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# Deciphering Your Health Insurance Plan

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# Deciphering Your Health Insurance Plan

## What is Health Insurance?

Health insurance coverage varies greatly, but basically it is a type of insurance policy that pays a pre-negotiated percentage of a policy holder's covered medical treatments. Do you really need health insurance or can you live without it? The answer depends on whom you ask and the question is not always an easy one.

Like other forms of insurance, health insurance doesn't really become an issue until you need it. Automobile insurance doesn't do you any good until you get into a car accident. Life insurance doesn't do you any good until you die. And health insurance doesn't do you any good until you need medical assistance. If you believe in Murphy's Law--that whatever can go wrong, will--then you probably should consider getting health insurance.

In some countries, health insurance is not offered by private companies like it is in the United States. In England, France, Canada, Sweden and Norway, for example, the doctors and hospitals are reimbursed by the government instead of an insurance company.

In the United States, there are three basic types of health insurance:

**1) Self-Insured/Uninsured.** This is where an individual has no insurance or has health insurance but is responsible for paying 100% of the insurance premium. This group is estimated to comprise at least 30% of the US population.

**2) Managed Care Plans.** Managed Care Plans fall into three categories. All are essentially networks to provide contracted services by specific providers at contracted prices:

i) Health Maintenance Organizations (HMO) are prepaid plans in which members pay a fixed monthly fee, regardless of how much medical care is needed in a given month. HMOs provide medical services ranging from office visits to hospitalization and surgery, and usually insist that you stay within the network when you need services from physicians and hospitals.

ii) Preferred Provider Organizations (PPO) are groups of doctors and hospitals that provide medical service only to specific groups. PPO members typically pay for services as they are provided, and the PPO sponsor typically reimburses the member for the cost of the treatment. In most cases, the price for each type of service is negotiated in advance by the healthcare providers and the PPO sponsor.

iii) Point of Service (POS) plans are not as common as the other two. This is a type of managed healthcare system in which you pay no deductible and usually only a minimal co-payment when you use a healthcare provider within your network. You also must choose a primary care physician who is responsible for all referrals within the POS network. If you choose to go outside of the network for healthcare, you will be subject to excess charges or deductibles.

**3) Indemnity Plans** enable participants to seek medical assistance whenever they need. Participants can visit any doctor or specialist, as often as they feel necessary. There are no restrictions when it comes to seeking medical help, but this is by far the most expensive type of health insurance plan.

Which of these types of health insurance is right for you will depend on your personal situation. Choosing health insurance coverage is a time-consuming task and it can certainly be frustrating, but it's something that everybody needs to consider sooner rather than later.

### **Your Health Insurance Policy: A Guide To Understanding It**

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

The first things you want to understand are the many terms that are in your policy. One of the common terms that you will see a lot and deal with a lot is a deductible. A deductible is what you would have to pay before any benefits in your health insurance policy would be accessible. Usually this is an annual amount and will vary greatly by the underwriters of the policy.

Most of the time there are separate deductibles for an individual account and a family account. Some policies will let you use some of their services with out meeting the deductible. Once you meet your deductible then you're done for that calendar year. The following year though you have to start all over again.

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

Out of Pocket is what you will have to pay out of your own pocket. This could include your deductibles, co-insurance, and your co-payments. If you hear the term "annual out of pocket expense" this is the maximum out of your own pocket you would have to pay for the services minus the premiums, which are due no matter what.

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

Exclusions will be one section that you must read very carefully and fully understand in your health insurance policy. Exclusions are things the policy will not cover and this can be a very

gray area. The policy could cover operations but not after care or cover after care and not the operation. This is one of the most important sections of your policy so read it and reread it over a lot to make sure you grasp all of the contents and what it covers and what it doesn't cover.

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

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

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

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

### **When Health Insurance Doesn't Cover Your Medical Care**

While it's true that the costs for health insurance coverage continue to increase, having a health insurance plan will save you more money in the long run. But no health insurance plan will cover every medical treatment an insured individual needs over the course of his or her coverage period.

No matter how good your health insurance is, you may occasionally encounter a medical treatment or condition that is not covered by your health insurance policy. Although these situations are normally confined to elective treatments like cosmetic surgery and liposuction, that is not always the case.

If you are in need of a non-elective treatment that your insurance company is unwilling to cover, and it is not specifically listed on the "excluded treatments" section of your health insurance policy, ask your insurance company for a written explanation of their reasons for issuing such a denial.

Then show this to your physician. Many times, simply re-coding a procedure or treatment and re-presenting it to your insurance company are all that's needed to get approval for the treatment.

But what happens when the procedure hasn't been miscoded or can't be re-coded and coverage for a medical treatment you already received has been denied by your insurance agency? The

hard truth is that by this point in the process, you do not have many options, and you may end up being responsible for paying the full cost out of your own pocket.

One option you do have is the opportunity to appeal a decision if you do not agree with it. Every insurance company has a process to go through to appeal a claim, and you need to follow the steps involved in the appeals process precisely.

Insurance companies would rather throw your appeal out on a technicality than invest the resources necessary to investigate the claim. The appeal process is typically outlined in your policy handbook. You can also discuss the situation over with your medical care provider before proceeding with the appeal to get another point of view or advice on how to proceed.

If, despite your best efforts, the treatment still is denied, all is not lost. Here are some other options that are worth pursuing that may help you avoid paying full price:

1. See if your doctor will negotiate a lower payment or authorize a payment plan.
2. See if your doctor is a member of a medical discount program that you can join. There are thousands of doctors who participate in these networks.
3. If you've not yet had the procedure, shop around for another doctor who is willing to do the procedure for a lower price.
4. See if you qualify for free treatment at a public hospital or clinic because of your income level, veteran's status, or some other socio-economic reason.

With a bit of persistence and some extra effort, it is very likely that you'll end up with the treatment that you need at a price you can afford.

### **Cosmetic Surgery: Costly or Covered?**

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

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

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

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

So as to qualify as a reconstructive surgery rather than an elective cosmetic procedure, the operation must be performed in order to improve a body part's functions, but quite often it is accepted if the surgery is merely used to give the body part a societal accepted normal appearance. Yet, the buyer must beware! While insurance companies will quite often cover such reconstructive surgery, they may not cover it to the extent the patient wishes the surgery to go.

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

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

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

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

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

## **Gastric Bypass: When is it Covered?**

Overweight and obesity is a major health crisis in North America. More and more adults and children are struggling with the weight and the array of health problems that is associated with carrying around dangerous and unwanted pounds. The weight loss/diet industry is a multi-billion dollar business, with desperate people willing to try anything from books to commercial diet plans and pills in order to lose weight for health and beauty reasons.

One of the more drastic and expensive weight loss treatments is gastric bypass surgery. This controversial surgery can be life-saving, life-changing or life-taking, but it always costs a lot and not everyone can afford the multi-thousand dollar price tag which begs to question: will my insurance company pay for gastric bypass surgery?

Gastric bypass surgery is an extremely invasive procedure that involves shrinking the stomach so that only a small pouch remains. Effectively, patients that have undergone successful gastric bypass surgery are unable to eat more than a few tablespoons of food at a time. The technique has been proven effective for quickly reducing the mass of morbidly obese people for whom regular activity and nutritional monitoring has not worked.

The surgery is not a quick fix for minor weight loss, however. It is a serious procedure applied in only serious cases. To qualify for the surgery, whether covered by health care insurance or not, you must have a body mass index (BMI) greater than 40.

For an average man, that means about 100 pounds overweight and 80 pounds over weight for an average woman. Individuals with a slightly lower BMI may also be considered for gastric bypass surgery if they also have a serious condition, such as diabetes or heart disease that can be worsened by obesity. Surgery candidates must also realize the severity of changes gastric bypass surgery will mean in terms of lifestyle changes and responsibility.

In cases where gastric bypass surgery is deemed medically necessary, most health care insurance companies will pay for the procedure, even if the initial application is refused. If you have to fight to have the surgery covered, arm yourself with information and support from your physician, along with any information you can gather about the potential savings in future medical costs as a result of the weight you would lose if the surgery is carried out.

There are abundant studies from reputable organizations that trumpet the benefits of weight loss to the prevention and reduction of several associated problems such heart attack, stroke, Type 2 diabetes (so-called adult-onset diabetes), and sleep apnea to name a few.

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

Even if you are the perfect candidate for surgery, do not expect a quick process. Between the time you contact your insurance provider about possible gastric surgery and the time you

actually get the surgery, many months may have passed.

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

It is important that you know, in advance, how your health insurance provider would handle any costs associated with post-operative complications associated the bypass surgery. Will you receive blanket approval for any additional care that may be necessary or will you have to secure case-by-case approval for each new procedure or measure?

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

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

Diabetes, also known as hyperglycemia, can be the precursor of devastating health problems. The inability to produce sufficient insulin leaves the body vulnerable to a dangerous glucose buildup that will eventually lead to heart disease, stroke, high blood pressure, kidney disease, blindness, amputations, and a host of other complications.

In the past, patients who suffered from diabetes and sought to purchase health insurance coverage were very often denied a policy and labeled as "uninsurable." While Medicaid and Medicare are the legislated safety nets for American society, many an uninsured diabetic found that he or she did not qualify for benefits under these plans, and hence was in the awkward position of desperately needing healthcare coverage yet being unable to receive it.

Fortunately, things have changed somewhat, but diabetics still need to be savvy consumers! For example, if a consumer has not had insurance coverage for more than 63 days prior to seeking new coverage, then some insurance companies, although will now insure patients who suffer from diabetes, will require a waiting period. This waiting period may be as long as six months; and since diabetes is a chronic illness that requires constant care, this will be a very costly six months for a patient.

Additionally, other insurance companies simply exclude pre-existing conditions altogether, and will only cover non-diabetes related illnesses. For a diabetic this is a most dreaded circumstance. It is not surprising that those who have the misfortune to fall through the cracks of the healthcare system very often incur staggering medical debts, and sometimes even find themselves forced into bankruptcy because of the mounting medical bills. In order to avoid this spiral of misery, here are some suggestions every diabetic needs to know about:

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

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

## **2. Learn about High Risk Pools**

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

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

While the cap is firm, there is still some elasticity in the rates, and they sometimes may vary based on plan participants' ages, or even domicile addresses. Sadly, it is often these high rates that prevent eligible individuals from seeking out this kind of insurance. Additionally, many a person in need of such a plan is not aware of its existence!

## **3. Get educated**

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

## **4. Purchase Medigap Insurance**

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

## **Health Insurance and The Terminally Ill**

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

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

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

Even with Medicare-provided hospice palliative care, terminally ill patients will still usually be responsible for their room and board costs but many other fees are paid under the Medicare plan. For example, a hospice Medicare beneficiary would not have to pay for: physicians' visits and care; nursing care; equipment such as wheelchairs, walkers, or monitoring devices; standard hospital supplies such as catheters and bandages; pain killers and symptom-controlling medications; short-term respite or hospital care; homemaker/aide services; physical, occupational or speech therapy. Emotional or spiritual counseling may also be available to patients and their families.

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

Accelerated or living benefits are life insurance monies paid to life insurance policyholders before they die. A few policies include accelerated benefit options, but if yours doesn't, you can ask your insurance provider about adding the appropriate provisions to new or current policies.

The amount of money available as early payment with accelerated benefits ranges according to what kind of policy you have. However, the amounts are typically between one quarter of the total policy. There are also limited circumstances under which living benefits will be awarded, and these also vary by policy. Speak to your provider to see what options are available to you.

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

Turning to accelerated benefits or viatical settlements does provide a good source of quick money to cover sudden or unanticipated costs, but don't jump into either prospect without considering the long-term effects of what you are choosing to do. If your life insurance policy is a central part of your estate plans or is something to pass on to family members, using

accelerated benefits or viatical settlements will have a big impact on your future financial situation.

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

## **Health Insurance for Those with Special Needs**

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

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

However, when it comes to special needs insurance coverage, it is wise to ensure your policy addresses the extended parameters of special needs care including more frequent doctor visits, greater need for surgery and physical and emotional therapy, expensive prescription medicines, custom equipment, home care, assisted living or nursing home facilities.

Securing an all-encompassing policy can be a daunting task, particularly if you are opting to purchase a private plan. Recognizing that individuals with special needs may require extra expenses, many private insurance companies put extreme limitations on "addition" or above-standard services. When it comes to trying to secure health insurance as an individual with special needs, there is no guarantee you will even be approved: nearly all private health care insurance providers enact stringent rules on what is covered and what isn't allowed.

You will likely find that your special needs fall under the category of pre-existing conditions, and you will not be eligible for coverage of health expenses related to those pre-existing conditions. If your application is accepted and your special requirements are covered by the insurance plan, you can count on very high premiums. Do research when looking at private health care insurance options and don't be afraid to ask questions about your specific needs. It is better to have reliable information ahead of time rather than to discover your insurance company will not support you later when you need it.

Employer-sponsored insurance (ESI) is by far the most popular choice of health care insurance for adults, whether fully able or with special needs. If you receive a health benefits package as part of your employment, you will be accepted under the company's plan regardless of your health status. However, when you apply for individual coverage, there are no such guarantees

and, as described above, you may not be able to secure the coverage you need, even with high premiums or reduced benefits.

The same is true when it comes to renewing your health care insurance: if you are covered under your company's EIS medical plan, you can renew your coverage as necessary, even if you are sick. With most individual plans, there is no guarantee your policy will not be cancelled.

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

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

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

### **Insurance and Infertility: Is There A Loophole?**

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

One of the biggest loopholes was that the states didn't want to cover vitro fertilization as it could get quite expensive and might not work all the time so insurance companies would balk at this added expense. Now most states have listed this as a non-necessary expense and covered it under maternity coverage. Many states have balked at this idea and only a handful of states are providing coverage for maternity expenses.

Some people even consider this practice of not giving coverage as discrimination and they want the government to step in. Most of the basic health plans have no coverage at all for this type of medical treatment, which makes it hard for infertility patients to get any help at all.

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

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

Many insurance companies have exclusions on infertility treatments and this is something you will have to check on as it varies by each carrier. Certain carriers will cover one thing while another won't. The worst part is that there really is no universal set of guidelines that the insurance companies are following to make it easier for consumers.

What many people don't realize is the cost isn't really that much more for insurance companies. So why won't they do it then? The answer is that it would bring a flood of different fertility treatments to the forefront. In other words what ones will they pay for and which ones won't they? That's a very fine line and the insurance companies don't want to go there and confront this issue.

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

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

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

### **Suicide: When Is It Covered**

We've all seen this scenario before, either in a movie or on the evening news. A spouse, distraught over his or her family's crushing financial burden, decides to commit suicide so that the surviving family members can collect his or her life insurance benefits. For Jimmy Stewart in

*It's a Wonderful Life*, his intended act of suicide was halted through the intervention of a guardian angel and everyone lived happily ever after. Unfortunately, this is not the way the story ends for families living in the real world.

What really happens to a family in the aftermath of a suicide attempt can be many times more devastating than the original circumstances that led to the attempt. If the attempt is successful, then the survivors may be left with a double tragedy. Not only have they lost a loved one, but what if the relevant life insurance policy will not pay benefits in the event of a suicide? Now the surviving family members are looking at even more debt because of funeral and burial costs and the deceased's lost income.

If the suicide attempt is unsuccessful and there is no lasting injury, then the disturbed individual and his or her family are very lucky. There is no loss of a loved one and psychological counseling can be sought. Most health insurance policies will even pay for the treatment. If, on the other hand, a suicide attempt leaves the individual physically incapacitated permanently or for an extended period of time, this could spell even greater financial disaster for the affected family members.

If the individual is also the primary wage earner, then the family has lost its major source of income (along with any attendant benefits) and must pay for physical care that may not be covered by any insurance policies.

The information that follows gives a brief overview of different insurance policies and what they will or will not cover in the case of a suicide or suicide attempt.

### **Suicide Coverage**

The desperate soul who rushes out to buy an insurance policy and then immediately commits suicide is misguided in two respects: first, he or she should have sought help from a mental health professional for assistance in dealing with such self-destructive thoughts; and, second, the life insurance policy won't pay if the suicide is committed immediately after its purchase.

Most life insurance policies have a suicide clause. Either death resulting from suicide is not covered at all or a death resulting from suicide is covered only after two years have passed since the date of the policy's purchase. Why the two-year period? It's thought that a clause that excludes suicide as a valid cause of death in the first two years of the policy's life will stop someone contemplating suicide from buying the policy on impulse.

There's no immediate benefit, so they won't buy the policy. Even if a person intent on committing suicide does buy a policy, the chances that they will still want to end their life after waiting two years is slim. There are life insurance policies that do not exclude suicide at all, but most of these plans are prohibitively expensive.

### **Coverage for Suicide Attempts**

The most relevant type of insurance coverage for someone who has survived a suicide attempt is health insurance. Obviously, someone who attempts suicide is in need of psychological help and many health insurance plans will pay for this. Some families might be hesitant to use this

benefit because of the stigma attached to suicide and may be concerned that word of the family member's mental health problems will become the subject of workplace gossip.

Fortunately, those who handle and view insurance claims in an office are bound to strict rules of confidentiality and are prohibited from discussing any worker's medical or psychological condition. The family can seek treatment and know that word of their situation will not be spread.

If someone survives a suicide attempt but sustains injuries that are permanent or that require long-term care, the situation can be pretty grim. Most health insurance companies will not cover injuries that are self-inflicted. So, things like hospital bills, rehabilitation costs, doctor's bills, home care attendants and all other potential medical necessities would have to be paid for by the individual who attempted suicide.

### **Your Health Insurance and Your Vacation: What to Know Before You Go**

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

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

Travel or vacation insurance is available in many formats. You can buy a basic package that protects you from logistical issues such as being bumped from a flight and not making your cruise departure, to more complex packages that incorporate logistical issues, health care, and loss or theft. You can also purchase limited policies that guard against specific risks or events either on or before your trip.

For example, you may want an "out" to cancel your walking tour of England if you broke your leg three days before your departure. Or you may want to purchase health coverage so that if you break your leg while on the walking tour, you can receive proper medical attention without having to deal with the possibility your provider won't pay for care administered in another country. This is a super way to protect against loss of deposits and pre-paid expenses.

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

Vacation or travel health care insurance is a valuable tool, especially if you purchase a comprehensive policy that includes coverage death or injury to yourself or your family/travel

companions; accidents or illness requiring hospitalization while at your vacation destination; emergency dental work; ambulance fees, medi-coptor, or transport back to the United States while you are abroad; and, medical evacuation to a safe location if necessary. You may have comprehensive domestic health care insurance in the United States, but many plans provided by insurance, HMO or governmental organizations are not honored if you require medical attention while abroad.

Long before you leave home, while you are still in the planning stages of your vacation or business trip, it is wise to review your existing health care insurance package to see what, if any, coverage you may have while in transit or once you have reached your destination. Pay special attention to the exclusions section of your agreement, and if you are confused or unclear about any of the language, contact your provider for a more understandable explanation.

In fact, have your provider review the entire policy with you so you can take note of what coverage you have, what documentation you need to carry in order to access insurance-sponsored health care while you are away, and any particular accommodations you may need to make, such as whether family members have to be named individually on your agreement in order to be protected.

By figuring out what coverage you have, you can avoid the cost of purchasing duplicate coverage. You may think you are doubling your protection by buying a redundant policy, but almost all plans exclude coverage of claims that can be made under an already existing policy.

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

## **Health Insurance Benefits**

One thing that's important to understand when researching health insurance benefits is that each policy includes its own set. It's easy to make the mistake of assuming that features or health coverage exists when they don't. However, these types of assumptions not only are wrong, but they could one day leave you facing insurmountable medical bills.

The ideal personal or family health plan would pay for every health issue that may arise-- pregnancy, blood transfusions, sick and well care, minor and major surgery, hospital stays, etc. But the truth is health insurance benefits typically are limited and they seldom will cover 100% of the costs, which is why it's so important to read the policy's fine print. You've got to know exactly what is and is not actually covered.

While health insurance benefits do vary from policy to policy, one thing that most health insurance companies are offering in their policies nowadays is something called preventative or 'well' care. Administrators realize that their overall medical costs can decrease significantly when those they cover seek routine medical treatment. Staying healthy by getting annual check-ups and regular immunization oftentimes helps prevent illnesses from developing in the first place. And identifying potential health issues early on, before they become difficult and expensive to treat is saving insurers money and saving lives.

Generally, the types of health insurance benefits that most policies cover in full or partially include: annual physical examinations, emergency/urgent care, laboratory work including blood testing and x-rays, prenatal care, well baby visits, an annual routine eye exam, and most care required while admitted into a hospital. Some plans even offer discounts on health club facilities and programs that help individuals stop smoking.

While health insurance benefits are sometimes difficult to determine, those responsible for putting policies together often do a great job delineating the types of medical treatments and services that are not covered. This is typically an alphabetical, detailed listing of everything that is not covered under a policy, from acupuncture to vision correction treatments such as Lasik and radial keratoplasty. When selecting a health plan, don't forget to carefully review this section.

Dental care and vision/eye care beyond an annual eye examination are usually not included in health care plans in the USA. Coverage for these types of services is instead typically offered as separate plans with separate benefits, separate premiums and separate deductibles. They'll typically have different forms to use and different procedures to follow.

Because of the soaring costs associated with prescription drugs, many insurers have eliminated this type of coverage from their health insurance benefits package. More and more, prescription drug plans are being offered separately in the same manner as dental and vision plans.

Finally, several states have developed unique state-mandated health insurance requirements for their residents. These are usually designed to be consumer-oriented to protect consumers from predatory practices. The requirements are not transferable from one state to another so when a person moves out of state, they lose them (or they gain them). That's why it's important to use your correct residential address to ensure that you receive the health insurance benefits you're entitled to.

## **The Health Insurance Claims Process**

Having health insurance is one thing, but what happens when you need to file a health insurance claim? Unfortunately, there's no one straightforward answer to this question. The reason is because every type of health insurance plan generally includes its own way of handling claims. And when you stop and consider the number of companies offering multiple types of health insurance policies, you can begin to understand why answering such a seemingly simple question can be so complex.

If you need help understanding how to file a health insurance claim for a benefit that is covered under your health insurance policy, the best place to begin is with the insurance company itself. Most will offer a toll-free telephone number that is staffed during normal business hours that you can call. You'll typically be first required to provide some basic information about your policy including the policy or group number and the name of the primary insured on the policy. From there, the insurance company representative can access the details of your health insurance policy and advise you how to proceed with your claim.

If you have a Managed Care Plan and you're dealing with a covered benefit, you'll find that the process is surprisingly simple. Most often, those staffing the front offices of the medical facilities you visit take care of processing the necessary paperwork. They input the proper medical codes for the services rendered and send the paperwork to the insurance company.

Patients typically make the required co-payment at the time services are rendered and need take no further action until they receive from the insurance company the paperwork that corresponds to the office visit. The paperwork shows the percentage that the insurance company paid, how much was applied towards the deductible, and it will show if there is a balance due by the patient.

In the past, those with Indemnity Plans were required to pay in full for the services rendered at the time they were rendered. They were given lengthy claims forms to complete and submit to the health insurance company. It would take weeks to get reimbursed for the services provided.

But today, front office personnel typically will directly bill the insurance company for the services rendered first and then they'll wait to see what percentage the insurance company pays. In situations where there is a balance due afterwards, the patient is billed. Anytime there's a dispute, the medical services provider bills the patient directly and the patient does need to pay. It's then the patient's responsibility to work out an agreement with his or her health insurance company.

With all the computerization involved in the medical billing process today, patients typically don't have any out of pocket costs aside from their co-payment. If they are required to first meet their deductible, the paperwork still gets forwarded to the insurance company first, so that those in charge can keep accurate track of the policy's usage and payment history. Given the enormity of the task, health insurance claims for covered benefits get settled rather quickly.

## **Health Insurance Costs Explained**

Have you ever taken a moment to have someone explain health insurance costs to you? We know that health insurance costs just keep going up and up, but how do these spiraling costs affect your health insurance coverage? You know the amount you're paying every month for your health insurance premium, so it's easy to know when this cost increases, but what about all the other costs involved with health insurance? Do you know what they mean? Before you're hit with an excessively large medical bill, read the following explanation of health insurance costs.

## **Premium**

The premium is the amount you'll pay for the benefits covered under your health insurance plan. The premium is typically broken down into equal monthly payments. If you've got group insurance, your employer or a union is probably sharing some percentage of this cost.

## **The Deductible**

If your health insurance policy includes an annual deductible, it's important to understand the details. A deductible is an amount that you are responsible for paying before the insurance company begins paying out claims. As with car insurance, the higher your deductible the lower your monthly premium and vice versa. A family health insurance plan typically includes multiple deductibles.

## **The Co-Payment**

A co-payment is a fixed amount that the insured has to pay each time they visit the doctor. The co-payment amount differs based on the type of health insurance plan you have and typically an HMO will have the lowest co-payment. The co-payment can however, increase for different types of medical service and/or if you go outside the network.

## **Co-Insurance**

Co-Insurance is the amount of a claim that the insured is responsible for paying, once the deductible has been met. A typical ratio is 80/20 where the insurance company pays 80% of a claim and the insured pays 20%. An insured's percentage will typically increase when he goes outside the network. Also, in situations where the claim exceeds what the insurance company deems 'reasonable and customary' the difference is another form of co-insurance that must be paid by the insured.

If you don't fully understand these health insurance costs have someone explain them to you. These are the things you've got to ask about when requesting quotes, especially online health insurance quotes. When you're comparing quotes from different insurance companies, it's important to know all your costs, not just the premium.

Make sure the person preparing your quote clearly defines the deductible amount and whether there is a separate deductible for different types of services, the co-payment amount and the co-insurance amounts. Also ask the person to elaborate on other costs that may not be readily apparent.

To keep costs as low as possible, always stay within your network. If you can choose any medical care professional, be sure that the fees for the services you'll need fall within your insurance company's 'reasonable and customary' guidelines. If not, shop around for a less expensive provider. Other tips for keeping health insurance costs as low as possible include living a healthier lifestyle and seeking medical care only when absolutely necessary.

## **Don't be Victimized by Health Insurance Fraud**

It's unfortunate but true: health insurance fraud is prevalent in our society and it's not always possible to protect yourself from becoming a victim. In fact, most people won't even know they've fallen prey to health insurance fraud until they submit a claim for a medical service that they think is covered under their policy. It's often not until after a claim is denied that most people realize they've been a victim of health insurance fraud.

### **How to Spot Health Insurance Fraud**

Is it possible to keep yourself from becoming a victim of health insurance fraud? Would you even know what to look for? While there probably are as many different fraud scenarios as there are victims, there is one thing that should always throw up a glaring red flag: health insurance coverage that seems too good for a price that seems incredibly low.

Be wary of unsolicited mail that advertises discounted health insurance, especially if you're not familiar with the name of the company making the offer. Before you take any further action, you should do what you can to research the credibility of the company. Health insurance companies are rated at this web site <http://www.ambest.com/>. You should also check with your State Insurance Commission to see if the company is licensed to do business in your state.

Most importantly, you also need to read the offer in its entirety, especially the fine print. Be very careful of any salesperson that asks you to pay using cash and/or requires you to pay the total amount of your premium in advance.

If you find that you are a victim of health insurance fraud, follow these guidelines immediately:

1. Contact your State Insurance Commissioner. Find out if they have any other complaints about the company from which you purchased your coverage. Also file a health insurance fraud complaint.
2. Contact your bank or credit card company to stop any future automatic payments that may be scheduled.
3. Contact your local law enforcement agency.

Be sure to have all of your cancelled checks or credit card statements and a copy of the health insurance contract that you signed. Also get a copy of your personal credit report from all three major credit reporting agencies as soon as possible. Many times people who perpetrate health insurance fraud also use your personal information to steal your identity and to commit other fraudulent acts.

Be smart and check out the health insurance company before you sign on the dotted line. As a final precaution, call your local hospital or personal physician and ask if they accept the insurance. If not, at least find out if they have ever heard of the insurance. When it comes to protecting yourself from health insurance fraud, an ounce of prevention really is worth a pound of cure.

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