Buyers Guide For Health Insurance
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No matter your intellect or current profession Health Insurance can be confusing. It is intentionally ambiguous and can make all of us feel and helpless and lost. The key to understanding is education, and math, and professional assistance. Knowing what your comfort levels are, and getting insurance that is a perfect balance of monthly price, and out of pocket cost should be your ultimate goal.

Paying too much for insurance you don't use will allow the insurance companies a high level of profitability. Think of a season pass to a ski resort you visit once a year.

Not paying enough on the other hand isn't always apparent until it is too late, and something goes wrong. Being left with thousands of dollars in out of pocket cost can be financially crippling at times, and most plans that look too good to be true, often are.

Understanding terms and definitions can help you make an informed decision on the best plan, for the least amount of money for you and your family.

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Introduction

If you have ever been sick or injured, you know how important it is to have health coverage. But if you're confused about what kind is best for you, you're not alone.

What types of health coverage are available? If your employer offers you a choice of health plans, what should you know before making a decision? In addition to coverage for medical expenses, do you need some other kind of insurance? What if you are too ill to work? Or, if you are over 65,will Medicare pay for all your medical expenses?

These are questions that today's consumers are asking; and these questions aren't necessarily easy to answer.

This booklet should help. It discusses the basic forms of health coverage and includes a checklist to help you compare plans. It answers some commonly asked questions and also includes thumbnail descriptions of other forms of health insurance, including hospital-surgical policies, specified disease policies, catastrophic coverage, hospital indemnity insurance, and disability, long-term care, and Medicare supplement insurance.

While we know that our guide can't answer all your questions, we think it will help you make the right decisions for yourself, your family, and even your business.

Making Sense of Health Insurance

The term health insurance refers to a wide variety of insurance policies. These

Health Insurance Terms

actuary - a mathematician in the insurance field. Responsible for calculating premiums, developing plans and defining underwriting risk.

agent - a licensed individual who represents several insurance companies and sells their products.

benefit - reimbursement for covered medical expenses as specified by the plan.

brand-name drug - prescription drug which is marketed with a specific brand name by the

range from policies that cover the costs of doctors and hospitals to those that meet a specific need, such as paying for long-term care. Even disability insurance - which replaces lost income if you can't work because of illness or accident - is considered health insurance, even though it's not specifically for medical expenses.

But when people talk about health insurance, they usually mean the kind of insurance offered by employers to employees, the kind that covers medical bills, surgery, and hospital expenses. You may have heard this kind of health insurance referred to as comprehensive or major medical policies, alluding to the broad protection they offer. But the fact is, neither of these terms is particularly helpful to the consumer.

Today, when people talk about broad health care coverage, instead of using the term "major medical," they are more likely to refer to fee-for-service or managed care. These terms apply to different kinds of coverage or health plans. Moreover, you'll also hear about specific kinds of managed care plans: health maintenance organizations or HMOs, preferred provider organizations or PPOs, and point-of-service or POS plans.

While fee-for-service and managed care plans differ in important ways, in some ways they are similar. Both cover an array of medical, surgical, and hospital expenses. Most offer some coverage for prescription drugs, and some include coverage for dentists and other providers. But there are many important differences that will make one or the other form of coverage the right one for you.

The section below is designed to acquaint you with the basics of fee-for-service and managed care plans. But remember: The detailed differences between one plan and another can only be understood by careful reading of the materials provided by insurers, your employee benefits specialist, or your agent or broker.

Fee-for-Service

This type of coverage generally assumes that the medical provider (usually a doctor or hospital) will be paid a fee for each service rendered to the patient - you or a family member covered under your policy. With fee-for-service insurance, you go to the doctor of your choice and you or your doctor or hospital submits a claim to your insurance company for reimbursement. You will only receive reimbursement for "covered" medical expenses, the ones listed in your benefits summary.

When a service is covered under your policy, you can expect to be reimbursed for some, but generally not all, of the cost. How much you will receive depends on the provisions of the policy on coinsurance and deductibles. Here's how it works:

- The portion of the covered medical expenses you pay is called "coinsurance."

company that manufactures it. May cost insured individuals a higher co-pay than generic drugs on some health plans. (see "generic.")

broker - a licensed insurance professional who obtains multiple quotes and plan information in the interest of his client.

carrier - insurance company or HMO insuring the health plan.

Certificate Booklet - the plan agreement. A printed description of the benefits and coverage provisions intended to explain the contractual arrangement between the carrier and the insured group or individual. May also be referred to as a policy booklet

claim - a formal request made by an insured person for the benefits provided by a policy.

COBRA (Consolidated Omnibus Budget Reconciliation Act) - Federal legislation that requires group health plans to provide health plan

Although there are variations, fee-for-service policies often reimburse doctor bills at 80 percent of the "reasonable and customary charge." (This is the prevailing cost of a medical service in a given geographic area.) You pay the other 20 percent - your coinsurance.
However, if a medical provider charges more than the reasonable and customary fee, you will have to pay the difference. For example, if the reasonable and customary fee for a medical service is $100, the insurer will pay $80. If your doctor charged $100, you will pay $20. But if the doctor charged $105, you will pay $25.
Note that many fee-for-service plans pay hospital expenses in full; some reimburse at the 80/20 level as described above.

- Deductibles are the amount of the covered expenses you must pay each year before the insurer starts to reimburse you. These might range from$100 to $300 per year per individual, or $500 or more per family. Generally, the higher the deductible, the lower the premiums, which are the monthly, quarterly, or annual payments for the insurance.
- Policies typically have an out-of-pocket maximum. This means that once your expenses reach a certain amount in a given calendar year, the reasonable and customary fee for covered benefits will be paid in full by the insurer. (If your doctor bills you more than the reasonable and customary charge, you may still have to pay a portion of the bill.) Note that Medicare limits how much a physician may charge you above the usual amount.
- There also may be lifetime limits on benefits paid under the policy. Most experts recommend that you look for a policy whose lifetime limit is at least $1 million. Anything less may prove to be inadequate.

Managed Care

The three major types of managed care plans are health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans.

Managed care plans generally provide comprehensive health services to their members, and offer financial incentives for patients to use the providers who belong to the plan. In managed care plans, instead of paying separately for each service that you receive, your coverage is paid in advance. This is called prepaid care.

For example, you may decide to join a local HMO where you pay a monthly or quarterly premium. That premium is the same whether you use the plan's services or not. The plan may charge a copayment for certain services - for example, $10 for an office visit, or $5 for every prescription. So, if you join this HMO, you may find that you have few out-of-pocket expenses for medical care - as long as you use doctors or hospitals that participate in or are part of the HMO. Your share may be only the small copayments; generally, you will not have deductibles or coinsurance.

One of the interesting things about HMOs is that they deliver care directly to

members the opportunity to purchase continued coverage in the event their insurance is terminated. Applies only to employer groups with 20 or more employees. Learn more about COBRA at the Department of Labor's website. - Please note this may take a few minutes to appear.

co-insurance - the percentage of covered expenses an insured individual shares with the carrier. (i.e., for an 80/20 plan, the health plan member's co-insurance is 20%.) If applicable, co-insurance applies after the insured pays the deductible and is only required up to the plan's stop loss amount. (see "stop loss.")

co-pay/co-payment - the amount an insured individual must pay toward the cost of a particular benefit. For example, a plan might require a $10 co-pay for each doctor's office visit.

credit for prior coverage - any pre-existing condition waiting period met under an employer's

patients. Patients sometimes go to a medical facility to see the nurses and doctors or to a specific doctor's office. Another common model is a network of individual practitioners. In these individual practice associations (IPAs), you will get your care in a physician's office.

If you belong to an HMO, typically you must receive your medical care through the plan. Generally, you will select a primary care physician who coordinates your care. Primary care physicians may be family practice doctors, internists, pediatricians, or other types of doctors. The primary care physician is responsible for referring you to specialists when needed. While most of these specialists will be "participating providers" in the HMO, there are circumstances in which patients enrolled in an HMO may be referred to providers outside the HMO network and still receive coverage.

PPOs and POS plans are categorized as managed care plans. (Indeed, many people call POS plans "an HMO with a point-of-service option.") From the consumer's point of view, these plans combine features of fee-for-service and HMOs. They offer more flexibility than HMOs, but premiums are likely to be somewhat higher.

With a PPO or a POS plan, unlike most HMOs, you will get some reimbursement if you receive a covered service from a provider who is not in the plan. Of course, choosing a provider outside the plan's network will cost you more than choosing a provider in the network. These plans will act like fee-for-service plans and charge you coinsurance when you go outside the network.

What is the difference between a PPO and a POS plan? A POS plan has primary care physicians who coordinate patient care; and in most cases, PPO plans do not. But there are exceptions!

HMOs and PPOs have contracts with doctors, hospitals, and other providers. They have negotiated certain fees with these providers - and, as long as you get your care from these providers, they should not ask you for additional payment. (Of course, if your plan requires a copayment at the time you receive care, you will have to pay that.)

Always look carefully at the description of the plans you are considering for the conditions of payment. Check with your employer, your benefits manager, or your state department of insurance to find out about laws that may regulate who is responsible for payment.

Self-insured Plans

Your employer may have set up a financial arrangement that helps cover employees' health care expenses. Sometimes employers do this and have the "health plan" administered by an insurance company; but sometimes there is no outside administrator. With self-insured health plans, certain federal laws may apply. Thus, if you have problems with a plan that isn't state regulated, it's

prior (qualifying) coverage will be credited to the current plan, if any interruption of coverage between the new and prior plans meets state guidelines.

deductible - the dollar amount an insured individual must pay for covered expenses during a calendar year before the plan begins paying co-insurance benefits.

dependents - usually the spouse and unmarried children (adopted, step or natural) of an employee.

effective date - the date requested by an employer for insurance coverage to begin.

exclusions - expenses which are not covered under an insurance plan. These are listed in the Certificate Booklet.

Explanation of Benefits (EOB) - a carrier's written response to a claim for benefits. Sometimes accompanied by a benefits check.

Generic drug Â the

probably a good idea to talk to an attorney who specializes in health law.

Appropriate Care

HMOs, PPOs, and fee-for-service plans often share certain features, including pre authorization, utilization review, and discharge planning.

For example, you may be asked to get authorization from your plan or insurer before admission to a hospital for certain types of surgery. Utilization review is the process by which a plan determines whether a specific medical or surgical service is appropriate and/or medically necessary. Discharge planning is an approach that facilitates the transfer of a patient to amore cost-effective facility if the patient no longer needs to stay in the hospital. For example, if, following surgery, you no longer need hospitalization but cannot be cared for at home, you may be transferred to a skilled nursing facility.

Almost all fee-for-service plans apply managed care techniques to contain costs and guarantee appropriate care; and an increasing number of managed care plans contain fee-for-service elements. While the distinctions among plans are growing increasingly blurred, the number of options available to consumers increases every day.

How Do I Get Health Coverage?

Health insurance is generally available through groups and to individuals. Premiums - the regular fees that you pay for health insurance coverage - are generally lower for group coverage. When you receive group insurance at work, the premium usually is paid through your employer.

Group insurance is typically offered through employers, although unions, professional associations, and other organizations also offer it. As an employee benefit, group health insurance has many advantages. Much - although not all - of the cost may be borne by the employer. Premium costs are frequently lower because economies of scale in large groups make administration less expensive. With group insurance, if you enroll when you first become eligible for coverage, you generally will not be asked for evidence that you are insurable. (Enrollment usually occurs when you first take a job, and/or during a specified period each year, which is called open enrollment.) Some employers offer employees a choice of fee-for-service and managed care plans. In addition, some group plans offer dental insurance as well as medical.

Individual insurance is a good option if you work for a small company that does not offer health insurance or if you are self-employed. Buying individual insurance allows you to tailor a plan to fit your needs from the insurance company of your choice. It requires careful shopping, because coverage and costs vary from company to company. In evaluating policies, consider what medical services are covered, what benefits are paid, and how much you must

chemical equivalent to a "brand name drug." These drugs cost less, and the savings is passed onto health plan members in the form of a lower co-pay.

group insurance - an insurance contract made with an employer or other entity that covers individuals in the group.

Health Maintenance Organization (HMO) - An alternative to commercial insurance that stresses preventive care, early diagnosis and treatment on an outpatient basis. HMOs are licensed by the state to provide care for enrollees by contracting with specific health care providers to provide specified benefits. Many HMOs require enrollees to see a particular primary care physician (PCP) who will refer them to a specialist if deemed necessary.

HIPAA - Health Insurance Portability and Accountability Act of 1996, P.L. 104-91. This law relates to underwriting, pre-existing limitations,

pay in deductibles and coinsurance. You may keep premiums down by accepting a higher deductible.

Pre-existing Conditions

Many people worry about coverage for preexisting conditions, especially when they change jobs. The Health Insurance Portability and Accountability Act (HIPAA) helps assure continued health insurance coverage for employees and their dependents. Starting July 1, 1997, insurers could impose only one 12-month waiting period for any preexisting condition treated or diagnosed in the previous six months. Your prior health insurance coverage will be credited toward the preexisting condition exclusion period as long as you have maintained continuous coverage without a break of more than 62 days. Pregnancy is not considered a preexisting condition, and newborns and adopted children who are covered within 30 days are not subject to the 12-monthwaiting period.

If you have had group health coverage for two years, and you switch jobs and go to another plan, that new health plan cannot impose another preexisting condition exclusion period. If, for example, you have had prior coverage of only eight months, you may be subject to a four-month, preexisting condition exclusion period when you switch jobs. If you've never been covered by an employer's group plan, and you get a job that offers such coverage, you may be subject to a 12-month, preexisting condition waiting period.

Federal law also makes it easier for you to get individual insurance under certain situations, including if you have left a job where you had group health insurance, or had another plan for more than 18 months without a break of more than 62 days.

If you have not been covered under a group plan and have found it difficult to get insurance on your own, check with your state insurance department to see if your state has a risk pool. Similar to risk pools for automobile insurance, these can provide health insurance for people who cannot get it elsewhere.

What Is Not Covered?

While HMO benefits are generally more comprehensive than those of traditional fee-for-service plans, no health plan will cover every medical expense.

Very few plans cover eyeglasses and hearing aids because these are considered budgetable expenses. Very few cover elective cosmetic surgery, except to correct damage caused by a covered accidental injury. Some fee-for-service plans do not cover checkups. Procedures that are considered experimental may not be covered either. And some plans cover complications arising from pregnancy, but do not cover normal pregnancy or childbirth.

Health insurance policies frequently exclude coverage for preexisting conditions,

guaranteed renewal, COBRA and certification requirements in the event someone terminates from the plan. The new law, commonly known as the "Kennedy-Kassebaum Bill," establishes new requirements for self-funded, fully-insured group plans (including church plans) and Individual Health policies. The purpose of the law is to:

- Improve portability and continuity of health insurance coverage in the group and individual markets
- To combat waste, fraud and abuse in health insurance and health care delivery
- To promote the use of medical savings accounts
- To improve access to long-term care services and coverage
- To simplify the administratio

but, as explained, federal law now limits exclusions based on such conditions.

You should also remember that insurers will not pay duplicate benefits. You and your spouse may each be covered under a health insurance plan at work but, under what is called a "coordination of benefits" provision, the total you can receive under both plans for a covered medical expense cannot exceed 100 percent of the allowable cost. Also note that if neither of your plans covers 100 percent of your expenses, you will only be covered for the percentage of coverage (for example, 80 percent) that your primary plan covers. This provision benefits everyone in the long run because it helps to keep costs down.

What Happens to My Insurance if I Lose My Job?

If you have had health coverage as an employee benefit and you leave your job, voluntarily or otherwise, one of your first concerns will be maintaining protection against the costs of health care. You can do this in one of several ways:

- First, you should know that under a federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA), group health plans sponsored by employers with 20 or more employees are required to offer continued coverage for you and your dependents for 18 months after you leave your job. (Under the same law, following an employee's death or divorce, the worker's family has the right to continue coverage for up to three years.) If you wish to continue your group coverage under this option, you must notify your employer within 60 days. You must also pay the entire premium, up to 102 percent of the cost of the coverage.
- If COBRA does not apply in your case - perhaps because you work for an employer with fewer than 20 employees - you may be able to convert your group policy to individual coverage. The advantage of that option is that you may not have to pass a medical exam, although an exclusion based on a preexisting condition may apply, depending on your medical history and your insurance history.
- If COBRA doesn't apply and converting your group coverage is not for you, then, if you are healthy, not yet eligible for Medicare, and expect to take another job, you might consider an interim or short-term policy. These policies provide medical insurance for people with a short-term need, such as those temporarily between jobs or those making the transition between college and a job. These policies, typically written for two to six months and renewable once, cover hospitalization, intensive care, and surgical and doctors' care provided in the hospital, as well as expenses for related services performed outside the hospital, such as X-rays or laboratory tests.
- Another possibility is obtaining coverage through an association. Many trade and professional associations offer their members health coverage - often HMOs - as well as basic hospital-surgical policies and disability and long-term care insurance. If you are self-employed, you may find association membership an attractive route.

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- Learn more about HIPAA at the Department of Labor's website. - Please note this may take a few minutes to appear.

pre-certification - an insurance company requirement that an insured obtain pre-approval before being admitted to a hospital or receiving certain kinds of treatment.

ID card/identification card - card given to insured individuals which advises medical providers that a patient is covered by a particular health insurance plan.

indemnity insurance plans - traditional insurance plans (not HMOs or PPOs) which permit insured individuals to choose their doctors and hospitals. Insured individuals do not have to choose doctors or hospitals from a specific list of providers. Also called "fee-for-service"

Frequently Asked Questions

Q What is the first thing I should know about buying health coverage?

A Your aim should be to insure yourself and your family against the most serious and financially disastrous losses that can result from an illness or accident. If you are offered health benefits at work, carefully review the plans' literature to make sure the one you select fits your needs. If you purchase individual coverage, buy a policy that will cover major expenses and pay them to the highest maximum level. Save money on premiums, if necessary, by taking large deductibles and paying smaller costs out-of-pocket.

Q Can I buy a single health insurance policy that will provide all the benefits I'm likely to need?

A No. Although you can select a plan or buy a policy that should cover most medical, hospital, surgical, and pharmaceutical bills, no single policy covers everything. Moreover, you may want to consider additional single-purpose policies like long-term care or disability income insurance. If you are over 65, you may want a Medicare supplement policy to fill in the gaps in Medicare coverage.

Q I'm planning to keep working after age 65. Will I be covered by Medicare or by my company's health insurance?

A If you work for a company with 20 or more employees, your employer must offer you (through age 69) the same health insurance coverage offered to younger employees. After you reach age 65, you may choose between Medicare and your company's plan as your primary insurer. If you elect to remain in the company plan, it will pay first - for all benefits covered under the plan - before Medicare is billed. In most instances, it is to your advantage to accept continued employer coverage.

But be sure to enroll in Medicare Part A, which covers hospitalization and can supplement your group coverage at no additional cost to you. You can save on Medicare premiums by not enrolling in Medicare Part B until you finally retire. Bear in mind, though, that delayed enrollment is more expensive and entails a waiting period for coverage.

Q I've had a serious health condition that appears to be stabilized. Can I buy individual health coverage?

A Depending on what your condition is and when it was diagnosed and treated, you can probably buy health coverage. However, the insurer may do one of three things:

â€¢ provide full protection but with a higher premium, as might be the case with a chronic disease, such as diabetes;

â€¢ modify the benefits to increase the deductible;

plans.

in-network - describes a provider or health care facility which is part of a health plan's network. When applicable, insured individuals usually pay less when using an in-network provider.

lifetime maximum benefit - the maximum amount a health plan will pay in benefits to an insured individual.

limitations - a restriction on the amount of benefits paid out for a particular covered expense.

long-term disability (LTD) - insurance which pays employees a percentage of monthly earnings in the event of disability.

managed care - the coordination of health care services in the attempt to produce high quality health care for the lowest possible cost. Examples are the use of primary care physicians as gatekeepers in HMO plans and pre-certification of care.

â€¢ exclude the specific medical problem from coverage, if it is a clearly defined condition, as long as the insurer abides by state and federal laws on exclusions.

Q One of my medical bills was turned down by the insurance company (or health plan). Is there anything I can do?

A Ask the insurance company why the claim was rejected. If the answer is that the service isn't covered under your policy, and you're sure that it is covered, check to see that the provider entered the correct diagnosis or procedure code on the insurance claim form. Also check that your deductible was correctly calculated.

Make sure that you didn't skip an essential step under your plan, such as pre admission certification. If everything is in order, ask the insurer to review the claim.

Comparing Plans

Whether you end up choosing a fee-for-service plan or a form of managed care, you must examine a benefits summary or an outline of coverage - the description of policy benefits, exclusions, and provisions that makes it easier to understand a particular policy and compare it with others.

Look at this information closely. Think about your personal situation. After all, you may not mind that pregnancy is not covered, but you may want coverage for psychological counseling. Do you want coverage for your whole family or just yourself? Are you concerned with preventive care and checkups? Or would you be comfortable in a managed care setting that might restrict your choice somewhat but give you broad coverage and convenience? These are questions that only you can answer.

Here are some of the things to look at when choosing and comparing health insurance plans.

Health Insurance Checklist

Covered medical services

- Inpatient hospital services
- Outpatient surgery
- Physician visits (in the hospital)
- Office visits
- Skilled nursing care
- Medical tests and X-rays
- Prescription drugs
- Mental health care
- Drug and alcohol abuse treatment
- Home health care visits
- Rehabilitation facility care

Multiple Employer Trust (MET) - an arrangement created to obtain health and other benefits for participating employer groups. Small employers can pool their contributions to receive the advantages of large group underwriting.

network - a group of doctors, hospitals and other providers contracted to provide services to insured individuals for less than their usual fees. Provider networks can cover large geographic markets and/or a wide range of health care services. If a health plan uses a preferred provider network, insured individuals typically pay less for using a network provider.

out-of-network - describes a provider or health care facility which is not part of a health plan's network. Insured individuals usually pay more when using an out-of-network provider, if the plan uses a network.

out-of-pocket maximum - the total of an insured individual's co-insurance payments

- Physical therapy
- Speech therapy
- Hospice care
- Maternity care
- Chiropractic treatment
- Preventive care and checkups
- Well-baby care
- Dental care
- Other covered services

Are there any medical service limits, exclusions, or preexisting conditions that will affect you or your family?

What types of utilization review, pre authorization, or certification procedures are included?

Costs

How much is the premium?

$____

Are there any discounts available for good health or healthy behaviors (e.g., non-smoker)?

____

How much is the annual deductible?

$__________________________________ per person

$__________________________________ per family

What coinsurance or co-payments apply?

__________________________________% after I meet my deductible

$__________________________________copay or % coinsurance per office visit

$__________________________________copay or % coinsurance for "wellness" care (includes well-baby care, annual eye exam, physical, etc.)

$__________________________% copay or coinsurance for inpatient hospital care

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and co-payments.

plan administration - overseeing the details and routine activities of installing and running a health plan, such as answering questions, enrolling new individuals for coverage, billing and collecting premiums, etc.

point-of-service (POS) - health plan which allows the enrollee to choose HMO, PPO or indemnity coverage at the point of service (time the services are received).

pre-certification - Pre-admission review and approval of appropriateness and medical necessity of hospitalization or other medical treatment.

pre-existing condition - an illness, injury or condition for which the insured individual received medical advice, treatment, services or supplies; had diagnostic tests done or recommended; had medicines prescribed or recommended; or had symptoms of typically within 12 months (time periods

Other Forms of Health Insurance

In addition to broad coverage for medical, surgical, and hospital expenses, there are many other kinds of health insurance.

Hospital-surgical policies, sometimes called basic health insurance, provide benefits when you have a covered condition that requires hospitalization. These benefits typically include room and board and other hospital services, surgery, physicians' non surgical services that are performed in a hospital, expenses for diagnostic X-rays and laboratory tests, and room and board in an extended care facility.

Benefits for hospital room and board may be a per-day dollar amount or all or part of the hospital's daily rate for a semi-private room. Benefits for surgery typically are listed, showing the maximum benefit for each type of surgical procedure.

Hospital-surgical policies may provide "first-dollar" coverage. That means that there is no deductible, or amount that you have to pay, for a covered medical expense. Other policies may contain a small deductible.

Keep in mind that hospital-surgical policies usually do not cover lengthy hospitalizations and costly medical care. In the event that you need these types of services, you may incur large expenses that are difficult to meet unless you have other insurance.

Catastrophic coverage pays hospital and medical expenses above a certain deductible; this can provide additional protection if you hold either a hospital-surgical policy or a major medical policy with a lower-than-adequate lifetime limit. These policies typically contain a very high deductible ($15,000 or more) and a maximum lifetime limit high enough to cover the costs of catastrophic illness.

Specified or dread disease policies provide benefits only if you get the specific disease or group of diseases named in the policy. For example, a policy might cover only medical care for cancer. Because benefits are limited in amount, these policies are not a substitute for broad medical coverage. Nor are specified disease policies available in every state.

Hospital indemnity insurance pays you a specified amount of cash benefits for each day that you are hospitalized, generally up to a designated number of days. These cash benefits are paid directly to you, can be used for any purpose, and may be useful in meeting out-of-pocket expenses not covered by other insurance.

Hospital indemnity policies frequently are available directly from insurance companies by mail as well as through insurance agents. You will find that these policies offer many choices, so be sure to ask questions and find the right plan to meet your needs.

may vary depending on state laws) prior to the effective date of insurance coverage.

Preferred Provider Organization (PPO) - A network or panel of physicians and hospitals that agrees to discount its normal fees in exchange for a high volume of patients. The insured individual can choose from among the physicians on the panel.

premiums - payments to an insurance company providing coverage.

provider - any person or entity providing health care services, including hospitals, physicians, home health agencies and nursing homes. Usually licensed by the state.

referral Â within many managed care plans, transfer to specialty physician or specialty care by a primary care physician.

rider - a modification to a Certificate of Insurance regarding clauses and provisions of a policy. A rider usually

Some policies contain limitations on preexisting medical conditions that you may have before your insurance takes effect. Others contain an elimination period, which means that benefits will not be paid until after you have been hospitalized for a specified number of days. When you apply for the policy, you may be allowed to choose among two or three elimination periods, with different premiums for each. Although you can reduce your premiums by choosing a longer elimination period, you should bear in mind that most patients are hospitalized for relatively brief periods of time.

If you purchase a hospital indemnity policy, periodically review it to see if you need to increase your daily benefits to keep pace with rising health care costs.

Medicare supplement insurance, sometimes called Medigap or MedSup, is private insurance that helps cover some of the gaps in Medicare coverage.

Medicare is the federal program of hospital and medical insurance primarily for people age 65 and over who are not covered by an employer's plan. But Medicare doesn't cover all medical expenses. That's where MedSup comes in.

All Medicare supplement policies must cover certain expenses, such as the daily coinsurance amount for hospitalization and 90 percent of the hospital charges that otherwise would have been paid by Medicare, after Medicare is exhausted. Some policies may offer additional benefits, such as coverage for preventive medical care, prescription drugs, or at-home recovery.

There are 10 standard Medicare supplement policies, designated by the letters A through J. With these standardized policies, it is much easier to compare the costs of policies issued by different insurers. While all10 standard policies may not be available to you, Plan A must be made available to Medicare recipients everywhere.

Insurers are not permitted to sell policies that duplicate benefits you already receive under Medicare or other policies. If you decide to replace an existing Medicare supplement policy - and you should do so only after careful evaluation - you must sign a statement that you intend to replace your current policy and that you will not keep both policies in force.

People who are 65 or older can buy Medicare supplement insurance without having to worry about being rejected for existing medical problems, so long as they apply within six months after enrolling in Medicare.

Long-term care policies cover the medical care, nursing care, and other assistance you might need if you ever have a chronic illness or disability that leaves you unable to care for yourself for an extended period of time. These services generally are not covered by other health insurance. You may receive long-term care in a nursing home or in your own home.

Long-term care can be very expensive. On average, a year in a nursing home costs about $40,000. In some regions, it may cost much more. Home care is less expensive, but it still adds up. (Home care can include part-time skilled nursing care, speech therapy, physical or occupational therapy, home health aides, and

adds or excludes coverage.

risk - uncertainty of financial loss.

short-term medical - temporary health coverage for an individual for a short period of time, usually from 30 days to six months.

small employer group - groups with 1 Â 99 employees. The definition of small employer group may vary between states.

state mandated benefits - state laws requiring that commercial health insurance plans include specific benefits.

stop-loss - the dollar amount of claims filed for eligible expenses at which the insurance begins to pay at 100% per insured individual. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of co-insurance.

Third Party Administrator (TPA) - An

homemakers.)

Bringing an aide into your home just three times a week - to help with dressing, bathing, preparing meals, and similar chores - easily can cost$1,000 a month, or $12,000 a year. Add in the cost of skilled help, such as physical therapy, and the costs can be much greater.

Most long-term care policies pay a fixed dollar amount, typically from$40 to more than $200 a day, for each day you receive covered care in a nursing home. The daily benefit for at-home care is usually half the benefit for nursing home care. Because the per-day benefit you buy today may be inadequate to cover higher costs in the future, most policies also offer an inflation adjustment feature.

Keep in mind that unless you have a long-term care policy, you are not covered for long-term care expenses under Medicare and most other types of insurance. Recent changes in federal law may allow you to take certain income tax deductions for some long-term care expenses and insurance premiums.

Disability insurance provides you with an income if illness or injury prevents you from being able to work for an extended period of time. It is an important but often overlooked form of insurance.

There are other possible sources of income if you are disabled. Social Security provides protection, but only to those who are severely disabled and unable to work at all; workers' compensation provides benefits if the illness or injury is work-related; civil service disability covers federal or state government workers; and automobile insurance may pay benefits if the disability results from an automobile accident. But these sources are limited.

Some employers offer short- and long-term disability coverage. If you are self-employed, you can buy individual disability income insurance policies. Generally:

- Monthly benefits are usually 60 percent of your income at the time of purchase, although cost-of-living adjustments may be available.
- If you pay the premiums for an individual disability policy, payments you receive under the policy are not subject to income tax. If your employer has paid some or all of the premiums under a group disability policy, some or all of the benefits may be taxable.

Whether you are an employer shopping for a group disability policy or someone thinking of purchasing disability income insurance, you will need to evaluate different policies. Here are some things to look for:

- Some policies pay benefits only if someone is unable to perform the duties of their customary occupation, while others pay only if the person can engage in no gainful employment at all. Make sure that you know the insurer's definition of disability.
- Some policies pay only for accidents, but it's important to be insured for illness, too. Be sure, as you evaluate policies, that both accident and

organization responsible for marketing and administering small group and individual health plans. This includes collecting premiums, paying claims, providing administrative services and promoting products.

underwriter - entity that assumes responsibility for the risk, issues insurance policies and receives premiums.

waiver of coverage - a section on the enrollment form which states that an employee was offered insurance coverage but opted to waive this coverage.

Worker's Compensation Insurance - insurance coverage for work-related illness and injury. All states require employers to carry this insurance.

illness are covered.

- Benefits may begin anywhere from one month to six months or more after the onset of disability. A later starting date can keep your premiums down. But remember, if your policy only starts to pay (for example) three months after the disability begins, you may lose a considerable amount of income.

- Benefits may be payable for a period ranging anywhere from one year to a lifetime. Since disability benefits replace income, most people do not need benefits beyond their working years. But it's generally wise to insure at least until age 65 since a lengthy disability threatens financial security much more than a short disability.

A Final Word

If you get health care coverage at work, or through a trade or professional association or a union, you are almost certainly enrolled under a group contract. Generally, the contract is between the group and the insurer, and your employer has done comparison shopping before offering the plan to the employees. Nevertheless, while some employers only offer one plan, some offer more than one. Compare plans carefully!

If you are buying individual insurance, or any form of insurance that you purchase directly, read and compare the policies you are considering before you buy one, and make sure you understand all of the provisions. Marketing or sales literature is no substitute for the actual policy. Read the policy itself before you buy.

Ask for a summary of each policy's benefits or an outline of coverage. Good agents and good insurance companies want you to know what you are buying. Don't be afraid to ask your benefits manager or insurance agent to explain anything that is unclear.

It is also a good idea to ask for the insurance company's rating. The A.M. Best Company, Standard & Poor's Corporation, and Moody's all rate insurance companies after analyzing their financial records. These publications that list ratings usually can be found in the business section of libraries.

And bear in mind: In some cases, even after you buy a policy, if you find that it doesn't meet your needs, you may have 30 days to return the policy and get your money back. This is called the "free look."