

Unravel the slang, the obscure terms and the Acronyms that can mislead you. Eliminate the confusion and master your insurance policy so you grab the benefits you need **before you sign on the dotted line ! ! !**

Here are the Systematic Keys that will help you understand and use Your Insurance Policy Before, And After You Sign.

Our Exculpatory Clause

Please be advised and forewarned: All information, suggestions, techniques, ideas and resources are provided "as is".

The publisher doesn't claim to know everything there is to know about this subject, nor does the author. Inside this book we have tried our best to be as helpful as possible in the suggestions we make, but in the final analysis your results are entirely up to you.

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As always, it is suggested that you obtain local legal advice from competent sources near you. When you do so, do not assume they have heard of these strategies, nor assume you are wiser than they are just because you do know them. Remember that everything in this field is subject to change without notice and that changes do not propagate throughout the world at the same rate. Above all, it is necessary that you be careful in using any information you acquire, from any source. Consequently, you are strictly enjoined to seek and use the advice of competent authority figures in your local area before applying any techniques, strategies or resources in this book.

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The very best thing you can do to trim the size of your insurance premiums is to stay healthy! There are just 3 major keys to staying healthy.

1: Clean Air.

2: Clean water

3: aerobic exercises.

Staying away from Junk Food will help a lot too. Throw in real religion and a healthy respect for good, [clean humor](#) and you'll have a wonderful life, no matter how sick you are.

Before we slip off into definitions of various health insurance terms please be aware that you need to study the policies with a jaundiced eye. My own company that has stuck by me when the costs of my critical illness shot through several roofs has just notified me that premiums are going up, co-pays are going up and yikes... the dosages of required medications are being limited. Sounds awful.

Consequently, I began studying the next best choice (for me) and liked what I saw. Pay by the year. Coverage here, coverage there.. Yep. Great. It also said, no co-pay for services or for medications. Man alive, how good can you ask for? Right?

Well, my daddy taught me how to look for steamboats in all insurance policies. He mentioned one company that offered a one million dollar accidental death clause. Daddy got to the bottom of the policy and found some print so fine it could not even be classified as visible, more of a smudge. He got a high-powered magnifying glass out and found it was the final clause. It would pay off only if the party of the second part was on a mountain top when run over by a steamboat.

I listened to my daddy a whole lot more after I got grown than I did when I was a kid. He could read through a contract and point out things that were important to me, like the time I was enthusiastically selling a food service that "gave away" a freezer to people that signed up.

Using nothing else but their figures he showed the cost of that freezer was 8 times what one would cost on the open market, not to mention how long my customers would be constrained to buy food from the company at prices free to accelerate at any factor deemed necessary.

Anyway, I started going through THIS policy. Again and again I struck words in their pledges.. words like "may", can, should, and other qualifiers that let the company off the hook. The company "may" pay for all your medications. May? What does that mean? Well, it means that your doctor can only prescribe the medications listed by the company and only in quantities deemed fair by the company to the company.

As I went to the Internet and [found the company's own web site](#) it became more and more obvious that I did not like this company's way of doing business. By this time I had made my decision to stay with my current company. Had that not been the case I could also have gone to [national reporters on companies](#).. and also to [state regulatory commissioners](#).

However, in the case of state regulatory commissioners, you'll want not just a report on your prospective choice, but also reports on the other companies that are in the same grade. You want to know more than how many complaints they have received in the previous 12 months, but also how many complaints are considered frivolous, and also how many complaints there have been per thousand paid clients. Only in this way can you come anywhere close to comparing apples with apples and oranges with oranges.

Okay, now we are ready to look at terminology arcane to the health insurance field.

POS: What It Means

POS is a basic managed health care foundation in which one can attain lower medical costs in exchange for much more limited choices. Once you're in a POS health care program you will be asked to choose a primary care physician to monitor your health care. This physician will become your point of service within the health care network. In the event that your primary care physician deems it necessary for you to see another doctor or specialist, he/she may make referrals for you outside the network but only the insurance company will cover a percentage of the cost. The paperwork for medical visits, which take place inside your network, is completed for you, but if you go outside the network you are responsible for filling out the paperwork and keeping very accurate records.

POS does give you some advantages that some people do like. Annual out-of-pocket costs are usually very limited. In today's world many people have limited resources set aside for medical costs so low out-of-pocket expenses will be a plus for many consumers. There is no deductible for network care. This is another advantage people like a lot. With no deductible you don't have to spend a certain amount out-of-pocket before things start to get paid for. There is a deductible, however, if you go outside the network for care. You aren't limited to HMO providers only. This gives you the freedom of more choices for your health care needs, which is something we all strive for. Co-payments for non-network care are very high. This discourages going outside the network and promotes using more primary care providers in your network.

Your actual costs will only consist of a monthly premium and co-payment for health care services under the plan within the POS network. If you're still wondering which program is best for you a PPO, a HMO, or a POS, consider some of these questions. Are there a lot of doctors to choose from?

No matter which plan you go decide on, a good selection of doctors is something you should consider before choosing a plan.

The prices of the health insurance premiums could very well be the most important question you may have. It won't do you any good to have health insurance if you can't afford to pay the monthly premiums. Therefore this is a subject that needs great attention so that the right decision can be made. Coverage is another thing that should be looked into. Different plans have different coverage. Emergency room converge can also vary by whatever plan you choose. Whatever plan you choose make sure it has the coverage you're looking for.

The hospitals that are available to you is something many people will rank high on their list of considerations. Having a place where you feel comfortable and trust the value of their service means a lot to most people. Hospitals can have a good reputation or a bad one. That's why choosing a hospital will play into which health care plan you choose. No one likes hospitals, but if you are comfortable at the hospital that is covered, it will certainly make for a more pleasant experience. So it is important to know which hospitals are covered by your health care plan.

Are their limits on the medical treatments and services a certain plan offers? There's really no sense in paying for a plan that won't let you use the services you really need. Isn't that the main reason we buy medical insurance so that we can use the services when we need them? Be sure a think about the services that you are most likely to use, and be sure to ask if those services are covered.

Consider the application in non-network care. This is a very important part of any plan. Sometimes your physician may not be available. Be sure to find out how much more you would be responsible for paying to go outside your network and see a doctor. It can be quite costly with some plans and far less in another.

POS plans have many advantages and many disadvantages. Looking over everything is something you must do before any decision is made. Looking through each plan will take some time and should always be done before you make that decision. You never want to rush into your decision. POS plans are a little different than the others but lower costs and out-of-pocket expenses are some good reasons for choosing a POS plan. Whatever managed care you decide on, and the choices are many, it is important to remember that with each plan there are good parts and bad. You, as the consumer, must do your homework so you won't be disappointed.

PPO: What It Means

PPO stands for Preferred Provider Organization. These organizations have contract agreements with the insurance companies. A PPO's big advantage is the rules are a little more relaxed than an HMO which means they tend not to be so restrictive. Fewer restrictions usually help the consumer, which is a good thing for you.

PPO's allow you to see whichever doctor you like. This is a huge advantage to many people, especially the elderly and those with young children. Repetition is very important to those with children and the elderly since they usually feel

more comfortable going to a doctor they trust and will tend to be more open with that doctor or hospital. If the patient chooses and out-of-network physician, they will have to pay a higher out-of-pocket expense but don't need a referral to see a specialist.

Many times life's financial situations determine our choices and health care is no different. HMO's are a lot cheaper but if you want input into your healthcare choices and the services you will be receiving then the best choice is a PPO. PPO's give the consumer basically total control over his or her needs when it comes to their health.

PPO's were created originally to give a big group lower rates for health care coverage and to gain a growth in business for their organizations. Many reasons that PPO's have been so successful are the many things that they have been able to do within their organizations. A lot of times second guessing is never needed with a PPO, as more detailed information is available to PPO doctors. This helps cut down the costs for medical insurance for the group of a PPO.

Many PPO's were credited with reducing the rapid rise of medical expenses in the 1990's, however with expansion, a lot of PPO's joined each other to make larger companies, which doesn't necessary help the health care consumer. PPO's usually require insurers to pay a claim in a certain time frame to be eligible for the PPO discount. PPO's goal was to make things simpler but now it seems maybe the opposite is true. PPO's have great power in getting cheaper prices for their customers in the already complex health care system in the United States.

Let's now look at some common rules and questions many people have about PPO's. One of the most common questions people ask is "What if there isn't a provider in my area?" Under most PPO plans you are given the standard benefit for someone who is local. Prescription drug programs

are covered in PPO's and have two different coverage options. One is to get them at your local pharmacy and the other is to search online and purchase them.

Many people don't realize, and this is probably one of the more important rules of a PPO, certain services must have prior approval before the service is rendered. One reason for this is that there is nothing more horrible than going through an operation and finding out after recovery that without prior approval no payment will be made. Doctor visits which use the co-pay option is another reason people love PPO's.

PPO's also have a yearly deductible which basically means even though you have a co-pay there is a certain amount you must reach before they PPO will start paying for the medical fees. Most PPO's will pay 80% of the medical bills as long as you use the in network physician. PPO's offer flexibility that other plans just can't offer you. Usually the overall premium is cheaper for PPO than it is for other traditional plans and also for health insurance. One important thing to remember is any work done outside the network will cost you a lot more money. It's best to try and find providers close to you or in the network.

So if you want to control more of your health care decisions then a PPO is probably one of the best choices for you and your family. PPO's are a natural choice for most Americans, it could be the best choice for you too.



COBRA: What You Need To Know

COBRA Insurance coverage is something many people don't understand or realize how it works for them and the benefits they can draw from it. COBRA might just be what you're looking for to fill those insurance needs. But lets look at what COBRA is and if it's in your best interest to continue it or end it.

COBRA is also known as the Consolidated Ominbus Budget Reconciliation Act of 1985 or COBRA for short. COBRA is still a very useful law to many and people still use it today. COBRA makes it possible to keep health insurance coverage from their employer for up to 18 months if their employment status changes. Some of these changes could be layoff, reduced work hours or a termination of employment by either party involved.

COBRA has helped countless Americans keep insurance coverage. Now, is it good for you or not? Many times when individuals lose health coverage they have a very hard time getting coverage in the private sectors for various reasons. If they do find insurance coverage it's extremely expensive and many times not feasible for the displaced worker. For the worker to continue his insurance coverage through his employer he must pay the monthly premium, which can add up because he's not getting a discounted price anymore.

Internet access has helped many people find various health care programs. Now people can get on the Internet and do their own research and find out which company can give them the best deal and will give them the most benefits for the money. Since the Internet encompasses so much information more choices and comparison-shopping has become the buzzword.

Now one of the most important questions you need to ask yourself is whether or not to continue COBRA insurance coverage from your employer. If you have many health problems that are being treated right now you probably should strongly consider using the COBRA insurance option. Having health problems with pre-existing conditions could make it very difficult for you to get insurance coverage. If you do get health care coverage it will be so expensive it wouldn't be worth it.

If you are changing jobs and you know that your new employer doesn't offer health care coverage or if you know you won't qualify for the new company's health plan then highly consider COBRA as a viable option. It is also a good idea not to have gaps in health care coverage, as this tends to get you a better deal.

If you tend to be on the healthy side then you can choose not use COBRA as an option. There are a few reasons for that. Being healthy you should shop around as you will be able to get better coverage and at a more affordable price. Insurance companies love to insure young healthy individuals as they know it usually costs them a lot less money therefore, they will be glad to give you a good deal on your health care needs.

There are a few things you should know about COBRA so you can make a very informed decision. Once your health care coverage is lost, you are given a 60 day grace period in which time you must chose to use COBRA or not, otherwise you will lose it all together. Once the 60 days has past, it is not offered again. COBRA also has provisions that give certain former employees, retirees and spouses the right to get temporary continuation of health care coverage at group rates.

Some of the things that COBRA will continue to cover if you decide to keep the coverage are:

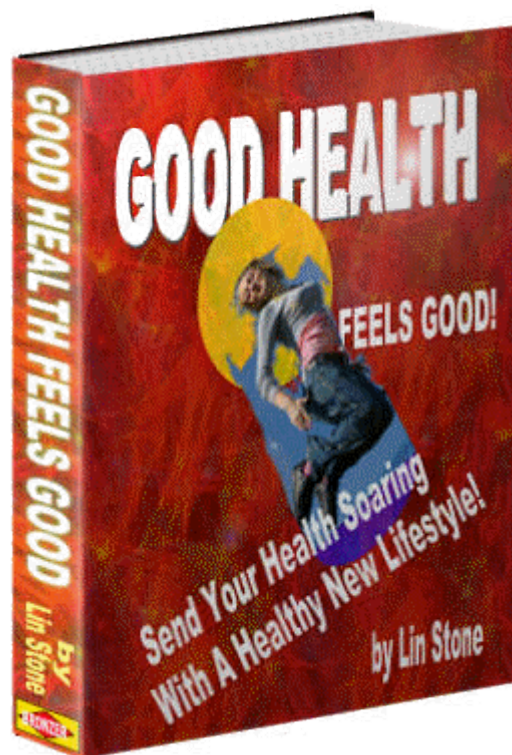
Inpatient and outpatient hospital care

Physician care is also covered under COBRA

Surgery and major medical benefits

Prescription drugs are also covered but life insurance is not covered under COBRA.

COBRA has many advantages and disadvantages and just like anything else an informed decision will take some time and research. COBRA has been helpful to many employees and will continue to provide coverage when needed for many more years to come. For some COBRA just doesn't fit into their plans; each individual will have to choose whether COBRA can benefit them.



HMO: What It Means

With so many different health insurance programs, how do you know which one is right for you? HMO is one that you should become familiar with. HMO stands for Health Maintenance Organization. It's a network of healthcare providers that have contracts with an insurance company to provide their services at a set price. HMO's do have many rules that you will have to follow and do tend to be very restrictive. So how does HMO basically work for you and is it for you?

HMO requires that you select a primary care physician who will manage every aspect of your healthcare needs. This primary care physician must be a member of the HMO. The disadvantage of this is you may have to switch primary care physicians until you find one in the network that is near you unless you want to travel. If the physician isn't in the network of HMO's then the work will not be covered under your insurance plan. If you need a specialist for anything you must first get a referral from your primary care physician.

HMO's main advantages over the other programs, is the cost. HMO's are cheaper for the consumer and premiums are a lot cheaper with an HMO. Co-payments are usually low cost or free, so this is a big selling point to consumers as less out of pocket expenses are something today's consumers are looking for. HMOs are designed for profit so you can expect your doctor to be very busy, as he has to see many patients since the goal of the HMO is to turn a profit. Doctors tend to want to spend more time with their patients but that's not always possible as HMO's need to turn a profit or will be forced to close. Employers pay a portion of the monthly fee that is required to join the HMO. Usually whatever is left is the employee's responsibility to pay weekly out of their paycheck.

Co-payments are a big issue in most HMO's for a number of different reasons. The main reason is that a co-payment sometimes deters people from using the service. For example hospital co-pay is a lot more expensive which tends to get the person wait and go to his primary care physician, as the co-pay for your doctor is a lot less. This seems to work well in the HMO scheme of things. Co-pays are also used to offset the overall cost of the insurance and makes everyone pay their fair share which forces the people who use it the most to pay the most into the plan.

So is a HMO best for you? Or would regular health insurance be the way you should go? These questions have many various answers, depending on a lot of factors. If you have a family buying your own group insurance for your family can get quite expensive. HMO's were designed for controlling expenses and managing all aspects of your healthcare in one place. This seems to work well with a family. Now as an individual this may or may not be for you. If you personally have a favorite doctor or hospital and it's not on the list of HMO providers than you probably would better off not going with the HMO system as it won't cover doctors or hospitals not listed as a approved provider.

People for the past few years have watch healthcare costs skyrocket with no end in sight it seems. HMOs try to help control costs, which are one of the reasons HMO's keep growing and getting more popular each and every day. The only real disadvantages with HMO's are that they can be restrictive and might not let you do what a normal health insurance company will. The main reasons is with all the members they have to insured they do need an across the board rules that everyone can follow to make it fair to all the people they insure. HMO's aren't for everyone so if you are going to join an HMO does plenty of research before you join so you know what you will be receiving and what you

won't be getting. That way you can make an informed decision on your healthcare needs.

Shopping Around: 10 Things TO Consider When Choosing A Health Care Plan

You have decided it's time to buy health insurance and it can be a very daunting task to figure out everything. Here are 10 of important factors you should consider when you choose your next health care plan.

1. Let's start with the most important one first, doctors are the backbone of any health care plan and you will have to consider a few things before you grab that health care plan. If you have a family doctor that you have had for many years or someone you really trust than you will have to be sure that an continue seeing him or if you have to chose one from the listed health care providers who are on the plan you are considering. You may also have to consider whether there is a doctor close enough to where you live.

2. Pre-Existing Conditions can cause a lot of confusion because a lot of times people take this part of the health care plan for granted. Many times people don't realize they must check and make sure how the plan deals with pre-existing conditions or they could be left out in the cold. Every insurance carrier has different pre-existing conditions that are covered so checking into that will be very important for you to do.

3. Specialists for certain medical conditions are another very important factor you may want to look into. If you use a specialist now you will want to see if he or she is in the network of approved specialists. If not, you may have to

look for new one. Not every health care network will cover this in their insurance.

4. Emergency Care is probably one of the most important things you will need to check out. In today's fast paced world more and more people are using emergency rooms instead of visiting their doctors. The word emergency can also get you into some trouble with your health care provider. Not every person and health care plan define emergency the same way so finding out what is covered is crucial.

5. Check ups and Physicals are usually given yearly but sometimes more often. If you getting these done often most health care plans cover them but some don't so be sure to check into that. If you have kids you will want to make sure they are covered for checkups too.

6. Exclusions can be a gray area if you don't have a list to go over from your health care provider. Exclusions can vary by carriers so finding what is in your plan will be very important.

7. Costs are another very important factor to compare. Once you have all the plans in front of you comparing the costs of each plan and what they offer could be the most important decision you make about your health care future.

8. Prescription Drug Coverage has become one popular part of any health care plan. In today's world prescriptions can get very expensive so coverage for this kind of medicine is extremely important. Most health care providers have co-pay for prescription drugs and some are free or at a very reduced rate. Some will pay for generic medicine and some won't, all these all very important factors for you to consider.

9. More services are given under certain health care plans. Some of these extra services will be of no use to you; however some of them are ones that you will want to have. Some of these are mental health, nursing homes, and drug treatment to just name a few.

10. OB-GYN coverage is another important part of any health insurance plan especially if you see an obstetrician often. If you're also considering fertility treatments you will also have to look into that when you go over your coverage. Finding out how much you will have, as an out of pocket expense is very important when you are considering OB-GYN coverage.

When you look at health insurance coverage there are a lot of factors you will have to consider before you can make that decision. Never rush into any decision without getting all the information you can get. Take your time and you will make a good health care decision.



What Do You Mean "That's Not Covered?" Common Exclusions

Am I covered on my health plan for this, or am I not?
Does This Clause Mean I'm paying premiums for nothing?
Common exclusions vary considerably among insurance carriers and what one may cover, the others may not. Just getting to know what the common lists are is half the battle and will help you make some important decisions about your health care needs.

Let's take a look at the most common exclusions.

One of the most common exclusions is home care or private nursing. A lot of people don't realize that these two things are not covered. Patients sometimes take these for granted as covered under their health care program even though most of the time they're not. Another good thing to remember is that these two exclusions could be listed under something else and you might not see them right away. If you can't find them, it's always good to ask.

Behavioral problems are sometimes covered under health care programs, but most of the time they are not. Many reasons for this as behavioral problems can last for many years and the cost could bankrupt most insurance companies. Behavioral or learning problems are one of the most common health care problems especially in children and people are just realizing this. Health care companies are now realizing this and some companies are covering it but for the most part it's excluded.

Abortions are one of the hottest and more controversial subjects people talk about in today's society. Elective abortions are also excluded from health care insurance. With all the legal issues that can be involved with abortions you really can't blame the health care companies for that stance.

Excluding elective abortions is a natural reaction.

There are some very common items too that you think would be covered but just aren't. Band Aids, telephones, and some comfort items that aren't covered. You would think items that you would use all the time may be covered, but they are not. Each company has their own list when it comes to the common items so you would have to check with the individual company.

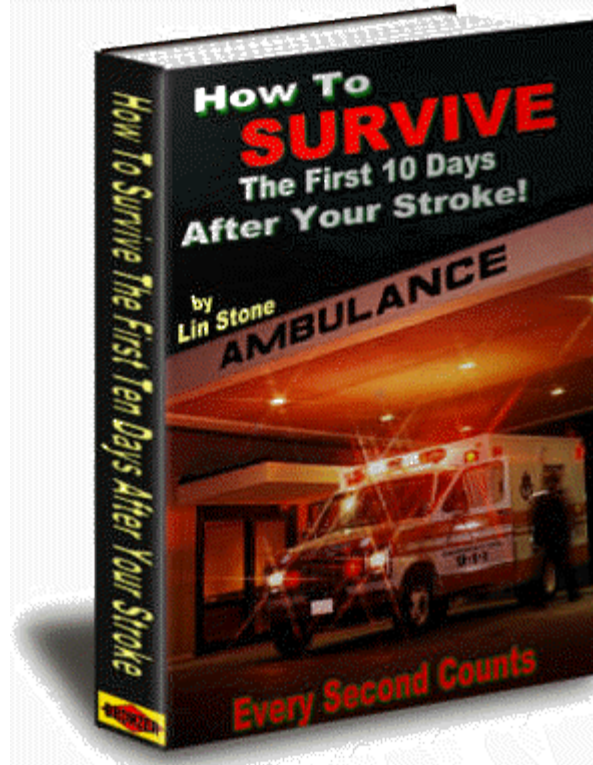
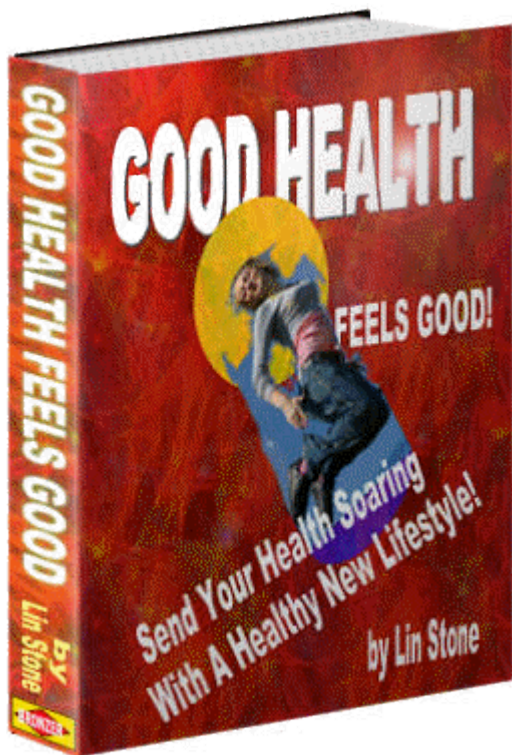
Dental Care and Hearing/Vision care are another section of general health care insurance that isn't covered. For the most part these items are not covered as there is usually separate insurance for these items. Putting all this on one policy would make the policy quite expensive so excluding this makes good business sense for the health care industry.

Cosmetic surgery is another excluded item and it should be noted that circumcision is now considered cosmetic surgery under most health care plans and would not be covered. The past few years it has been covered but aren't anymore. Experimental treatments and drugs are also not covered on most insurance plans either.

A couple of important things that you should remember are to always try to keep a list handy of things that is excluded on your health insurance. Why you may ask? Sometimes after a hospital stay you could actually get a bill for an item that was already paid for by your insurance. Itemize your hospital bill so you can make sure your not being overcharged for anything while you were there. Some states actually mandate what services that maybe excluded and what ones can. You will have to check with each individual state to see what is covered and what isn't. Now some insurance companies will have a long list of exclusions while others will only list a few.

Beware of the small list as they may be disguising their exclusions under different things they may not be under normally or listed somewhere throughout the policy.

Remember not everything is excluded and it's your job as a policyholder to find out what is excluded and what isn't. You cannot delegate this study to your doctor's staff, or to the hospital's staff. The insurance company probably won't volunteer any information either if you don't ask for it. Health care insurance is an ever-changing market with changes coming down almost weekly sometimes. Your exclusion list could change weekly too so keeping on top of it is also very important. Exclusions list should always be kept on hand and updated as it becomes necessary. As long as you're prepared, you will be able to handle a situation that changes.



Your Health Insurance Policy: A Guide To Understanding It

You now are the proud owner of a health insurance policy through your place of employment, but you have no clue what anything in it means. Some of the larger companies are assigned insurance representatives to help you wade through the clauses. If you don't have that resource, You must start reviewing the policy even if it gets more confusing as each word is read. This happens too often to a lot of people and it shouldn't. Insurance policies for the most part are simple to understand -- **if** you know the language they speak. Now if you don't that's another story. Let's get started and see if we can help you make sense of your new health insurance policy.

The first things you want to understand are the many terms that are in your policy. One of the common terms that you will see a lot and deal with a lot is a deductible. A deductible is what you would have to pay before any benefits in your health insurance policy would be accessible. Usually this is an annual amount and will vary greatly by the underwriters of the policy. Most of the time there are separate deductibles for an individual account and a family account. Some policies will let you use some of their services with out meeting the deductible. Once you meet your deductible then you're done for that calendar year. The following year though you have to start all over again.

Co-insurance, or co-payments which they are sometimes called, are amounts that are paid by the insured before the insurance will pay and this is in addition to the deductibles. Some policies let you pay a co-payment for certain services without meeting the deductible.

Out of Pocket is what you will have to pay out of your own pocket. This could include your deductibles, co-insurance, and your co-payments. If you hear the term "annual out of

pocket expense” this is the maximum out of your own pocket you would have to pay for the services minus the premiums, which are due no matter what.

Most every policy that you get especially health insurance policies have a lifetime maximum term. What this means that your policy basically has a cap on it. During the lifetime you can't go over a predetermined amount or the health insurance won't pay after the set amount. Now don't get worried it's usually a very high figure but with today's rapid escalating health care costs you can reach it fairly quickly.

Exclusions will be one section that you must read very carefully and fully understand in your health insurance policy. Exclusions are things the policy will not cover and this can be a very gray area. The policy could cover operations but not after care or cover after care and not the operation. This is one of the most important sections of your policy so read it and reread it over a lot to make sure you grasp all of the contents and what it covers and what it doesn't cover.

Pre-existing conditions is one of the things you will want to know about. Pre-existing basically means it was a condition you already have and been treated for which the policy will not cover it or pay for any work done for that pre-existing condition. Some health insurance policies will cover pre-existing where others won't which is why knowing what is in your policy is very important.

Waiting period is usually the time you will have to wait for your health insurance policy to become effective. Most policies do have a waiting period and the benefits aren't available until you have met the waiting period requirements. Different companies have different policies so check with your insurance company so you will know the rules for your policy.

Grace period is the amount of time that is given for one to pay their health insurance premium after the original due date has passed.

There are many things that you should always remember as you look over your health insurance policy. Read each and every paragraph and make sure you understand how the whole policy works so you will never be in the dark or have any questions about what is covered and what isn't. Remember that it is okay to ask questions!

Insurance and Infertility: Is There A Loophole?

Not too long ago there were many loopholes that existed for infertility treatments for women. Most insurance carriers found loopholes where the patient would have to pay for these services and most of these women couldn't afford them. Some insurance companies even would try to underwrite them under different things to get away with out paying for them. Luckily many state governments and the federal government stepped in and put a stop to it. There are still some gaps but more and more women are getting the coverage they need.

One of the biggest loopholes was that the states didn't want to cover vitro fertilization as it could get quite expensive and might not work all the time so insurance companies would balk at this added expense. Now most states have listed this as a non-necessary expense and covered it under maternity coverage. Many states have balked at this idea and only a handful of states are providing coverage for maternity expenses. Some people even consider this practice of not giving coverage as discrimination and they want the government to step in. Most of the basic health plans have no coverage at all for this type of medical treatment, which makes it hard for infertility patients to get any help at all.

With only 15 states having any kind of laws on the books to help patients with infertility the problem just seems to be getting no better. There is some new house bills that may or may not be passed. The hardest thing is when women groups are going up against the big insurance companies and all their money it makes it hard to get any laws passed. Progress has been slow so far but they continue to push on. Approximately over 5 million Americans have an infertility problem and about only 20 % actually can get any help with the problem. Many insurance carriers are reluctant to pay for any treatment.

Fertility treatments can run upwards of over \$30,000 dollars, which makes it non-accessible to many Americans. Some states are mandating more money for treatments but it's slow in coming. Many companies are also reluctant to step forward and talk about it as they fear it would spawn an increasing demand and more expenses then companies want to cover.

Many insurance companies have exclusions on infertility treatments and this is something you will have to check on as it varies by each carrier. Certain carriers will cover one thing while another won't. The worst part is that there really is no universal set of guidelines that the insurance companies are following to make it easier for consumers. What many people don't realize is the cost isn't really that much more for insurance companies. So why won't they do it then? The answer is that it would bring a flood of different fertility treatments to the forefront. In other words what ones will they pay for and which ones won't they? That's a very fine line and the insurance companies don't want to go there and confront this issue.

What recourses to women have left? First thing to do is check their health care policy. Many companies still don't exclude treatments in their policy. If it's not excluded then they have to cover it. Also look under the pregnancy section to make sure they don't limit what they will cover. Your last recourse is of course to sue them and go to court and present your case to the judge. He may or may not rule in your favor.

The only other real option is contact your congressman and see if you can get the laws changed to make fertility treatments mandated in all 50 states. This is the only way anything will probably get done. Many people won't realize, until the loophole is totally closed up, that money is always the insurance company's number one goal. And since fertility treatments are so expensive, they will shun away

from coverage. Hopefully one day soon the loophole will be closed and every woman can get the treatment she deserves when she wants it. This is one problem that has an easy solution and now if we can only convince congress to give the women of America a law that will help them instead of hurting them.

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On Your Own And Covered: Keeping Insurance After Moving Out

Now you're heading to college and you are worried about losing your insurance that you had when you lived with your parents. Insurance that you had at home usually doesn't carry with you unless you are home. These are important factors to look into before you can make any kind of decision about insurance. Should you be worried? Will the coverage follow you no matter where you live? All good questions that need some good answers. Let's look and see if we can figure it out. Now that you know college is in your future it's time to check all your options you have for health insurance. If you are staying in school most companies will let you keep your parent's coverage as long as you're between the ages of 19-25. Now not every policy will let you do this and there could be some exclusions that you're not aware of. The best thing to do is have your agent check the policy to make sure you're covered in the way you want to be. It's always best to have more than enough coverage than not enough. Another option that you have open is COBRA. COBRA is the Consolidated Omnibus Budget Reconciliation Act which basically means you could be eligible for temporary insurance coverage under the act by continuing the coverage your parents have on you. As always check with your parent's agent to see if you're eligible.

Short term insurance coverage is something that you might consider, if you will no longer be covered on your parent's policy, or if you were never covered to begin with. If you're getting a job in a short period of time you may only need a short term fix for your insurance needs. Try comparison shopping for short term insurance as the prices could vary with different carriers. Short term insurance is just what the name implies, for a short period of time. This also means that the price may be more costly than most can afford.

College students tend to have to pay higher prices than those not currently enrolled in school, so if you are a student, this might not be the best option for you.

Individual health insurance coverage will keep you covered permanently, but has a lot of drawbacks as well. Individual coverage can be quite expensive and you probably will have to qualify medically to get coverage. This is really a last resort as you should try the other options like getting it through your employer or through COBRA might even be a little cheaper. Different jobs from different companies sometimes give you instant coverage. Other companies give you coverage usually 30-90 days after you're hired in. If you are seeking a low premium, you can select a higher deductible.

College students might even have the luxury of going to their school and see if they have insurance that is available to students enrolled at the college. Many times schools can get a cheaper rate for their students while they are attending. This is something you may look into before you purchase any kind of insurance.

Parents may also have the option of insuring you while you're in school on their own policy for a little more than they normally pay. Insurance agents will be able to help you out with that if it's available. Most agents will try and work with you as their job is to make money and helping you out now will earn them a customer in the future. It's just good business sense. Make sure you check back often with your agents as today's insurance market is ever changing.

Insurance is probably one of the most misunderstood things for young college students. Never really dealing with it most of their lives it's hard for students now to realize they have to take the lead in getting insurance coverage. Words like COBRA and deductible can sometimes overwhelm the young

college student. Proper education is the key to making sound decisions when it comes to buying insurance. In the end you will need to sit down with people you trust and make informed decisions on your insurance needs. There are many variables so sitting down with people you trust are very important before you sign any agreement.

Universal Health Care: What Is It?

Universal Health Care has been in the news lately and every political campaign usually talks about it somewhere down the line. Universal health care is getting health care for every living American no matter how poor, how rich or ethnic backgrounds. Universal Health Care is one of the few services that haven't reached across the board of all American citizens. Universal health care would reduce the burden that is taxing our health care system, which is right now in crisis. We don't have enough doctors or nurses to staff our hospitals now.

A universal health care must meet certain requirements to work well in the United States. We must include the entire population, which would include men, women, children, and immigrants. No one should be without it. This program could be wide open to discrimination so we must make sure it runs smoothly and corruption isn't anywhere to be found. Access to care is a must. Many times people don't have ways to get health care. We must provide transportation to and from the medical facilities so they can receive the proper treatment.

A benefits package for universal health care is a must. Primary and specialty care must be included in the package. If we don't make sure we cover every aspect of health care we are doomed to fail. Most people can't afford health care and it has become a luxury for most rather than a necessity. A lot of consumers have been priced right out of it. We need to get universal health care so these consumers can get the health care they need. Why is this important? Millions and millions of dollars are lost to workers being sick and not being able to do their jobs. Lost productivity hurts everyone involved. Fewer goods are manufactured thus increasing prices for the consumer. Health care is probably the most important subject in America today. Universal health care needs to be adopted and implemented by a single source. This will save a lot of heartaches and problems.

Poor health causes many problems that universal health care could stop. The poor struggle to pay for housing and other needs just to make it through everyday. This can lead to mental illness and the quick depletion of their resources and becoming homeless is the natural progression. One number that people will find unbelievable is the amount of people without access to health care. Over 15 percent of Americans lack public or private health care. No universal health care puts public health at risk as untreated diseases can go unabated for years before the government can catch them. How many lives will we lose to this?

With insurance premiums skyrocketing one of the main reasons for this is; all the uninsured people who have to access free or low cost medical services. The only real way to recuperate the loss revenue by companies is to increase premiums to people who are now paying them. Universal health care would help control; costs and give everyone at least the opportunity to access health care. It should be a right of every American to have good health care.

Universal health care is something Americans have come to believe is needed for a number of years now. We've had several states providing good coverage for several years and it seems strange that these working programs are to be dismantled so that the mangling claws of the Federal Gov be turned loose to tell US what we need and don't need.

But, anyway, what's keeping Universal health care from happening? Many factors contribute to this and there really are no easy answers. Let's look at a few causes and see why we're one of the few civilized countries still without universal healthcare. Being a free country having universal health care would limit the amount of money doctors, dentists could charge everyone. Having their earning power capped would not make those in the medical community very happy. How would you like to be told that your earnings are capped – or even REDUCED, and then capped? In how many other industries do we limit what someone can earn. Maybe we should cap how much lawyers can earn, and then after the dust settles, remind those lawyers in Congress that their earnings should have that same cap put on them. Can we really tell anyone that they are only worth some amount?

I have a lot of other questions too, like why should I be compelled to pay for abortions? Why must I pay for the fools that deliberately go out to risk life and limb? Why must I pay for the damage smokers are doing to their bodies? Why must I pay for the damage drug addicts – including drunks and smokers – are doing to themselves? Why must I pay for breast implants, cosmetic surgery? Why must I pay for illegal aliens and people that constantly abuse the medical system with groundless complaints?

Universal health care has a lot of questions that probably will have to be answered before it will universally sweep the board. Getting major health care providers on board is really the only way that it will work in America.

The State Insurance Pool: Can it help you?

"State Insurance Pool" is a ground-breaking program that secures insurance benefits for all individuals, even those who are considered to be high-risk by the insurance industry. Quite often referred to as "Guaranteed Access Programs", these pools are unique plans created by individual state legislatures in order to make available a sturdy safety net for those folks to whom the dreaded term "medically uninsurable" has been applied. Previously, this determination meant that a person in need of medical care was denied health insurance coverage -- usually because of a pre-existing health condition. Sadly, it is the patient with such health issues who is in the greatest need of quality health care, yet quite often unable to afford the treatments because of the financial strain involved. Previously, this has led to interruptions in medical care for patients who had exhausted available COBRA (The **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct of 1985) benefits, and were now unable to meet steep financial demands from care providers.

It is noteworthy that state insurance pools vary from state to state; however, they usually function within the confines of a state formed not-for-profit alliance, which is governed by a board of directors. In general, this board has representative members from the insurance industry, individual insurance customers, and members of the specific state insurance department. Operating very much like a clearing house, the board enters into contracts with an insurance company, and then oversees the day to day operations of collecting members' premiums, receiving and paying out claims, and answering questions on eligibility for treatment.

While coverage is frequently comparable to the coveted 80/20 major medicals and outpatient coverage, prospective members may still be denied plan benefits because of perceived issues of being uninsurable, yet this limitation is often restricted to a 12-month period. Thereafter, acceptance is all but guaranteed. While this is good news for patients seeking insurance protection, it is important to remember that this coverage, while state sponsored, is not free. As a matter of fact, premium costs are usually quite a bit higher than comparable plans offered on the open market by competing insurance companies, yet because of state law regulations, there is a firm cap on the amount of money a patient may be charged for insurance. In general, this cap runs between 125 to 150 percent of the base individual market rate. While the cap is firm, there is still some elasticity in the rates, and they sometimes may vary based on plan participants' ages, or even domicile addresses.

Quite often copies of rejection notices must accompany an application for coverage under the umbrella of a state insurance pool from state-licensed insurance carriers. Additionally, anyone wishing to take advantage of a state-run plan must be a resident of the state in which the plan is offered. In lieu of a rejection by an insurance carrier, an individual who can evidence 18 months or more of uninterrupted health care coverage and is considered HIPAA eligible will quite often qualify for pool coverage. Coverage for dependents is available as well.

In short, a state insurance pool is of invaluable help to anyone who has been denied health insurance because of pre-existing conditions or has exhausted the allotted time period of COBRA benefits, and needs assistance in receiving needed medical care without fear of exorbitant out-of-pocket expenses.

As of 2003, thirty-three states offered high-risk pools to their residents. Twelve states have chosen to opt out of these programs by providing alternatives. For example, the District of Columbia has contracted with Carefirst Blue Cross Blue Shield to have an open enrollment period where interested individuals may purchase coverage regardless of medical conditions, and enjoy full benefits after only a short two-month waiting period. Rhode Island and Pennsylvania have contracted with Blue Cross/Blue Shield to offer year-round enrollment for otherwise deemed uninsurable patients.

Interestingly, this health care concept has since been expanded to also apply to hurricane insurance. "Windstorm Coverage Pools" are an alternative for homeowners who are unable to purchase individual coverage for their residences. Homeowners in a few coastal counties of Georgia and New York are even to participate in pool coverage for wind and hail damage through a program entitled "FAIR" (Fair Access to Insurance Requirement).

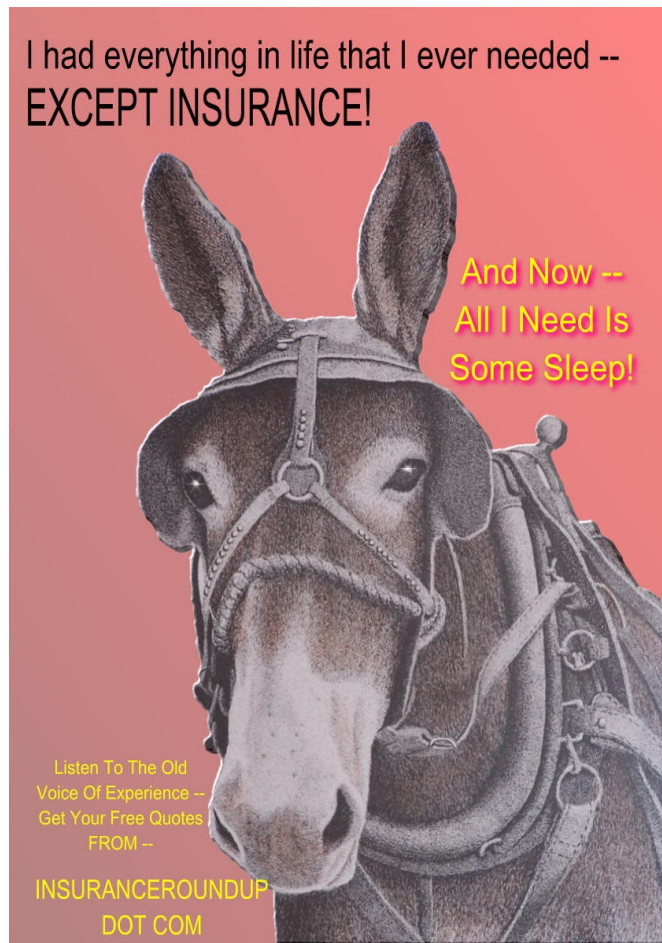


Cosmetic Surgery: Costly or Covered?

How many of us have stood at the checkout counter of the local mega mart, and perused the tabloids while waiting for our turn? A staple of many a tabloid is the guessing game: which celebrity has had cosmetic surgery or perhaps some liposuction? Yet, what about the lady at the front of the line, has she had costly surgery?

The term "cosmetic surgery" encompasses a wide variety of procedures, i.e. liposuction, tummy tuck, nose correction, face lift, etc. These procedures are not cheap. For example, a liposuction, which is essentially a fat reduction procedure in the areas of the thighs, hips, abdomen, knees, and face, may cost between \$1,500 and \$6,000. A face lift, which is the tightening of the skin and facial muscles while excess skin is removed, runs from \$2,500 to \$8,000, and quite possibly higher.

In general, insurance companies do not cover cosmetic surgery unless it is deemed to be medically necessary. Medical necessity is not always easy to ascertain, but as a rule of thumb, if the cosmetic surgery to be performed necessitates reconstructive surgery in the wake of trauma,



tumors, infection, developmental abnormalities, or congenital disease, the patient will have the good fortune of having the insurance company foot the bill. Conversely, if the patient is not able to establish medical necessity, the insurance company will consider the treatment to be an elective procedure and will not be obligated to pay anything.

So as to qualify as a reconstructive surgery rather than an elective cosmetic procedure, the operation must be performed in order to improve a body part's functions, but quite often it is accepted if the surgery is merely used to give the body part a societal accepted normal appearance. Yet, the buyer must beware!

While insurance companies will quite often cover such reconstructive surgery, they may not cover it to the extent the patient wishes the surgery to go.

One of the procedures that are quite often covered is ear surgery, also known as otoplasty. In the course of this surgery, prominent ears are set back to lie closer to the head; in some cases, the size of overly a large ear is drastically reduced. When this surgery is done on children, the insurance companies quite often cover it; when it is done on an adult, the patient will have the obligation of proving the reconstructive aspect of the treatment as opposed to the cosmetic angle.

Another cosmetic surgery that may be covered by insurance is eyelid surgery (blepharoplasty), which corrects drooping upper eyelids, or puffy bags below the eyes. This is accomplished by removing fat, skin, and muscle that cause the undesired drooping/puffing. This surgery may be covered if the patient can prove to the insurance company's satisfaction that it is deemed to be medically necessary to correct visual field defects.

Nose surgeries, also known as rhinoplasties, accomplish a wide variety of effects, such as the reduction or increase in the nose's size by simple reshaping, the removal of a prominent hump, or the correction of a previously broken nose. If the surgery is a reconstruction due to damage to the nose, it will most likely be covered by the insurance company. Otherwise, the patient will need to establish that the procedure is not simply an esthetically motivated treatment, but actually offers a medical benefit, such as the relief of breathing problems.

Insurance companies in many ways still have the upper hand when deciding whether or not to cover a cosmetic surgery. Policies are plentiful and vary from plan to plan, yet the American Medical Association and the American Society of Plastic Surgeons set a guideline that is generally followed forth.

If the aforementioned entities declare a procedure to be a reconstructive surgery, which does not necessitate a causal event but may easily apply to a simple improvement of function of the body part in question, then the insurance companies will be more likely to consider the claim for payment. If, however, a procedure is considered devoid of medical benefits and is simply deemed elective for the sake of improving a patient's self-esteem or body image, the insurance companies will be very hesitant to even accept the claim.

HIPAA: What do all those letters mean?

HIPAA, an acronym for what is also known as the Health Insurance Portability and Accountability Act, is a piece of legislation that was passed under the title "Kennedy-Kassebaum Act" in 1996. It aims to aid workers who may have lost a job with an employer-funded health insurance program, and who deal with healthcare needs, especially if these needs may identify them as otherwise uninsurable due to pre-existing conditions or serious health problems. While it may appear to be a confusing jumble of letters, HIPAA is an important benefit to workers who need health coverage and just started a new job, workers who have medical needs and fear a loss of existing health coverage, workers who change employers and thus stand to face an interruption in employer funded health insurance plans, and also workers who seek to purchase a health insurance policy independent of an employer.

These benefits are accomplished by HIPAA designed limitations on the designation of pre-existing condition exclusions. In addition to the foregoing, HIPAA forbids insurance carriers to inflate premiums for perceived poor health risks, either the individual seeking insurance, or a dependant of the eligible individual. Subsequently, insurance carriers are no longer able to refuse policy renewals in light of paid or submitted claims for coverage.

While these benefits are of tremendous helps to individuals who have found themselves with medical needs and are simultaneously transitioning in their workplace, HIPAA very specifically does not obligate employers to offer health care coverage for employees, and their families. Additionally, while it improves the ability of an individual to receive insurance coverage, it does not guarantee the coverage, nor does it regulate the exact dollar amounts an insurance company will charge an individual for coverage.

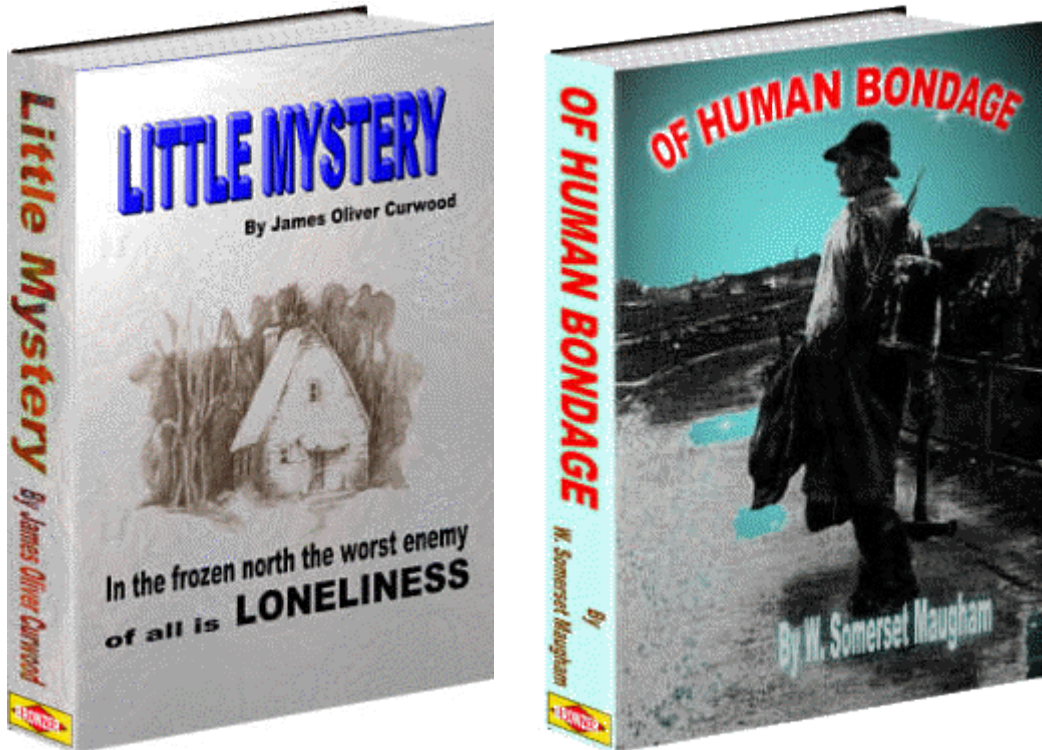
While HIPAA does limit the pre-existing condition exclusions, it does not define the specific benefits an insurance company is required to offer. In addition to the foregoing, it is noteworthy that while the list of pre-existing conditions that may be recognized is decreased, it is not eliminated!

For example, if a worker receives employer sponsored preferred provider organization health insurance on January 1st, 2005, and then on January 2nd, 2006 decides to switch to another health plan the employer offers, perhaps a health maintenance organization, no pre-existing condition exclusion may be applied since 12 consecutive months of coverage have been fulfilled. The most noteworthy constant in HIPAA rulings is the fact that pregnancy is never considered a pre-existing condition but must always be covered by an insurance company. Please note that HIPAA is not a panacea for spotty insurance coverage! If a worker's insurance history evidences long breaks in applicable coverage, i.e. at least 63 consecutive days without insurance coverage, HIPAA protection will be lost. Thus, a worker will be wise to accept COBRA coverage when available. If a worker is indeed eligible for COBRA, HIPAA coverage will not be available until COBRA benefits have been exhausted.

Since its passage, HIPAA has been amended with the Mental Health Parity Act of 1996 (MHPA). Very specifically, this piece of legislation precludes group health plans from enacting yearly dollar limits on mental health benefits that are lower than annual dollar limits for covered medical benefits. The MHPA does not order insurance plans to specifically offer mental health benefits, and only regulates those plans that actually offer this coverage. Another amendment to HIPAA is the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) which regulates the amount of time a new mother and her infant you are covered for a hospital stay following childbirth. The final amendment occurred with the WHCRA (Women's Health and Cancer

Rights Act) of 1998. This protection is designed very specifically for cancer patients who elect to undergo breast reconstruction surgery in connection with a mastectomy. It is important to understand that the WHCRA does not order health plans to cover mastectomies, and only applies to insurance plans that already do cover this procedure.

HIPAA legislation has greatly increased the affordability of health care for workers, regardless of their economic backgrounds, health histories, or even the claim histories of their covered dependants. Nonetheless, it is not an unlimited safety net, and individual workers must be cognizant of the limitations HIPAA does have.



Medicaid and Medicare: What's the difference?

Medicare and the Medicaid both fall under the umbrella of the Social Security Act. They were established in 1965 and sought to expand the budding safety-net for the elderly and the indigent.

Medicare's first and foremost goal was the creation of a system that would guarantee that the elderly population's medical care needs would be met. While Medicare originally limited its benefits to individuals aged 65 and older, in 1972 Medicare coverage was expanded to also include those individuals who are severely disabled and because of their disability entitled to at least 24 months of disability benefits, and also to include patients who suffer from the advanced stages of kidney disease that require dialysis or a kidney transplant. In 1973, the Medicare program was further extended to also include individuals who did not fall into any of the three categories previously mentioned, yet who wished to buy into it.

Medicare is a two-tier program that consists of a Part A and a Part B. Part A is the portion that deals with hospital insurance, while Part B is referred to as supplementary medical insurance. Part A goes into effect automatically when a person reaches age 65 or enters the 25th month of disability benefits, while Part B requires an application process. Hospital insurance allows for an unlimited lifetime benefit of inpatient hospital stays and up to 100 days of subsequent skilled nursing care per benefit period. Part A is not entirely free, and a co-payment is required. Hospital care benefits are extensive, and they include semi-private rooms, drugs, laboratory tests, and any medically necessary services, procedures, and supplies. Skilled nursing care consists of the services covered by hospital care, but it also allows for rehabilitation therapy and appliances, such as oxygen tanks, C-Pap machines, apnea monitors, etc. In conjunction with skilled nursing care, home health care may

be used without limitation. In 1983, Medicare Part A was amended to also include hospice care for terminally ill patients whose life expectancy was six months or less, and who have chosen to no longer receive conventional treatments for their illness.

Medicare Part B is an optional coverage that must be purchased and paid for with monthly payments on a regular basis. While it appears that Part B and Part A overlap, the supplementary medical insurance actually goes further than Part A in that it covers services such as flu vaccinations, ambulance services, blood for transfusions, and other services and products not covered under Part A.

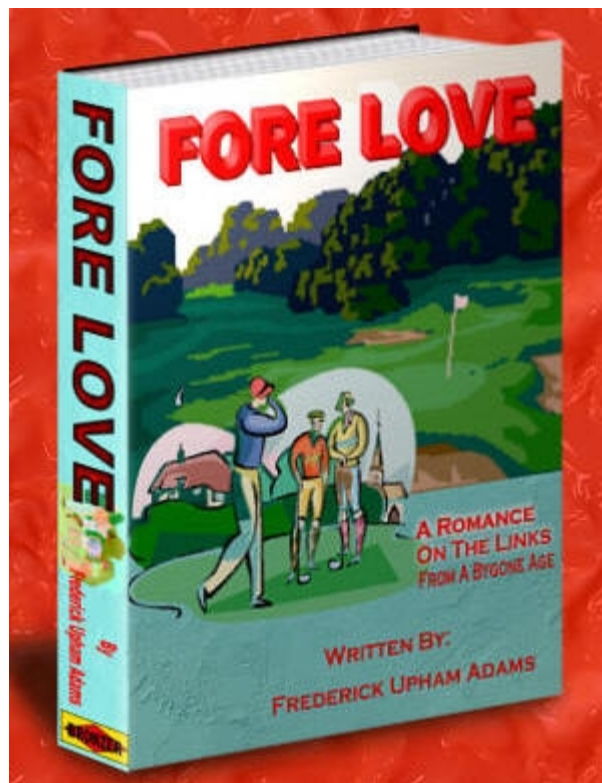
It is important to note that Medicare does not cover custodial care for individuals in need of round the clock treatment or long-term nursing home stays. Additionally, dentures, dental care, glasses, hearing aids and prescription drugs are not covered.

Medicaid, on the other hand, sought to improve upon the medical care provisions that were available to those individuals who were eligible for public assistance. It is not an all-inclusive program, and a low income alone does not guarantee eligibility for the program benefits. In general, families who receive Aid to Families with Dependent Children (AFDC), pregnant women whose income falls below the poverty level, recipients of Supplemental Security Income (SSI) and adoption assistance are eligible to receive Medicaid benefits.

Medicaid has two loosely defined components that may or may not be available in each state. If a state has a "medically needy" component to its Medicaid program, it will allow individuals who may have more income than the poverty level, yet who are burdened by extreme health care expenses, to receive benefits.

All states offer a “categorically needy” definition, and usually the benefits are more extensive than for individuals who take advantage of the “medically needy” program (if available). Medicaid benefits will stop if individual eligibility criteria no longer apply. For example, if recipients of AFDC or SSI lose their eligibility to those programs, and if Medicaid coverage was received solely because of participation in those programs, then in addition to losing AFDC or SSI the individual will also lose Medicaid coverage.

While this could have catastrophic implications for a family, it is noteworthy that most states provide state-only programs that mimic Medicaid yet apply to those individuals who lose Medicaid eligibility, thus easing the transition.



Medicare Prescription Drug Assistance Drug program

Medicare's first and foremost goal was the creation of a system that would guarantee that the elderly population's medical care needs would be met. While Medicare originally limited its benefits to individuals aged 65 and older, in 1972 Medicare coverage was expanded to also include those individuals who are severely disabled and because of their disability entitled to at least 24 months of disability benefits, and also to include patients who suffer from the advanced stages of kidney disease that require dialysis or a kidney transplant. It is important to note that Medicare does not cover custodial care for individuals in need of round the clock treatment or long-term nursing home stays. Additionally, dentures, dental care, glasses, hearing aids and most prescription drugs are not covered.

The small number of prescription drugs that Medicare Part B will cover up to 80% is limited to an injectable drug for osteoporosis, erythropoietin by injection for end-stage kidney disease, immunosuppressive drug therapy for transplant patients, some oral cancer drugs, and a few other drugs. Thus, if a Medicare recipient is not enrolled in the optional Part B coverage, these benefits will not apply. Additionally, patients will be required to pay an annual \$110 deductible for Part B services prior to Medicare's paying its agreed upon 80%.

The high cost of prescription drugs has long since been a major consideration for Medicare recipients, and many a patient is not taking prescribed drugs simply because they are too expensive. Unfortunately, the inability to obtain such needed drugs quite often negates the benefits received under Medicare provisions, and the program is seeking to remedy this situation by offering Medicare-approved drug discount cards to plan participants. In order to qualify for a drug discount card, an individual must participate in Medicare Part A and/or Part B, and not receive any

prescription drug benefits through Medicaid. Furthermore, benefits are sometimes curtailed if prescription drugs are covered (in whole or in part) through a current health insurance policy. Enrollment in a Medicare-approved drug discount card program is not free. As a matter of fact, costs may be \$30 per year. It is of vital importance that interested individuals do their homework and compare the card programs, as each may not cover the exact same drugs, may not be accepted at a locally convenient pharmacy, and may not permit for easy mail-order refills.

Another way for Medicare recipients to receive prescription drug coverage is through the purchase of a, optional Medigap insurance policy, available from local insurance companies. Those individuals, who already own a Medigap policy that includes prescription coverage, may choose to not sign up for the new Medicare insurance coverage. However, new enrollees in Medigap policies who sign up after January 1, 2006 will no longer be able to purchase a policy that contains a prescription drug benefit.

The year 2006 will mark the beginning of a new Medicare insurance coverage for prescription drugs as well as the phase-out of the Medicare-approved drug discount card programs. The plan will not offer free prescriptions, but it will cover most often about half of the cost of prescriptions. Additionally, this insurance coverage requires a fee-based subscription and enrollment must be completed by May 15, 2006. While it is still costly, this plan does guarantee that an individual will not pay more than \$3600 per year for prescriptions. Keeping in mind the growing numbers of Medicare recipients who are also borderline indigent, special plans are available for individuals who are unable to meet the deductibles, co-payments, or enrollments fees by substantially increasing the payment percentages and lowering the co-payment amounts.

Generally speaking, Medicare recipients who join the prescription drug plan will pay a monthly fee of about \$37. Also, they will pay the first \$250 in a calendar year for qualifying prescriptions. This sum is considered a deductible, and once it is met, participants will be liable for 25% of the costs of drugs per calendar year up to and including \$2,250. If a plan participant requires further prescriptions, any costs above \$2,250 will be the sole responsibility of the patient, unless the out-of-pocket costs reach \$3,600. At that point the plan will pay 95% of the drug costs.



You Can Have A Smile
Too Bright To Hide!

Choosing a Health Insurance Company Online

Purchasing health insurance used to be a tedious process. Usually, one had to make appointments with agents, visit their offices, fill out reams of paperwork, and then submit to a physical exam. Fortunately, times have changed, and consumers are now able to preview and choose a health insurance company from the comfort of home, at any time of day or night they may find convenient. All this can be accomplished by the use of the Internet; however, the convenience comes at a price, and buying health insurance online is only an enjoyable experience if done correctly. To this end, here are a few tips to keep in mind:

1. Don't Call Me, I'll Call You

Many of us receive SPAM e-mails on a regular basis. Aside from the prescriptions and get-rich-quick schemes these e-mails offer in staggering numbers, some of them have now ventured into the health insurance coverage domain. If you have received a SPAM e-mail that advertises insurance, health plans, or even prescription drug coverage, stay away! If any company will stoop so low as to send unsolicited e-mails to prospective customers, they will probably not be too picky about their other business ethics either.

2. Protect Your Privacy

When taking advantage of the many insurance companies and agents that offer to give a free online quote, a prospective client will almost always be asked to give out personal information and also an e-mail address. Unless you are certain that you want to do business with a particular company, take a very close look at the privacy policy that should be posted. These privacy policies will spell out what the company promises to do and refrain from doing with the data you provide to them. It is safer to do business with a company who will not share or sell your information to anyone else than to have your sensitive data go to a variety of companies and individuals.

3. By All Means, Call!

While the Internet will most likely supply you with any and all of the information you may need, it is wise to check out an insurance company's telephone support prior to actually needing it. Having to read through long pages of fine print in order to glean a number is a bad sign. Additionally, if the company does not offer a toll free number, but expects you to pay for a long distance call out of your own pocket, you may wish to consider if you are willing to spend your money while holding for an agent or supervisor, etc. Last but not least, call the telephone number and get a feel for average hold times, times of operation, and also services offered via telephone.

4. Hire An Agent

Unless you have already decided which insurance company you wish to do business with, it is wise to contact a licensed health insurance agent who will be able to access, compare, and discuss health insurance plans from any given number of insurance companies. In addition to comparing prices and products, an agent will be able to give you personalized service, such as feedback received from other consumers about a company, their support, services, and also rates. Naturally, an agent will also be able to give you some suggestions about needed coverage and ideas about foreseeable changes to your situation that will necessitate a health plan update of possibly and overhaul.

5. Compare Apples To Apples

With so many different health plans to choose from, it is easy to get side-tracked. In addition to the foregoing, some insurance companies will showcase a full range of their products online, while others may only highlight their most popular plan choices. When relying on a website for complete information, it is wise to choose one that will allow you to have access to a broad range of plan information.

In closing, buying health insurance online is a welcome convenience for any consumer who does not wish to be inconvenienced by banker's hours, weekend restrictions, or the faxing of lengthy documents to and from an office fax. Yet, since health insurance is such a critical component to anyone's quality of life, let the buyer beware!

10 Things to Consider When Choosing an Insurance Company

We don't think of it too often; as a matter of fact, unless we are faced with a health crisis or need, we don't think about health insurance at all! It is no wonder that many of us are caught unawares when an emergency happens, and some of us suddenly realize that the insurance coverage we had ten years ago is woefully out of date for our current needs. While purchasing insurance can be a daunting task in itself, please remember that any plan is only as good as the company that underwrites and stands behind it. To this end, here are ten things to consider before choosing your next insurance company:

1. Full Disclosure

When purchasing an individual health insurance policy, the underwriter will look at your medical history. Prior to comparing rates, be sure to write down all pertinent information, so you will be able to compare apples to apples. Additionally, it will give you a feel for what kind of information raises red flags for insurance companies. If you suddenly deal with a company that does not bat an eyelash at your skydiving accident that happened just last month, you will need to ask a few more questions to make sure the rates don't suddenly change after you sign on.

2. Pre-Existing Conditions

Most companies will not insure pre-existing conditions; others will do so after a sometimes lengthy waiting period.

Still others are legally mandated to carry "guaranteed issue" policies. Prior to signing on with a company, get a detailed list of what is considered a pre-existing condition, the exclusionary period, and also what kind of coverage will be provided once the exclusion ends.

3. Interview An Agent

A licensed, independent insurance agent is a goldmine of information and industry gossip. Furthermore, the agent will be able to share feedback received from other clients about a given health insurance company, insurance products, and even customer service.

4. What Does The Future Hold?

When picking an insurance company it is imperative that its products and coverages can grow with you and your changing needs. Thus, a company that specializes in catastrophic coverage only will be of little use once you have children in the house.

5. Have It Your Way!

Since you will have to live with the health plan of your choosing, it is imperative that it will work for and with you. Therefore, you should think through your wants and needs when it comes to coverage. For example, how important is it to you to pick your own doctors? If it does not really matter to do, then an HMO may be a cost-saving choice. On the other hand, if you have a favorite doctor and wish to continue consulting this physician rather than picking someone else, you may wish to consider the pricier PPO.

6. Add-Ons

Some companies will bundle their products with other coverages, such as short- and long-term disability, prescription drug coverage, dental and vision coverage. If these are important to you, you should make sure the insurance company you wish to do business with will offer them.

7. Out Of Pocket Expenses?

Take the time to look at the fine print. For example, how much are the co-pays? Is there an annual cap on the co-pays? Do these caps pertain to a calendar year or any 365-day period? In addition to co-pays, what is the percentage of coverage?

8. Accessibility

An insurance company should be easy to get a hold of, should have extended office hours, and naturally also a toll-free number. Give the company a call and get a feel for average hold times, times of operation, and also services offered via telephone.

9. Rating

Check out the insurance company's rating with the Better Business Bureau. A company that has too many unanswered complaints does not need your business!

10. Rate Increases

Talk to friends and neighbors who are insured with the company you are choosing, or if you are working with an agent, seek to find out how often the insurance companies has raised its rates in the last two years. This will be a fair measure of the possible rate changes that will await you once you sign on!

Job Based Coverage vs. Individual Coverage

Many of us are fortunate enough to be employed by mid-sized or large companies that offer comprehensive benefits packages. These packages almost always contain job based health insurance coverage in addition to life insurance, long- and short-term disability, and flexible spending accounts. Unfortunately, rising health insurance premiums are causing more and more companies to cut this important benefit, or they may require employees to dig deep into their pockets to share the mounting costs. Nonetheless, it has long been held that individual coverage is not the best route to go when job based coverage is available, but is this true?

Job based coverage may be just what the doctor ordered, unless it is too costly. Employee spending for health insurance coverage, deductibles, and co-pays has risen sharply, and there are times when individual coverage will actually cut the cost of insurance for an employee. For example, a single insurance customer in good health and without dependants to cover will be able to purchase less comprehensive coverage than a married consumer with children in the house. Granted, many a job based plan offers a scaled back version of their plan, but realistically, these options still may cost more money since the financial insurance risk is spread out amongst the plan participants. An individual plan will only take the applicant's health care history and needs into consideration, and it may thus be a lot more cost-effective.

Individual coverage may be a wonderful idea, but it depends largely on where the individual lives! It is important to remember that individual health insurance coverage is regulated at the state level, and thus may vary widely from state to state. If a consumer lives in a favorably regulating state, then such a policy may be rather advantageous and offer a host of benefits.

If, however, an employee lives in an unfavorably regulated state, it might be wiser to stay with job based coverage which is, after all, regulated by the federal government, and thus endowed with numerous protections for the worker. In addition to the foregoing, if a worker anticipates a move to another state, this becomes an important consideration when opting for benefit portability or perhaps starting over with a new health insurance company.

Job based coverage is quite often somewhat limited in which selections the company will offer its employees. Usually, the plans that offer the most freedoms are also the most expensive and thus the most likely to get cut by the company when the renewal date arrives. If an individual is happy with a more limited coverage option, then job based coverage will be adequate. Yet, if someone desires extensive coverage with the freedom to choose providers, and services offered, a PPO might be a good choice. If this is not available through the employer, then an individual plan will be most likely the best route to choose. The important point to remember, however, is that PPO coverage is expensive, and thus a worker who has access to such a benefit from an employer will almost always be financially better off by signing on with the job based plan, rather than seeking to purchase such a policy on an individual basis.

Workers with pre-existing health conditions will quite often enjoy the ability to sign up with an employer based plan rather than having to go through the waiting periods that individual plans will dictate -- if the worker can qualify as a new enrollee. Additionally, insurance premiums of job based plans will not skyrocket because of any pre-existing condition, while an individual plan will take into account these conditions when selling a policy. For this reason, if you or any dependants you wish to cover under your policy have pre-existing conditions, and you have the choice to sign on with job based coverage, it may very well be a fiscally sound move. I

t is obvious that there is no “one size fits all” template when it comes to individual insurance needs, and consumers will do well to not only shop around different plans in addition to their job based benefits, but also do some soul-searching prior to signing on for any coverage, so as to truly ascertain what the needs are and who may best fill them.

Got Diabetes? Got Insurance? Need Insurance? Read this.

Diabetes, also known as hyperglycemia, can be the precursor of devastating health problems. The inability to produce sufficient insulin leaves the body vulnerable to a dangerous glucose buildup that will eventually lead to heart disease, stroke, high blood pressure, kidney disease, blindness, amputations, and a host of other complications. In the past, patients who suffered from diabetes and sought to purchase health insurance coverage were very often denied a policy and labeled as “uninsurable.” While Medicaid and Medicare are the legislated safety nets for American society, many an uninsured diabetic found that he or she did not qualify for benefits under these plans, and hence was in the awkward position of desperately needing healthcare coverage yet being unable to receive it.

Fortunately, things have changed somewhat, but diabetics still need to be savvy consumers! For example, if a consumer has not had insurance coverage for more than 63 days prior to seeking new coverage, then some insurance companies, although will now insure patients who suffer from diabetes, will require a waiting period. This waiting period may be as long as six months; and since diabetes is a chronic illness that requires constant care, this will be a very costly six months for a patient. Additionally, other insurance companies simply exclude pre-existing conditions altogether, and will only cover non-diabetes related illnesses. For a diabetic this is a most dreaded circumstance. It is not surprising that those who have the

misfortune to fall through the cracks of the healthcare system very often incur staggering medical debts, and sometimes even find themselves forced into bankruptcy because of the mounting medical bills. In order to avoid this spiral of misery, here are some suggestions every diabetic needs to know about:

1. If you have health coverage, don't let go of it!

Life's circumstances change in a blink, and job security is a thought of the past. If you find yourself unemployed, do not let go of your insurance coverage! Most employers are now required to offer COBRA coverage to terminating employees, and even though the cost for this insurance appears to be forbiddingly high, it will allow you to navigate around the 63 day exclusion that some insurance companies will require.

2. Learn about High Risk Pools

The majority of states have created insurance pools that target patients who have lost insurance coverage yet who are in desperate need of medical care. These pools are unique plans created by individual state legislatures in order to make available a sturdy safety net for those folks to whom the dreaded term "medically uninsurable" has been applied. Coverage is frequently comparable to the coveted 80/20 major medical and outpatient coverage, and while prospective members may still be denied plan benefits because of perceived issues of being uninsurable, this limitation is often restricted to a 12-month period.

Thereafter, acceptance is all but guaranteed. It is important to remember that this coverage is not free. As a matter of fact, premium costs are usually quite a bit higher than comparable plans offered on the open market by competing insurance companies, yet because of state law regulation, there is a firm cap on the amount of money a patient may be charged for insurance. In general, this cap runs between 125 to 150 percent of the base individual market rate. While the cap is firm, there is still some elasticity in the rates, and they sometimes may vary based on plan participants' ages,

or even domicile addresses. Sadly, it is often these high rates that prevent eligible individuals from seeking out this kind of insurance. Additionally, many a person in need of such a plan is not aware of its existence!

3. Get educated

If you are unsure what kind of diabetes coverage your state mandates, make a phone call to your local state insurance commissioner to find out exactly what the individual coverage requirements are in your state, and also where to start looking for insurance companies.

4. Purchase Medigap Insurance

Medicare recipients know that many expenses are not covered by the program. However, if a patient applies for a Medigap policy within six months of first becoming eligible to Medicare, the program will not be able to deny the additional coverage because of chronic diabetes.

Rising Health Care Costs: What you need to know

Americans pay more than one and a half trillion dollars for medical care each year and costs related to all manner of health care, such as prescription drugs, continue to skyrocket. While some of the reasons behind this booming bill are understandable, Americans caught in a cash crunch might be surprised to find out some of the lesser-known causes of high health care costs.

The words 'health care' might invoke images of doctors, nurses and hospitals, but the reality is that the medical field is a business and a ruthless one at that. Individual practitioners, researchers and participants may have wonderful intentions and a true desire to help people, but the structure of the American health care system ensures profit is the number one issue of importance.

Here are some facts that may help explain the high costs of American health care:

- Pharmaceutical research and development companies spend roughly \$20 billion each year on R&D, and about the same amount on advertising and self-promotional marketing activities.
- Additionally, drug companies have as many sales people as there are doctors in the United States. One of the responsibilities of this sales force is to convince doctors to attend pharmaceutical company-sponsored seminars where drugs are showcased.
- According to some economists, the purchase of new technology is responsible for more than 50 percent of new health care spending over the last three years.
- Much of the money Americans pay for health care finds its way into the rising profits on health care-related products and services such as the provision of medical

insurance. Even higher costs have been forecasted for the future, especially for prescription drugs.

For many Americans who are unable to afford the health care they need, rising costs represent an ever-increasing barrier to medical services and products. The financial burden is also felt on the larger national scale with about 15 percent of gross domestic product going toward health care costs. That is equal to about one quarter of the annual federal budget.

Comparatively, Canada invests around 10 percent of its GDP on its public health care program. Unlike the United States, Canada's health care program is universally available to all citizens and permanent residents without cost. Other countries, such as Germany, where there is a public/private delivery system model for health care, manage to serve their populations for even less while still having better longevity than Americans. This proves that the quality of health care does not rise proportionally with the amount of money spent to attain it.

While many Canadians supplement their universal health care with added insurance to cover the cost of medication and perks such as semi-private or private hospital rooms, health care insurance is much more essential in the United States. Unfortunately, costs have been rising dramatically, making health care insurance out of reach for many Americans. Currently, more than forty million Americans do not receive any kind of health care benefit.

For employers, providing health care insurance for employees is also becoming more expensive, with increases dramatically outpacing inflation rates. Some years, the difference is four or six fold. Even if premiums were to remain static, offering health care insurance to employees still costs several thousand dollars per worker. For smaller companies, or for those who employ a large number of people, these costs can be prohibitive.

Measures to reduce health care costs are always under consideration, though many are not popular choices. Suggestions that have been put forward by various sources have included:

- Increased drug awareness and education. Millions could be saved if health care insurance covered only generic versions of drugs that have been proven just as effective as their more expensive brand name counterparts.
- Terminate expensive treatment options will only add a short amount of time to a patient's life, particularly if it will not be quality time (i.e. patient is in a coma).
- Promote preventative care such as smart lifestyle choices, proper nutrition and exercise.
- Examine to ways to control drug advertising to consumers. There is speculation that advertising has led to prescriptions of non-necessary drugs.
- Limit malpractice liability so doctors and medical professionals do not feel pressured to cover themselves by ordering unnecessary tests to substantiate conditions they already know to be present.
- HMO management reform

Health Insurance: is it worth the gamble

Unlike in Canada and parts of Europe where the bulk of health care costs are put on a government tab, most able-bodied, mentally sound Americans under the age of 65 must generally rely on themselves to manage personal health care funding. For most Americans, that means incorporating some kind of health insurance into their overall personal financial strategy.

Over time, however, the costs of health care insurance add up, and the total spent can be staggering. So should you have health insurance? Is it worth the gamble? There is no single answer to these questions, of course, but there are several items you should consider before making a decision one way or the other about your health care insurance future.

First of all, about 44 million Americans do not have any health insurance coverage. Many of these people are members of poor families who do not qualify for Medicaid, employment-based health insurance and who cannot afford, or who have been refused for, individual coverage. If you are looking to purchase individual health care insurance coverage, be aware that the costs tend to be higher than employer-sponsored plans and the plans less user-friendly.

With so many types and ranges of personal or individual private health care insurance available, it can be confusing as to what kind of health insurance you should buy, and how much coverage you should have. You may not think you need several hundred thousand dollars worth of coverage, but consider how much one hospital visit costs if you need a serious (yet common) procedure like a heart bypass or even minor surgery to remove a gall bladder or appendix. Even slight complications can result in an enormous bill.

If you receive a health benefits package as part of your employment, you will be accepted under the company's plan regardless of your health status. However, when you apply for individual coverage, there are no such guarantees and you may not be able to secure the coverage you need, even with reduced benefits. The same is true when it comes to renewing your health care insurance. If you are employed and are covered under your company plan, you can renew your coverage as necessary, even if you are sick. With most individual plans, there is no guarantee your policy will not be cancelled.

Similarly, there are differences between job-based and individual-based insurance when it comes to limitations and portability. If you have had a pre-existing condition when you apply for job-based medical coverage, there is a limit of about a year to a year and a half on what can be counted 'against' you. With individual coverage, limitations are prescribed by the state, and vary greatly state-to-state, but generally, you may not be eligible for coverage of costs related to a pre-existing medical condition for the entire duration of your policy.

When it comes to portability, again, depending on the state in which you reside, it is possible that you may receive no credit for past coverage. That means even if you are lucky enough to qualify for health insurance coverage, you could end up waiting for the entire pre-existing condition exclusion period.

Whether you choose job-based, employer-sponsored health insurance or a private, individual plan, health care insurance is going to cost you a lot of money, especially if you have a family or if you have any ongoing medical issues. The exact amount depends on your particular situation needs. You may never need medical attention, and in that case, you might consider the money spent on health care insurance wasted.

However, most of us need medical attention at some time or another. Even healthy, positive lifestyle-oriented people have unexpected health events, car accidents and broken bones. You can't anticipate when these events will happen, or how severe they will be, but without significant financial means or a decent health care insurance plan, you could end up financially devastated. Are you willing to make that gamble? To assume the risk of not being able to pay for medical services or products that you or a member of your family needs? Money spent on premiums is certainly a consideration when deciding whether to purchase health care insurance, but there are other priceless things to consider before you make a final decision.

State Funded Health Insurance for Your Child

Health care is one of those services that everyone needs, especially children. Yet, like in many other countries, the United States does not provide either federal or state blanket medical coverage for children.

For a lot of parents, the answer is individual or job-based health care insurance coverage. Unfortunately, many of these plans aren't as comprehensive as people might think, and your child may not be covered. If that is the case, you will have to increase your coverage or look to state-funded health insurance, which can provide medical insurance security for children of working families – those who may earn too much income to qualify for Medicaid assistance but not enough to realistically handle medical care or even ongoing private insurance.

Medicaid is a federally-funded program aimed at assisting low-income families get the medical attention they need. Medicaid-insured families may also receive access to discounted prescription drugs.

Each state has its own version of Medicaid delivery. There are many Internet resources available to guide you through the intricacies of Medicaid in your state, or you can call your local Medicaid office or your state representative's office for more information.

Ask how much income you can earn before being disqualified from Medicaid coverage, and what the guidelines are for determining income for Medicaid assessment and qualification purposes.

Figures from Centers for Medicare & Medicaid Services indicate that while a higher percentage of children are now enrolled in Medicaid insurance programs (nearly 20 percent, up from under 16 percent in the late 1980s), the percentage of children who have no health insurance coverage at all has

also jumped from 13.1 percent to 15.4 percent. The Centers for Medicare & Medicaid Services website suggests fewer children being eligible for coverage under company-sponsored plans is behind a large part of the increase.

The State Children's Health Insurance Program, or SCHIP, was created in 1997 so that each state could provide medical health insurance to children under the age of 19 who are not otherwise covered under a health care insurance plan. State Children's Health Insurance Program guidelines and eligibility vary widely from state to state, so you will have to find out the specifications for where you live, but generally children under the age of 19, who are part of a family with an annual income of up to \$36,200 per year are eligible for services such as physician visits, hospitalization, immunizations, prescriptions, and emergency room treatment. For children who qualify, there is no cost or only a nominal fee for these services. Again, depending on in which state you live, coverage may also extend to eye care, dental care and medical equipment.

Literally millions of children are covered by SCHIP every year, but there are millions of others who do not have health care insurance. Uninsured children are unlikely to receive adequate medical attention, which can be cost prohibitive, leaving them at risk for serious illness and health conditions.

Children of immigrant or alien families are among those kids who are often lacking medical insurance thanks to fears that an individual's or a family's immigration status will be adversely affected if their children are enrolled in Medicaid or State Children's Health Insurance. The only case in which immigration officials consider a child's participation in a government-funded health care program is if the child requires long-term care, such as in a mental health facility or nursing home. There may be certain limitations on some services, such as long-term care, but for the most part,

using government insurance to protect the health of their children is risk-free for immigrants hoping to obtain a green card.

Regardless of your financial or other status, it is vital that children receive proper medical attention from the time they are born until they are old enough to look after their own needs. This includes responsive medical care such as treatment of illness, disease and trauma, as well as regular preventative care such as vaccinations, checkups and nutritional monitoring. It has become a cliché, but children really are the future, and with proper medical care and attention now, that future can be one with a lot of healthy people who create far less strain on American's already burdened healthcare system. Think of health insurance for children as an investment in the future.

CHIP: What is it and how can it help you?

American parents work hard to ensure the health and well being of their children. Sometimes, however, the bills get to be too much, and they need help. Financing the soaring costs of children's health care could bankrupt most parents, but the costs are particularly prohibitive for parents of families who do not or cannot benefit from employer-sponsored or individual health care insurance.

Recognizing the short and long term benefits and value of consistent health care for children, the government provides a number of insurance options to help parents access the medical care they need for their families. This investment in the health of America's children comes in two major formats: Medicaid assistance for low-income families and the Children's Health Insurance Program, or CHIP. CHIP is also sometimes referred to as the State Children's Health Insurance Program (SCHIP).

CHIP was introduced in 1997 as a means of increasing the number of children able to access consistent, quality health care. Medicaid was designed to provide assistance to the elderly, disabled and very poor, but a huge segment of the American population is made up of working families who earn too much money to qualify for Medicaid assistance, but who are realistically unable to afford private health insurance coverage or to pay out-of-pocket for medical expenses. The result? Millions of children were not getting the medical care they so desperately needed, but that they could not afford to receive.

Since its inception in the late 1990s (the program celebrated its eighth anniversary Oct. 1, 2005), the Child Health Insurance Program has allowed children to benefit from regular checkups, immunizations, eye care, dental care and discounted prescriptions at little or no cost to their families. It is difficult to measure the impact this insurance has had

on the children who were able to receive care because of it, but aside from the financial and social benefits, it has been proven that children who receive regular preventative medical care such as check ups and vaccinations are sick less often and miss less time away from school.

Administered by the Centers for Medicare & Medicaid Service and by each state, the Child Health Insurance Program committed \$40 billion in federal matching funds over a ten year period. Although much of the funding for CHIP comes from federal coffers, each state has its own guidelines and eligibility requirements for participation in the program. While there are variations depending on where you live, the income cut-off for a family of four is about \$35,000 per year. Additionally, children must also be under the age of 19, and not be insured under any other program.

Of the more than 40 million Americans who still do not have any health insurance protection, many are immigrants who fear enrolling their children in a government sponsored program will have a negative impact on their green card application status. With the exception of situations where children require long-term care such as in a nursing home, participation in CHIP is available without penalty to children of immigrant adults seeking their green card. Children who need long-term care may receive it, but this may be considered as part of their families' green card applications. Generally, all so-called 'qualified aliens' who fall under one or more of nine categories (defined by the U.S. Citizenship and Immigration Services - USCIS) are able to apply for CHIP: lawfully admitted permanent residents; refugees; aliens seeking asylum; aliens granted a minimum one year parole; aliens whose deportation has been withheld; aliens granted conditional entry; battered aliens; and, victims of a severe form of trafficking.

Another group of children who are often overlooked when it comes to health care insurance coverage are the homeless.

Uninsured children who do not have a home may be eligible for either Medicaid or CHIP even without a mailing address. In some states, the application process is simplified with a single application process, which may make obtaining either CHIP or Medicaid health care insurance more attractive for parents who are confused about which program for which they and their children are eligible.

Although millions of children remain uninsured for health care, CHIP is an effective way to help families just out of reach of Medicaid gain the protection they need until they are able to acquire independent or employment-based coverage.

Health Insurance for Those with Special Needs

More than 40 million Americans do not have any kind of health insurance protection, and as a result, are at risk of either not receiving the level of care they should have, or alternately receiving the care and the massive bill that accompanies it.

Having adequate health care insurance, whether public or private, in place plays an essential role in making sure medical care is accessible to all Americans. This is especially true for adults and children with special needs, because of the increased requirement for specialized and expensive services that typically accompany special needs conditions. More frequent medical treatment, therapy and adaptive equipment can quickly devour the budget of even an affluent family with a member with special needs, making health insurance a necessity.

However, when it comes to special needs insurance coverage, it is wise to ensure your policy addresses the extended parameters of special needs care including more frequent doctor visits, greater need for surgery and physical and emotional therapy, expensive prescription medicines, custom equipment, home care, assisted living or nursing home facilities. Securing an all-encompassing policy can be a daunting task, particularly if you are opting to purchase a private plan. Recognizing that individuals with special needs may require extra expenses, many private insurance companies put extreme limitations on 'addition' or above-standard services. When it comes to trying to secure health insurance as an individual with special needs, there is no guarantee you will even be approved: nearly all private health care insurance providers enact stringent rules on what is covered and what isn't allowed. You will likely find that your special needs fall under the category of pre-existing conditions, and you will not be eligible for coverage of health expenses related to those pre-existing conditions.

If your application is accepted and your special requirements are covered by the insurance plan, you can count on very high premiums. Do research when looking at private health care insurance options and don't be afraid to ask questions about your specific needs. It is better to have reliable information ahead of time rather than to discover your insurance company will not support you later when you need it.

Employer-sponsored insurance (ESI) is by far the most popular choice of health care insurance for adults, whether fully able or with special needs. If you receive a health benefits package as part of your employment, you will be accepted under the company's plan regardless of your health status. However, when you apply for individual coverage, there are no such guarantees and, as described above, you may not be able to secure the coverage you need, even with high premiums or reduced benefits. The same is true when it comes to renewing your health care insurance: if you are covered under your company's EIS medical plan, you can renew your coverage as necessary, even if you are sick. With most individual plans, there is no guarantee your policy will not be cancelled.

There are also differences for people with special needs to consider between job-based and individual-based insurance when it comes to limitations and portability. If you have had a pre-existing condition when you apply for job-based medical coverage, there is a limit of about a year to a year and a half on what can be counted 'against' you. With individual coverage, limitations are prescribed by the state, and vary greatly state-to-state, but generally, you may not be eligible for coverage of costs related to a pre-existing medical condition for the entire duration of your policy.

When it comes to portability, again, depending on the state in which you reside, it is possible that you may receive no credit for past coverage. That means even if you are lucky

enough to qualify for health insurance coverage, you could end up waiting for the entire pre-existing condition exclusion period.

If you have special needs, your best bet may be to see if you qualify for Medicaid or Medicare. More than half of the states operate 'high-risk pools' health care insurance plans for people with special needs who, because of their conditions, are unable to secure medical insurance through regular channels. Information about these high-risk pools, and to see if you qualify for coverage under your state's program can be found under the National Association of Health Underwriters' website.

Health Insurance and The Terminally Ill

By its very nature, terminal illness is devastating for both the sick people and their families and friends. Unfortunately, the pressure of worrying about medical costs and trying to secure health insurance that addresses the needs of a terminally ill individual adds to the burden loved ones must endure during an already difficult time.

Depending on how a terminally ill person decides to spend his or her last days, the costs can be enormous. At the lower end of the spectrum, a terminally sick individual may want to refuse treatment, and die at home. While this is an option, a more popular choice is to seek aggressive treatment programs that will allow a terminally ill patient to extend the length of his or her life as comfortably as possible. Without adequate medical health insurance, this second option may not be financially available to everyone faced with making such a difficult decision.

Some relief is available through public health insurance plans such as Medicare and Medicaid, even in cases where hospice care is required. Hospice benefits can be provided by Medicare if the client is eligible for hospital insurance under Medicare Part A; the client's doctor and the hospice director sign a declaration that the terminally ill person is expected to live less than six months; the hospice where you will receive care is a Medicare-approved facility; and the beneficiary signs away his or her regular Medicare coverage as it relates to his or her terminal condition in favor of hospice care. Conditions not related to the terminal illness are not affected by signing the statement.

Even with Medicare-provided hospice palliative care, terminally ill patients will still usually be responsible for their room and board costs but many other fees are paid under the Medicare plan. For example, a hospice Medicare beneficiary would not have to pay for: physicians' visits and

care; nursing care; equipment such as wheelchairs, walkers, or monitoring devices; standard hospital supplies such as catheters and bandages; pain killers and symptom-controlling medications; short-term respite or hospital care; homemaker/aide services; physical, occupational or speech therapy. Emotional or spiritual counseling may also be available to patients and their families.

If traditional health care insurance is not enough to cover the health-related expenses, looking to life insurance policies may provide additional financing options. Accelerated benefits (also called living benefits) and viatical settlements could be the answer to the financial woes of a terminally ill individual.

Accelerated or living benefits are life insurance monies paid to life insurance policyholders before they die. A few policies include accelerated benefit options, but if yours doesn't, you can ask your insurance provider about adding the appropriate provisions to new or current policies. The amount of money available as early payment with accelerated benefits ranges according to what kind of policy you have. However, the amounts are typically between one quarter of the total policy. There are also limited circumstances under which living benefits will be awarded, and these also vary by policy. Speak to your provider to see what options are available to you.

Viatical settlements are funds you receive from selling your life insurance policy to a viatical settlement company. Life insurance policy holders who sell their benefits to a viatical settlement company will receive a lump sum payment equal to a percentage of the benefit that would be awarded if the policy holder had died.

Turning to accelerated benefits or viatical settlements does provide a good source of quick money to cover sudden or unanticipated costs, but don't jump into either prospect

without considering the long-term effects of what you are choosing to do. If your life insurance policy is a central part of your estate plans or is something to pass on to family members, using accelerated benefits or viatical settlements will have a big impact on your future financial situation.

Whatever you decide to do, it is important to make sure you are fully informed about your options and the possible consequences. Ask a lot of questions and don't be satisfied until you get appropriate answers. Remember that policies offer many options so be certain to choose the best policy for your family. Most importantly, don't sign anything until all of your questions and concerns have been addressed.

Health Insurance Scams: How to protect yourself

Crime invades every spectrum of life in the United States and around the world and sadly, even people trying to protect them and their loved ones from health-related financial burden are at risk. Federal statistics show a steep rise in the number of fraudulent or unlicensed health insurance companies in recent years. The result? Hundreds of thousands of Americans spent their money on what could be worthless health care coverage that should have been worth more than a quarter billion dollars. Most of the bogus insurance is provided through employer-sponsored programs where scurrilous shysters have access to hundreds of potential victims, or to self-employed workers and small businesses that may not be able to afford or participate in a decent group plan.

It has been suggested that the high cost of health care benefits in the United States has contributed to the rising number of health insurance scams. With more than 40 million Americans living without any kind of health care insurance, fraudsters have a huge market of people who want to think they are getting a deal on a service that offers medical protection for their families. In fact, a Georgetown University study found the dramatic increase in medical care insurance scams has risen at the same time health care insurance premiums have recorded double-digit rate hikes.

Often, the scam does not reveal itself until after one of these unfortunate beneficiaries tries to use their health insurance to cover an approved medical situation. By then, depending on the family's ability to pay for medical services without insurance, a financial crisis may already be in the works. State governments tend not to offer guarantees or financial protection when health care insurance plans are revealed as a swindle or if the insurance provider is unwilling or unable to pay for legitimate claims.

Despite the awfulness of perpetuating such a horrible crime, fraudulent health insurance companies often get away with their stolen money intact. Authorities are unable to simply swoop in and arrest the bad guys; investigations take time and organization if they are to succeed in getting enough evidence to bring about a guilty verdict in court.

Unfortunately, by the time such an investigation can be mounted and authorities can make a move, fraudulent health insurers have had a chance to hide their assets or have moved on to another location under another name.

There are several things that may make you suspicious about the legitimacy of a health insurance provider. First among these is price. Fraudulent medical insurance companies tend to offer cut-rate prices as a way of luring victims to hand over their money. The truth is that health insurance can be a pricey prospect. If you think you're getting too good of a deal, you're probably not getting a deal at all. As the old adage goes, if something seems too good to be true it probably is.

A second indicator that the health insurance provider you are dealing with might be a scam operation is the presence of less than usual or even the absence of the regulations that govern other insurance providers. Fraudulent health insurance plan providers also try to attract potential clients by boasting about regulatory freedom at the state level. Don't be fooled: legitimate health insurance providers are not immune from state regulation. Quite the opposite is true. Many types of insurance, including health care insurance, are regulated primarily by each state.

Additionally, while health care insurance fraud is a nationwide problem, a survey of some of the identified medical insurance scams has revealed Texas and Florida as particular hotbeds of fraudulent insurance activity. Beware of any health care insurance providers that have recently

started business. Check with your better business bureau to make sure there have been no complaints.

There are some things you can do to protect yourself against fraudulent health insurance plan scams. The first thing you can do is be aware that bogus plans are out there. The second step you take to protect yourself while still getting a reasonable health care insurance plan is to educate yourself about your available options: shop around, ask questions, request proof of licensing (operating an unlicensed insurance operation is illegal in every state), get recommendations and contact a state insurance commissioner to verify the legitimacy of a health care insurance operation before you sign anything.

Gastric Bypass: When is it covered?

Overweight and obesity is a major health crisis in North America. More and more adults and children are struggling with the weight and the array of health problems that is associated with carrying around dangerous and unwanted pounds. The weight loss/diet industry is a multi-billion dollar business, with desperate people willing to try anything from books to commercial diet plans and pills in order to lose weight for health and beauty reasons. One of the more drastic and expensive weight loss treatments is gastric bypass surgery. This controversial surgery can be life-saving, life-changing or life-taking, but it always costs a lot and not everyone can afford the multi-thousand dollar price tag which begs to question: will my insurance company pay for gastric bypass surgery?

Gastric bypass surgery is an extremely invasive procedure that involves shrinking the stomach so that only a small pouch remains. Effectively, patients that have undergone successful gastric bypass surgery are unable to eat more than a few tablespoons of food at a time. The technique has been proven effective for quickly reducing the mass of morbidly obese people for whom regular activity and nutritional monitoring has not worked. The surgery is not a quick fix for minor weight loss, however. It is a serious procedure applied in only serious cases. To qualify for the surgery, whether covered by health care insurance or not, you must have a body mass index (BMI) greater than 40. For an average man, that means about 100 pounds overweight and 80 pounds over weight for an average woman. Individuals with a slightly lower BMI may also be considered for gastric bypass surgery if they also have a serious condition, such as diabetes or heart disease that can be worsened by obesity. Surgery candidates must also realize the severity of changes gastric bypass surgery will mean in terms of lifestyle changes and responsibility.

In cases where gastric bypass surgery is deemed medically necessary, most health care insurance companies will pay for the procedure, even if the initial application is refused. If you have to fight to have the surgery covered, arm yourself with information and support from your physician, along with any information you can gather about the potential savings in future medical costs as a result of the weight you would lose if the surgery is carried out. There are abundant studies from reputable organizations that trumpet the benefits of weight loss to the prevention and reduction of several associated problems such heart attack, stroke, Type 2 diabetes (so-called adult-onset diabetes), and sleep apnea to name a few.

Even though most insurance companies will agree to fund gastric bypass surgery that has been deemed necessary, there are some plans that do not pay for it or will do so under certain circumstances only. These circumstances, like proven attempts to lose weight in other ways, may need to be authenticated by your physician. Review your policy to find out exactly what coverage you qualify for, or speak to your insurance provider for a more precise explanation. Get the information in writing, if possible.

Even if you are the perfect candidate for surgery, do not expect a quick process. Between the time you contact your insurance provider about possible gastric surgery and the time you actually get the surgery, many months may have passed.

While it can act as a catalyst for fantastic weight loss, gastric bypass is a serious surgery, and as a result, you may be at risk of post-operative complications ranging from mild infection or discomfort to digestive issues. One study has produced the alarming statistic that up to 98 percent of gastric bypass recipients experience at least one post-operative complication or side effect. It is important that you know, in advance, how your health insurance provider

would handle any costs associated with post-operative complications associated the bypass surgery. Will you receive blanket approval for any additional care that may be necessary or will you have to secure case-by-case approval for each new procedure or measure?

Once again, gastric bypass surgery is a potentially dangerous procedure that requires serious thought and consideration. Health insurance coverage may be one of the elements of your decision, but it shouldn't be the only thing you think about.

Choosing a Plan That is Right For You and Your Family

The abundance of available medical or health care insurance plans on the market can make choosing a policy and a provider an intimidating proposition. Consider the following factors when searching for a health care plan that is appropriate for the needs of your family.

- **Working with a physician:** many health care insurance providers have a pool of doctors and health care professionals with whom they are affiliated. You may be forced to find a new family doctor if yours is not a member of this network. If you don't mind switching doctors, take care in choosing a new physician. Ideally, see if a doctor in your area who has verifiable credentials and accessible office or clinic hours services your insurance plan. The American Medical Association can help you determine a doctor's legitimacy and in which hospitals and medical facilities he or she has working privileges.
- **Access to specialists:** some plans limit coverage of fees associated with consultations with medical specialists. Read the fine print to see if your plan will pay for access to specialists. This is especially important if you have, or anticipate having, a particular condition that requires a specialist's care. Similarly to your family doctor, you may have to switch specialists if yours is not part of the insurer's established network. Though common, OB-GYN care may be considered specialist care, so ask specifically whether this service is available under your plan. Fertility and pregnancy treatment are also areas that should be addressed directly.
- **Pre-existing conditions:** verify that any pre-existing conditions you have will be covered under a new plan before you sign. You may experience a degree of flexibility on this point if you are applying for

employer-sponsored insurance, but you will likely find greater resistance if you are applying for private individual health insurance.

- Emergency care: your insurance provider may insist that you go to only certain hospitals for emergency treatment, or that you contact your family doctor before obtaining emergency care. Have your provider define emergency so you aren't left with unpaid claims for emergency room visits for conditions that don't qualify for coverage.
- Check ups and screening: there is great variance between insurance plans when it comes to check ups and screening. Determine if, and how often, you can expect to be able to submit claims for physicals and other preventative measures.
- Medication: is it covered under your proposed health insurance plan? Prescription drugs, particularly if required on an ongoing basis, are expensive. Having prescription drug costs covered as one of your health benefits can add up to substantial savings over the years. If prescription medication is a benefit of your plan, ask whether both brand and generic varieties are covered.
- Extras: additional services such as drug and alcohol rehabilitation, counseling, home care, chiropractic, massage therapy, alternative treatments and palliative or hospital care should be outlined in your service agreement. With perhaps the exception of massage therapy, no one likes to think about having to use services such as these, but it is a good idea to have them included in your health care policy if you are able to do so.
- Fees: a health care insurance plan will help you manage the costs of health care, but nearly all plans incorporate a fee structure on top of the monthly premiums you pay. Fees may come in the form of deductibles, percentages of services that aren't fully

covered, or penalties if you do not comply with your agreement (i.e. you seek care from a doctor that is not affiliated with your insurer's network). You may also have to pay for care once you surpass a monthly, annual, or lifetime limit on specific services. Find out what these limitations are before you finalize the purchase of your health care insurance.

- Exclusions: you will reduce the potential for rejected claims if you have a clear idea of what your plan covers and what it does not. There will always be grey areas, but for the most part, you should know which claims are acceptable and which will meet resistance.

Regardless of the plan you choose, the best health care plan is still a preventative approach based on sound, moderate living.

Your Health Insurance and Your Vacation: What to Know before you go

Nothing ruins a fabulous vacation faster than an unanticipated medical emergency—except, that is, experiencing such an emergency and knowing you are unprepared to handle it. Buying travel insurance before you leave for your trip won't guard against emergencies, but it may ease some of the difficulty of dealing with whatever problem has interrupted your vacation.

Whether you are traveling for business or pleasure, you never know when something might happen. You could miss a flight and be stranded somewhere, your partner might have a heart attack, or you might be caught up in a natural disaster. Whatever the case may be, having additional options available will make the situation much more bearable.

Travel or vacation insurance is available in many formats. You can buy a basic package that protects you from logistical issues such as being bumped from a flight and not making your cruise departure, to more complex packages that incorporate logistical issues, health care, and loss or theft. You can also purchase limited policies that guard against specific risks or events either on or before your trip. For example, you may want an 'out' to cancel your walking tour of England if you broke your leg three days before your departure. Or you may want to purchase health coverage so that if you break your leg while on the walking tour, you can receive proper medical attention without having to deal with the possibility your provider won't pay for care administered in another country. This is a super way to protect against loss of deposits and pre-paid expenses.

Trip insurance can be purchased from a number of sources including your travel agent and insurance agent. In addition

to the different kinds of travel or vacation insurance that are available, you can also find a plan that is flexible in terms of length. Policies may be obtained to cover a specific period such as two weeks, on a price-per-day open-ended basis, or, particularly in the case of organized vacations, for a flat rate covering your vacation getaway.

Vacation or travel health care insurance is a valuable tool, especially if you purchase a comprehensive policy that includes coverage death or injury to yourself or your family/ travel companions; accidents or illness requiring hospitalization while at your vacation destination; emergency dental work; ambulance fees, medi-coptor, or transport back to the United States while you are abroad; and, medical evacuation to a safe location if necessary. You may have comprehensive domestic health care insurance in the United States, but many plans provided by insurance, HMO or governmental organizations are not honored if you require medical attention while abroad.

Long before you leave home, while you are still in the planning stages of your vacation or business trip, it is wise to review your existing health care insurance package to see what, if any, coverage you may have while in transit or once you have reached your destination. Pay special attention to the exclusions section of your agreement, and if you are confused or unclear about any of the language, contact your provider for a more understandable explanation. In fact, have your provider review the entire policy with you so you can take note of what coverage you have, what documentation you need to carry in order to access insurance-sponsored health care while you are away, and any particular accommodations you may need to make, such as whether family members have to be named individually on your agreement in order to be protected.

By figuring out what coverage you have, you can avoid the cost of purchasing duplicate coverage. You may think you

are doubling your protection by buying a redundant policy, but almost all plans exclude coverage of claims that can be made under an already existing policy.

So should you buy travel health insurance? Probably. Hopefully you will never need it, but you will have to make a personal decision about whether you are willing to take a chance to save a couple hundred dollars or less. Your destination and the nature of your trip should be considered when making a decision. For example, an authentic African safari or wilderness white water rafting trip has a higher probably of medical implications than a seniors' train tour, but life isn't predictable. Assess your risk, financial capability to handle possible emergencies and your comfort level, and work from there.

Bring Your Wandering Pet

BACK HOME

This Amazing GPS System will locate your lost pet **INSTANTLY** faster than tattooing or implanting a micro-chip under your pet's flesh.

The advertisement features a young girl with blonde hair smiling next to a black dog with a red collar and a glowing blue GPS tag. The background is a white box with a colorful, abstract border.

Health Insurance Plans for Your Pet

Many pet owners dread the news that Rover or Kitty are seriously ill or injured. Too often, an anxious pet-lover is forced to make a fiscal decision when veterinary care is needed, and quite a few have had to endure the heartbreak of saying good-bye to a beloved pet that could be saved -- but only at a cost prohibitive expense. To many of us, a pet is a member of the family. Treated sometimes like a child, the animal is companion, friend, confidante, and even dinner guest! It is no surprise that the insurance industries realized the advantages of this widely untapped market, and fortunately for us pet lovers, health insurance for pets is no longer a wished for ideal, but a new reality!

There are some similarities to health insurance for humans; for example, be sure to read the fine print! The most common misconception is the myth that all the distraught pet owner needs to do at the time of an emergency is to present an insurance card, and no money changes hands. Nothing could be further from the truth!

As a matter of fact, most pet insurance plans will require the pet's owner to make an upfront payment at the time of service. Later on, a claim may be sent to the insurance company, and a reimbursement is made.

Many plans cost as little as \$30 a month, but it is imperative that the pet owner understands the scope of coverage. Minimum cost implies minimum coverage. For example, one major pet health insurance plan will cover the same illnesses and emergencies at different plan levels, yet those who choose to purchase a minimum plan will receive less of a reimbursement than those who choose a more expensive plan.

In addition to the foregoing, pet insurance is not without its complications. For example, benefits are limited when it comes to an initial diagnosis. While your veterinarian may charge \$150 to examine Rover's bite wound after he had a run-in with the neighbor's Doberman, the insurance plan will only cover about \$92. If Rover needs to undergo anesthesia, the insurance is willing to pay an extra \$44, but will not pay any more. In addition to the foregoing, if the bite wound is considered a secondary diagnosis, and Rover is instead treated for a puncture wound, then the coverage for the bite wound is reduced to only \$65 in its entirety. On the other hand, if you choose to purchase the higher level plan, then a similar situation will result in the reimbursement of \$154 for the examination of the bite wound, \$74 for anesthesia, and \$108 in case of the bite wound's being a secondary diagnosis.

Some pet owners don't think that such coverage is worth the money, but they had best think again! While a pet is young, veterinary visits are few and far between, but once Rover ages, new problems crop up. Additionally, if Kitty begins to venture into the great outdoors, the risks and potential for injury increases. Also, it is noteworthy that pet health insurance does not only cover the catastrophic

injuries, but even the mundane dental cleanings, shots, heartworm medication, flea prevention, and more. In closing, concerned pet owners owe it to their furry (or feathered) friends to ensure that adequate care will be available in case of an emergency. Yet, they owe it to themselves to become well educated in the multifaceted aspects of pet insurance, and the exclusions and limitations. To this end, here are some suggestions:

1. Understand the deductible

The pet's age and even pre-existing conditions may change the deductible the plan applies. Additionally, a co-payment may be charged that can run as high as 20% of the veterinary fee.

2. Understand the exclusions

Just like human insurance, pet insurance too has exclusions. They may vary from company to company, and often deal with pre-existing conditions. Other exclusions may apply to dental care, vaccinations, etc.

3. Know the caps

The insurance plan will only pay a certain amount per covered incident. Discuss hypothetical fees with your veterinarian and find out if these caps are realistic. Additionally, are these caps applicable to a lifetime treatment, or to a per-occurrence charge?

The End

This has been a **BrowzerBooks** Book Club Edition

