No dose adjustment appears necessary in subjects with any degree of renal impairment, since less than 10% of eszopiclone is excreted unchanged in the urine.

The dose of LUNESTA should be reduced in patients who are administered potent inhibitors of CYP3A4, such as ketoconazole, while taking LUNESTA. Downward dose adjustment is also recommended when LUNESTA is administered with agents having known CNS-depressant effects.

Use In Patients With Depression: Sedative/hypnotic drugs should be administered with caution to patients exhibiting signs and symptoms of depression. Suicidal tendencies may be present in such patients, and protective measures may be required. Intentional overdose is more common in this group of patients; therefore, the least amount of drug that is feasible should be prescribed for the patient at any one time.

Information For Patients: Patient information is printed in the complete prescribing information.

Laboratory Tests: There are no specific laboratory tests recommended.

Drug Interactions

CNS-Active Drugs

Ethanol: An additive effect on psychomotor performance was seen with coadministration of eszopiclone and ethanol 0.70 g/kg for up to 4 hours after ethanol administration.

Paroxetine: Coadministration of single doses of eszopiclone 3 mg and paroxetine 20 mg daily for 7 days produced no pharmacokinetic or pharmacodynamic interaction.

Lorazepam: Coadministration of single doses of eszopiclone 3 mg and lorazepam 2 mg did not have clinically relevant effects on the pharmacodynamics or pharmacokinetics of either drug.

Olanzapine: Coadministration of eszopiclone 3 mg and olanzapine 10 mg produced a decrease in DSST scores. The interaction was pharmacodynamic; there was no alteration in the pharmacokinetics of either drug.

Drugs That Inhibit CYP3A4 (Ketoconazole): CYP3A4 is a major metabolic pathway for elimination of eszopiclone. The AUC of eszopiclone was increased 2.2-fold by coadministration of ketoconazole, a potent inhibitor of CYP3A4, 400 mg daily for 5 days. C_{max} and $t_{1/2}$ were increased 1.4-fold and 1.3-fold, respectively. Other strong inhibitors of CYP3A4 (e.g., itraconazole, clarithromycin, nefazodone, troleandomycin, ritonavir, nelfinavir) would be expected to behave similarly.

Drugs That Induce CYP3A4 (Rifampicin): Racemic zopiclone exposure was decreased 80% by concomitant use of rifampicin, a potent inducer of CYP3A4. A similar effect would be expected with eszopiclone.

Drugs Highly Bound To Plasma Protein: Eszopiclone is not highly bound to plasma proteins (52-59% bound); therefore, the disposition of eszopiclone is not expected to be sensitive to alterations in protein binding. Administration of eszopiclone 3 mg to a patient taking another drug that is highly protein-bound would not be expected to cause an alteration in the free concentration of either drug.

Drugs With A Narrow Therapeutic Index

Digoxin: A single dose of eszopiclone 3 mg did not affect the pharmacokinetics of digoxin measured at steady state following dosing of 0.5 mg twice daily for one day and 0.25 mg daily for the next 6 days.

Warfarin: Eszopiclone 3 mg administered daily for 5 days did not affect the pharmacokinetics of (R)- or (S)-warfarin, nor were there any changes in the pharmacodynamic profile (prothrombin time) following a single 25-mg oral dose of warfarin.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis: In a carcinogenicity study in Sprague-Dawley rats in which eszopiclone was given by oral gavage, no increases in tumors were seen; plasma levels (AUC) of eszopiclone at the highest dose used in this study (16 mg/kg/day) are estimated to be 80 (females) and 20 (males) times those in humans receiving the maximum recommended human dose (MRHD). However, in a carcinogenicity study in Sprague-Dawley rats in which racemic zopiclone was given in the diet, and in which plasma levels of eszopiclone were reached that were greater than those reached in the above study of eszopiclone, an increase in mammary gland adenocarcinomas in females and an increase in thyroid gland follicular cell adenomas and carcinomas in males were seen at the highest dose of 100 mg/kg/day. Plasma levels of eszopiclone at this dose are estimated to be 150 (females) and 70 (males) times those in humans receiving the MRHD. The mechanism for the increase in mammary adenocarcinomas is unknown. The increase in thyroid tumors is thought to be due to increased levels of TSH secondary to increased metabolism of circulating thyroid hormones, a mechanism that is not considered to be relevant to humans.

In a carcinogenicity study in B6C3F1 mice in which racemic zopiclone was given in the diet, an increase in pulmonary carcinomas and carcinomas plus adenomas in females and an increase in skin fibromas and sarcomas in males were seen at the highest dose of 100 mg/kg/day. Plasma levels of eszopiclone at this dose are estimated to be 8 (females) and 20 (males) times those in humans receiving the MRHD. The skin tumors were due to skin lesions induced by aggressive behavior, a mechanism that is not relevant to humans. A carcinogenicity study was also performed in which CD-1 mice were given eszopiclone at doses up to 100 mg/kg/day by oral gavage; although this study did not reach a maximum tolerated dose, and was thus inadequate for overall assessment of carcinogenic potential, no increases in either pulmonary or skin tumors were seen at doses producing plasma levels of eszopiclone estimated to be 90 times those in humans receiving the MRHD—i.e., 12 times the exposure in the racemate study.

Eszopiclone did not increase tumors in a p53 transgenic mouse bioassay at oral doses up to 300 mg/kg/day.

Mutagenesis: Eszopiclone was positive in the mouse lymphoma chromosomal aberration assay and produced an equivocal response in the Chinese hamster ovary cell chromosomal aberration assay. It was not mutagenic or clastogenic in the bacterial Ames gene mutation assay, in an unscheduled DNA synthesis assay, or in an *in vivo* mouse bone marrow micronucleus assay.

(S)-N-desmethyl zopiclone, a metabolite of eszopiclone, was positive in the Chinese hamster ovary cell and human lymphocyte chromosomal aberration assays. It was negative in the bacterial Ames mutation assay, in an *in vitro* ^{32}P-postlabeling DNA adduct assay, and in an *in vivo* mouse bone marrow chromosomal aberration and micronucleus assay.

Impairment Of Fertility: Eszopiclone was given by oral gavage to male rats at doses up to 45 mg/kg/day from 4 weeks premating through mating and to female rats at doses up to 180 mg/kg/day from 2 weeks premating through day 7 of pregnancy. An additional study was performed in which only females were treated, up to 180 mg/kg/day. Eszopiclone decreased fertility, probably because of effects in both males and females, with no females becoming pregnant when both males and females were treated with the highest dose; the no-effect dose in both sexes was 5 mg/kg (16 times the MRHD on a mg/m^2 basis). Other effects included increased preimplantation loss (no-effect dose 25 mg/kg), abnormal estrus cycles (no-effect dose 25 mg/kg), and decreases in sperm number and motility and increases in morphologically abnormal sperm (no-effect dose 5 mg/kg).

Pregnancy

Pregnancy Category C: Eszopiclone administered by oral gavage to pregnant rats and rabbits during the period of organogenesis showed no evidence of teratogenicity up to the highest doses tested (250 and 16 mg/kg/day in rats and rabbits, respectively; these doses are 800 and 100 times, respectively, the maximum recommended human dose [MRHD] on a mg/m^2 basis). In the rat, slight reductions in fetal weight and evidence of developmental delay were seen at maternally toxic doses of 125 and 150 mg/kg/day, but not at 62.5 mg/kg/day (200 times the MRHD on a mg/m^2 basis).

Eszopiclone was also administered by oral gavage to pregnant rats throughout the pregnancy and lactation periods at doses of up to 180 mg/kg/day. Increased post-implantation loss, decreased postnatal pup weights and survival, and increased pup startle response were seen at all doses; the lowest dose tested, 60 mg/kg/day, is 200 times the MRHD on a mg/m^2 basis. These doses did not produce significant maternal toxicity. Eszopiclone had no effects on other behavioral measures or reproductive function in the offspring.

There are no adequate and well-controlled studies of eszopiclone in pregnant women. Eszopiclone should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labor And Delivery: LUNESTA has no established use in labor and delivery.

Nursing Mothers: It is not known whether LUNESTA is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when LUNESTA is administered to a nursing woman.

Pediatric Use: Safety and effectiveness of eszopiclone in children below the age of 18 have not been established.

Geriatric Use: A total of 287 subjects in double-blind, parallel-group, placebo-controlled clinical trials who received eszopiclone were 65 to 86 years of age. The overall pattern of adverse events for elderly subjects (median age = 71 years) in 2-week studies with nighttime dosing of 2 mg eszopiclone was not different from that seen in younger adults. LUNESTA 2 mg exhibited significant reduction in sleep latency and improvement in sleep maintenance in the elderly population.

ADVERSE REACTIONS

The premarketing development program for LUNESTA included eszopiclone exposures in patients and/or normal subjects from two different groups of studies: approximately 400 normal subjects in clinical pharmacology/pharmacokinetic studies, and approximately 1550 patients in placebo-controlled clinical effectiveness studies, corresponding to approximately 263 patient-exposure years. The conditions and duration of treatment with LUNESTA varied greatly and included (in overlapping categories) open-label and double-blind phases of studies, inpatients and outpatients, and short-term and longer-term exposure. Adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs.

Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tabulations that follow, COSTART terminology has been used to classify reported adverse events.

The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while the patient was receiving therapy following baseline evaluation.

Adverse Findings Observed in Placebo-Controlled Trials

Adverse Events Resulting in Discontinuation of Treatment: In placebo-controlled, parallel-group clinical trials in the elderly, 3.8% of 208 patients who received placebo, 2.3% of 215 patients who received 2 mg LUNESTA, and 1.4% of 72 patients who received 1 mg LUNESTA discontinued treatment due to an adverse event. In the 6-week parallel-group study in adults, no patients in the 3 mg arm discontinued because of an adverse event. In the long-term 6-month study in adult insomnia patients, 7.2% of 195 patients who received placebo and 12.8% of 593 patients who received 3 mg LUNESTA discontinued due to an adverse event. No event that resulted in discontinuation occurred at a rate of greater than 2%.

Adverse Events Observed at an Incidence of ≥2% in Controlled Trials. The following lists the incidence (% placebo, 2 mg, 3 mg, respectively) of treatment-emergent adverse events from a Phase 3 placebo-controlled study of LUNESTA at doses of 2 or 3 mg in non-elderly adults. Treatment duration in this trial was 44 days. Data are limited to adverse events that occurred in 2% or more of patients treated with LUNESTA 2 mg (n=104) or 3 mg (n=105) in which the incidence in patients treated with LUNESTA was greater than the incidence in placebo-treated patients (n=99).[1]

Body as a whole: headache (13%, 21%, 17%), viral infection (1%, 3%, 3%). Digestive system: dry mouth (3%, 5%, 7%), dyspepsia (4%, 4%, 5%), nausea (4%, 5%, 4%), vomiting (1%, 3%, 0%). Nervous system: anxiety (0%, 3%, 1%), confusion (0%, 0%, 3%), depression (0%, 4%, 1%), dizziness (4%, 5%, 7%), hallucinations (0%, 1%, 3%), libido decreased (0%, 0%, 3%), nervousness (3%, 5%, 0%), somnolence (3%, 10%, 8%). Respiratory system: infection (3%, 5%, 10%). Skin and appendages: rash (1%, 3%, 4%). Special senses: unpleasant taste (3%, 17%, 34%). Urogenital system: dysmenorrhea* (0%, 3%, 0%), gynecomastia** (0%, 3%, 0%).

*Gender-specific adverse event in females

**Gender-specific adverse event in males

[1]Events for which the LUNESTA incidence was equal to or less than placebo are not listed, but included the following: abnormal dreams, accidental injury, back pain, diarrhea, flu syndrome, myalgia, pain, pharyngitis, and rhinitis.

Adverse events that suggest a dose-response relationship in adults include viral infection, dry mouth, dizziness, hallucinations, infection, rash, and unpleasant taste, with this relationship clearest for unpleasant taste.

The following lists the incidence (% placebo, 2 mg, 3 mg, respectively) of treatment-emergent adverse events from combined Phase 3 placebo-controlled studies of LUNESTA at doses of 1 or 2 mg in elderly adults (ages 65-86). Treatment duration in these trials was 14 days. Data are limited to events that occurred in 2% or more of patients treated with LUNESTA 1 mg (n=72) or 2 mg (n=215) in which the incidence in patients treated with LUNESTA was greater than the incidence in placebo-treated patients.[1]

Body as a whole: accidental injury (1%, 0%, 3%), headache (14%, 15%, 13%), pain (2%, 4%, 5%). Digestive system: diarrhea (2%, 4%, 2%), dry mouth (2%, 3%, 7%), dyspepsia (2%, 6%, 2%). Nervous system: abnormal dreams (0%, 3%, 1%), dizziness (2%, 1%, 6%), nervousness (1%, 0%, 2%), neuralgia (0%, 3%, 0%). Skin and appendages: pruritus: (1%, 4%, 1%). Special senses: unpleasant taste (0%, 8%, 12%). Urogenital system: urinary tract infection (0%, 3%, 0%).

[1]Events for which the LUNESTA incidence was equal to or less than placebo are not listed, but included the following: abdominal pain, asthenia, nausea, rash, and somnolence.

Adverse events that suggest a dose-response relationship in elderly adults include pain, dry mouth, and unpleasant taste, with this relationship again clearest for unpleasant taste. These figures cannot be used to predict the incidence of adverse events in the course of usual medical practice because patient characteristics and other factors may differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators.

The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contributions of drug and non-drug factors to the adverse event incidence rate in the population studied.

Other Events Observed During The Premarketing Evaluation Of LUNESTA. Following is a list of modified COSTART terms that reflect treatment-emergent adverse events as defined in the introduction to the **ADVERSE REACTIONS** section and reported by approximately 1550 subjects treated with LUNESTA at doses in the range of 1 to 3.5 mg/day during Phase 2 and 3 clinical trials throughout the United States and Canada. All reported events are included except those already listed here or listed elsewhere in labeling, minor events common in the general population, and events unlikely to be drug-related. Although the events reported occurred during treatment with LUNESTA, they were not necessarily caused by it.

Events are listed in order of decreasing frequency according to the following definitions: **frequent** adverse events are those that occurred on one or more occasions in at least 1/100 patients; **infrequent** adverse events are those that occurred in fewer than 1/100 patients but in at least 1/1,000 patients; **rare** adverse events are those that occurred in fewer than 1/1,000 patients. Gender-specific events are categorized based on their incidence for the appropriate gender.

Frequent: chest pain, migraine, peripheral edema.

Infrequent: acne, agitation, allergic reaction, alopecia, amenorrhea, anemia, anorexia, apathy, arthritis, asthma, ataxia, breast engorgement, breast enlargement, breast neoplasm, breast pain, bronchitis, bursitis, cellulitis, cholelithiasis, conjunctivitis, contact dermatitis, cystitis, dry eyes, dry skin, dyspnea, dysuria, eczema, ear pain, emotional lability, epistaxis, face edema, female lactation, fever, halitosis, heat stroke, hematuria, hernia, hiccup, hostility, hypercholesteremia, hypertension, hypertonia, hypesthesia, incoordination, increased appetite, insomnia, joint disorder (mainly swelling, stiffness, and pain), kidney calculus, kidney pain, laryngitis, leg cramps, lymphadenopathy, malaise, mastitis, melena, memory impairment, menorrhagia, metrorrhagia, mouth ulceration, myasthenia, neck rigidity, neurosis, nystagmus, otitis externa, otitis media, paresthesia, photosensitivity, reflexes decreased, skin discoloration, sweating, thinking abnormal (mainly difficulty concentrating), thirst, tinnitus, twitching, ulcerative stomatitis, urinary frequency, urinary incontinence, urticaria, uterine hemorrhage, vaginal hemorrhage, vaginitis, vertigo, vestibular disorder, weight gain, weight loss.

Rare: abnormal gait, arthrosis, colitis, dehydration, dysphagia, erythema multiforme, euphoria, furunculosis, gastritis, gout, hepatitis, hepatomegaly, herpes zoster, hirsutism, hyperacusis, hyperesthesia, hyperlipemia, hypokalemia, hypokinesia, iritis, liver damage, maculopapular rash, mydriasis, myopathy, neuritis, neuropathy, oliguria, photophobia, ptosis, pyelonephritis, rectal hemorrhage, stomach ulcer, stomatitis, stupor, thrombophlebitis, tongue edema, tremor, urethritis, vesiculobullous rash.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class: LUNESTA is a Schedule IV controlled substance under the Controlled Substances Act. Other substances under the same classification are benzodiazepines and the nonbenzodiazepine hypnotics zaleplon and zolpidem. While eszopiclone is a hypnotic agent with a chemical structure unrelated to benzodiazepines, it shares some of the pharmacologic properties of the benzodiazepines.

Abuse, Dependence, and Tolerance

Abuse and Dependence: In a study of abuse liability conducted in individuals with known histories of benzodiazepine abuse, eszopiclone at doses of 6 and 12 mg produced euphoric effects similar to those of diazepam 20 mg. In this study, at doses 2-fold or greater than the maximum recommended doses, a dose-related increase in reports of amnesia and hallucinations was observed for both LUNESTA and diazepam.

The clinical trial experience with LUNESTA revealed no evidence of a serious withdrawal syndrome. Nevertheless, the following adverse events included in DSM-IV criteria for uncomplicated sedative/hypnotic withdrawal were reported during clinical trials following placebo substitution occurring within 48 hours following the last LUNESTA treatment: anxiety, abnormal dreams, nausea, and upset stomach. These reported adverse events occurred at an incidence of 2% or less. Use of benzodiazepines and similar agents may lead to physical and psychological dependence. The risk of abuse and dependence increases with the dose and duration of treatment and concomitant use of other psychoactive drugs. The risk is also greater for patients who have a history of alcohol or drug abuse or history of psychiatric disorders. These patients should be under careful surveillance when receiving LUNESTA or any other hypnotic.

Tolerance: Some loss of efficacy to the hypnotic effect of benzodiazepines and benzodiazepine-like agents may develop after repeated use of these drugs for a few weeks.

No development of tolerance to any parameter of sleep measurement was observed over six months. Tolerance to the efficacy of LUNESTA 3 mg was assessed by 4-week objective and 6-week subjective measurements of time to sleep onset and sleep maintenance for LUNESTA in a placebo-controlled 44-day study, and by subjective assessments of time to sleep onset and WASO in a placebo-controlled study for 6 months.

OVERDOSAGE

There is limited premarketing clinical experience with the effects of an overdosage of LUNESTA. In clinical trials with eszopiclone, one case of overdose with up to 36 mg of eszopiclone was reported in which the subject fully recovered. Individuals have fully recovered from racemic zopiclone overdoses up to 340 mg (56 times the maximum recommended dose of eszopiclone).

Signs And Symptoms: Signs and symptoms of overdose effects of CNS depressants can be expected to present as exaggerations of the pharmacological effects noted in preclinical testing. Impairment of consciousness ranging from somnolence to coma has been described. Rare individual instances of fatal outcomes following overdose with racemic zopiclone have been reported in European postmarketing reports, most often associated with overdose with other CNS-depressant agents.

Recommended Treatment: General symptomatic and supportive measures should be used along with immediate gastric lavage where appropriate. Intravenous fluids should be administered as needed. Flumazenil may be useful. As in all cases of drug overdose, respiration, pulse, blood pressure, and other appropriate signs should be monitored and general supportive measures employed. Hypotension and CNS depression should be monitored and treated by appropriate medical intervention. The value of dialysis in the treatment of overdosage has not been determined.

Poison Control Center: As with the management of all overdosage, the possibility of multiple drug ingestion should be considered. The physician may wish to consider contacting a poison control center for up-to-date information on the management of hypnotic drug product overdosage.

Rx only.

12/06

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of the policy.

■ **Permanent insurance.** As the name suggests, these policies are designed to remain in effect as long as you live. "They include an investment account that may be known as the cash value," says Lee Slavutin, M.D., CLU of Stern Slavutin-2, a life insurance agency in New York City. Permanent insurance may also be called "whole life" insurance.

Often term life is the better value, especially for younger people. The amounts you'll pay for the coverage—the premiums—are much lower with term than with permanent policies.

For example, suppose Dr. Brown is 40 years old, a nonsmoker in good health. Dr. Brown may be able to buy a 20-year, $2-million term policy for $2,800 a year. Alternatively, Dr. Brown may pay $24,000 a year for a $2-million permanent life policy.

In recent years, term life insurance policies have become even more affordable. According to an article in the April issue of *Kiplinger's Personal Finance,* premiums have fallen quite a bit. Discounts are available to those who fall within an optimal weight range—and some companies also offer additional discounts if you stay within that range after five years. In addition, select companies are now willing to insure people who have certain health conditions that previously would have made coverage difficult, if not impossible. According to the article, even people with a past cancer diagnosis may be able to get coverage.

In recent years, term life insurance policies have become even more affordable. According to an article in the April issue of *Kiplinger's Personal Finance,* premiums have fallen quite a bit. Discounts are available to those who fall within an optimal weight range—and some companies also offer additional discounts if you stay within that range after five years.

But there are drawbacks to term life insurance. The premiums often increase as you grow older. However, unless you keep paying the ever-steeper costs, you will have no life insurance.

If the policy is not renewable, you will need to get new coverage at the end of the term. That new insurance can be very expensive if your health has deteriorated. If you should be truly in poor health then, you might not be able to buy life insurance at all.

Permanent life insurance policies have certain tax advantages

over term life policies. Both term and permanent life insurance policies offer tax-free death benefits: At your death, the amount received by your beneficiary may not be subject to income tax. In addition, permanent life insurance offers the following:

- **Tax-free buildup**. "With cash value policies, any investment income typically can accumulate without an income tax obligation," says Dr. Slavutin, who is a licensed medical doctor as well as a seasoned life insurance agent. There is no investment income with term life policies.
- **Tax-free access to investment income**. When you own a permanent life policy, you may be able to tap the cash value without owing income tax. Before you do so, you probably will have to wait several years for enough cash value to build up to allow tax-free loans and withdrawals.

Why do you have to wait? Because steep upfront sales commissions may reduce the amount that goes into the cash value in the first years you own the policy. After most or all of the sales commissions have been paid, your premium payments go largely into the cash value, where they can be invested for growth.

Even after waiting for several years, though, you should limit loans or withdrawals from a permanent life policy. If you strip too much cash from the cash value, your policy can lapse. Then you'll lose your life insurance, your family will lack coverage, and you may owe income tax on the investment earnings that occurred within the policy.

As long as you don't withdraw money from a permanent life insurance policy, the cash value can grow substantially, free of income tax. As you grow older and life insurance becomes more expensive, money from the cash value can be directed to paying for the coverage.

"A truly long-term need for life insurance may be best served by a permanent life policy," says Dr. Slavutin. You probably will need to keep a policy in force for 20 years or longer to reap the benefits of permanent life insurance.

When you consider permanent life insurance, there are several varieties to choose among. With "whole life" and "universal life" policies, the cash value probably will grow at rates that match the yields you'd receive from bonds. Whole life insurance may have stronger guarantees regarding the cash value and the death bene-

fit while universal life has more flexibility in paying premiums.

Alternatively, "variable life" and "variable universal life" policies allow you to invest your cash value in stock funds, where the growth may be greater. With either form of variable life, the results of your investment accounts will determine your cash value and your death benefit. You'll bear investment risk, but you may well get better returns with a variable life policy over a holding period that exceeds 20 years.

If you are in a group practice or if you are employed by a large organization, you may be offered life insurance through your employer. "A common error," says Marilyn Dimitroff of Capelli Financial Services in Bloomfield Hills, Mich., "is obtaining all of your life insurance through your employer. You might choose a certain amount of coverage and then feel safe. There's no hassle (no physical exam or onerous paperwork), and premiums are paid through payroll deduction." However, according to Ms. Dimitroff, there are problems with group insurance. You may be paying relatively high costs to cover the less-than-healthy members of the group.(This can actually work in your favor if you have a pre-existing medical condition. "If you have a poor medical history, group coverage may be your only reasonable option," she says.)

There are other problems with group insurance, too: With group coverage, you may lose the life insurance if you move to another job or another practice. Also, employers may not offer the coverage you need, Ms. Dimitroff adds. "Choosing a multiple of compensation as the amount of life insurance, which many people do, is not the way to determine how much life insurance you need. That assessment really depends on your family situation—your investments, financial needs, etc. It is different for each individual, and it changes over time."

Life Insurance Sales in 2005

	Term life	Permanent life
Number of policies sold	4,457,530	6,645,989
Amount of Insurance	$1,256,572,738,000	$514,507,487,000

Source: Insurance Information Institute.

Still another problem, Ms. Dimitroff asserts, is that your group life insurance coverage may not keep pace with your needs. "Few people change their coverage once they have made a choice," she says. "They continue to carry the coverage they chose when they were hired."

On the Home Front

Taking care of your loved ones requires more than life insurance. To make sure your family continues to have a place to live in case of a total loss, buy enough homeowner's insurance to enable you to rebuild your home. Buying "guaranteed replacement cost" is better than buying coverage based on your home's original cost because the latter may provide less insurance than you need.

Your homeowner's policy should cover at least 80% of the replacement value of your home, and perhaps even 100%. Without sufficient coverage, you may not get full protection after a catastrophe.

Nevertheless, you shouldn't over-insure. If your home is currently valued at, say, $800,000, that doesn't mean it will necessarily cost $800,000 to rebuild it. Even if your house is hit by a hurricane or a tornado, you won't have to replace the land, and you probably won't have to replace the foundation.

When it comes to homeowner's insurance, remember that it's easy to wind up with inadequate coverage if you have done extensive renovation or improved your house through remodeling. Your dwelling coverage may not meet the 80% test if you have increased the replacement value of your home. You can prevent such shortfalls by informing your insurance agent whenever you add value to your home.

You might think your homeowner's insurance will pay for repairs in case of flooding. However, most standard policies cover damage from falling rain, but not flooding. As insurers define the term, floods occur when bodies of water overflow or when ground water from heavy rains oozes into your basement. Such a possibility should not be overlooked. According to the Federal Emergency Management Administration (FEMA), flooding is the leading natural disaster in the U.S. From 1996 to 2005, annual flood losses in the U.S. averaged $2.4 billion per year.

To protect your home, you can buy flood insurance through the National Flood Insurance Program (NFIP). Flood insurance policies are sold by private insurance companies; so the agent who sold you your homeowner's policy probably can help you get coverage.

Through the NFIP, you can buy flood insurance that covers your home for up to $250,000 while the contents can be insured for up to $100,000. If you rent your home, the contents can be insured for as much as $100,000. What's more, the building where you practice medicine can be covered for as much as $500,000, including contents.

The price of flood insurance will depend on the amount of coverage you choose and on your home's location. If your home is in a high-risk flood zone (with at least a 1% chance of being flooded in any given year), you may be required to have flood insurance in order to get a mortgage.

In some cases, though, you can get a lower rate even if you are in a high-risk area. That will be the case if your house was built before your area's flood map became effective, which may apply if your home was built before the 1980s.

The cost to rebuild your house and its contents could be greater than the $250,000 and $100,000 maximum coverage allowed by the NFIP. If you want to buy more flood insurance, insurers such as American International Group, Chubb, and Fireman's Fund offer excess coverage.

You might, for example, buy basic coverage from the NFIP, up to the $250,000 and $100,000 limits, and add extra insurance by

Maximum Flood Insurance Premiums

The following are sample premiums for $250,000 floor coverage for a home and $100,000 on the contents. Rates change according to risk level of the property.

Preferred Risk	$317
Low-to-moderate Risk	$1,132
High Risk	$2,233
High Risk—Coastal	$4,323

Source: FloodSmart.gov.

buying a policy not included in the federal program. Another tactic is to add flood coverage to your basic homeowner's policy at an extra cost of around 5%.

Dependent Care

Physicians with young children also face other financial challenges: namely, child care and/or tuition. These costs may even forestall other investments for a while, but experts warn that you should not neglect your retirement savings. No one wants to skimp on child care or education, but there are ways to reduce these costs or at least to plan for them effectively.

More than 90% of employers offer dependent-care flexible-spending accounts (FSAs) in a cafeteria plan, according to Hewitt Associates, a consulting firm in Lincolnshire, Ill. A dependent-care account allows working parents to use pretax dollars to pay for babysitting or day care for children under the age of 13.

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Each year, your employer will ask you how much you'd like to contribute from your pretax income into the account, up to $5,000 per family. You can spend the money on child care and get reimbursed from the account. However, these accounts are use-it-or-lose it: If you set aside more than you actually spend, you won't get a refund, and unused balances don't carry over from year to year.

Regardless of whether you are employed at a company with a dependent-care account, you might qualify for another tax break: the dependent-care tax credit. The maximum amount of expenses that qualify for the dependent-care tax credit is $3,000 for one child under age 13. For two or more children, the maximum is $6,000.

The money must be spent for child care so that a parent can go to work or be a full-time student. "Child care" includes day camp but not overnight camp.

For most physicians (or anyone whose annual income is over $43,000), the credit rate is 20%. Suppose you and your spouse both work and your joint income is $150,000. If you pay $9,000 for child care for two children this year, the first $6,000 is eligible for a 20% credit, which cuts your tax bill by $1,200—20% of $6,000.

If either spouse participates in an FSA that covers dependent care, the tax break can be even better. Up to $5,000 can be contributed to the FSA and used to pay for dependent-care expenses with pretax dollars. If you are in a top 35% income tax bracket, that saves you $1,750—35% of $5,000.

Using $5,000 from the FSA reduces the amount you can use for the dependent-care credit from $6,000 to $1,000. As a result, your dependent-care credit would save you another $200—20% of $1,000.

As a physician, you know what it's like to go through many years of higher education—and the eventual rewards that can result. Chances are, you want your children to benefit from higher education, too. To accomplish that goal, you need to be prepared for steep college costs that will become even steeper five and 10 and 15 years from now.

If you haven't already started saving for college, a good time to do so is when your children no longer need full-time day care. You can redirect the funds used for child care to education costs.

The Tax Increase Prevention and Reconciliation Act of 2005 (which became law in 2006) might have protected pensions, but it made college funding more challenging. Under this law, unearned income over $1,700 (in 2007) is taxed at the parents' rate, before youngsters reach age 18.

"Previously, at age 14, children put all their transactions in their own tax bracket, not the parents' tax bracket," says Elfrena Foord of Foord, Van Bruggen, Ebersole & Pajak, a financial planning firm in Sacramento, Calif. "Now parents pay the tax until the transactions go into the child's bracket at age 18."

While the Tax Increase Prevention and Reconciliation Act reduced the appeal of custodial plans, that same act enhanced the appeal of Section 529 college plans. Several other new laws have also made 529 plans more desirable.

Those include the Bankruptcy Abuse Prevention and Con-

sumer Protection Act of 2005, which shelters assets from creditors after they've been in a 529 account for two years. The Deficit Reduction Act of 2005 improved the financial aid treatment of 529 plans, especially prepaid tuition plans. Moreover, the Pension Protection Act of 2006 says that all the tax benefits of 529 plans will be permanent.

If you haven't already started saving for college, a good time to do so is when your children no longer need full-time day care. You can redirect the funds used for child care to education costs.

The tax benefits of 529 college savings accounts include tax-free investment buildup as well as tax-free withdrawals if the money you take out does not exceed your adjusted qualified higher education expenses for the year. Eligible expenses include tuition, books, and fees. For room and board, tax-free withdrawals are permitted for on-campus housing or for the amount of the school's official budget for students living off campus.

Besides income tax, 529 plans offer estate tax breaks. You can contribute up to five times the annual gift tax exclusion amount, tax free. That amount is $12,000 per recipient in 2007.

Suppose, for example, you and your spouse are concerned about estate tax. In 2007, you can contribute up to $120,000 to a 529 plan for each of your children: $60,000 (five times $12,000) from each spouse.

With this tactic, significant assets can be removed from your estate. There will be no gift tax consequences if you file a gift tax return, electing to spread the gift over a five-year period. (However, if you make a multi-year election and die during that period, a portion of the gift will be returned to your estate.)

Most states sponsor 529 plans. At *www.savingforcollege.com,* you can find a complete list. When you're evaluating them, look for a good selection of investment options managed by qualified professionals. Funds that have low management fees may be your best choices. Some states offer state tax deductions for contributions to their own plans. If you live in a high-tax state, such a tax break may be attractive. Even in this situation, though, you also should examine other states' plans in order to compare investment options and costs.

Other College-saving Tools

Although 529 plans are the most popular tool for college savings now, there are reasons to look at other options. For example, if you may be interested in private school for your children, a Coverdell education savings account (ESA) may be appropriate. Formerly known as education IRAs, Coverdell ESAs can accept annual contributions up to $2,000 per student. Coverdell ESAs can be used, tax free, for a wide variety of educational expenses, including tutoring (such as prep courses for standardized tests) and software, beginning in kindergarten. Thus, money can be withdrawn to pay private school bills.

> **"When clients ask me** about a college fund, I suggest a separate growth account," says Jane King, president, Fairfield Financial Advisors, Wellesley Hills, Mass. "It can be held in the name of one spouse, who will retain control." That money can be invested in growth stocks and low-turnover growth-stock funds, according to Ms. King. "The annual tax bill from such an account probably will be low," she says.

Unlike Section 529 plans, there are income limits for making contributions to a Coverdell ESA. Married couples with adjusted gross income (AGI) over $220,000 are excluded while those in the $190,000-to-$220,000 range can contribute an amount less than the $2,000 maximum. (For single filers the numbers are exactly half: $95,000 and $110,000.)

In practice, this may make no difference because any number of other people can contribute to your child's Coverdell ESA. If you and your spouse are over the limit, you might ask each of four grandparents to put in $500 per child per year, assuming they file jointly and have an AGI under $190,000.

Assuming the income limits are not a problem, it may be wise to fund a Coverdell ESA first, up to $2,000 per year, then put what you can afford into a Section 529 plan. Coverdell ESAs are self directed while Section 529 plans compel you to turn the money over to an investment pool.

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That money can be invested in growth stocks and low-turnover growth-stock funds, according to Ms. King. "The annual tax bill from such an account probably will be low," she says, "and if appreciated stocks or funds are eventually sold to pay college bills, any profits probably will be taxed at low long-term capital gains rates."

Before such sales, appreciated stocks or funds can be given to the children. As long as the youngsters selling the securities are at least 18 years old and have modest amounts of taxable income, the gains will be taxed at 5% or even 0%, under current law. The bottom line, from Ms. King's point of view, is that the family's tax bill will increase only slightly, compared with a Section 529 plan, while the parents can choose from a much broader range of investments.

Helping Adult Children

Once your children have finished college, you may breathe a sigh of relief that those bills will stop coming. However, you may still want to keep helping your children financially.

If you provide them with funds, be careful. No good deed goes unpunished, and you may be surprised by the adverse tax consequences if you mishandle a loan to a relative.

Suppose, for example, your son wants to buy a house. You loan him $250,000, payable in six years, so he can purchase the house, and you don't charge him any interest.

The IRS will impute interest on such loans. The interest will be set at an applicable federal rate (AFR), published every month at *irs.gov*.

Suppose the AFR on loans from three to nine years is 5%. If

IRS Interest Rates, February 2007

For interest compounded annually.

Loan term	Applicable Federal rate
Less than three years	4.93%
Three to nine years	4.69%
Longer than nine years	4.86%

Source: IRS.

so, the imputed interest would be $12,500: 5% of $250,000.

On such transactions, the tax treatment is painful. For instance, you would have to recognize $12,500 worth of taxable interest income each year. You would owe tax on that amount even though you collected no interest payments from your son.

Moreover, the IRS might say you have made your son a $12,500 gift for each year of the loan. You would have to file a gift tax return. In addition, you would have to pay gift tax, if you have used up your $1 million lifetime gift tax exemption. Even if you don't have to pay gift tax, such gifts will reduce your estate tax exemption.

On the other hand, your son may be able to take a $12,500 deduction for the imputed interest, because he borrowed to buy a home. However, loans between you and your children might not generate tax deductions.

Can you avoid such tax traps? Perhaps—if the loans are relatively small. If the money you loan to a relative is $10,000 or less, no interest will be imputed. To qualify for this break, the loan can't be used for income-producing investments.

In addition, loans up to $100,000 also can avoid income tax problems. To get this tax benefit, the borrower's net investment income can be no more than $1,000 each year.

To calculate net investment income, start by adding up interest, dividends, and short-term capital gains for the year. Then subtract any investment interest that was paid.

Loans at below-market interest rates also create tax complications. If you loan money to your daughter at 2% when the AFR is 5%, the 3% gap will be used to calculate imputed interest. Gift tax will apply on the 3% spread, even though income tax may be avoided by using either the $10,000 or the $100,000 loopholes.

To avoid income and gift tax complications, charge your children a market interest rate on any loan and collect it regularly. You and the children should sign a written agreement, spelling out the terms of the loan, and those terms should be followed.

If you do not have a formal loan agreement and no interest has been paid, the IRS may say the transaction was a gift, not a loan. The entire amount could be called a gift, which could trigger a gift tax.

If your child pays the going interest rate, no income or gift tax

will be imputed. You'll have cash flow to pay tax on the interest income, and your child may get to deduct interest that's paid.

Aging Concerns

Many physicians add another generation of concern to their financial plans: their parents. As parents grow older, they may face failing health. It's natural for adult children with some financial means to want to help, if necessary. And, like it or not, it pays to prepare for your own long-term care needs.

If you or your parents need custodial care in a nursing home—or some kind of home care—the costs can be steep. The average cost of a private room in a nursing home is $206 a day, according to a survey by MetLife last year. That's just over $75,000 a year. In some areas, the average cost is over $100,000 a year. Home care also can be expensive.

To keep from spending down all your wealth on such care, you can buy long-term care (LTC) insurance. Ideally, you'll find a policy that will pay if you need care in a nursing home, an assisted living facility, or your own home.

That LTC policy should be designed so that it will pay if you can't handle two or more activities of daily living (ADLs). Those ADLs include eating, bathing, moving around, and using the bathroom. The policy also should pay for care that's necessary in case of dementia, such as Alzheimer's.

When you buy LTC insurance, you choose a certain daily benefit. You can get a policy that pays $150 a day, for example. The higher the benefit the policy will pay, the higher the premiums will be.

The amount of coverage you should buy will depend on where you think care will be needed. In San Francisco, for example, the average cost of a nursing home is $311 a day while nursing homes in Chicago average about $143. In a high-cost area, you may want a policy with a higher daily benefit.

Another approach is to partially self-insure. You might buy an LTC policy that pays, say, $120 a day. You'd pay any extra costs from your own pocket. "We normally suggest that our clients buy a policy with a benefit of somewhere between $100 and $200 a day," says Ed Fulbright, a CPA and financial planner in Durham, N.C. The more you are willing to self-insure, the lower

the daily benefit you can choose, and the less expensive the policy will be.

You also can cut the cost of LTC insurance by buying a policy at the right age. “The perfect age to purchase this coverage is between 50 and 62,” says Mr. Fulbright. “People under 50 years old usually should not consider LTC insurance.” Still, it doesn’t pay to wait too long.

“After age 70,” says Mr. Fulbright, “premiums become much more expensive.” The longer you wait before buying a policy, the more risk that your health will deteriorate. If this occurs, LTC insurance will cost even more.

Even if you are under 50 and not ready to buy LTC insurance for yourself, you may be interested in helping your parents get this coverage. If the insurance helps to pay your parents’ long-term care costs, fewer family funds will be spent, and your inheritance can be conserved. You, your parents, and perhaps your siblings might help pay the insurance premiums.

Certain tactics can reduce the premiums that need to be paid. “I usually recommend that benefits be paid no longer than five years” says Mr. Fulbright. An LTC policy that pays benefits as long as care is needed can be extremely expensive. Moreover, such a policy may not be needed because few people will need care for more than five years.

Another cost saver is to specify a long waiting period before benefits have to be paid. “Our clients often choose a 90-day waiting period,” says Mr. Fulbright. That is, they agree to pay for the first 90 days of long-term care out of pocket, before the policy kicks in. That will drop the cost of an LTC policy, compared with policies that have little or no waiting for benefits.

Saying no can cut costs, too. You might decline to add a feature that starts the policy at, say, $120 a day and increases that daily benefit by 5% per year. “A 5% inflation rider may increase the cost to a point where most people can’t afford the policy,” says Mr. Fulbright.

A lower-cost strategy is to buy a policy with a “future purchase option.” With this feature, you can buy inflation increases later on, if you can afford them and you feel they are necessary.

No matter what extra features you select or decline, purchase an LTC policy from a company in good financial condition, so it

is likely to be around to pay benefits in the future. Look for companies rated AAA and AA1 by Moody's (212-553-0300) or A++ and A+ by A.M. Best (908-439-2200).

The Pension Protection Act of 2006 included a provision to make the purchase of LTC insurance more affordable. "Even though that provision won't take effect until 2010, you can take steps now to prepare for buying LTC insurance with pre-tax dollars," says Dr. Slavutin.

To do so, you can make additional payments to a deferred annuity or permanent life insurance policy. This will increase the buildup of cash value inside the annuity or insurance policy, with no income tax due on the investment earnings. After 2009, you can use that cash value to buy LTC coverage with still-untaxed dollars. Either you can add an LTC feature to the existing contract, or you can exchange the original contract for an LTC insurance policy with a tax-free exchange.

Helping Elderly Parents

If your parents or other elderly loved ones are suffering from a cash crunch, you may be lending a helping hand—even offering them a room in your home. In these circumstances, tax breaks are available if you know how to best handle your family finances.

One approach is to claim an older person as a dependent. Each dependency exemption you can claim provides a $3,400 tax deduction in 2007, an amount that will go up in the future, to keep up with inflation.

High-income taxpayers may not get the full deduction, however. Couples filing jointly start losing the benefits of dependency exemptions as their income goes over $234,600 in 2007. Single filers start losing the tax break with income of $156,400 this year. In addition, there is no tax saving at all from dependency exemptions if you're among the many taxpayers subject to the alternative minimum tax (AMT).

Assuming you're eligible to benefit from a dependency exemption, there are requirements to meet if you want to claim an elderly relative:

■ **Income.** The dependent's taxable income can't exceed the dependency exemption amount: $3,400 in 2007. Fortunately,

Social Security benefits aren't taxable for low-income seniors; so this test may be passed.

"For the purpose, tax-exempt interest doesn't count," says Sandy Soltis, a partner with Blackman Kallick Bartelstein, an accounting firm in Chicago. You might suggest that your parent switch from a taxable bank CD to a tax-exempt municipal bond fund in order to reduce taxable income.

- **Support.** You must provide more than one half of a dependent's support, which includes the amount spent on the elderly person's clothing, housing, education, health care, recreation, and transportation.

"If your parent lives with you, you can put a fair rental value on the housing you provide," says Ms. Soltis. Determine how much he or she would have to pay to rent a comparable place to live.

You should keep records throughout the year to be sure you pay over 50% of a parent's support in order to qualify for a dependency exemption.

Beyond the income and support tests, a dependent must meet all of the following requirements:

- A U.S. citizen or a resident of North America.
- A relative or a full-time member of your household. A relative can be a parent, step-parent, parent-in-law, grandparent, great-grandparent, aunt, or uncle.
- One who does not file a joint tax return, unless the return is filed only to receive a tax refund.

If you and your siblings are sharing support of an elderly parent, it may happen that no one sibling provides over 50% of the parent's support.

In such situations, the participating siblings can sign IRS Form 2120, a Multiple Support Declaration. This form can be filed with the tax return of one sibling, who'll claim the exemption.

"Each signer must contribute at least 10% of the parent's support for the year," says Ms. Soltis. Among all the signers, the total must exceed 50% of the parent's support.

For example, in 2007 you might agree that your sister takes the exemption. For 2008, the tax break might go to your brother instead. Then your turn will come in 2009. And so on.

Be careful, though, not to include a high-income sibling or anyone subject to the AMT in the rotation. He or she won't be

able to get the tax benefits of the dependency exemption.

Retirement Planning: Taking Care of Your Own Future

Protecting your family, from youngsters to seniors, may be among your prime goals in life. At the same time, you shouldn't neglect your own well-being. In fact, most financial advisors will tell you to save for your own retirement first, then look at college and other savings goals. This has at least two advantages: setting you up for a secure retirement in the future and reaping tax benefits now or later.

A traditional 401(k) may be a good choice when you're in a high tax bracket. If you'll be in a lower bracket after retirement, these plans can work very well. A Roth 401(k) might appeal if you're a young physician, still in a low tax bracket. You can withdraw the money tax-free in the future, when your bracket may be higher.

The federal government provides several ways for you to save for your retirement on a tax-deferred basis. If you're a decision-maker at your medical group or if you practice as a self-employed professional, you can pick the plan that best suits your situation. In most plans, contributions are tax deductible, investment income is untaxed, and withdrawals are subject to income tax as well as a 10% penalty tax before age 59½. Here are the main options:

- **Traditional 401(k)**. You can contribute up to 100% of your income or a maximum of $15,500 in 2007. If you will be 50 or older by year end, you can contribute up to $20,500. If you're an employee, be sure to contribute as least enough to earn any matching contribution from your employer.
- **Roth 401(k)**. This feature can be added to a traditional 401(k). The Roth 401(k) limits are the same, but contributions are not deductible. All withdrawals are tax free after (1) five years and (2) age 59½. You can participate in both types, if they're offered, but your combined contribution can't exceed the $15,500 or $20,500 limits.

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withdraw the money tax-free in the future, when your bracket may be higher.

- **Profit-sharing plan**. Despite the name, these plans are not tied to profitability. Employers can contribute anywhere from zero to 25% of each participant's compensation. The percentage can vary from year to year; in 2007, the maximum contribution is $45,000.
- **Profit-sharing/401(k) combination**. Here participating employees can make contributions up to $15,500 or $20,500 in 2007. In addition, the employer can contribute a certain percentage of pay to all participants, up to 25%. The total in 2007 can be as high as $45,000, up to $50,000 for those at least 50 years old.
- **Solo 401(k)**. These plans are available to physicians with no employees other than a spouse. Solo 401(k) plans permit you to contribute as much as $45,000 this year ($50,000 for participants who are 50 and older), combining contributions as an employer and as an employee.
- **SIMPLE plan**. These can be SIMPLE IRAs or SIMPLE 401(k)s. (SIMPLE stands for Savings Incentive Match Plan for Employees.) The former are more common because the latter may take more time and effort to administer. With either version, you can contribute 100% of compensation, up to $10,500 in 2007. If you are 50 or older, you can contribute $13,000. Employers must make a contribution, too. Among several methods, employers can offer a dollar-for-dollar match to all participants, up to 3% of compensation.
- **Simplified employee pension (SEP) plan**. As an employer, you can contribute a certain percentage of compensation—up to 25%—for each participant. For self-employed physicians, contributions can be 20% of self-employment income. With any SEP, the maximum contribution in 2007 is $45,000.

You may still have time to create and fund an SEP for 2006. This can be done up to your tax filing deadline, including extensions. Therefore, if you have requested a filing extension, you can contribute and deduct up to $44,000 for 2006 until October 15, 2007.

- **Defined benefit (DB) plan**. With the plans described above, the limits are on annual contributions. DB plans limit benefit—

the amount you'll receive in retirement. Those amounts are determined by your career earnings and the number of years with your employer.

In 2007, the maximum pension that can be funded is $180,000. To deliver that kind of retirement income, you'll need to build up a large account. That means making hefty contributions, especially if you're 50 years old or older. For example, a 60-year-old physician could contribute $165,000 to a DB plan this year. That assumes he or she earns at least $225,000, the maximum amount of compensation that can be counted for calculating DB contributions this year.

There's another reason to fund the above retirement plans: They may provide you with protection from creditors. "There are three levels of protection for retirement plans," says Bob Keebler, partner in the Green Bay, Wis., office of the accounting firm Virchow, Krause & Company. "ERISA is the first level."

ERISA is the Employee Retirement Income Security Act, the federal law covering pension plans. A Supreme Court decision in 1992 held that ERISA protects from creditors any money in employer-sponsored defined benefit and defined contribution plans. That includes 401(k)s and profit-sharing plans.

Not all plans are covered by ERISA's protection. A one-person plan for a self-employed physician won't qualify. Neither will a plan covering only a physician and spouse. Moreover, even an employer-sponsored plan with employees isn't entirely protected: it can be attached by the IRS, and it can be divided under a divorce settlement between a plan participant and spouse.

"After ERISA, the next level of protection is the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005," says Mr. Keebler. "You have to file for bankruptcy to get the protection."

The third level of asset protection for retirement accounts comes from state law, which would apply to retirement plans not covered by ERISA, such as IRAs. If you are unwilling or unable to file for bankruptcy, state law will apply to your IRA.

Some states provide full creditor protection to IRAs, but others have limits. What if your retirement account is not protected by ERISA, you don't want to rely upon going bankrupt, and your state's laws don't provide much protection from creditors?

"You might consider moving your IRA to Alaska," says Mr.

Keebler. That state has passed a law that will allow nonresidents to form an Alaska IRA, using a bank or trust company based in Alaska as custodian. Alaska law protects IRAs, but this law's power to shield out-of-state residents has yet to be tested in court.

Deciding which retirement plan to use is just one step. Next you must designate the right beneficiary, the person you wish to inherit the account.

"Retirement accounts are not covered by your will," says Tom Ochsenschlager, vice president of taxation at the American Institute of Certified Public Accountants in Washington, D.C. "They will go to beneficiaries you have named."

"You should review your beneficiary selection every few years," says Mr. Ochsenschlager. Changing your beneficiary designations can be vital after a major life event such as a marriage, a birth, or a family death. It's especially important to change your beneficiary designation after a divorce. You probably won't want your ex-spouse to inherit your IRA.

You name beneficiaries by filling out a form provided by the financial firm administering the plan. They will collect when you die. You also can name secondary beneficiaries, who will collect if your primary choice dies before you.

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"Neglecting to name beneficiaries can penalize your heirs," says Mr. Ochsenschlager. "This is especially true for retirement accounts."

An individual beneficiary of an IRA, 401(k) account, or other plan may be able to stretch withdrawals over an extended time period if the cash is not needed right away. The longer the distribution period, the more tax-deferred wealth accumulation may occur. If a retirement account goes into your estate, though, the money must be withdrawn (and taxed) more rapidly.

Therefore, naming beneficiaries has two advantages: it can lead to substantial income tax deferral and it can help insure the

money winds up where you want it to go.

When you change jobs or retire, you can roll over your retirement account to an IRA. This will maintain your tax deferral and allow you to control the investments in your account.

A further strategy is to convert this IRA to a Roth IRA. You will have to pay the deferred income tax, but all future withdrawals will be tax free after five years as long as you are at least 59½ years old.

"Year-end Roth IRA conversions may make sense," says Ed Slott, a CPA in Rockville Centre, N.Y., who publishes the newsletter *Ed Slott's IRA Advisor.* "A December 2007 conversion, for example, starts the Roth IRA clock at January 1, 2007. As long as you're at least 59½ years old, you can take tax-free withdrawals from a Roth IRA after five years, which means after January 1, 2012. This technique gives you one of those five years right away."

A Roth IRA conversion will be valid only if your income this year is no more than $100,000. "Even if you're unsure about your income," says Slott, "go ahead and convert anyway. If you're over the limit, or if you change your mind for any reason, you have until October 15, 2008, to reverse the conversion with no penalty." Moreover, after 2009 the $100,000 requirement will lapse; so you can convert a traditional IRA to a Roth IRA then, no matter how much money you make.