

How To Save Money Buying Health Insurance



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Welcome: You are looking at this guide because you either are leaving a job which offered coverage or you can not afford the plan you have or your employer does not offer coverage and you think it prudent to cover you and your family with a good plan. We will try to guide you through the maze of health insurance terms and coverage's available to you as an individual.

The first thing you should know is private health insurance is a very different product than any employee sponsored plan and very different from any plan your parents or others that have spent their working lives under or even the coverage

afforded medicare recipients. Private coverage first and foremost is expensive and almost all plans will require that you contribute a much larger portion of the costs of treatment than you will be comfortable paying. Welcome to our world. The world of high cost low coverage health care for the individual and self employed.

Chapter One

Types of Health Insurance

Employee Sponsored group health plans, Individual and Self Employed plans and Government Sponsored Plans are covered here. This guide is designed to assist the individual and self employed gain an intermediate level of understanding of the various types of health insurance plans that are available in the market place.

This guide is divided into seven (7) chapters beginning with the types of health insurance and culminating with a step by step comparison between two live plans. This guide should help you with the terms associated with the health insurance industry and the methodology employed by Health Insurance Companies when designing a plan of coverage.

There are three basic types of Insurance plans or indemnity programs available for an individual and family coverage.

- Employee Sponsored group health plans
- Individual and Self Employed plans
- Government Sponsored Plans

We will first discuss Employee Sponsored group health plans. While this guide is not directed toward these plans it is important to gain a level of understanding of these plans because many individuals have been covered by an employee plan or may become eligible for an employee sponsored plan.

Employee Sponsored group health plans are plans offered by Health Insurer's such as Blue Cross or United Health or a wide number of the many Insurer's that also sell individual plans. There are two classes of plans available to an employer a small group insurance program which usually requires as little as 2 company employees up to about 50 employees. The second plan available to employers is a large group program usually requiring more than 50 employees.

The first class, the small group plan requires two or more participants. The plans available to an employer in this class may be offered to an employee without

employer participation. Employer participation means that under the guidelines of a small group plan the employer is not required to pay for a portion of the cost of the plan. Many small businesses offer these plans and some companies do provide plan cost support. However, it is our experience that the full cost of a small group plan is passed to the individual employee.

The second class of group coverage is the large group plan. Most companies that offer a large group plan are required to pay for a portion of the plan cost for the individual employee. It is the employer's option to cover the full cost of the employee and some employer's cover some or all of the family members of an employee. The employer plans are available to every immediate family member of the employee once the employee becomes eligible for coverage. These group plans are highly regulated and controlled to insure coverage is made available to every eligible employee and family member.

Both large and small group plans usually have more than one coverage option. However, with rising costs many small businesses that offer a group plan are opting to offer one coverage option. While most large companies limit their offerings to three types of plans each plan can have different deductible options and co-pay options.

The three most common plan options are:

- Preferred Provider Plans
- Health Maintenance Organization Plans
- Doctor Select Plans

After an employee selects a plan they must remain in the selected plan until the renewal period, usually at the beginning of the calendar or fiscal year of the company or during a specific open enrollment period. The employee may choose a plan or opt out at any time and in most plans may add family members or opt family members out of the plan at any time.

However, once an employee or family member opts out of coverage it may require waiting until open enrollment before they can reclaim coverage. These rules are usually company driven and as of this writing many companies have relaxed these rules and will allow an employee more flexibility with coverage. A new born is automatically eligible for coverage.

The Preferred Provider Plan or more commonly known as a PPO is a plan that allows an employee to choose from a number of primary physicians and specialists and hospitals within the greater community where the employee works and lives.

This plan option will usually be more expensive and the employee must weigh the cost of the plan against the gain or comfort level of retaining a family doctor or a hospital the employee deems necessary for their family.

The second type of plan is a Health Maintenance Organization or HMO plan. The primary difference between this plan and the PPO plan is the HMO plan provides a select group of doctors and hospitals available to the employee. The PPO usually allows a greater flexibility in physician and hospital choice. The HMO plan will always be the least expensive plan available. Normally the HMO plan will also provide the employee and family with the lowest level of deductible and co-pay options. The reason is an insurer can contract with a specific group or individual hospital at a better price than with a larger group.

Another option is A Doctor Select Plan which sometimes is labeled a special PPO plan. The difference between a PPO and a Doctor Select Plan is the employee can select any doctor or hospital they choose not just the physicians and hospitals within the select PPO or HMO plans. This plan will cost the employer and employee the most.

Employee plans are very expensive and costs are escalating. One of the main reasons an employee sponsored plan is expensive is guaranteed issue. No employee under a group plan can be denied coverage. Insurance companies price up the plans to cover all possible conditions and then further price the plan based upon a workup of each employee health history. When a plan is renewed the insurer further prices the plan based upon plan experience and general cost of living increases.

Because of these constant cost increases many businesses are offering less and less options to the employee and increasing plan deductibles and co-pay programs in an effort to curtail costs. We are also witnessing companies canceling employee coverage as costs increase. We believe this trend will continue and more individuals will be required to buy private insurance or cover the full cost of an employee plan.

The next plan type and what this guide is all about is purchasing private coverage for you and your family and coverage for Self Employed individuals.

Most of us are not fortunate to work for a company that offers a health plan. Or if we do we have to cover the cost of our family which as discussed above is an ever increasing cost and in many cases the coverage options even with a group plan continue to be reduced or in some cases eliminated.

If you are one of the more than 80 million that are not covered by a group plan your only options are to buy a private plan or go without. There are a few exceptions to this rule.

If you are economically challenged you may be eligible for assistance or if you are 65 or older Medicare insurance is your coverage option. There are a wide variety of insurance companies that offer individual health insurance and the plans range from comprehensive coverage to scheduled benefit coverage.

If you have ventured into this complex and confusing and sometimes misleading realm of purchasing private health insurance this guide will be helpful.

There are a number of plan types available to the individual they include:

- Preferred Provider Plans
- Health Maintenance Organizations
- Specific Medical Organization sponsored plans
- Specific limit plans
- Health Savings Accounts
- Small group plans for Business

The Preferred Provider Plan, PPO

The Preferred Provider Plan, PPO as mentioned in the employer program above allows the customer to select from a number of plan doctors and hospitals. A PPO plan requires a family or primary physician be selected then all referrals usually for specialist review must funnel through the primary physician.

The insurer contracts with individual hospitals and doctors or buys into a network service than uses specific doctors and hospitals and usually obtains select pricing per service and passes that cost to you in the form of a monthly payment based upon the size, sex, and age of your family plus your health history. You will find that most individual plans offered are PPO plan offerings.

The Health Maintenance Organization plan or HMO

The Health Maintenance Organization plan or HMO is usually provided by a select company that only offers this plan. A large HMO provider in California is Kaiser Health. The primary difference between a PPO and an HMO is the HMO is usually provides a very limited list of physicians usually attached to a specific hospital so your choices are much more controlled by the plan than a PPO. As with a PPO plan all activity is controlled through a primary physician and the time it takes to schedule visits are much more limited and spaced than a typical PPO

plan. Usually, the HMO plan cost is less than a PPO plan and the coverage is better in terms of deductibles and co-pay's and the cost of medicines or the drug plan contained within the HMO plan.

In many large cities and now more and more local communities hospitals and medical groups are designing their own health plans and offering coverage on a monthly basis to individuals and families. The Specific medical organization sponsored plan is this type of coverage option becoming more popular. In Texas the Children's Hospital offers a great plan for children up to the age of 18. Many hospitals offer maternity programs.

You should be aware that individual health plans no longer cover normal pregnancy. In fact one of the questions on a health insurance application is are you or any member of your family pregnant. If the answer is yes you are immediately declined for coverage until the baby is born.

Some insurers offer a limited maternity supplement but it is very expensive and does not cover very much and has an extended waiting period before the full coverage amount becomes available. It is almost never cost effective to buy this coverage. On the other hand private hospitals offer very competitive programs that cover the full range of maternity requirements from pre to post natal care. They even have savings plans and monthly payment options.

Mid-West and United American are examples of health insurance companies that offer limited coverage plans or scheduled benefit plans as options within their portfolio of plans.

These limited coverage plans are gaining popularity because they are usually priced below a standard major medical plan. The individual then makes the decision that X amount of insurance per condition or hospitalization that the plan covers is sufficient.

If you consider that an average individual is hospitalized once every 20 years and the average cost of a hospital stay is about \$50,000.00 then you can see how these plans are gaining as alternatives to standard comprehensive plans. In other words more and more people are beginning to roll the dice.

Many people are opting out of the system altogether by not purchasing coverage. The number is somewhat elusive but close to 50 million do not have health insurance and over half of them could afford to purchase a program. Now we believe going uncovered or buying a scheduled benefit plan is a very dangerous. The environmental changes and food options are becoming limited.

In other words our bodies and health are being greatly affected by forces outside our control. These forces will in our opinion change the above stats regarding hospitalizations and costs per for the worse and by multiples. We don't mean to

be alarmists but you can figure it out for yourself. How many people are considered clinically obese today, just look around, especially young people and how many people do you know that have some form of diabetes or heart issue or cancer compared with the number you new say 10 years ago.

Do you think the trend will increase or decrease? The answer to that question makes the \$300 to \$700 per month difference between purchasing a comprehensive plan and a scheduled benefit plan a sobering thought, and going without when you can afford it very risky.

The Health Savings Plans

Health Savings Plans are a new and very interesting way to purchase and cost out health care. Today most health insurance companies offer an approved savings plan. The health savings plan requires that the individual or family contract with a financial institution and set up an account similar to an IRA account.

Money in the form of a deductible is placed in the financial institution in a health designated account and then the insurance company offers the customer one of a number of health plans similar to any other individual plan. The major advantage of the HSP is the initial deposit or deductible is considered a pre-tax investment and is calculated as a tax credit on your income tax return.

The difference is you can use the funds for health purposes without incurring a tax penalty for taking the money out of the account and you can replenish the account up to the maximum each year as long as the money is used for health purposes. The plan costs are usually low because the deductible is considered a high deductible for plan purposes.

We discussed group plans in the employee discussion above. However, most small businesses have less than 50 employees and can obtain an individual plan grouped as a small business plan for their employees.

The advantage to the employer is they can deduct a portion of the cost of the plan the advantage for the employee is the plan qualifies as a group employer plan and employees become eligible without consideration of prior health concerns.

This type of plan is offered by most of the major health insurance companies. The plan costs are again determined by past employee history but because the population is less plan costs tend to rise faster than large group plans or even individual plans. Also the coverage options are usually limited compared with a large group plan primarily because the cost of the offering becomes out of the reach of a small business.

The Government Sponsored Plans

The last group of health insurance coverage plans that are available to individuals and the self employed are government sponsored plans.

The largest of these plans are the Medicare and Medicaid programs offered by the federal government. Standard Medicare is age determinate. At 65 an individual with sufficient social security points becomes eligible for Medicare coverage at zero cost to the individual. Medicare is comprised of two separate but connected programs. The A portion of the Medicare coverage is automatic and covers hospital visits and procedures. Part B is an elective coverage option and covers 80% of all out patient coverage such as doctor visits, emergency room costs. Neither plan covers drug or dental costs.

The government approved the sale of Medicare supplements which cover up to all of the costs not covered by part B. The supplements are sold by most of the health insurance companies that offer individual coverage plans. The main requirement to become eligible for a supplement is be eligible for Part B of the Medicare program.

During the first 90 days after you become eligible and accept Part B you can obtain a supplement policy without medical condition requirements. After the grace period you must qualify health wise for a supplement plan.

The government recently authorized a Part D plan which covers some drug costs. This plan is sold separate from a supplement and is available to any individual over the age of 65 or who otherwise is eligible for the plan through special approval such as a social security disability recipient or someone eligible for Medicaid coverage.

A third plan named Part C is a combination of the coverage provided by Part A and Part B and is sold through major health insurance companies. You can apply for such coverage and be offered plans ranging from PPO, HMO, and MPES or Medicare private fee or service plans which allow you to visit any doctor or hospital.

Each of the above plans are offered at the same price or more depending upon which program you select than the current cost of Medicare. Medicare Part A is free with an annual deductible. Part B is optional. If you select Part B you will be charged a monthly fee for the coverage. Most supplements cover the part A deductible and most of the Part B costs and of course require a monthly fee for the coverage.

Medicaid coverage is available for those that cannot afford health care or the full cost of Medicare costs. The federal government and state governments have combined programs that comprise the funding for Medicaid. Each state has their specific eligibility requirements which include financial, special needs, and other considerations to become eligible for this very special coverage.

An example of the above coverage is the Texas Gold program which is offered low income individuals in Harris County Texas. Harris County is located in the greater Houston Texas area. This program provides individual coverage including hospitalization, out patient, drug, office visits all at no cost or in some cases based upon verifiable income a small co-pay for the drug program. This coverage is similar to an HMO plan in as much as the applicant has specific hospitals and physicians available and must go through a primary care test to be scheduled to see specialists.

The COBRA Plan or the Consolidated Omnibus Budget Reconciliation Act

COBRA or the Consolidated Omnibus Budget Reconciliation Act was passed to help assure that all individuals and their families have access to group medical insurance for a period usually up to 18 months after an individual leaves their employer if they were covered under a group health plan.

The coverage remains exactly the same as the coverage the individual had with the company and there are no health qualification requirements to continue with COBRA coverage. Upon exit your prior employer is required to provide you with information regarding COBRA and how to apply for the program. T

he cost, however, is an eye opener. You will be charged the full cost of the plan you were in while employed. In most cases the costs will be many times your contribution level while employed. Many of you are currently on COBRA coverage and are either at the end of the qualification period or cannot afford the premiums and are now looking at private health insurance as a replacement. This guide will help you evaluate that process.

Looking for individual health coverage is not for the faint of hart and we recommend you work with an expert. The only problem is most times you will be forced to go through a number of company representatives and most reps have one specific plan that they sell.

It is almost impossible for you as a layperson to compare plan comparisons except by premium costs, deductibles, and co-pays. An agent will always downplay any other plan and gloss over the real hidden holes in the plan they are trying to get you to buy. We have also found this to be true of Brokers that claim to allow you to choose any plan.

We have a blog site that you can use to send us questions or if you like we will be happy to help you evaluate plans. We have a chapter that guides you through three completely different plans as an example of the questions you will need to be clear about before applying for a plan.

The blog address is: <http://blog.businesshealthinsurance.com>

We always recommend looking at a variety of options and today you can actually get a good handle by going to a site such as ehealthinsurance.com and select some that make sense then let us know and we can advise you regarding the good and not so good with each plan.

Since we do not sell insurance we don't have an axe to grind. Our mission is to help you make the most informed decision you can regarding a plan. The worst thing that can happen while on COBRA is a family member has a serious illness and becomes ineligible for individual coverage. Well there is an option.

The option to standard coverage is the state offered alternative health plan program. Each state offers an alternative plan of health coverage for those individuals that do not qualify for regular health insurance. Once you obtain a rejection for health reasons from an insurance provider you can apply for coverage from your state health organization.

The plans do require a period of time before the specific condition is covered a waiting period but the individual is covered for all other issues and once the waiting period is over the condition is fully covered. These plans are of course very expensive but may be your only alternative.

A hint, sometimes with a very high deductible plan, (remember if you are coming from a company plan you may think a high deductible is \$500 per person), usually above \$5,000.00 per person the underwriting department may slide on qualifications per applicant and it is worth a try to apply for this type of coverage for the individual in your family that otherwise would not qualify for a private plan.

The Children's Health Insurance Program

There are millions individuals in the US that are not covered by health insurance. Some of the reasons are financial and some are choice. The Children's Health Insurance Program, CHIPS is a way to obtain insurance for your children even if you are unable to afford a plan for your family.

This program is part of the Medicaid sponsored government and state funded program to provide insurance to a greater population. The plan covers eligible children up to 18 usually the requirements are financial not health related.

Chapter 2

Health Insurance Costs: Deductibles, Co-pay's and Out of Pocket Limits

Private health insurance premium pricing is usually dictated by the annual deductible amount. A low deductible will normally be priced higher than a higher deductible plan. That is not always the case but in general true.

As an example, the Blue Cross Select Blue Advantage plan deductible ranges from \$250 up to \$10,000.00 per person and the premium for a family of 4 ranges from \$1,405 to \$558 per month. The basics within the plan are the same. Co-insurance 15% after deductible, 3 person maximum deductible, \$25 physician co-pay and an RX plan and optional dental coverage.

The Blue Cross family of plans requires a deductible per person up to a maximum of 3 deductibles per family. The maximum deductible allowed by law for a family is 3. The maximum is regulated and all health plans must comply. Some Insurer's like Unicare offers a lower number of deductibles per family on their plans. That is why it is necessary to evaluate a number of plans before settling on one.

The deductible amount per person covered, (but not the number) will increase if you use a hospital or physician that is outside the plan scope.

A deductible is also usually applied to the drug plan if such a plan is included and normally only on the brand name drug not the generic drug. Some plans offer a dental plan as an option and a deductible is normally part of the plan. The drug plan and Dental plan deductible is per person per year with no family maximum regulation so you will pay the deductible for each family member that uses the plans. Many plans offer substantially reduced deductibles that are separate from the plan deductible and will not apply to the health deductible when used.

It is also important to understand that a deductible is usually based upon a calendar year cycle regardless of when you buy the plan. If you buy in August then you are responsible for one deductible for that year and in January the plan will require a current year deductible per person. What that means is if you or a family member incurs an event in December you will be subject to the deductible requirement. Once January hits you are again responsible for another plan year deductible. I don't know any plan than has a continuation of coverage that waives the deductible once you go into a new plan year.

However, the maximum out of pocket expense may help defer that deductible if the event is a continuation going from one year to the next so check the plan details very carefully.

Insurance co-pay's are sometimes included as a feature of an individual private health plan. Believe it or not many private plans are not offering co-pay plans until after the deductible is met or not at all. This will probably be one of the major differences between a company sponsored plan and private insurance.

The plan Co-pay unless otherwise noted will only cover the office visit and consultation. If you have had an employee sponsored plan this will be a big change. In order to be covered for tests and x-rays with a standard plan you will be required to pay your deductible before coverage begins. A limited number of plans have the extended coverage available but you will pay for it in the premium.

In order to mitigate some of the burden of test costs some plans include an annual physical or check up per person that includes some test costs usually up to a maximum of around \$300 per person per year. This feature sometimes referred to as a "bucket of services" is very complicated and should be fully explained because it is often misstated even by agents selling the plan and can end up costing you a lot of money.

Again, co-pay costs go up if you use an out of network physician. Also it may be necessary for you to use an out of network specialist because of the nature of an illness so really understand the differences between a plans in network coverage and out of network coverage before you buy.

Most health insurance plans require a coinsurance payment. The coinsurance is the amount of money you must contribute once the deductible has been met. The term most commonly mentioned is 80/20 plan or 70/30 plan. What that means is after the deductible you pay either 20% or 30% of the remaining authorized bill and the plan pays the rest of the bill.

In a major comprehensive plan you pay the deductible then your portion of the remainder of the authorized bill your coinsurance only up to a maximum out of pocket amount. This is termed the Maximum out of Pocket expense. The maximum amount included in your plan limits your exposure on any one medical experience. We believe you should never buy a plan without a defined maximum out of pocket limit. As with all plan features if you use an out of network service this maximum will increase.

Some drug plans also offer a maximum out of pocket limit some though only cover a maximum amount per year so again it is important to really understand the plan coverage. Lastly, there will be a lifetime maximum limit to coverage in a plan per person. That lifetime maximum is becoming more and more important as health costs increase. The maximum is the amount of money that the insurance company pays not the total of the billing costs.

Try to buy a plan with the highest life time coverage amount that you can. We are seeing most plans offering \$5 million life time per person but some are lower so make sure yours is the highest.

Chapter 3

Plan Coverage

This section will introduce the various terms associated with plan coverage generally associated with an individual health insurance plan. The items below should be considered as a check list for you to assess a new plan or your existing plan coverage to insure that you are getting what you think you are getting and that the price for what you are really getting is worth it.

There are a number of items you need to review before you make your decision they are as follows:

- Life Time Coverage amount
- Maximum out of pocket expense per person
- Deductible policy
- Is the plan a major medical plan or a limited coverage plan
- Emergency room coverage and terms
- Hospitalization coverage
- Physical Therapy coverage
- Maternity policy
- Continuing care policy
- Specialist care policy (Out of Network)
- Office Visit limits and dollar maximums
- diagnostic policy (X-Ray and lab work)
- Out of Network policy

- Requirements for procedure approval
- Is the plan guarantee issue
- Is the plan guarantee reissue
- What is the guarantee period of price protection
- Drug Plan and maximums
- Does the insurance company pay their bills (complaints)

The above are the major considerations that must be discussed before you make a decision regarding any health insurance plan. We will analyze each

We talked about the maximum life time coverage. In today's environment a \$5 million per person is a requirement. Anything less will leave you open for hitting the maximum before you become eligible for Medicare.

More important than the deductible is the maximum out of pocket limit feature. Be sure your intended plan has a maximum out of pocket limit. Usually the max will only cover a specific occurrence. You may be offered a plan that does not have a maximum out of pocket limit per. If so, it is important to review every aspect of that type of plan and understand that most likely it is a limited coverage plan.

Understand the deductible policy. It is usually per person per year and the maximum deductible is 3 per year. Some plans offer a spill over feature. If you meet your deductible during the last 3 months of the plan year your deductible is deemed to be met for the following year. Unicare plans offer this feature.

As we discussed earlier if the plan has a maximum out of pocket limit then it is considered a major medical plan if not it is a limited coverage plan. Most plans require you to meet your deductible before they cover any of the cost of an emergency room visit. Some plans offer separate emergency room coverage that may require a different deductible and different coverage limits. This can be a very good feature to add to a plan.

Some companies offer a plan called an accident policy that pays per occurrence that can supplement your existing plan and give you the emergency room coverage and provide enough money to cover your deductible and any out of pocket expense you have to pay.

American General has a great plan that provides up to \$10,000.00 in coverage per occurrence per family member with no life time limits and the payment is guaranteed for the life of the plan. This coverage could be a great supplement to a standard medical plan.

You should ask about a supplemental coverage plan especially if you have children. We see more and more combinations of standard major medical plans supplemented with accident and illness plans and even a new life insurance program that pays a lump sum benefit upon detection of a heart attack or cancer. These are great supplemental programs to enhance a standard health plan.

Most major medical plans cover hospitalization. Many limited coverage plans offer a maximum payment per day with limits on the number of days covered for hospitalization. The real issue with hospitalization coverage is to understand which hospitals are covered and how coverage for out of network and some in network specialists work. I will cover this in some detail under the out of network section.

Now you are out of the hospital and require physical therapy. Review your plan to see how your coverage works. Many major medical plans offer limited coverage and maximum payments per visit. Some plans cover physical therapy as an out patient procedure and cover the full program but less than you think so really look into this coverage. Many times your agent will not know this answer check it out with the company.

I can guarantee your plan will not cover maternity in fact it will specifically exclude maternity coverage. In fact one of the questions you will be asked is, "are you or one of your family members pregnant". If so that person will be denied coverage until after the baby is born. Some insurance companies will not offer the plan if any family member is pregnant.

Some plans do offer a maternity program as a separate cost, again there is a waiting period before coverage is available and if you are pregnant or a family member pregnant even if the program is offered under the plan the applicant will be denied coverage until the baby is born. We have reviewed all the available maternity plans and none are worth investing your time or money. The best way to obtain maternity coverage is to work out a plan with your local hospital for pre and post natal coverage. The plans are competitive and can be negotiated especially if you live in a large city with many hospitals.

If you become pregnant after you accept a policy and your pregnancy develops complications as deemed so by the insurance company, then and only then will the actual procedure be covered subject to normal deductibles and co-insurance payments. No pre or post natal coverage will be offered except in cases where the baby's health is in danger.

Sometimes an illness requires long term home care. A standard major medical plan will not include sufficient coverage for an individual facing a long term recovery situation. Check the coverage plan details contained in the terms and conditions contained in the plan.

An easy way to review the details of the plan is to pull up any plan on the net pull up the plan from the company you are interested in and go over the terms and conditions section plus review the other coverage section. There are good supplements for long term care that will cover you and any good agent should be able to point you in the right direction to compare some plans. Once our blog is up we will be happy to research long term care plans and make our evaluations available.

Most plans allow for specialist visits and care as long as the specialist is inside the provider network that you chose as part of your plan. However, in some cases a serious surgery or illness and treatment require a specialist that is not part of the plan network. In those instances assuming the plan administrator approves the specialist the costs that are paid by the insurance company will be considered as out of network costs and you will be required to pay the out of network pricing. In addition, the insurance company or the network they contract with will not have a contractual agreement to price services.

So not only will you receive a major reduction in coverage from your insurance plan you may very well receive a bill from the specialist for any amount of billing that is not paid by your insurance company.

To illustrate this, Houston Texas has a world class cancer center and is also home to one of the most prestigious heart centers in the United States. Neither center participates with provider networks. They both charge their full pricing because they are the best in their respective fields and they do not need to hassle with the pricing and payment models that most individual health plan administrations present.

Therefore, if you need a specialist or specialized treatment your individual plan may not cover the costs at all or at best a small portion of the costs. What is more disturbing is many times a patient is denied service because their plan will not adequately compensate for the full cost of treatment. Also because the centers are on the leading edge of treatment the individual plan and even many group plans will not authorize the treatment because it is deemed experimental.

We discussed the reasons why it may prove cost effective not to take a plan that offers office visits. If you do wish a plan with office visits be sure you are getting what you think you are getting. If your experience is with an employee sponsored group plan then your co-pay will usually cover the full office visit including, diagnostics, drugs, X-rays, and so forth.

That is hardly ever the case with an individual plan. Most plans that offer office visits with a co-pay will cover the office visit consultation only.

Diagnostics, X-rays and other costs are usually subject to your deductible and co-insurance. This includes annual physicals, OBGYN visits and specialist visits. We have investigated a few plans and some provide a limited amount of dollars that can be used for office visits or physicals without meeting a deductible or co-insurance and some plans actually offer the X-ray and other diagnostics within their office visit plan. You will always pay more for these inclusions and your annual increases with these inclusions will also be more than a plan with limited office visits or office visits that are covered after you meet your deductible.

The out of network feature which is contained within most insurance plans. All plans that are network driven have out of network requirements. What that means is if you use a doctor or hospital outside the network of providers in your specific plan you will be required to pay a higher deductible and your co-insurance requirement will be more plus the plan will usually not cover the full cost of the out of network service and you will be responsible for any overage of cost.

If you have an emergency and can not use an in network facility the plan will cover the cost as if you were in network. Some plans offer open network programs. These plans allow you to see doctors and use hospitals of your choice without network restrictions. These plans are more expensive but very flexible. Celtic is an example of an insurance company that allows an open network plan. Of course, it is much more expensive than comparable plans if you are looking at the deductible only but some individuals appreciate the flexibility of a high end plan.

It is important to understand that even if you have a company plan such as Blue Cross which is nationwide, your in network coverage is usually limited to the state that you reside in or the list of doctors and hospitals contained in the specific network of the plan you signed up for. In that instance if you move out of the area you will be charged the out of network pricing even if the hospital you go to or doctor you visit accepts Blue Cross.

This is not limited to any one carrier all carriers that provide network coverage are the same. You should also know that if you move out of the service area that is covered under your plan you may be required to apply for a new plan.

Many times you will be required to qualify all over again. If you have a health issue the qualification process could prove difficult as most plans do not guarantee issue.

If you apply for an HMO plan or even a PPO plan most times become you have a procedure even one recommended by your primary physician the procedure must be pre approved by the insurance company. You should determine the requirements for procedural approval.

The approval process is usually included in the terms of your contract and you can find them and review them prior to signing up for any plan by visiting the site and looking at the terms and condition section. More and more insurance companies are opting to reduce procedures in order to save what are termed unnecessary procedural costs or experimental treatments. In some cases they are correct in their determination.

In many cases they are not correct and it must be remembered that an underwriter not a doctor on the scene makes the determination. Now this procedural approval process is also required if you have an employee sponsored plan so it is just part of the movement to reduce benefits by the insurance industry. hat is our educated opinion.

Check to see if the plan you have or are apply for offers a guarantee of issue and or a guarantee of reissue. Most plans do not guarantee issue. Some states like Massachusetts require all plans to guarantee issue. That means regardless of your medical condition you cannot be denied coverage. Some plans also guarantee reissue. Each year your plan is renewed by the insurance company. They can increase your plan offer you another plan or deny renewal based solely on their review and determination of your experience.

Some plans offer a guarantee and some states require that a company offer guaranteed renewals. Again, you will be able to determine if the plan is guaranteed by reviewing the terms and conditions. Most plans outside the state of Massachusetts do not offer either guarantee. Some plans can and will cancel coverage if they believe the cost of the plan is more than they should pay. In other words if you are in the middle of an extensive and expensive treatment plan you can be cancelled. This happens more than you would think and is just one more thing to review when choosing an individual plan for coverage.

Each plan has a period of time that guarantees the premium. Some plans guarantee the premium for one year increments other plans guarantee the premium for as little as 6 months and a few plans guarantee the premium for the life of the plan. The health insurance field is very competitive and in order to attract individuals plans often offer a teaser rate to get a customer into the programs then after a grace period of say 6 months they begin raising the plan premium.

This raise can be as much as 10% to 30% of the base premium depending upon the insurance company and plan selected. This is regardless of the qualifications and health history of the applicant or usage. Sometimes it is very difficult to determine when your plan premium will rise without discussing the plan language with an agent of the company.

Until you know when the grace period is over it is very hard to compare one plan with another especially if the plan you are comparing has a one year set premium and the plan you like does not have that long a guarantee period.

Some plans offer a drug plan as an option and some plans offer drug coverage as part of the basic plan. In either case review the coverage to determine if a deductible is required and what class of drug is covered and of course check out the cost or co-pay amount per class type.

There are generally three classes of drug coverage, generic, formula, and standard brand. There is now a fourth class of drug special formula which sometimes includes specialty items such as chemotherapy serum. It is critical to review the specialty drug plan to determine if a cap is contained. Some plans do set an annual limit on the amount of drugs that are covered.

Once the maximum is met then all remaining drug costs during the plan year are not covered and must be paid by the customer, that means you. Again, if you choose the drug plan that is contained in the plan you can bet your boots that upon renewal the plan will increase in price more than if you did not have the drug coverage.

When you review an insurance plan one of the areas to review is the payments history and complaint history that a particular insurance company has received. You can gain a sense of how the insurance company will treat you and your claim issues by the way they work with others. Most insurance companies are rated A or A-.

However, that rating does not indicate how well they pay claims and solve treatment issues for you the customer. The best way to get that information is to review their history with the state. You can find that information by going to the Internet and doing a search for insurance information related to your state.

Chapter 4

Why Insurance Matters

We will devote this chapter to exploring if purchasing health care insurance is something you should do or if being covered by a plan is even necessary. You

are probably aware that more than 44 million individuals in the United States are not covered by health insurance.

The latest data also points out that many of the uninsured can afford to purchase and maintain a policy but choose to remain uninsured in fact only 16% of the uninsured are not employed.

The very idea that many individuals remain uninsured even though they can technically pay the cost of a premium is an area we thought we would look into. Now in order to evaluate the uninsured we should break down the data.

According to Families USA June 2004 article the uninsured are up to four times less likely to have a regular source of care than the insured. Uninsured are more likely to use the emergency room as a regular source of care than insured individuals. Two thirds of all care delivered to uninsured is delivered by hospitals. Uninsured are more than 30 percent less likely than insured to have had a checkup in the past year.

The uninsured often delay or forgo needed medical care and the main reason cited is the high cost of care. Over 18,000 deaths of people between the ages of 25 and 64 can be attributed to a lack of insurance coverage. Uninsured patients are three times more likely to die in the hospital than insured patients.

Also when admitted, (which is usually only through a life threatening occurrence after admitting to the emergency room), uninsured patients are more likely to receive fewer services and to experience second-rate care than insured patients.

In 2001 uninsured Americans received \$35 billion in uncompensated care. The uninsured are often charged more for health services than people with insurance. Major insurers negotiate large discounts with hospitals and physicians. These discounts are passed to the uninsured. We will examine the listed rates charged by hospitals for specific procedures and the average negotiated rate for the same procedure later in this chapter.

According to the National Survey of family Growth and the National Health Survey, nearly 59 percent of all individuals state that health insurance ranks high as a priority for their personal budgets and over 40 percent of all uninsured state they would have to cut back on necessary items to buy health insurance.

Of the 85 percent of employed individuals that are uninsured 13 percent have incomes above \$74 thousand, 25 percent of the uninsured come from incomes between \$32 and \$56 thousand and the remainder 62 percent of employed have incomes below \$32 thousand. As mentioned above only 16 percent of individuals that are unemployed are uninsured.

So what do these statistics mean for you and me. Well, first of all the statistics show if you get sick and do not have health coverage you will have to pay a lot more than someone that has insurance. In addition, the cost of providing care to the uninsured has an unintended consequence for the insured, higher costs of insurance.

Chapter 5

Eligibility Factors

Credible Coverage

There are a number of Eligibility factors that go into the Insurer approving your application for health insurance coverage. You are now entering into the world of private individual health coverage. This is quite different from the plans many of you have experienced. Quite a few people have spent their adult lives covered by their employers insurance plans and go straight into Medicare.

Today more and more companies are unable to provide health care to their employees or if they do offer sponsored plans the price burden is beginning to fall to the employee to pay the costs of insuring the remainder of the family.

The reasons for this burden transfer is not always obvious but the primary reason is employee sponsored plans require that the insurer take on the health risk of each and every employee in the group which is the company. The Insurer can and will assign a risk cost as they review each individual's health records when they first sign up a new company and each year when they renew the plan for the company.

One can imagine then the cost of group coverage when the Insurer has carte blanche to assign risk costs at will with no local, state, or national risk cost standards. Then as the health experience of the company matures, (usage by the members of the plan the employee's), the price often increases to the point where it becomes financially impractical for the company to pay all the costs or in many cases any of the costs.

So you are looking for health coverage because your cost burden with your employer's plan has made it impossible for you to continue paying for your family or your employer has discontinued a group plan altogether or you are self employed.

Now comes the hard part, qualifying for coverage with a private health plan through a health insurer. We discussed continuation of coverage (credible coverage) in an earlier chapter, (COBRA coverage).

However, getting into the COBRA plan program is not easy and just because a company discontinues a plan you are not automatically eligible for that coverage and you nor your family would be eligible just because you are unable to pay for the cost of your family. Also as detailed COBRA is a very high cost alternative and offers a limited time frame for coverage.

Under current law if you leave your job and your group plan qualified you will be offered COBRA coverage for you and your family. In most cases the COBRA coverage will be available for 62 days after separation from your last employer.

Individual coverage will test that requirement and usually will wait until you have passed the 62 day period before they allow you to qualify for coverage in one of their plans. What that 62 day waiting period does for you is break the chain of automatic coverage regardless of your prior health condition and place you and your family into the bag of qualifying for coverage.

Again, there are a few states that require an insurance company to offer insurance regardless of prior or current health status of the proposed insured but at this writing there are only two states Massachusetts and Washington State that are subject to this requirement.

So now that the reality of qualifying for coverage has hit home lets discuss what the insurance company is looking for.

First of all if you or a family member to be covered has had any prior health issues they will be reviewed by the insurer in detail. The health business has a credit history on each individual that is in the health system or at some time was covered by a health plan this includes drugs.

After review the insurer will either insure you without restrictions, place restrictions on the health issue such as a rider that may exclude a condition from coverage or establish a time frame before they will cover a specific condition. Any time the insurer includes a rider the cost of the plan will increase. If there are a number of past or current conditions in your history the insurer can and will decline coverage.

Also if you fail to disclose a condition and the insurer provides coverage they have the right to cancel coverage or exclude coverage for the condition that was not disclosed on the application. There is a stipulation that once insurance has been in force for more than 2 years in some limited cases 1 year and then a prior condition is repeated the insurer will be obligated to cover the condition unless, of course, you failed to disclose the condition.

Now what are the death conditions that insurers usually will decline an applicant for? Well, most cancers, heart conditions, diabetes types I or II, and past drug use. Now drug use is a tricky one because most health insurance companies will not insure if you are or have taken depression medicine under a doctor's care, (prescription). So beware of that little complication.

Usually normal accidents are OK such as broken leg but again beware such things as knee problems or compound breaks. They can be severely limited with riders or exclusions of coverage. It is not uncommon for all but one person in a family being approved and that one unfortunate person denied coverage.

There is another hidden gem in the health care business. Let's say you want to shop for coverage which is a very intelligent thing to do. After all you would not buy the first car you see and health care for a family will cost more than most cars. Now once you submit your application with an insurer for consideration they log you into the health system. If you or a family member is denied coverage that notation will stay with you for a lifetime.

So if you plan to shop health insurance companies it would be best if you used an independent agent and not an agent representing a specific company or a specific company unless you submit to multiple companies at the same time. The reason this is important is if you wait for an answer from one company before applying to another company and you are subsequently turned down or a rider is not what you want you must disclose that fact to any other company you apply through greatly reducing your chances of approval.

In short the health insurance company has got you coming or going.

Let's continue. Now you have walked the maze and have been approved for coverage and for some bizarre reason you actually use the plan to go to a doctor or you get sick and require treatment. All within the bounds of the plan and assuming the hospital or doctor puts the correct billing codes on the procedure notice to the insurer you get the treatment paid within the scope of the plan you have chosen.

One year later and it is time to renew the plan. Most individual plans are allowed to review your health history again and make a decision to continue coverage or not. Let's say the illness was severe, after all the primary reason to have health care coverage is to insure against catastrophic occurrences.

Yah! That's what you think! Regardless of whether you are in the middle of treatment or the procedure is long past if the insurer decides to cancel or deny renewal coverage you will be left to pay for the remainder of the costs of care on your own and there is no appeal to a state agency or panel or board. Simply put you are out on your own. Now this does not happen to every one or all the time

but it does happen frequently enough to think about getting a policy that offers guaranteed renewals.

Guaranteed renewals are not offered by every company. In fact, they are only offered by a limited number of companies and most of the insurer's that provide a guarantee of continuation or renewal have limited scheduled plans. You are not going to be denied or cancelled because of a normal occurrence or procedure. But let it be something that could linger such as a Cancer or Heart Problem or Diabetes or anything that requires multiple procedures or continual rehab costs and your chances of review for cancellation go up dramatically.

We have a couple more things to talk about in this section with regards to coverage and plan costs. The first is Tobacco use. Almost every plan offered in the market place puts a premium price on Tobacco use so if you smoke or have smoked you will pay more a lot more.

The next item that is cost and risk measured by the insurance company is residence. They review health incidences by area usually groupings of zip codes. If you fall within a higher risked zip code your premium will be higher day one. It could be assumed then that if you live in a rural area most times your premium will be less than if you live in a more populous area. If you live near an oil refinery or power plant it can be safely deducted that your premium will be more than if you live on the family farm in the middle of Nebraska.

Why are we going into all of this information? Well unless you have experienced the vagaries of individual health insurance qualification requirements you will quickly become frustrated and in many cases end up paying much more for coverage than you should or not get the coverage you need.

Chapter 6

What Health Plan Should I Purchase?

Well we have traversed through the individual health options, definitions, suggestions, and plan options. I will devote this chapter to a discussion about the plan I have and why and a suggested plan for a family or Husband and Wife.

This chapter will be completely bias and to the point. I have sold health insurance for a number of years. I do believe that a health plan is something everyone should have and at minimum everyone should have a catastrophic plan which is usually has lower premiums than any other plan but not always.

I started in the workforce covered by my wife's insurance plan. We lived in California and my wife was a teacher. Our plan was a Kaiser HMO plan. The School district paid for the plan 100%. We made a conscious decision to choose

the HMO plan instead of a PPO plan out of pure economics. The PPO plan required a deductible and larger co-pays. The HMO plan had a zero deductible and low co-pays plus a full dental plan and a great drug plan that was really useful. The Dental plan was 100% coverage with a \$50 deductible per person per year. The Drug Plan was \$1.00 per prescription regardless of brand or generic.

Now that type of plan was my full experience with health care insurance for 20 years. The plan was every bit as good as it sounds. Just to illustrate, my wife had about with breast cancer. Kaiser referred her to every major expert in the field in an effort to cure her. The cost over the 5 years she was in and out of the hospital and on every experimental treatment available was close to \$3 million in 1984 terms or about \$15 million today. This included being referred to many out of network specialists.

When she passed away I had to fend for myself buying health care insurance for me as an individual. Now my previous experience with health care was going to the dentist 2 times a year plus two leg muscle pulls and a cut lip and cut on my arm. Oh yes, one night in the hospital for a kidney stone. I was never on any drugs or had a real experience with the medical profession other than as a deeply concerned partner to one who exhausted the system.

So I never experienced a real health problem that would be covered by an individual plan. The emergency room for the leg pulls and the cuts are not covered under an individual plan until you pay your deductible, unless you choose an HMO plan which at the time was not available to me in California outside an employee plan. It is offered today and from what I have seen the Kaiser HMO is still a good plan. With the experience of my wife and my experience co-mingled I decided to buy a low cost plan with a modest deductible. The plan I have is a Unicare 2000 deductible plan.

However, I had two concerns regarding the plan. First if you need to visit the emergency room you have to cough up the \$2,000.00 deductible plus 20% of the difference until the out of pocket total is met. The second concern was the spill over in deductible requirement if I experienced a serious long term problem.

So by choosing a higher deductible plan I have been able to add two supplemental plans in order to broaden my coverage and not increase my costs very much. The first and foremost concern I had was emergency accidents so I looked around and purchased a lifetime fixed cost accident plan.

The plan I have has a \$100 deductible per accident, but covers the next \$7,500.00 in costs per accident with no maximum limit to the number of accidents the plan will cover over the life of the policy. The policy premium is fixed for life so it was easy to budget for the accident plan.

The second plan I purchased was a life insurance plan that pays a one time lump sum to me if I am diagnosed with an internal cancer or have a heart attack. Again, this life plan with the lump sum benefit is fixed for 20 years so I was able to budget the plan as part of my overall health plan costs.

Why did I add the supplements? The Accident supplement seems very clear. My past experience with health care was the determining factor. I spent 1 night in the hospital and visited the emergency room more so the decision was easy. Also I liked the idea that if I had an emergency room experience and as most emergency room visits run about \$2,000.00 or more the supplement would cover all but \$100 of the expense and I would have the added benefit of having the supplement paying for my annual deductible.

You see how that works? Say the emergency room cost was \$2,100.00 total. According to my Unicare plan I would be required to pay the first \$2,000.00 and then Unicare would pay 80% of the difference or \$80 of the next \$100 owed.

The supplement I have requires a \$100 deductible and will then pay up to the next \$7500 of the cost. Well I am billed by the emergency room for the full \$2100. The emergency room notifies Unicare and they will cover 80% of the \$100 and I am responsible for the first \$2,000.00.

Unicare then considers my deductible to be met for the remainder of the year because they consider the first \$2000 paid by me not them. In reality I am out \$20 in this deal. Now I have satisfied my deductible for the year. My plan costs about \$35 per year a family can be covered for about \$60 per year.

To me this represents a great costs benefit trade off, a \$720 annual premium to save \$2,080 in costs. What if you had two family member accidents that required emergency room treatment during the year. The numbers add up quick and it just seems to make sense to have an accident supplemental plan.

By the way this example works regardless of the health insurance plan you buy or currently have including an employee plan, so an accident supplement can be very valuable especially if you have children. Children seem to be more susceptible to emergency room incidents except for out of shape ex-athletes.

The life plan with the accelerator rider takes a little more thought. My experience with my wife ingrained in me the importance of life insurance especially if you have other family members that you are responsible to and for. However, in our case we had a health plan that would not cancel us part way through a treatment and they did not decline any treatment experimental or not. You will probably not be so lucky. Also if you are purchasing an individual health plan for you and or your family you may very well be the primary income earner for your family or you may be self employed.

The cost of the health care in a catastrophic incident is one thing but in most cases the major cost of the illness or accident can be and usually is the out of pocket costs associated with recovery and in some cases loss of job due the lengthy time of recovery.

Let us say you are off the job for 60 days and make a full recovery. All the bills you have outside of the health care issue such as house payment, car payment, food, non authorized health care, some drugs, your deductible, and a number of other bills and obligations that life has in store for us daily. Having an additional source of immediate income while you are in recovery is a blessing that most of us do not have and many have never thought about until it is too late. Also the money paid is non taxable life insurance payments.

I have had two clients that purchased the plan and getting the check saved their lives and in one case the business of a client. If I had children I would buy the maximum amount of coverage available on a 30 year fixed rate plan with return of premium for all my children over age 18. Best Christmas gift one could buy for a loved one.

It took about 30 days after submission of the paperwork to get paid. You can imagine the positive impact that money had. I am sure you hear stories of people with debilitating illnesses or accidents that are forced into bankruptcy and loose everything. Think about your situation and what you would do if your insurance company did not pay all the bills and you were out of work for an extended period of time. Scary is it not?

I want to end this chapter with a discussion on doctor visits. Doctor visits are a way for insurance companies to pad premiums in two ways. First if you use your plan the insurance company will increase your premium for usage and the number one usage is doctor visits.

An adult between the ages of 18 and 65 is hospitalized on average once every 10 to 15 years. The hospital portion of a plan is not used much but when it is it is very expensive for the insurer. On average a hospitalization is a \$20,000 to \$30,000 occurrence and since your premium is only based partially on your personal experiences but more on your population (zip code) so every year up goes your premium.

The second way your premium will increase is frequency of use and the most common frequency is office visits. If you choose a plan with doctor visits you will have a co-pay somewhere between \$15 and \$50 per visit depending upon the plan and price you pay and whether the visit is to a specialist or general practitioner.

The insurance company contracts with doctors for office visits and usually the negotiated price is the same as your deductible. When the negotiated price goes

up the insurer will pass the increase on a balanced basis over the base of the plan population. Sometimes they will increase the co-pay but that is a bigger change and not one the insurer likes to announce.

By upping the premium over the population the insurance company actually gets a bigger increase than changing the co-pay because they can pass an increase over the base increasing the co-pay just changes the price for the people that use the service and many people with the doctor plan do not use it.

If you think about the number of times you visit the doctor you will probably discover that you may go less than once per year. Now that's for a female, a man maybe once every 5 years on average.

If you fall into this category go for a plan without doctor visits the premium differential is well worth negotiating a cash price with your doctor and you can usually get a plan for less money that has the office visit covered after your deductible or no office visits included in the plan at all.

Chapter 7

Plan Decision

We have discussed the various types of Health Insurance Plans for individuals and the self employed including some of the more common terminology and definitions. This chapter will concentrate on comparisons of some live plans.

The object of this chapter will be to familiarize yourself with the various nuances and sometimes subtle differences that will you make you a better shopper of health care insurance.

There are a myriad of health care plans available to you depending upon which state you live in and geographic territory within a state. Each Insurance Company plan that is offered must be approved by a state regulatory board for approval of issue so not every insurance company plan is available in every state.

Also some states require guaranteed issue of a health insurance policy. Guarantee issue means that no prior health conditions are used to determine eligibility. The idea that a plan may not be offered in a particular state is important to understand especially if you move to another part of a state or out of state or travel on business a lot.

With the above in mind we will look at three specific examples of plans and the differences that you will want to be clear about prior to selecting a plan for yourself and or your family.

For the below examples I have selected Texas as the plan state. I will use a family of 4. The Husbands age is 42. Wife is 40. They have two children, a boy 7 and a girl 11 all in good health. They do not have a health provider at present and are looking for a plan.

Blue Cross PPO Select Choice Plan IV Plan Price as Listed \$587.00 per month

Aetna 5000 Plan Plan Price as Listed \$390.00 per month

Unicare Fit 3000 Plan Plan Price as Listed \$467.00 per month

All three plans are PPO provider plans. The Blue Cross plan shows an in network deductible of \$1,500.00 per person per year with a 3 family member cap on the deductible. This plan shows a maximum out of pocket expense of the deductible plus \$2,000.00 per person per year. This means that if one family member has an illness or surgery that during the calendar year costs \$25,000.00 the maximum payment (out of pocket expense) would be \$3,500.00 with the insurance company paying the remaining \$21,500.00.

The Aetna plan has an in network deductible of \$5,000.00 per person per year with a 2 family member cap on the deductible and a \$7,500.00 per person maximum out of pocket expense. Using the above scenario the family member would pay \$12,500.00 total out of pocket and the insurance company would pay \$12,500.00.

The third plan the Unicare Fit 3000 plan has an in network deductible of \$3,000.00 and a maximum out of pocket expense of \$3,000.00 per person. Again using the above scenario the family member would pay \$6,000.00 total out of pocket and the insurance company would pay \$19,000.00.

The annual premium cost of each plan is:

Blue Cross \$7,044.00

Aetna \$4,680.00

Unicare \$5,604.00

Using the above example the total cost of the plan payments and the incident costs would be:

Blue Cross \$10,544.00

Aetna \$17,180.00

Unicare \$11,604.00

As you can see in this scenario Blue Cross offers the least expensive plan even though they have the highest premium. If two or more family members had the same cost illness as above during the same year the Blue Cross plan would still cost less than the other plans. Even though Aetna has the lowest premium the annual cost for the above incident makes Aetna the most costly.

This cost relationship does not change even though both Unicare and Aetna have 2 person maximums on deductible and out of pocket expense limits. So what this illustrates is you can't just look at premium cost to determine the real cost of the plan. Let us go on to other parts of each plan.

The Blue Cross plan offers a doctor co pay of \$25 per visit with unlimited visits including OBGYN and periodic check up visits. However, you must meet your deductible and pay 20% of the cost for any lab work or X-rays.

The Aetna plan offers doctor visits for a co pay of \$40 per visit with unlimited visits. The OBGYN visit is free no co pay and specialist visits are \$50. You also must cover your deductible and pay 20% of the cost for any lab work or X-rays.

The Unicare plan offers doctor visits at \$30 per year with a maximum of 6 visits per year. Periodic health visits are not included and the plan pays the first \$300 of your OBGYN costs per year. You must also cover your deductible and pay 25% of the other costs for any lab work or X-rays.

None of the plans covers emergency room expenses until the deductible is met and then subject to the particular co insurance.

If you were purchasing one of the above plans for price and office visits alone then the Aetna plan would be the plan of choice. However, as you can see from the above illustration if you have an illness the plan with the lowest deductible makes the most sense because it will cost you the least for the total annual outlay. But you and your family are statistically not going to get a major illness more than once in a 20 year period so the chances of spending \$25,000.00 on medical costs every year are not reasonable.

In the end I would opt for the Unicare Plan, if these were my choices, and buy an accident plan to supplement the lack of emergency room coverage any of the above plans offer. The annual difference between the Blue Cross plan and the Unicare plan is \$1,440.00.

The difference is more than enough to buy an accident plan and have plenty of money left over to cover that \$5 difference in office visit co-pay cost. The Aetna plan is the least expensive but one illness and the cost difference will be eaten up in deductible and maximum out of pocket requirements.

Some other things to look for in the above plans and questions to ask include, how is chemotherapy treatment handled. Are the treatments part of the drug plan or covered as part of the outpatient costs. Some plans have a separate schedule of payment for chemo costs and some plans consider this a drug cost. Some plans cap drug coverage and if the chemo is considered part of the drug plan you could end up paying most of the per treatment cost out of pocket.

Also, is there a limit to the number of physical therapy treatments in the plan and if so what portion is covered and is there a co-payment. If your treatment transcends a calendar year are you required to begin your deductible and co insurance payments again for a carry over illness?

What happens if you are in surgery and an outside specialist is required to help. Will your plan classify the costs of the out of network specialists to be out of network or in network.

Each plan considered these items differently and you need to know these answers. After surgery is no time to start to understand your policy. We have friends and so do you that waited too long and now sufferer the dire consequences of waiting too long and not having health insurance.

Don't wait and let a medical emergency endanger your retirement funds or your current standard of living. Life is too precious to not seek out medical care when it is needed.

People with "no insurance" generally wait too long and then the illness is a major catastrophe to themselves, their family and to their way of life. Protect yourself, your quality of life and your family, they love you, love yourself enough to protect yourself for them.

Please be safe, take care of yourself and your family, get your health insurance and do the right thing and do it now.

Please feel free to visit us at: <http://www.businesshealthinsurance.com> for your free health insurance quote right now before it is too late.