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Category: Acquiring Short-Term Health Insurance

Subcategory: About Temporary Health Insurance

Tip: Coverage Between Jobs
Short-term health insurance, sometimes called temporary health insurance, is perfect for different situations. Acquiring short-term health insurance plans is a great idea for people going through a brief gap in standard health insurance coverage, short-term health insurance is ideal if you are between jobs, a recent graduate, or waiting for a for a new health insurance plan to start. However, before you pay for a short-term insurance policy, make sure you understand your rights under COBRA law. If you have left your job and your employer has at least twenty employees, you are legally entitled to continue your coverage under your employer's group plan for up to eighteen months. You will have to pay the entire premium out of your own pocket, but if you have a significant pre-existing condition that you expect to require care for, you may end up better off financially staying on your employer's plan than risking denial of benefits under a new short-term insurance plan.

Tip: The Costs Of Short-Term Insurance
As with standard insurance, all short term health insurance plans vary from company to company. However, because most insurers protect themselves by limiting or excluding benefits for pre-existing conditions, preventative, and routine health care services, premiums can be much lower than those for standard health insurance. Where a standard health insurance plan's monthly premium for individual coverage may be in the $250 to $400 range depending on coverage and deductible levels, the monthly premium for most temporary health insurance policies is usually below $100. What you pay will depend in large part on the deductible level you choose when acquiring short-term health insurance plans. Just like with standard health insurance, the lower the deductible, the higher the premium and vice-versa.

Category: Buying Health Insurance

Subcategory: Health Insurance Coverage

Tip: Deductibles

A deductible is the amount you must pay each calendar year before your medical insurance plan begins paying benefits. Many, though not all, health insurance plans have deductibles. Deductibles can be as low as $250 and as high as $5,000. For example, if your plan has a $500 deductible, which means you will need to pay for $500

worth of medical care before your health plan will begin paying benefits according to the terms of your contract.

Even though you are paying the $500, you should still have your health provider bill your insurance company. Otherwise, your insurance company will have no way of knowing when you have met your deductible and when to begin paying benefits. While each plan is different in most cases, things such as office visits, lab tests, and prescriptions count toward the deductible. Things that might not count toward most deductibles include over-the-counter medications and cosmetic and other elective procedures that are not considered covered items under your insurance plan.

Tip: Managed Care Plans

Managed care health insurance coverage are those plans that aim to control costs by negotiating agreed upon fees, with a network of medical service providers called participating providers. As a means of maintaining cost control, the insurer requires a high degree of service coordination on the part of both the service providers and the health care consumer--in other words, you! You will need to designate a primary care physician from among the insurers approved provider network. All your medical needs must be coordinated through that provider.

For example, if you need to see an ear, nose, and throat (ENT) specialist, your primary care provider will need to submit a referral to the specialist and your insurance company. If you go to the ENT doctor without first receiving the referral, your insurance company will most likely deny your claim and you will have to pay for the treatment.

If you expect to receive the bulk of your health care in your own community and you would not mind some loss of flexibility and the extra coordination required, a managed care health insurance plan can save you a considerable amount on your insurance premiums. Most managed care plans make exceptions for emergency care provided outside of the network when you are traveling.

Category: Finding Affordable Health Insurance

Subcategory: Low Cost Health Insurance

Tip: Finding Low Cost Health Insurance

The statistics on health insurance affordability are grim: Since 2000, health insurance costs have spiked 59% while in that same period of time worker's pay has only increased 12%. With the cost of health insurance squeezing the family budget ever

tighter, more and more families are dropping the coverage they have because they cannot afford it. Finding low cost health insurance is difficult these days.

Your best bet as far as insuring a family is to try to get employer-sponsored health insurance. Even though you will likely need to contribute to cover the cost of the premiums, employers are able to get far better rates for a group than you would be able to get buying an individual policy. A plus is that employers will pay part of the premium.

If your employer does not offer insurance, or if you are a freelance contract worker or small business owner, see about joining a professional organization or union. Many of them offer access to group health insurance for members. Finally, if you have to consider an individual (private) health insurance plan, a health maintenance organization (HMO) will be the least expensive followed by a preferred provider organization (PPO). While HMOs require cutting through a lot of red tape and will limit your medical care options in terms of where and when you can receive services, most offer fairly robust coverage to families.

Tip: Know The Difference Between Basic And Major Medical Coverage

Every insurance company has their own definition of what is “basic coverage” and what is “major medical coverage.” Some policies combine basic and major medical coverage into one plan, called a "comprehensive plan." Generally, basic protection pays toward the costs of a hospital room and care while you're in the hospital. It covers some hospital services and supplies, such as x-rays and prescribed medicine. Basic coverage also pays toward the cost of surgery, whether it is performed in or out of the hospital, and for some doctor visits. Major medical insurance takes over where your basic coverage leaves off. It covers the cost of long, high-cost illnesses or injuries. Be sure to check your policy for both types of protections because there may be limits on the amount or number of days your insurance will pay for these services.

Tip: Plan Ahead And Stay Insured

Planning on leaving your job next year? Switch to the lowest-cost plan during this year's open enrollment. Then, after you quit, federal rules (known as COBRA) will let you stay on your employer's health plan for up to 18 months, although you'll usually have to pay the full cost, plus 2%. Once you've tapped out COBRA, you must sign up for a new policy within 63 days or insurers can legally turn you down or refuse to cover pre-existing conditions.

Tip: Smoking and Health Insurance Premiums

If you are a smoker, you can reduce your premiums by as much as a few hundred dollars just by quitting. This is due to the fact that health insurance companies know that

people who smoke get sick more often and use proportionally more medical services than non-smokers. Equally important to insurers, the type of services smokers are likely to use are generally more expensive than those used by non-smokers, particularly when you consider diseases such as emphysema and lung cancer. The savings on your health insurance premiums is not the only benefit you will receive.

If you are sick less often and using fewer medical services, this would mean lower out-of-pocket expenses for co-pays, and for doctor visits and prescriptions. That easily adds up to another couple hundred dollars in your pocket. If you are also a pack-a-day smoker and you quit, at a conservative $3.50 per pack, which is nearly $1,300 in savings per year alone.

Anyone trying to quit smoking and needing help should visit QuitNet.com. Aside from providing a lot a helpful tips and articles on quitting smoking, you can plug in your zip code and receive a list of smoking cessation support programs in your area.

Category: Finding Health Insurance Resources

Subcategory: Online Health Insurance Resources

Tip: Have Your Insurance Define “Usual Reasonable And Customary”
Most insurance plans will pay only what they call a “reasonable and customary fee” for a particular service. If your doctor charges $2,500 for a colonoscopy, while most doctors in your area charge only $1,500, you will be billed for the $1000 difference. This is in addition to the deductible and coinsurance you would be expected to pay. To avoid this additional cost, ask your doctor, hospital or billing department how much the procedure will cost and find out if the providers accept your insurance and if your insurance has them on their list. You may have to ask for the diagnostic code for the procedure and call other providers to get a sense of what the customary charge is for that procedure in your area and go back to your insurance company with your findings. Be sure to document the date, your insurance contact's name and contact information. If you can, try to get their answer in writing before you continue with the procedure, or even with the insurance, thus, if you are denied coverage in the end, for something you were told was approved, you have the documentation and you can appeal to your insurer. If you do not get results, you can then go to the state department of insurance with all your documentation in hand. Even if you lose your battle against your insurance company, your message will start to be heard and you can start investigating other insurance companies “who play fare," and be sure to start writing letters to elected officials and key executives at your insurance company.

Tip: About America's Health Insurance Plans

Wondering how to go about finding health insurance resources? Try America's Health Insurance Plans. America's Health Insurance Plans is a national trade association that has nearly 1,300 member companies that provide health benefits to more than 200 million U.S. citizens. The organization's Web site includes a consumer information page where you can find facts and figures as well as consumer guides on individual and group health insurance, managed care, long-term health insurance, and information specifically for business owners.

Category: Getting Family Health Insurance

Subcategory: Family Health Insurance Coverage

Tip: Calculating Your FSA Contribution

Calculating how much to contribute to your flexible spending account (FSA) can take time, if you have never done this before. However, it is well worth the time used. If this is the first time you have used an FSA, you should play it conservatively until you know your actual usage patterns. The most common things people use FSA contributions for include paying for annual deductibles, co-pays, and goods and services not otherwise covered by your family health insurance plan. These services include things such as eyeglasses, over-the-counter medications used to treat diagnosed conditions, and co-pays for dental care.

For example, if you have a child with lactose intolerance, you probably go through Lactaid tablets fairly often. At anywhere from $7 to $14 a box, save your receipts, and you can get reimbursed for them. In fact, you will need to get in the habit of saving your receipts for all out-of-pocket medical expenses, including co-pays for office visits, prescriptions, and any other approved expenses. If you keep these receipts, then once a month you can fill out a simple claim form and mail or fax your receipts in. It usually takes anywhere from two to four weeks to get your check. Keep copies of anything you submit. If there is a problem with the paperwork, you can refer back to your receipts.

Keep in mind that the money you contribute in a given calendar year must be used to pay for goods or services received in that calendar year, but you have until March of the following year to submit your claim. It is a good idea to check your balance in October to see if you are at risk of forfeiting any money. If you still have not used your full balance, start scheduling appointments and stocking up on prescriptions and over-the-counter medications before the end of the calendar year.

Tip: Flexible Spending Accounts (FSAs)

A FSA, or flexible spending account, is a federally approved, employer-administered account to which you can contribute money that you then use to pay for out-of-pocket medical expenses. FSAs are woefully misunderstood and underutilized by American families. FSAs provide benefits a couple of different ways. First, the money you deposit into your FSA does not get taxed. The money is deducted from your pay before your employer calculates Medicare, Social Security, and income taxes.

For someone in the 28 percent tax bracket, every dollar you deposit to an FSA, you can cut your federal income tax bill by $0.28. If you place $3,000 a year into your FSA, that would result in a savings of $840. The other great thing about FSAs is that even though the total amount of the contribution will be deducted from your pay in equal installments throughout the calendar year, you can file claims against the full contribution from Day One as if it were sitting in your account already. For example, if you three family members will need new eyeglasses, schedule your eye exams and purchase your glasses in January. Even if the bill is $1,500 and you've only deposited $150 to your FSA, you can submit your receipts and receive reimbursement from your FSA for the full $1,500. The only time this can come back to bite you is if you leave your job mid-year. At that point, you would need to make an additional contribution to cover the benefits that had been paid to date.

Be careful when you estimate your annual FSA contribution, because if you overestimate and do not use all the money, it reverts to your employer who then uses it to offset the overall cost to provide employee benefits. Also, while FSA contributions can be used to pay for just about any out-of-pocket medical expense from co-pays to over-the-counter medications, FSA contributions cannot be used to pay for family health insurance premiums.

Tip: Married: Together Or Separately?

Many married couples maintain separate health insurance coverage even though it may not be cost-effective to do so. Examine both your coverage and your spouse's coverage to see if it makes sense for either of you to join the other's plan. Keep in mind that most plans allow you to add a spouse to your plan within a certain time period after you get married (e.g. 30 days). Otherwise, you may have to wait for the plans' annual open enrollment period. Often it is less expensive to obtain a family policy (2 adults and up to 3 children) than it is to insure two adults individually. You may also be able to coordinate both plans for maximum coverage. In some cases, it may be cheaper to have separate insurances such as if one spouse has a chronic, preexisting condition which may cause your insurance to double in price if he/she joins. There may also be a limit as to how much an insurance company will pay for your claim if both you and your spouse file under two different insurance plans. A coordination of benefits clause usually limits benefits under two plans to no more than 100 percent of the claim.

Category: Getting Group Health Insurance

Subcategory: Group Health Insurance Coverage

Tip: Summary Plan Descriptions (SPDs)

An SPD, or summary plan description, is your group health insurance plan administrator's description of your legal rights under the Employee Retirement Income Security Act (ERISA). ERISA is the federal law that protects your health benefits. Your company's SPD should include information about coverage for your dependents, co-pays, as well as when and under what circumstances your employer can cancel your health insurance.

You should receive a copy of your company's SPD each year in your benefits package as part of your group health insurance quote. Save it and any memos, letters, or e-mails (print these out) that relate to the SPD. If you cannot locate your SPD, ask your human resources department for a copy.

Category: Health Insurance And Prescriptions

Subcategory: What's Covered?

Tip: Ask For Samples
Drug companies are always giving away samples to physicians, so your doctor may be able to supply you with several weeks' worth of medication at no charge. Not only is this free, but if you find that the medication is not working, such as a cream for a rash, you won't be left with an expensive tube of cream you can't use

Tip: Beware Of The Cap
Some insurance plans have a "cap," which may be the most you will have to pay for medical bills in any one year. You reach the cap when your out-of-pocket expenses (for your deductible and your coinsurance) total a certain amount. It may be as low as $1,000 or as high as $10,000. Then the insurance company pays the full amount in excess of the cap for the items your policy says it will cover, but there are limits. The cap doesn't include what you pay for your monthly premium. It may also have a cap or limit on medical tests, number of doctors visits, preventative coverage and other services. Inquire as to what types of healthcare the cap will cover. For example, some policies will pay no more that $550 a day for hospital care and for a certain amount of days. Some insurance will impose a “lifetime maximum cap” which is the amount after which the insurance company won't pay anymore. This is important to know if you or

someone in your family has an illness that requires expensive treatments.

Tip: Find A Cheaper Alternative
If there is no generic version of a brand-name drug you're taking, ask your doctor about a therapeutic substitute or an older drug in the same category. A drug that has been on the market for more than 10 years will almost always have a generic version available.

Tip: Shop Around For A Pharmacy
The federal government doesn't regulate prices on drugs sold at pharmacies, so your costs can vary widely depending on where you buy. You may find that the pharmacy a few miles away may have one or two medications that are less expensive than the pharmacy across the street. Simply call the pharmacies in your area and compare prices. You may also want to ask if they have enough of the drug on hand to b dispensed so you do not run to the pharmacy only to find they have to ship it in from another store. The best prices are often found not only at discounters like Costco and Wal-Mart but also at drugstores that aren't part of a chain.

Category: Health Insurance Bills

Subcategory: Understanding Your Invoice

Tip: Arrange For A Payment Plan
Especially for more expensive procedures, but be sure the hospital does not charge you a large amount of interest. If that is the case, you might as well pay for the procedure on your credit card and gain frequent flyer miles in the process! Inquire about paying a larger amount in cash upfront and the hospital may opt to give you a steeper discount. Just remember, what ever you agree to, get it in writing!

Tip: Request The “Summary Of Benefits”
For those of you who do not have the time or patients to go through your entire healthcare benefits booklet, request the “Evidence of Coverage” (EOC) or “Summary Plan Description” (SPD). This is a “snapshot” of the plan's eligibility provisions, events that can cause you to lose coverage, your rights to continue coverage when you or your dependents are no longer eligible to participate in the Plan, and your rights to appeal a coverage decision or claim denial and the costs. Be sure you understand these terms and conditions, particularly the “exclusions” section setting out services that may not be covered. Ask your health insurance representative to explain what you do not understand in more detail, such as the out-of-pocket maximum benefit or if there is an annual or lifetime limit on coverage. Take note of all deadlines and procedures such as

how many referrals you can get a year and when the referral expires. Familiarize yourself with the sections and keep the entire booklet in a convenient place that you can easily come back and reference as needed.

Category: Health Insurance Tips

Subcategory: Coverage

Tip: Before You Check In, Shop Around
Ask your doctor where he/she has privileges and shop around to those facilities and comparison shop. You may be surprised to find that facilities have varying rates. If you find that one facility is cheaper than another for the type of procedure you are having performed, recommend that facility to your doctor. Some doctors may also be familiar with the facilities rates, so be sure to let them know what you are doing, and they may be able to save you some legwork. Again, always double check with you insurance to be sure they cover that facility.

Tip: Brush And Floss Daily
It's the best way to prevent periodontal disease and keep your teeth white (cost of treatment: from $200 for minor problems to $2,000 or more to replace a tooth). Dentists recommend at least twice a day, once in the morning and once before you go to bed. Be sure you have the best toothbrush for you (firmness, angle etc) and replace you toothbrush every few weeks.

Tip: Buy Your Own Equipment
Hospitals charge a significant markup on equipment like crutches or braces, so you're almost always better off buying them on your own.

Tip: Check Your Car
Check your car insurance policy—there is often a medical component. If you are ever in a car accident and need medical help, often times your car insurance will supplement what your regular insurance does not. If you do not have health insurance, the car insurance may cover a portion of your medical fees related to the car accident.

Tip: Don't Forget You Annual Check-Up
Conditions do not manifest themselves in our bodies overnight, it takes time. By going to the doctor and getting an annual physical, your doctor and yourself can reestablish you relationship by discussing any changes that may be occurring in your live that may

or may not be contributing to any symptoms you may be experiencing. Your doctor can then look over your family history and evaluate whether it is something serious or not or whether at a certain age you need to start becoming more aware of certain physical conditions that may start effecting you and adjust your diet, exercise, or even levels of stress at that point in your life.

Tip: Drink Grape Juice Instead Of Wine
Recent studies have show that the flavonoids in grape juice, like those in wine, prevent the oxidation of the “bad cholesterol” or LDL, which leads to formation of plaque in artery walls in addition to lowering the risk of developing the blood clots that lead to heart attacks. On the other hand, certain wines only prevent blood from clotting at levels high enough to declare someone legally drunk.

Tip: Is An Appointment Necessary
Before you go in for something minor, call and speak to the doctor or nurse over the phone. Talk over your symptoms and see if you really need the visit. If you have a solid relationship with your doctor, and he is familiar with your health history, he may be able to call a prescription in for you over the phone rather than you coming in and paying for a visit. If you need to renew a prescription, best to ask the nurse if she can ask the doctor to call it in for you. Medical bills Discrepancies occur rather often and can be challenged only if you have documented exactly what really happened. This process can be painstaking and difficult to do but it can save you thousands of dollars. For some arrhythmia reason, hospitals typically take up to a year to send a final, itemized bill. By this time, you will have forgotten details of your hospital stay and may not recall what specifically should or should not appear on the bill. If this done on purpose, it is termed delayed price escalation, and is dependent on your poor memory.

Tip: Never Pay A Bill Before Leaving The Hospital
In order to review a bill carefully, you will have to take it home. So don't pay in full when you are discharged, even if you have a small balance due.

Tip: Question Your Tests
You could spend thousands a year on cutting-edge medical tests, which usually aren't covered by insurance. Or you could hold on to that cash by sticking mostly with the baseline tests recommended by the U.S. Preventive Services Task Force (PSTF) www.ahrq.gov/clinic/uspstfix.htm, which makes recommendations for patients based on recent research. So if your doc insists you need a whole body CT scan that may not be covered my your insurance and can be very expensive, check the PSTF website as soon as you get home, and don't proceed until you get a second opinion.

Tip: Read Your Bill Carefully
Compare your bill to the log/journal you made along with the EOB and estimated costs you requested before you were admitted. Look for any discrepancies and bring them up the appropriate billing departments.

Tip: Take An Aspirin
An aspirin a day keeps the cardiologist away. If you're a man over 40, a woman past menopause or a smoker or have high blood pressure, high cholesterol, diabetes or a family history of heart disease, you can sharply lower your risk of a heart attack by taking an aspirin every day or every other day (consult your doctor first). The cost of aspirin: about 20¢ a day. The average cost of treating a heart attack: $25,000, including hospital, doctor and drug bills.

Tip: Wash Your Hands
Americans pay hundreds on flu treatments and countless more for colds but routinely neglect the best preventive treatment: soap and water. So get into the habit of scrubbing your hands for about 20 seconds, especially around the nails, before eating or handling food and after contact with any potential contaminants.

Tip: What Are The Extras?
Are you paying for acupuncture or chiropractic care and not using it? Do you really need the extras or can you substitute them for other forms of alternative medicine that you may use in the future? Check your insurer's website or call the help line to see if your plan covers alternative medicine treatments. Many also offer discounts on preventive measures like vitamins, bike helmets, and gym memberships. Others offer “healthy discounts” if you quit smoking, go for annual physicals, etc.

Category: Investing in Individual Health Insurance

Subcategory: Personal Health Insurance

Tip: Replacing Group Coverage with Individual Health Insurance
If you recently have become ineligible for health insurance coverage under a group policy there are a couple of options. If you were insured under your employer's group policy and the business had 20 or more employees, federal COBRA laws qualify to continue your insurance under that plan. COBRA stands for Consolidated Omnibus Budget Reconciliation Act. Employers with more than 20 employees are required to allow continuation of coverage to employees and their dependents who leave their jobs.

You will, however, be responsible to pay the entire monthly premium. You can continue your COBRA coverage for up to 18 months, and surviving dependents can receive coverage for even longer. If you had group coverage through a professional association or group and are no longer eligible for that coverage, you can purchase an individual insurance policy to cover yourself and your family. An insurance agent may represent a range of different insurance companies and will be able to provide you with an individual health insurance quote from a range of different companies. If you deal directly with a specific insurance company, it should be able to quote you on different products with different deductibles and coverage features. For a list of insurance companies approved to provide coverage in your state, visit your state insurance commission's Web site or call the office directly.

Tip: Single Disease Insurance Plans
A single disease health insurance plan is just as it sounds. It is a plan that is designed to only cover one disease. This type of insurance plan is available to cover a range of extremely serious illnesses such as cancer and multiple sclerosis. Make sure when you are gathering your individual health insurance quotes that you are not being quoted prices on single disease insurance plans, unless that is what you are specifically seeking. These plans will not cover routine or emergency health care costs, other than for the single illness defined in the policy.

Category: Keeping Health Saving Accounts

Subcategory: About Health Savings Accounts

Tip: High Deductible Health Plans
A high deductible health plan (HDHP), also known as a catastrophic health insurance plan, is a relatively inexpensive health plan that has a high deductible ranging from $1,000 to thousands of dollars. The premiums for HDHPs are usually considerably lower than those for traditional health insurance plans. You must have a HDHP in order to have a health savings account (HSA). To qualify for an HSA, your deductible must be at least $1,000 for single-person coverage or $2,000 for family coverage.

Tip: Setting Up A Health Savings Account
Opening a health savings account (HSA) is very similar to opening any other bank account. You can probably open a health savings account at your existing bank or credit union. Health savings accounts are also available through insurance companies and other approved companies as well as through many employers. As with any other banking service, do some homework before deciding where to open your account. There should not be opening fees associated with opening a HSA, but there may be

other service fees associated with maintaining the account similar to those with checking accounts and savings accounts. The interest paid on the account will vary from institution to institution, sometimes considerably. Finally, some institutions may offer greater conveniences linked to your HSA such as debit cards that allow you to pay for medical expenses at the point of purchase. That way you will not have the hassle of submitting receipts. If you open your HSA through your employer, your contributions will be made on a pre-tax basis directly through paycheck deductions. If you are opening an HSA on your own, you will need to keep all documentation of contributions made during the calendar year so you can claim them as a direct deduction to your gross income when you prepare your income taxes.

Category: Learning About Medicare Benefits

Subcategory: Medicare Insurance

Tip: Don't Wait To Sign Up For Medicare Part D

If you are receiving benefits from Medicare Part A or B, you are eligible for Medicare Part D. Medicare part D is optional and provides beneficiaries with assistance paying for prescription drugs. Open enrollment is held from Nov. 15 – Dec. 31 annually and it is when you can select or change your plan. Once people choose a plan they will not be able to change until the next enrollment period except in special situations. Unfortunately, if you opt not to enroll in Part D when they are first eligible, you will have to pay a higher premium if you decide to join later on. This penalty will be about 1% of the monthly premium. People who sign up late will have to pay this penalty unless Medicare decides they had drug coverage that was as good as Medicare's during the time they were not enrolled in Part D. This is known as “creditable” coverage. Hospital Visits: ER, inpatient, Rehab Many will argue that spending on hospital care is the fastest-growing segment of the nation's health care tab. On one hand, critics say hospitals are unfairly using their growing clout in many markets and charging far more than it costs to provide services. On the other hand, hospitals are saying that they are only trying to counter rising labor and equipment costs, while faced with insufficient payments from government and private insurers. Some where does this put the consumer? Hospitals are now demanding bigger payments by telling insurers to pay up or they will stop accepting their patients, thus if we are smart consumers, we may find ourselves falling victim to a high medical bill; thinking our insurance is paying for the bill, when it really is not. The next few tips will help you avoid that surprise.

Tip: Medicare Plan Details

The Medicare benefits application process is quite lengthy, and the best advice is to begin gathering information on the application process, benefits, and coverage specifics at least several months before your eligibility date. In this way, the information can be

carefully studied, and questions answered to ensure your benefits are not delayed. The Centers for Medicare & Medicaid Services, or CMS, publishes a "Medicare & You" guide each year that explains the program. It includes information about any changes to the plan, what is covered and what is not, how to pick a plan that is right for your needs, and a lot of other useful topics. You can request a copy of the guide by calling (800) 633-4227 or by visiting www.medicare.gov. You can also use the Medicare Personal Plan Finder, which guides you through a simple set of questions ultimately displaying a list of plans for which you are eligible.

Tip: Medigap Insurance
Medigap insurance is supplemental insurance privately purchased by individuals. These supplemental policies cover costs not paid for by Medicare that you would normally have to pay for out-of-pocket. Before signing up for Medigap, The American Association of Retired Persons (AARP) recommends considering other alternatives you may have available to you such as Medicare savings programs, Medicaid, retiree health insurance, and prescription drug assistance programs. AARP's Web site and its publications include a wealth of resources to help educate on these options as well as available Medigap plans.

Category: Long-Term Care Health Insurance Information

Subcategory: Long-Term Care Insurance

Tip: Home Health Care
Rather than enter a nursing home, many people are choosing to receive services in their own homes. While a traditional health care insurance may cover a portion of these expenses for the short-term, long-term delivery of these services in the home setting are an excluded item under your some plans. However, some long term health care insurance policies do include coverage for home health care services. Usually this is an add-on to the core policy, available if you agree to pay a higher premium. You will need to further the specifics of long term care insurance for more information. A home health care add-on often covers services received in the home as well as those received in places such as adult day care centers and assisted living facilities. When you compare long term health insurance plans, do not assume home health care is included. Ask specifically about what home health care benefits are provided under the plan.

Tip: Timing Your Long-Term Care Insurance Purchase
The younger you are when you purchase your long-term care insurance policy, the lower your premiums will be. This is because the insurer stands to collect premiums over a longer period of time. But you would not want to purchase it too early to avoid

overpaying. According to most financial planners, the best time to buy long term care insurance, sometimes called long term health care insurance, is in your late 50s or early 60s. In their late 50s and early 60s, the health of most individuals is stable, and the premiums for policies purchased at this stage of life are generally reasonable. Regardless of when financial planners think is the best time to purchase a long term care policy, one thing is certain: You must purchase your policy before you need long term care. Eligibility is based on your current health status, so if you are already ill and requiring constant care, you probably will not qualify for coverage.

Category: Obtaining Supplemental Health Insurance

Subcategory: Supplemental Medical Insurance

Tip: Medicare Coverage

Some of the health care services not covered by Medicare include anything not considered medically reasonable and necessary, based on a subjective interpretation! Other items that are not covered by Medicare are: Long-term nursing home stays Custodial care in a nursing home Private duty home care nurses Homemaker services Routine dental services and dentures Routine physicals Prescription medications Preventive care Vision exams and eyeglasses Hearing tests and hearing aids Routine foot care Physician charges above Medicare's approved amount Any care received outside the U.S.

As you can see, many of the services not covered by Medicare are the very types of services those individual's who qualify for Medicare are likely to need.

Tip: Supplemental Health Insurance
Supplemental health insurance, is basically insurance that is meant to fill in the gap, usually because your current plan does not cover certain services or the co-pays are too high. Obtaining supplemental health insurance is a good way to avoid paying additional out-of-pocket expenses. Types of supplemental insurance available include hospital indemnity plans and supplemental medical plans that come in a range of coverage levels and types. The most common type of supplemental health insurance is what is known as a Medigap plan. These plans are purchased by Medicare recipients to cover the out-of-pocket medical expenses, not covered by the original Medicare plan.

Category: Receiving Student Health Insurance

Subcategory: Student Health Insurance Plan

Tip: Online Quotes for Student Health Insurance
The Internet is a tremendous resource in conducting research of any kind, and shopping for student health insurance online can be beneficial. There are a multitude of legitimate Web sites that will supply you with quotes for student health insurance instantly. Some of these sites deal only with health insurance for college students, while others deal with all types of health insurance, including everything from short-term health insurance to long-term health insurance. Your school probably offers student health insurance to its students, so you may want to start there to see what type of coverage is offered and at what premium. Once you know what is available through the school, you can begin comparing it to plans offered by third-party agents and insurers. If you conduct an Internet search on the term "student health insurance" you will receive more returns than you know what to do with. Quotes will be provided free of charge, so do not ever pay to receive an insurance quote, and never reveal sensitive personal information on these quote sites such as your social security number or credit card number. Any quote site asking for that information is almost guaranteed to be a scam site. The only guarantee is to use good old-fashioned common sense!

Tip: Purchasing Student Health Insurance
Are you interested in receiving student health insurance for your child? There are generally two options available to you if you are looking to purchase health insurance for a college student. You can purchase an individual student health insurance policy through an independent insurance agent or directly from a company that offers such coverage. These types of policies are available as fee-for-service and managed care and many can be tailored to your needs in terms of deductible amounts. These plans usually provide the greatest flexibility in terms of when and where services can be rendered to the student. Another less expensive option is to purchase student health insurance through the school the student will be attending. Most colleges and universities offer students an opportunity to purchase student insurance through a school-sponsored plan. While these policies may be less expensive than purchasing an independent health insurance policy, the coverage terms also tends to be more fixed.

Category: Tips on HMOs & PPOs

Subcategory: About HMOs

Tip: Individual Practice Associations

An IPA, or individual practice association, is a group of doctors that have contracted with an HMO to provide services to the HMO's enrolled subscribers. If you are part of an

HMO that has contracted with an IPA in your community, you either pick or have been assigned a primary care physician from a list of doctors participating in an IPA. You would receive your primary care in this doctor's office. This is different from a prepaid practice group.

With a prepaid practice group, the HMO pays salaried staff physicians to provide health care services in HMO-owned facilities.

Tip: Managed Care

Managed care is a simple way to control health insurance costs. In the 1990s, health care costs increased dramatically. Insurers, in an attempt to control their risk, sought a means to control the way in which subscribers used health care services. This was achieved by many managed care plans requiring prior authorization for certain types of services.

For example, if you go to the hospital emergency room and the physician determines that you need to be admitted to receive proper treatment, a managed care plan will require that the hospital contact the insurance company and request an authorization to admit you. Without the authorization, despite how truly necessary the admission and medical care might be, your insurance company can deny payment to the hospital. Most doctor's offices and inpatient care facilities have become accustomed to the process of dealing with managed care, in order for them to receive payment and for patients to receive full benefits, and have a team of full-time staff dedicated to obtaining insurance verifications and authorizations.

Tip: Preventive Care

Preventive care, also called wellness care, is health care designed to promote healthy well being. While it might seem very altruistic of insurance companies to pay for preventive care, the truth is that it is in their best interest to keep subscribers healthy. It costs them far less to pay for annual physicals and routine screening tests than it does to pay for treatment for preventable conditions and diseases. Which preventive care services are covered vary from insurer to insurer, so pay close attention to plan details when shopping for insurance or comparing employer-sponsored plans.

Subcategory: About PPOs

Tip: Primary Care Physicians

Most health insurance plans that use managed care strategies to contain costs, whether it be a PPO insurance plan or an HMO insurance plan, require you to select a primary

care physician who you will visit to treat routine health problems, provide preventive care, monitor your health and diagnoses, and refer you to specialists should the need arise.

Most insurance plans recognize that different people have different health care needs depending on their life stage. As a result of this, you will be allowed to specify a primary care physician for each member of your family. You can list your pediatrician as the primary care doctor for your children, and separate or the same internists, and family care physicians for you and your partner. You can also change your primary care physician at any time by notifying your insurance company.