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What My Papa Told Me About... HEALTH INSURANCE

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HEALTH INSURANCE

Advantages to Indemnity Health Insurance Plans

Indemnity health insurance plans are more regularly known as traditional health insurance plans. These health insurance plans can be costly but often cover most health problems that may arise, while other insurance plans exclude some illnesses or diseases from their coverage. Some disadvantages to indemnity plans are that they do not usually cover preventative health care like physicals, and traditional health insurance plans often cover only a percentage of your bill. Research the advantages and disadvantages to indemnity health insurance when you are considering health insurance options.

While the disadvantages may seem problematic, there are many advantages to indemnity health insurance plans. You may have a higher monthly premium and you may need to pay upfront costs and submit claims paperwork, but your deductible will be more manageable and your coverage will be wider. Some health insurance plans will not cover certain medical expenses or care, but indemnity plans often do.

Another benefit of indemnity health insurance plans that many people desire is the freedom to choose your own physician. While other health insurance plans offered by the insurance industry limit your choice of physicians and hospitals to a list of preferred providers, indemnity insurance will cover any physician or hospital. This benefit may seem unworthy of mention, but there has been more than one instance where a mother finds that her son or daughter's pediatrician is not in their preferred provider network and has to search for another pediatrician. This also means that you can see a specialist without having to consult with your primary care physician first.

Overall, indemnity health insurance plans also offer you the best emergency medical coverage in the industry. While preferred provider organizations (PPOs) or point-of-service (POS) plans limit the physician you can see to a list of network physicians and hospitals, the freedom of choosing any physician is nationwide with indemnity health insurance plans. This means that if you are traveling across the country and have an accident or a medical emergency, you can go to the nearest hospital or see the closest physician without worrying about the expense. There have been instances where hospitals or physicians will either refuse to treat patients or treat them only minimally because the hospital or physician is not inside the plan's preferred provider network – meaning that the patient's health insurance will only cover a small part of the expense and the patient is liable to pay the rest of the bill. This is a risky financial situation for the physician and/or hospital since patients are often unable to fully pay costly medical bills. With indemnity health insurance plans, this is almost never the case. Consider this and the other benefits of indemnity health insurance when choosing the plan that is right for you.

Advantages to Managed Care Plans

There are many different types of Health insurance plans out there. Picking the right one for yourself can be troublesome in the beginning, especially if you don't know what you are looking for. You might have trouble deciding which one would be better for you.

Health insurance is divided into two large categories—indemnity and managed care plans. Indemnity plans, also commonly called reimbursement plans, will reimburse your medical expenses up to a certain limit. Under the Reimbursement plan, the insurer pays a percentage of the total charges, regardless of how much the charges are. With the indemnity plan, the insurer will pay a specified amount every day for a specified number of days. The amount reimbursed does not rely on the cost of medical care, but what you are reimbursed will never exceed your expenses.

The other popular type of health insurance plans is managed care plans. The three types of policies categorized as managed care plans are HMOs, POSs, and PPOs. This type of insurance is more popular than the indemnity plan, as they offer more flexibility. With these types of options you either pay a monthly fee no matter how many times you see a doctor, or pay a co-payment but no monthly fee. With managed care plans, you are given options of care. The plan you choose and the amount of money you wish to pay determines how big of a network of doctors and specialists you can see and still be covered under the plan. Some managed car plans (most often PPOs) offer sponsorship programs from a network of hospitals and medical services. You can often get this kind of plan through your employer.

Managed healthcare plans are better for the average person due to the fact that they are more cost effective. While indemnity plans may give you a lot more freedom in cost, you will have to use the healthcare provider that the insurer chooses. If you have a specific disability, this can present itself as a problem. In the long run, a managed care plan will save you money, especially if emergencies arise when you are out of town. These types of plans also are more flexible in policy. Before you purchase any kind of health insurance, be sure to research the many options available for you and your family to ensure you receive the best coverage possible for the lowest monthly premium or deductible.

Affordable Health Insurance for the Unemployed

Being unemployed can be a financial downside to say the least. You may be dependant on someone else to cover your daily expenses such as a place to live and food to eat. Health insurance is something that everyone needs and not enough people have available because of these other financial burdens. Any emergency such as a car accident or broken bone will require adequate medical assistance. What do you do when you don't have insurance and can't afford expensive medical bills? If you are unemployed, you need to find health insurance to prevent this from happening.

COBRA is a law in which many people could be eligible to remain on an employer's health insurance plan even after they lose their employment. The most ideal person for this coverage is someone who is between jobs and is not in need of long-term help. It can last at least a year to those who qualify, but the premium amount is still an expense that some unemployed individuals may not be able to take care of with their lack of income. If you are able to pay the premium and are eligible, COBRA will also cover your spouse and children who are dependent on you for insurance. The best way to determine if you could receive health insurance is to contact your local employer's benefits department and fill out the required forms.

You can also shop around for typical health insurance. Many free Internet services are proven reliable by the Better Business Bureau Online. By speaking with one of these insurance experts, you can get help finding the most affordable health insurance that will fit your specific needs. They know the rates of thousands of insurance companies and can fix you up with appropriate coverage for your specific needs. If you have a spouse or children, having health coverage is a necessity. Life is full of unexpected events and you cannot ensure that everyone will stay completely healthy until you have insurance again because accidents do happen. Finding an affordable coverage rate on your own can be a hassle. The experts at these companies are offering their assistance to you, often as a free service. Whether you need to find something short-term or for an extended period, they are qualified and dedicated to helping you.

If you find yourself unemployed at any time in your life, you are probably without health insurance. This can be a nightmare whether you have a family or not because medical expenses can put you into debt quickly. Luckily, there are ways of finding affordable coverage providers that can keep your health, as well as your finances, safe. A simple doctor visit can cost you significantly more money than it would with insurance. Do not let yourself become one of the many people who are unfortunately living life without proper insurance coverage.

Always on the Hunt for Knowledge: Information Sources on Health Insurance

Health insurance can be confusing, especially if it is your first time shopping around with different providers. Terms such as deductible, co-payments, and pre-existing conditions can be confusing if you do not know what they really mean. There are many ways to find out more about health insurance so that you are as knowledgeable as possible. You could talk to a health insurance company who can give you an explanation and also an example to further your understanding. The Internet is also a great informational tool when you have any questions regarding information that you need to know about health insurance.

Logically, you would assume that the experts at the insurance company would be able to answer any questions that you have about terminology and any other queries that you have. The best way to get in touch with them is to simply call your provider and ask any questions that you have, no matter how general or specific. They are there to help you, and this should be your primary concern. Think about it—if an agent isn't helpful with your preliminary questions, just how helpful will he or she be if you need to settle a claim? If you get your health insurance through the company that you work for, there is usually a person in charge of handling any

questions. Usually their title is “benefits administrator” and you would go to them with any questions regarding your health insurance plan, such as adding a spouse or children to your plan.

For answers to general questions such as terminology confusion, an Internet search engine can point you straight to your answer. This is a great options available to anyone who does not want to call their health insurance company just for a couple of simple questions. There may be information that you had overlooked in the past when you quickly skimmed through your policy. Your specific provider may have a web site where you can get facts about anything, including anything that you may not have been clear on regarding any additional benefits they offer. You can read all of the literature available at your own pace and on your own time.

If you would like to know more about health insurance, rest assured that there is a lot of information out there. You could make a call to your current provider and ask away on any questions that you have. For those who would prefer to learn the ins-and-outs of insurance at their own pace, the Internet has limitless information that is available to you at any time of day. Health insurance can be complicated at first, but the more you know the better off you will be.

Attract Employees: Group Health Insurance

Many small business owners know that in order for them to be successful they must offer an incentive to recruit employees to work for them. This can be any number of things, but most often it is the benefit of offering group health insurance. While this could be an excellent strategy for your small business to take in order to recruit new employees, there are a few things that you must know first before you dive into selecting a plan. Research group insurance policies thoroughly before choosing one for your company.

A group health insurance plan can be obtained by any small business that has as little as two employees to as many as fifty. There are two ways you can go about supplying the health insurance to your employees; this will mainly be decided by your own budget. Many small businesses that offer group health insurance help contribute towards the cost of the plan. On the other hand if an employee wants to have coverage for their families, the employer might offer to pay the employees’ premiums and have them pay the premium for their families.

Another aspect of the group health insurance plan will be deciding between managed care or fee-for-service. Managed care plans include Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Point of Service plan (POS).

An HMO will significantly reduce the cost that your members will have to pay for medical care as long as they use the providers specified by the HMO. A PPO will not require a referral in order for them to see a specialist. While the PPO is more flexible it will bring higher costs to the per-visit and annual deductibles. The POS plans are basically a combination of the features that you will find in an HMO and PPO. Members get to decide whether to pay a flat fee for offices in the network, or pay a deductible charge to see someone out of network. The fee-for-service plan

gives the employee the power to select health care providers themselves. This means that they will have way more flexibility with where they can go for medical assistance.

Adding an appealing Group Health insurance plan to your business could potentially bring you more employees. This is just the basic information about Group Health insurance; there are many options to consider when choosing a plan. Be sure to investigate all options to create the best plan for your employees.

Disability Insurance

We all know how important typical health insurance is, but did you know that disability insurance is just as important? In the event that you are hurt on the job, and cannot work, disability insurance will give you peace of mind—you will still be able to provide for your family. While we would like to think that we always work safely, accidents do happen and you need to be sure that you have every angle covered in the event of an accident. If you become ill or injured on the job and as a result you are unable to return to work, there are a couple of options that will replace lost income. These types of disability insurance are not going to fully replace your income because they want you to have an incentive for returning back to work once you get well.

Social Security benefits are paid to you when your disability is expected to last for at least 12 months. Most of the time this is when no gainful employment can occur and you must remain out of work for the entire duration of your leave. Employer-paid disability is required by almost every state in the United States. This type of disability insurance is deducted from your paycheck, and is there for you in the event of an accident. When you are looking at disability insurance policies, it is important to understand what they mean. While the two available policies are both for disability, they both cover a different amount of time you will be covered, and when you will start receiving your compensation.

A short-term disability policy means that you will be covered for no longer than 2 years. With this policy you may have to wait up to 14 days before you start receiving compensation. A long-term disability policy is a little different. The disability compensation will not kick in for several weeks, sometimes a couple of months. However, long-term disability will cover you for a longer period of time, and sometimes for the rest of your life.

Along with having the two different types of insurance policies, there are also two different protection features. Protection is offered to you to ensure that you are not going to be treated unfairly due to your inability to work. Non-cancelable means that for no reason other than not paying your premiums can your policy be canceled. With this type of policy you will lock in your premium and will not risk a decrease in the benefits. On the other hand, a guaranteed renewable policy means that the same benefits will be available every year. The only way that your premium will be increased is if every policyholder within the same rating class as yourself increases also.

While there are many options when choosing disability insurance as well, these are the most popular selections. It is important to discuss all available options when choosing a disability insurance policy to ensure that you know what you will receive in the event of an accident or illness. Research your options to find the best choice for you and your family.

Do You Need A College Health Insurance Plan?

When you are finally done with your high school education, there is no doubt that you'll be enrolling into a college. Many times when a child reaches the age of 20, they are no longer covered by their parents' insurance and this can lead to a troubling situation if they are not working and just strictly going to college. However, many colleges offer health insurance plans. Whether one of these insurance plans are right for you or not takes a lot of deliberation.

College health insurance benefits are going to vary from campus to campus. Although many people think that they are free, this is not true. While there is usually no charge for an office visit and routine checkups, the student will have to pay for lab work and other specialist type of visits. Benefits will usually pay completely for only types of covered services at the campus health center. In the event that you have to see an outside doctor then the student's coverage can drop up to 70% and run the risk of being required to pay a high deductible.

If you have a pre-existing condition, then you may have a problem with getting treatment at the college health center. Having a pre-existing illness or disability does not mean that you will be disqualified for obtaining a college health insurance plan, but you may not be able to get treatment for that pre-existing illness. This can lead to a number of problems if a new problem arises and is a product of a pre-existing illness.

All plans are different, so be sure you find out everything you can about your college's plan. Be sure to check if you or your child will be covered during summer break when students are not taking classes. This is important because you don't want to have an accident and find out that the insurance becomes inactive when they are not in class. Many colleges have coverage during summer break, but some do not.

Make sure you understand the plan. Is it an HMO, or can the member use any provider they want? This is just as important because you want to know where you can go in the event of an emergency, and there is nothing worse than finding out after the fact that you will be stuck with paying the full amount for a medical bill.

There really is no definitive answer as to whether you should or shouldn't commit to getting college health insurance. Be sure that you understand your plan fully so that no problems can arise in the event of an emergency. While it is not free insurance, it surely will save you money in the event of an accident or illness.

Don't Get Scammed: How to Protect Yourself

There are thousands of unsuspecting people who end up falling victim to health insurance scams each year. Unauthorized insurers are ready to sell you health insurance with a low-cost premium and most people would never think that there are fake insurance companies out there waiting to steal your money. With so many companies offering health insurance, how does one decipher which ones are scams? The current trend of scams is on the rise due to the large number of uninsured individuals compared to the rising cost of prescription drugs. Simply put, people are looking for the best deal. There are ways to keep yourself safe from these con artists and still pay a reasonable premium.

Does a health insurance company seem to be offering a policy that is too good to be true? It could be. Victims of health insurance scams are usually those who go shopping around and find a great deal (and then find that in an emergency they are without insurance). There are no clear indicators of fraud unless you know what particular red flags to listen for during their sales pitch of their particular policy.

Con-artists are professionals at what they do because it's often how they make their entire living. They will have paperwork that looks identical to a real insurer and uphold everything that seems to be that of a genuine and legitimate agent. First, common scams include loopholes that make sure what they are selling is not actually insurance. This would mean it is a discount program of some sort. These scams may reach you by telephone, offering a discount to individuals who, for any reason, do not qualify for real insurance. Also be wary if an agent mentions their plan being "reinsured." It is true that some legitimate insurance companies do have reinsurance to protect themselves, but it is never mentioned when trying to sell insurance to a customer.

Health insurance scams are not easily spotted—liars may be trying to take advantage of your ignorance. Therefore, it is important to know all you can about health insurance before purchasing a plan. If someone calls your home and tries to sell you a form of health care or health insurance, take what knowledge you have and ask as many questions as you can think of. Any indication that this may be a fake insurer should be taken to the state insurance regulators for investigation. You could be saving yourself and others from being a victim.

Easy as 1-2-3: Obtaining Health Insurance

Many people are often concerned about obtaining health insurance. They are confused about their options or about how to obtain the best health insurance for them or their family. There are several ways to obtain health insurance, though, and some of them are not always obvious, but can be quite easy in the end.

Health insurance is commonly obtained through an employer. Nearly all employers these days offer some sort of "group" health insurance plan for employees. The term "group" simply denotes that there is a large group of people on the plan, which decreases the cost of the

monthly premium for all members. These plans can cover yourself, your spouse, and your family, depending on the specific policy. Covering more than just yourself obviously increases your monthly premium, but the ability to cover your family inexpensively is a huge benefit. To obtain group health insurance through your employer, you should contact your human resources department or whoever is in charge of benefits in your company. You should be able to buy into the group health insurance plan at any time during your employment.

If you leave an employer who offers group health insurance without first finding other coverage, you can also use the COBRA law with your previous employer's health insurance coverage. COBRA is a government act that allows you to continue coverage under your previous employer, though at a more expensive rate. If you had coverage for your entire family, COBRA will allow you to continue this full coverage for a certain period of time.

There are several million people in the United States who are unable to participate in any group health insurance plans, however. Health insurance companies do offer individual plans for those who do not have coverage through their employer, are self-employed, or are ineligible for government health insurance assistance, such as Medicare or Medicaid. Individual health insurance plans are more often than not very expensive in relation to group health insurance plans. These plans can also cover family members and spouses for additional costs. Finding individual health plans is not difficult. Almost all health insurance companies offer individual plans; you can now search online for individual health insurance plans. Some Web sites even allow you to compare pricing and details of plans offered in your area – much like shopping for car insurance.

There is also federal health assistance available depending on certain criteria. If you are over the age of 65 or if you have a disability or specific condition (detailed by the government), you are eligible for Medicare. Medicaid is another government health insurance program that is based on income. Overall, it is simply important to be covered, no matter how you go about doing it. Research your options of coverage and speak with a professional to find out more about the health insurance options available to you.

For the In-between Times: Short-term Health Insurance

When people think of health insurance, they think of traditional health insurance, with office visits, co-payments, and prescription drug coverage. However, such health insurance is not always available. Perhaps you are transitioning from one job to another; or maybe you are employed part-time or with a temporary agency that does not offer full health coverage; or you might be attending or just graduating from school. In these situations, traditional health insurance is sometimes not available. If you are unable to afford traditional health insurance but would like some coverage in the case of an accident or emergency, short-term health insurance is your best bet.

Short-term health insurance fills the gap in health insurance coverage that may come about for a number of different reasons, including those listed above. The idea of short-term health insurance is built into the name – it is a short-term solution offering short-term coverage, with

the expectation that at some point, you will begin or resume traditional health insurance coverage. It is designed for those who would like some coverage in case of accident or injury and covers only emergency or serious medical expenses, such as x-rays, ambulance fees, intensive care, and a certain amount of hospital care. Though policies vary, these are often standard in short-term health insurance coverage. However, short-term health insurance does not cover regular physician visits, nor do they cover pre-existing conditions. If you are looking for this sort of coverage, you should consider obtaining a traditional health insurance policy or looking into other options.

Short-term health insurance costs vary greatly; you will have a monthly premium, ranging anywhere from \$25 to \$100, depending upon the plan's coverage and deductible, which often begins at \$250 and can increase to \$5,000. Most policies these days also offer a reasonable pay-out amount (often one or two million dollars). Policies allow you to choose coverage for specific lengths of time, from 30 days to 90 days or six months, but almost no short-term policies extend past one year.

How do you find short-term health insurance? It is not as difficult as it may seem. A simple Internet search will yield a number of companies that offer short-term health insurance coverage. Searching online will also give you the opportunity to compare different companies and different plans. Just be sure to research each of the policies carefully to understand your maximum pay-out as well as deductibles, coverage, and other terms of the agreement.

Health Insurance for Every Need: Understanding the Kinds Available

In the United States, there are about five different types of health insurance available: traditional health insurance; preferred provider organizations or PPOs; point-of-service plans or POS; health management organizations or HMOs; and most recently, health savings accounts or HSAs. With so many types of health insurance, it may be confusing trying to figure out which one best fits your needs, so thoroughly research each and speak with a professional if you need clarification.

Traditional health insurance is the one that most people think of when they think of health insurance. You pay the insurance company a premium every month, and if you have an accident or need for health coverage, you have a deductible amount you must pay and then the insurance company picks up the rest of the bill. You often have an inexpensive office and/or prescription co-pay with traditional health insurance.

With people living longer, health insurance companies began to look for more ways to reduce their costs, developing different health plans such as PPOs. PPOs are plans which will cover nearly all of your medical expenses as long as you stay within a preferred network of physicians or hospitals. This network creates a "preferred provider" list that you can choose from. Treatment outside this network of providers is covered but only at a reduced rate, meaning you end up paying more to see a physician outside the network. By limiting the physicians and hospitals covered in their network, the insurance company can control, to an extent, their costs and lower your premiums. POS plans work like PPOs, but require you to have a primary care

physician through whom you can receive referrals for specialists. If you need to see a neurologist or a dermatologist, you must first visit your primary care physician for an initial diagnosis in order to receive a referral to a specialist for a more thorough diagnosis. POS plans also have a preferred provider network, and if you choose to visit a specialist or physician outside that network, your coverage will be limited.

HMOs combine a stricter version of PPOs and POS plans. HMOs have a defined list of physicians, often much smaller than PPO networks, which you may see. You will not be covered at all if you see a physician outside your HMO network. Furthermore, you must also get a referral from your primary care HMO physician to see any specialist. However, these restrictions mean that you pay an extra low or no monthly premium.

HSAs were recently signed into law by President Bush. You can deposit money into a special non-taxed, interest-gaining savings account that must be used for medical expenses. The ideal situation for an HSA is to combine the account with a low-cost, high-deductible insurance plan. The savings account is designed to allow you to cover the high deductible if you find the need to cover expensive medical costs while the insurance company will pick up the rest of the bill.

Again, it is important to carefully consider each option before choosing a single health insurance plan. Your health is important—make sure it is protected in the best way possible.

Health Insurance When Living Abroad

You may not know this already, but when planning on traveling abroad you cannot take your local insurance with you. You will need to purchase an international insurance plan offered by a multinational insurance company. While they may be hard to track down, it is the best way to assure that in the event of an accident or illness you will be able to acquire medical attention if needed.

Many of these plans will cover you up to six months in another country. When you speak with the insurance company, be prepared to give an extensive list of information to them. This will range from health problems you've had in the past ten years, your hereditary conditions to substance abuse, and almost everything else—if it has anything to do with your health be prepared to disclose the information. If you are planning on traveling with more than one family member, then be prepared to give information for each family member as well.

Many times your basic coverage will include emergency treatment regardless of which facility it is administered. This is not the case with minor medical treatment. It is important to know whether you are buying an insurance plan that is an HMO or PPO. If you are under an HMO or health maintenance organization, then you will be limited to receiving care from only the providers who are in their network. You can retrieve a list of all the companies within your insurer's network upon request. If you are under a PPO, or preferred provider organization, you will have the opportunity to pick the best facility you see fit, but your insurer will only cover a portion of the incurred cost.

If you plan on staying abroad for more than six months then you will need to look into what is called expatriate health insurance. Only larger companies supply this type of insurance, as it is much more extensive with the type of options that can be applied to each policy. The type of treatment options that are covered with expatriate health insurance are those that are labeled as specialty treatments, like chiropractic therapy and acupuncture. There are many options that can be applied to expatriate health insurance depending on your family's needs and how long you plan on spending abroad.

There are many options for health insurance when you are traveling abroad. While many individuals never consider purchasing insurance when traveling to another country, this should be at the top of your list when planning for a trip. Health insurance should not be taken lightly. Be sure you understand every aspect of your policy before deciding with any one particular company.

Healthcare for Long-term Patients: Is this Insurance Right for You?

Long-term care insurance is not right for everyone. For a small percentage of the population this coverage is an affordable and worthwhile type of insurance. Determining whether or not long-term care insurance is right for you won't be the only task at hand; looking for scams will also be a concern.

As you get older, the need for assistance in your everyday life increases. Whether it is in-home care or residing in a nursing home for a few months you will most likely need some way to pay for these types of services. In order to maintain long-term care insurance you must pay for them each and every year until death. Many policies are canceled by policyholders that are on fixed incomes and are simply unable to pay for the increasing premiums as they get older. If the only funds you are receiving were those from Social Security or SSI, then it would be wise to not purchase a policy. Also, if you find that every day purchases and paying for utilities makes you stretch your budget to the limit, you probably should stay clear of this policy. This type of policy is only right for someone who has significant assets they want to preserve for their family, remain independent, or just to spare their family the expense of a nursing home bill.

Comparing policies can prove to be difficult because every company is selling a different combination of benefits and coverage. Many companies offer to pay a fixed amount for each day you receive care, while others will cover a percentage of the overall cost of care or supply a specified amount. Beware of these types of policies unless they offer inflation protection. You see, if they do not account for the increasing cost of nursing home costs, then you are stuck with a policy that really does you no good.

Just like a standard healthcare plan, you will have to receive services at designated locations. If you go outside of this network they will simply refuse to pay for any care that you receive. If you have any type of mental disease or nervous disorder then don't expect many carriers to accept

you (the one exception is Alzheimer's). There are more restrictions in this type of insurance than any other health insurance.

If this type of policy is right for you, please make sure that the company is reputable. There are many individuals who thrive on the fact that not many people will make an informed decision when it comes to purchasing long-term health insurance. Be sure to read the fine print and find out everything you can about the policy before committing to a company and a long-term health insurance plan.

How to Choose the Best Health Insurance for You

With so many different types of health insurance plans and restrictions out there, it can be difficult finding the best health insurance for you. However, this process is not impossible to do well with a little research. There are a few items to look for when deciding on health insurance plans, and by considering them all you can make a good decision for yourself and your family about health insurance.

The most important thing to look for is coverage. More often than not, insurance will cover physician visits and fees. Your health insurance should also cover hospital expenses such as room and board in case you are kept overnight or longer for observation or treatment. Good health insurance should also cover surgeries and any expenses associated with surgical treatment. Beyond these typical items of coverage, health insurance plans can diverge greatly. To really understand what coverage you would utilize and which plan would save you the most money, you will need to make a list of items that you want covered in an insurance plan. For instance, do you have glasses or contacts? Then you may be more interested in a plan that covers vision – either paying for your eye exam and/or partially paying for your glasses or contacts. Though many people think that health insurance covers prescriptions, prescription coverage is actually an optional benefit. If you know that you often have prescription drugs to fill, finding insurance that offers prescription coverage may be a must. If you are a woman and plan on having or want to have children, maternity care or family planning services are also optional benefits that you may want to consider. Once you make this must-have list of optional coverage, you can begin looking for health insurance plans that give you the opportunity to add these optional benefits.

Another item you should definitely consider is if your current physicians or specialists are included in the health insurance company's preferred provider network or if you have the opportunity to choose any physician (often the case only with indemnity or traditional health insurance plans). If you would like the freedom to choose your own doctor, traditional health insurance plans or preferred provider organizations may offer more attractive plans – though these also cost a little more.

Lastly, consider price. After researching different coverage plans and physician requirements, compare deductibles and monthly premiums to find the best deal. Often, you can get group rates through your employer, or you may find that artist organizations (for freelance artists)

offer health care plans. By researching price, as well as other health insurance options, you can make the best choices for your family.

Protection during the Golden Years: Health Insurance and Retirement

Health insurance for retirees or senior citizens can be confusing, especially with so many options and requirements. However, health insurance is crucial for retirees. As you grow older, your health obviously becomes more of an issue; you may visit the doctor more, need to fill more prescriptions, or even receive in-home care. Before you retire, prepare for health insurance to ensure that you receive the best benefits.

The first step in planning your health insurance coverage in your retirement is to see if your employer offers insurance coverage after you retire. If the company does, you should certainly consider it. Look at the plan, the deductible, and the coverage. Many near-retirees believe that Medicare will cover their medical payments, but this is not always the case. With this sort of coverage, you will most likely receive better health care but at a more expensive cost. As a retiree, you will certainly have a health insurance budget to maintain, and you will have to decide if the cost of your employer's insurance is too expensive.

If your employer does not offer coverage, Medicare will be an important and integral part of your health insurance if you are 65 years of age or older. Medicare works like traditional health insurance plans in that you have been contributing a small portion of every paycheck you earn into this plan. Once Medicare begins, you will make co-payments for office visits or treatment. Medicare will also cover the expense of certain medical equipment or needs.

However, Medicare did not cover a number of items that are typical of health insurance. The government recently updated Medicare and divided it into three parts: Part A, B, and C. Part A covers hospital care, such as home health care, hospital stays, and hospice care. This part does not require a premium. Part B covers the more routine medical expenses, such as office visits and laboratory tests, while Part C enrolls you into a fee-for-service or managed care plan that reduces your out-of-pocket costs. Despite these different options, Medicare restricts your coverage by not covering certain kinds of care or illnesses and diseases. Thus, there is also Medigap coverage, which helps fill in the gaps in health insurance that Medicare leaves. Medigap coverage differs from state to state and has different payments.

Beyond Medicare and Medigap, there are also long-term care insurance plans that you can buy. You often see these plans advertised on the television at very low prices. These plans can help cover the costs of a nursing home or home health care. With so many different options and limitations, if you are retiring soon, you should take a look at your budget and what you can afford as well as what sort of coverage you feel you will need.

Say Cheese: Dental Benefits

Dental insurance is often an afterthought when obtaining health insurance for a number of reasons. Some people may simply dislike the dentist and use the lack of dental insurance as a reason to not visit the dentist; others may feel that dental insurance is not worth the added cost to their monthly health insurance premium. Still others may simply feel that their teeth are in good shape and there is little need to spend the extra money to cover a part of their body that does not currently have any problems. Nevertheless, dental insurance is important because of several benefits.

When people think of the cost of dental work or procedures, they often think of costly bills. Even simple procedures like getting your wisdom teeth removed can average in the hundreds of dollars per tooth! However, one obvious benefit to dental insurance is the coverage of simple but costly dental procedures such as getting a tooth removed. In the end, the slight increase in a monthly premium may be worth it to avoid a high dental bill. Moreover, dental insurance also helps financially if a dental emergency develops. Perhaps you are in need of a root canal or dental implants – both extremely costly procedures that you often do not anticipate. Dental insurance will most likely cover a portion, if not all of these expensive procedures.

Also, while many feel that brushing and flossing daily is all the dental care they need this is simply not true – even for young, healthy adults. Dental disease is common and can affect your body in a number of ways. For instance, some dental diseases left untreated can lead to more serious medical issues such as kidney infections or even diabetes. Most people do now know of the connection between dental diseases and other illnesses. Thus, having dental insurance that covers routine visits to the dentist, which can help uncover dental diseases early, is extremely important. Dental insurance is designed to encourage preventative care, because spotting dental diseases or dental problems early reduces the overall cost of treatment.

Dental insurance may seem like just another gimmick to get a few more dollars out of you, but it is essential for your health. Your regular health insurance plan, whether it is through your employer as a group plan or an individual plan, should offer you the option of buying dental insurance coverage, and you should consider this piece of the plan thoroughly when purchasing health insurance.

Shop 'Till you Drop: Shopping for Health Insurance

Shopping for health insurance can be a frustrating hassle. There are so many companies with so many rates to compare. However, it is important to take your time and find the best company for your money. Although it may be frustrating, health insurance is a necessity. In any area, there are usually quite a few health care providers that can supply you with a quote over the phone. You could also use the Internet as a resource. By using these tools, you can make the shopping process go more smoothly.

The first step is going to be deciding which type of insurance you should be shopping for. If you have a family, it would be in your best interest to find a company that will give you one decided premium and co-payment plan no matter how many children you add to the plan at any time. Without a family, you would be shopping for individual health insurance but will need to decide if you are in need of short-term insurance or insurance for an extended period. Short-term insurance is for people who are in-between jobs and expect to enroll in whichever health insurance plan their future employer sponsors.

Once you have established what type of insurance you need, it is time to make some calls. Go through your local phone book and start calling down the line. After answering a few simple questions, you can get a quote and move on to the next company. Cost is one of the most important factors. If you find two or more of them with very similar premiums and a low co-payment amount, you should compare the benefits. Can you add immediate family at no charge? Will this health insurance include dental, emergencies, prescriptions, or doctor visits? This may help you find one that appeals more to your needs and is within your budget. Using the services of the Internet to find a company will be a very similar process. Some reputable web sites out there will ask you to fill in a few blanks and then give unbiased quotes from many different health insurance companies.

Whether you are going to be doing your shopping over the phone or on the Internet, you should use your best judgment of the information that you get on each company to decide on one that makes you comfortable. The Better Business Bureau can also help you be sure that you are not being scammed. Health insurance is a cost that is necessary to save you money in the long run on prescriptions, doctor visits, and unforeseen emergencies. Don't get left with bills that you have no way of paying because you didn't have insurance.

Something Old, Sometime New: Insurance When You are Getting Married

Health insurance providers are not created equal. Before a couple is married, the option of sharing coverage is extremely unusual unless one of your insurers offers domestic partner insurance. As you become engaged, if you both have separate insurance it is important to talk about the both of you switching to the better plan once you are married. There are a few factors consider, which include deductibles, co-payments, and the benefits of each separate plan. Marriage is a big step, and it can be done with ease if the two of you settle important decisions such as your health insurance plan before you take the big leap.

Your deductible is the amount you must pay each year to start your policy. Once this payment is made you will be responsible for whatever amount of co-payment your insurance company requires for you to pay for the health expenses that are covered in your particular policy. The amount of co-payments that you will be responsible for is established at the time you agree to your health insurance policy. It is going to be a certain percentage of health expenses; for instance, you pay 10% while your insurer will be paying the other 90%. You and your fiancé should compare both of your plans and figure out which deductible and co-payment plan seems most appropriate for the two of you.

Married couples are usually eligible for certain benefits that unmarried couples are not. Being insured separately by the health care provider sponsored by your employers may no longer be the most beneficial option for you. If you or your fiancé has insurance, and the other does not, once the two of you are married they can be added to the other partner's plan. Cost of adding an additional person is definitely something that should be examined. You should not be required to pay more for adding a spouse or even a child in the future because most plans are offered to immediate family at no extra cost. The best way to compare policies is to estimate a yearly amount of normal health expenses, emergencies, co-payments, and deductibles. Whichever plan has the lowest cost to you will almost always be the best choice.

In addition to sharing health insurance with your new spouse, you may also want to consider switching the rest of your insurance plans, such as the policies you have for your separate automobiles. This is because most companies will give you a discount on having more than one vehicle insured. You may also be interested in finding a company that can insure you home, automobile, and health in one place. If you carry more than one policy with a company, they will also usually give you some sort of discount on them. It is important to sit down and discuss insurance with your fiancé because the two of you could be saving money and stress by figuring out what decision is best before the time comes.

Stay Legal! Avoiding Insurance Fraud

Everyone knows that the health insurance industry is continually raising monthly premiums, and many feel this is unjust to you as the consumer. However, the health insurance industry has had to fight increasing health insurance fraud. The amount of money spent on investigating and prosecuting fraud is then passed on to policyholders. Many people do not understand what health insurance fraud entails, though. With reports estimating health insurance fraud is a \$30 billion to over \$100 billion industry per year, the topic should not be taken lightly. Every health insurance policyholder should understand what health insurance fraud is and its consequences. By doing so, you are more able to recognize and fight fraud.

Health insurance fraud is typically defined as intentionally deceiving, misrepresenting, or concealing information to receive benefits from the insurance company. Essentially this means that you assert that you paid for certain medical procedures or expenses out-of-pocket which you have not actually received, and you are submitting claims to the insurance company to receive reimbursement. Another example of member fraud is to conceal pre-existing conditions or to alter medical documents so that non-policyholders or ineligible members receive medical benefits under your policy. Perhaps your sister does not have insurance and needs medical attention. Having her use your name and policy to cover the expenses is health insurance fraud. While you may think that this is a small issue in comparison to your sister receiving treatment, it is actually very serious to your health insurance company and industry, and will result in fines and possible imprisonment if you are caught.

Not only policyholders commit fraud, but providers (physicians, hospitals, etc.) do as well. Since physicians and hospitals bill the insurance company for services they provide for you, they are also receiving reimbursement from the insurance company. When providers commit fraud, they may be billing the insurance company at higher rates for services rendered or they may bill for

services you never received. In these cases, you will probably be asked to cooperate in the insurance company's investigation.

Another type of health insurance fraud that has developed recently targets the policyholder more than the insurance company. Schemes have developed where fake insurance companies or agents sign unsuspecting customers for coverage at surprisingly low premium rates. They often act much like a regular insurance company for the first few months, paying for smaller medical claims like physicians visits. But once you have a more serious medical condition that needs treatment, the insurance company will disappear – along with the money you have been paying in premiums.

The rule with health insurance fraud is much like that of any other scam: if a deal seems too good to be true, just remember - it probably is. Remember to be honest in your dealings with health insurance companies and expect the same in the return from these companies, as well as your health care providers. Stay legal to avoid fines and prison and to continue receiving health insurance coverage.

The Importance of Good Records

Keeping your own records of any medical care that you and your immediate family have received is the only way to be sure that your insurance and bills are free from mistakes. It may seem unimportant now, but later in life when you try to get life insurance or get treatment that is appropriate for you, the importance will be in the spotlight. Everything from your allergies to your payment records with medical facilities can hurt you if they are wrong in your report. You could be given improper treatment or even denied treatment at all. By keeping your own records, you can dispute anything that is false.

Would you believe that you could be denied a job because of something erroneous on your medical records? It is true; if you are reported to have a disability, whether it is true or not, you could be turned down. You would be labeled as a risk, especially if the company offers insurance; they would know that you are going to cost more money to employ. The same goes for applying for health insurance where your medical records show that you would require prescription drugs, doctor visits, and increased chance of emergencies. It is quite the ordeal if you do in fact have a disability, but imagine if you did not have one at all—you would be turned down for insurance, while also being completely ineligible for disability financial help.

An example of a mistake that could be made on your record would be a diagnosis error. Perhaps you request that your doctor check a suspicious lump in your breast. On the first visit he may suspect that it is cancer. Most people will get a second opinion or go for a more thorough conclusive examination. If the second doctor decides that it is only a cyst and has it removed, your personal records would show that you are cancer-free. However, if this visit was documented incorrectly, or not at all, you may have trouble getting insured and not know why. If you had a record of the second visit that found the cyst, this situation would be easily disputed and your record would be accurate.

Human error is simply a part of life, even on medical documents. It is important to always keep your own records so that insurance companies get accurate information about you and your health condition. If you are being turned down for insurance and do not know why, you are best advised to be sure that you are not being misrepresented within your medical records. This problem can be cleared up quickly and easily if you are responsible enough to keep your own personal records.

Traveling Alternative Roads: Other Options for Health Care

Health insurance can be expensive if you are not lucky enough to have it provided by your employer. Even shopping around for the best quotes may not be within your budget. Luckily there are alternatives to health insurance that you can take advantage of so that you and your family will be safe even if an emergency situation comes up. You can apply for the prescription discount card program, which is a low monthly cost and works at most of the of corporation drug stores that we all use. There are also programs that give you health care but are not considered "health insurance".

The prescription discount card is great for anyone who has regular prescriptions that need to be filled over a long period of time. The cost of prescriptions without insurance is high and always rising. If you cannot afford health insurance, there is no way that buying these full priced prescriptions will come without difficulty. You can enroll in a discount card program on the Internet or you can call around to try and find one locally. The reported savings for each person is estimated to be at least 50%, and some programs will enroll you for under \$5 a month.

Health care programs are another popular alternative to expensive health insurance. BeniCard, for example, is a highly acclaimed health care program, and for a small monthly fee, you can have your immediate family covered. You will not be turned down because there is no limit to who is eligible, even if you have a pre-existing condition. It is not health insurance, but you will be able to save money on doctor visits, vision and hearing care, dental services, and prescription drugs. This is just one of the programs that can help you if you cannot get health insurance due to expense or because you have been turned down due to an illness.

No one should go without health care of some sort. Prescriptions are extremely costly without insurance, and if you or someone in your family has an emergency health situation, you could be left with a large debt for years. Insurance companies are hesitant to accept anyone with a pre-existing illness because it will definitely cost them plenty of money. For anyone who has been turned down for health insurance or simply cannot afford to pay a deductible, health care programs and prescription discounts are a low-cost alternative that could save you money.

Value Your Health—Buy Insurance

Many feel that health insurance is a waste of money. These people are often quite healthy and have no need to see their physician beyond yearly check-ups. However, health insurance is

extremely important because it not only offers you protection from harmful illnesses or diseases and creates a better quality of life, but it can protect you from financial devastation in the case of an emergency.

One of the most crucial reasons to have health insurance is to cover the costs of medical bills – emergency or non-emergency. Without health insurance, you may be tempted to not see a doctor about medical issues you have, or you may assume that they are not serious. Both of these options are harmful and unwise as medical issues will often progress and become worse over time.

Insurance is often about ensuring you are covered in an emergency situation. For instance, you carry automobile insurance so that if you ever get into an accident, you will not be responsible financially. Health insurance works in much the same way, but it is also used to cover basic medical expenses and sometimes even preventative care depending upon your insurance provider. This can increase or improve your quality of life by allowing you to be proactive in your health care instead of simply reacting to medical issues that may arise.

Furthermore, the costs of medical procedures and consultations have increased with time. Even a routine outpatient procedure, like the removal of gall bladder stones, can be a costly medical expense. Even a short visit to a specialist for diagnosis can be extremely expensive. Emergency medical issues or the development of possibly fatal or debilitating illnesses are one reason to have health insurance. The expenses to treat these medical issues can cost hundreds of thousands dollars and pull you into a financially disastrous situation. With late fees and minimum payments, you may never be able to pay off your medical bills, and hospitals and doctors will often send collection agencies after you. This is not only inconvenient, but can also ruin your credit and make it impossible to rent an apartment or buy a car.

As you can see, health insurance is very important. It will not only improve your quality of life and ensure that you are in top-notch health, but it can save you money in the long-run. When you consider what in your life is most important, your health has to be on the top of the list. If you protect your possessions or your home with insurance because of their value, then you should insure your health as well. After all, isn't your health valuable too?

Ways of Paying for Health Insurance

When it comes to health insurance, many people don't exactly know everything that there is to know about the subject. That only stands to reason, it is not something that is easily understood because of its complexity. For instance, when you visit the doctor you may be asked to pay something that is called the "co-pay", and other times you may not have to do anything at all depending on your plan. Let's look at some of the ways that health insurance is paid for.

Often times, your employer will sponsor your insurance and you only have to pay what is known as a "co-pay" or co payment. The co-pay is a set amount that is determined by your insurance company when you receive covered services. This is a significantly smaller fee than you would

be paying without the co-pay. Many companies offer this type of payment option because it is easier on the employee to pay this way.

You may consider opening what is known as a Healthcare Savings Account (HSA). This will assure that you always have a location in which to retrieve payments for various medical expenses. The HSA is a pre-tax savings account where a portion of your pre-tax income, determined by you, is deposited into an account automatically. Since this account comes from your paycheck pre-tax, that means it will lower your overall taxable income. This means you are saving money in terms of taxes and saving lots of money towards your overall health care costs.

For certain disabled individuals and those above the age of 65, Medicare is also another way to pay for health insurance. While they will not pay all of your healthcare expenses, they will pay for most of them. Medicare, however, doesn't cover prescription drugs and nursing homes. It is important that you check the different types of restrictions that may apply. There are low-cost prescription discount cards that have been proven to save people who require costly medications on a regular basis over 50% of what they would have been paying without any health care.

Paying for health insurance doesn't have to be complicated as long as you understand just what is going on in terms of where you stand with your plan. Discuss any questions you may have about the plan before committing to one. While one plan may be right for many people, it does not always mean that it will fit your specific needs.

What are HIPAA Laws?

Your visit to the doctor now contains a page where you sign that you acknowledge that the physician's office has notified you about their compliance with HIPAA laws. More often than not, you probably read through quickly or barely skim the authorization form before signing it. However, HIPAA laws are important, and they are in place to protect you from identity theft, being denied care, and/or health insurance coverage.

HIPAA stands for the Health Insurance Portability and Accountability Act, enacted in 1996. HIPAA laws created a new national standard in protecting your health information. As you see different physicians or become admitted to different hospitals, your health information should follow you. HIPAA delineates the need to properly protect your health information as it flows through to these different channels. As more and more transactions are completed electronically these days, HIPAA laws focus on the protection of your health information specifically through these channels.

So what does HIPAA protect? For you, HIPAA protects personally identifiable health information, such as your Social Security number, birth date, address, etc., as well as current, past, or even future physical and/or mental conditions or treatment. Such information may not be disclosed except for specific uses. Information that HIPAA does not cover must specifically be personally non-identifiable. In protecting this sort of information, there is more protection against identity theft and more recourse if such a thing should happen.

HIPAA also protects how health insurance providers may use your health information. These entities may use your information without your authorization only if they are sending you information, using this information to provide the best treatment or health care, or collecting payment on medical expenses, among other things. If disclosure of your health information does not fall under these categories, you must authorize the transfer of information in writing. Furthermore, because the government understands that highly technical language can be a barrier in understanding your health information privacy rights, any authorization must be in plain language.

This may all seem like unnecessary paperwork, but beyond identity theft, HIPAA laws also help those looking for health insurance coverage. Title 1 of the HIPAA laws oversees the availability and range of health insurance plans for those without perfect health. It outlaws any health insurance plan from creating discriminatory rules to create premium rates or deny coverage. HIPAA laws are quite extensive, but this gives you a look at how your health information is being protected and used. Your department of health should be able to give you further information, or you can search the government's Web site for the entire HIPAA law.

What You Don't Know Can Kill You: Health Insurance Limitations

Health insurance often requires a mountain of paperwork that has a lot of fine print. Unfortunately, this means that few people read their plans thoroughly nor do they fully understand what their plan covers or does not cover. Here are some common limitations in health insurance coverage that you should know.

Some of the most shocking health insurance limitations are found in the the fine print holes in the insurance policy. For instance, many people have found that their health insurance did not cover a routine or necessary medical procedure because they did not receive an authorization code prior to the procedure or the hospital did not correctly fill out the paperwork. Your medical claim can be denied simply because the hospital used odd codes for your treatment. While any claims denied by the insurance company can be disputed, this process is not only tedious, but time-consuming and draining, especially for someone who is already ill. There is also little success in winning disputed claims, which makes this option rather limiting.

Another surprising health insurance limitation happens more often than people realize. Imagine this situation: you are diagnosed with a medical condition and need an operation. You research surgeons and hospitals within your plan. You understand your plan's coverage of hospital care. You have your operation and then you find a massive medical bill in the mail. Apparently your health insurance did not cover the anesthesiologist or other specialists that may have consulted in your operation. Thus, you have to pay these specialists for their services, even though you were under the impression that your plan would cover these costs associated with the surgery. Such a bill can be in the thousands of dollars, and there is little you can do to dispute the charges. The only way to avoid these charges is to make sure that you ask *before the operation* who will be involved and ensure that they are covered in your health insurance plans.

Other limitations are put on a number of treatments. For instance, you may need physical therapy or visits to a psychiatrist. Many health insurance plans will put a limit on the number of covered visits for such medical treatment. Without realizing it, you may surpass the maximum visits allowed by your health insurance and end up racking up huge bills.

Many people think that buying health insurance will cover them medically, but this is only correct to a point. When securing insurance, you should read through your health insurance package carefully, and when you are about to undergo any expensive medical procedure, be sure to consult your health insurance plan first.



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