

This Report is brought to you by...

The WOW Experience

Overdelivery is our Specialty!

Where Vision and Value Go Hand in Hand with Information and Opportunity!



Other Companies Make Promises -- We Make Dreams Come True!
We Offer QUALITY CONTENT in Every WAY, TYPE and FORM

- Exclusive WOW Private Label Releases
- Private Label Products
- Public Domain Products
- Master Resale Rights eBooks
- Master Resale Rights Software
- Bestselling Audio eBooks by Top Authors
- Non-Fiction Audio eBooks
- Exclusive WOW Affiliate Products
- Resale Rights Products
- Exclusive WOW Private Label Reports
- eBook to Audio Conversion Software
- Resale Rights Generation Software



And, of course, if you want it all tied up in a neat website package, with *all the work done for you*, we have our NEW [Niche Empire Builder Software](#) – the Niche Real Estate Business Builder's Dream Come True!

Niche Empire Builder

The Complete Done-it-For-You Niche Real Estate Business Builder's Dream Come True!

www.the-wow-empire.com

The WOW Content Club

Your Full Spectrum Content Provider

If Content Is King,
The WOW Content Club is the Kingdom
You Have Been Searching For!



www.wow-content-club.com

WOW Profit Packs

Help Yourself to Hundreds of Brand New, Blockbuster Products at Bargain Basement Prices!



www.WOWProfitPacks.com

Enjoy this Free Niche Report, compliments of WOW Enterprises
For Many More Free Reports, simply click on the links below.

www.TheWOWExperience.com

www.NicheEmpireBuilder.com

www.WOW-Content-Club.com

www.WOWProfitPacks.com

Health Insurance Plans From A-Z

Topics Covered:

American Family Health Insurance

California Health Insurance

Healthnet Family Plans

HIPAA: What Do All Those Letters Mean?

HMO: What It Means

Understanding Indemnity Care Plans

Kaiser Family Plans

Understanding Managed Care Plans

PIP: What Is It?

POS: What It Means

PPO: What It Means

Short-Term Family Health Insurance

Texas Health Insurance

All About Travel Health Insurance

Universal Health Care: What Is It?

Health Insurance Plans From A-Z

American Family Health Insurance

American family health insurance are insurance plans for those living in America and for Americans living abroad. If you are in need of health insurance you owe it to yourself to do the research, find insurance that will fit your family and your budget, and it should start with American family health insurance.

Plans for Americans throughout the nation

The name says it all, American family health insurance, so you know you are working with a company that has your best interest at heart when it comes to protecting your medical and health needs. You need insurance so you can get treatment when you need it most for illness, disease or for other accidental medical needs. American health insurance costs are constantly rising, and with a health insurance plan that fits your budget and family needs, you are protecting your savings and your financial future.

Get the medical coverage you need

If you don't make regular trips to the doctors because you are afraid of the costs of doctor bills, you should be looking at the medical insurance plans, which are offered by American family. Insurance plans are arranged not only to fit the needs of your budget and your financial needs, but also those medical needs your family may have.

Some plans will include PPO's where you visit only doctors on the a preferred listing, but if you live in an area of the country where a preferred doctors list does not exist you can choose from additional plans so you can visit any doctor, anywhere.

Medical coverage research

In starting your search for medical coverage for your family, you need to address a few things. You need to first take a good look at your budget. If you were to visit the doctors four times a month, how much would this cost? Roughly, it would cost you \$200 just for office visits, and that is probably a low amount. Now if you were to have a problem you needed to see a specialist or an emergency doctor you can see just how fast your costs will raise.

Look at the prices that are similar, and the plans that read well for your family needs. You want prescriptions, include that in your research, but if you are looking for hospital coverage or coverage for doctors visits, that is where you will start your research.

Making a list of those important points for your health insurance

As you start researching what medical coverage you can afford you next want to take a closer look at the health insurance offered. You want to be sure you are comparing similar products or

at least very similar products when looking at the price. If you find a health plan that fits your budget, you want to be sure you also get the coverage you need, such as prescriptions, physicals, or if you only need hospital insurance, that is what you should be looking for.

Healthnet Family Plans

Healthnet family plans provide your family with the benefits you need for the times you never want to think about. If you join with Healthnet you will be able to check you account online, check your benefits, and your information online all with the click of a mouse. A large number of people can take advantage of the Healthnet information and plans available for medical coverage that is dependable.

Healthnet for employers and for consumers

Insurance plans are available for both the consumer and for the employer through Healthnet. If you are single or if you have a family of ten, no matter what the size you can apply for health insurance online and in just a few minutes. Applying online will give you the best personalized quote online that will keep all the hassles from you so you don't have to deal with salesman or long hours sitting on the phone talking about what type of plan you want or don't want.

You make the choices on the screen, and you can read more about the options available along with every step of the way. With the application online, you can find insurance for the short term of six months or for six years.

How to choose a plan that fits your budget

Of course, there are all types of insurance plans out there, which will give you a wide variety of premiums to choose from. Sit down and look at your monthly budget, for your home, and for your daily life. Now look at what your monthly income is and determine how much you want to or can possibly spend on insurance for your family. What you will find out is the less you are spending per visit and per occurrence on your medical bills the higher your premium is most likely going to be.

The more you are willing to spend per visit to the doctors, and the more you spend per occurrence per visit to the hospital the cheaper your insurance will be. Make sure you can afford your monthly or quarterly payment on your insurance plan so you never have to forego a payment and you never fall behind so you have constant coverage.

If you need health insurance, you are in the right place to get started. We suggest that you read all the information about any type of plan that you are going to choose. Be sure the deductible, the premium and the prescription plan are all what will match your family needs.

HIPAA: What Do All Those Letters Mean?

HIPAA, an acronym for what is also known as the Health Insurance Portability and Accountability Act, is a piece of legislation that was passed under the title "Kennedy-Kassebaum Act" in 1996. It aims to aid workers who may have lost a job with an employer-funded health insurance program, and who deal with healthcare needs, especially if these needs may identify them as otherwise uninsurable due to pre-existing conditions or serious health problems.

While it may appear to be a confusing jumble of letters, HIPAA is an important benefit to workers who need health coverage and just started a new job, workers who have medical needs and fear a loss of existing health coverage, workers who change employers and thus stand to face an interruption in employer funded health insurance plans, and also workers who seek to purchase a health insurance policy independent of an employer.

These benefits are accomplished by HIPAA designed limitations on the designation of pre-existing condition exclusions. In addition to the foregoing, HIPAA forbids insurance carriers to inflate premiums for perceived poor health risks, either the individual seeking insurance, or a dependant of the eligible individual. Subsequently, insurance carriers are no longer able to refuse policy renewals in light of paid or submitted claims for coverage.

While these benefits are of tremendous helps to individuals who have found themselves with medical needs and are simultaneously transitioning in their workplace, HIPAA very specifically does not obligate employers to offer health care coverage for employees, and their families.

Additionally, while it improves the ability of an individual to receive insurance coverage, it does not guarantee the coverage, nor does it regulate the exact dollar amounts an insurance company will charge an individual for coverage. While HIPAA does limit the pre-existing condition exclusions, it does not define the specific benefits an insurance company is required to offer. In addition to the foregoing, it is noteworthy that while the list of pre-existing conditions that may be recognized is decreased, it is not eliminated!

For example, if a worker receives employer sponsored preferred provider organization health insurance on January 1st, 2005, and then on January 2nd, 2006 decides to switch to another health plan the employer offers, perhaps a health maintenance organization, no pre-existing condition exclusion may be applied since 12 consecutive months of coverage have been fulfilled.

The most noteworthy constant in HIPAA rulings is the fact that pregnancy is never considered a pre-existing condition but must always be covered by an insurance company. Please note that HIPAA is not a panacea for spotty insurance coverage! If a worker's insurance history evidences long breaks in applicable coverage, i.e. at least 63 consecutive days without insurance coverage, HIPAA protection will be lost. Thus, a worker will be wise to accept COBRA coverage when available. If a worker is indeed eligible for COBRA, HIPAA coverage will not be available until COBRA benefits have been exhausted.

Since its passage, HIPAA has been amended with the Mental Health Parity Act of 1996 (MHPA). Very specifically, this piece of legislation precludes group health plans from enacting yearly

dollar limits on mental health benefits that are lower than annual dollar limits for covered medical benefits. The MHPA does not order insurance plans to specifically offer mental health benefits, and only regulates those plans that actually offer this coverage. Another amendment to HIPAA is the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) which regulates the amount of time a new mother and her infant you are covered for a hospital stay following childbirth.

The final amendment occurred with the WHCRA (Women's Health and Cancer Rights Act) of 1998. This protection is designed very specifically for cancer patients who elect to undergo breast reconstruction surgery in connection with a mastectomy. It is important to understand that the WHCRA does not order health plans to cover mastectomies, and only applies to insurance plans that already do cover this procedure.

HIPAA legislation has greatly increased the affordability of health care for workers, regardless of their economic backgrounds, health histories, or even the claim histories of their covered dependants. Nonetheless, it is not an unlimited safety net, and individual workers must be cognizant of the limitations HIPAA does have.

HMO: What It Means

With so many different health insurance programs, how do you know which one is right for you? HMO is one that you should become familiar with. HMO stands for Health Maintenance Organization. It's a network of healthcare providers that have contracts with an insurance company to provide their services at a set price. HMO's do have many rules that you will have to follow and do tend to be very restrictive. So how does HMO basically work for you and is it for you?

HMO requires that you select a primary care physician who will manage every aspect of your healthcare needs. This primary care physician must be a member of the HMO. The disadvantage of this is you may have to switch primary care physicians until you find one in the network that is near you unless you want to travel. If the physician isn't in the network of HMO's then the work will not be covered under your insurance plan. If you need a specialist for anything you must first get a referral from your primary care physician.

HMO's main advantages over the other programs, is the cost. HMO's are cheaper for the consumer and premiums are a lot cheaper with an HMO. Co-payments are usually low cost or free, so this is a big selling point to consumers as less out of pocket expenses are something today's consumers are looking for.

HMOs are designed for profit so you can expect your doctor to be very busy, as he has to see many patients since the goal of the HMO is to turn a profit. Doctors tend to want to spend more time with their patients but that's not always possible as HMO's need to turn a profit or will be forced to close. Employers pay a portion of the monthly fee that is required to join the HMO. Usually whatever is left is the employee's responsibility to pay weekly out of their paycheck.

Co-payments are a big issue in most HMO's for a number of different reasons. The main reason is that a co-payment sometimes deters people from using the service. For example hospital co-pay is a lot more expensive which tends to get the person wait and go to his primary care physician, as the co-pay for your doctor is a lot less. This seems to work well in the HMO scheme of things. Co-pays are also used to offset the overall cost of the insurance and makes everyone pay their fair share which forces the people who use it the most to pay the most into the plan.

So is a HMO best for you? Or would regular health insurance be the way you should go? These questions have many various answers, depending on a lot of factors. If you have a family buying your own group insurance for your family can get quite expensive. HMO's were designed for controlling expenses and managing all aspects of your healthcare in one place.

This seems to work well with a family. Now as an individual this may or may not be for you. If you personally have a favorite doctor or hospital and it's not on the list of HMO providers than you probably would better off not going with the HMO system as it won't cover doctors or hospitals not listed as a approved provider.

People for the past few years have watch healthcare costs skyrocket with no end in sight it seems. HMOs try to help control costs, which are one of the reasons HMO's keep growing and getting more popular each and every day. The only real disadvantages with HMO's are that they can be restrictive and might not let you do what a normal health insurance company will.

The main reasons is with all the members they have to insured they do need an across the board rules that everyone can follow to make it fair to all the people they insure. HMO's aren't for everyone so if you are going to join an HMO does plenty of research before you join so you know what you will be receiving and what you won't be getting. That way you can make an informed decision on your healthcare needs.

Understanding Indemnity Care Plans

For years, Indemnity Care Plans were the most popular type of health insurance coverage. However, because medical costs have continued to soar, this is not longer the case. Although still the first choice of many, more people these days are switching to managed care plans; not necessarily because they want to, but rather because these plans are the ones being offered by their employers. For clarification, Indemnity Care Plans are frequently referred to as 'fee for service' plans.

The main difference between Indemnity Care Plans and Managed Care Plans is the freedom to choose any medical care provider regardless of whether the patient first receives a referral or regardless of whether the medical care professional is part of the contracted 'network' of providers. Those who choose Indemnity Care Plans can visit the most well-known specialists and the hospitals with the best reputations for their care.

But with that freedom come a price and participants usually end up with higher out of pocket costs. After a participant receives medical care, a bill for his services is forwarded to the

insurance company. The insurance company then refers to its list of 'reasonable and customary' charges for the services that were provided to determine the amount it will pay. Of that amount, the insurance company will typically pay 80% while the remaining 20% becomes the responsibility of the patient. In many instances, especially when care is provided by top-notch institutions and/or professionals, the amount billed for the medical services will actually exceed 'reasonable and customary' charges. When this happens, the patient is responsible for paying his percentage PLUS the difference.

In addition to paying the above, those who choose Indemnity Care Plans also have to pay a premium and an annual deductible. And even though these costs can be high, this type of health insurance plan is right for many people.

When it comes to managed care plans, a PPO or Preferred Provider Organization is the plan that most closely matches an Indemnity Care Plan. With a PPO, participants have a wider network of providers from which to choose. Their costs will be lower if they choose a medical professional within the PPO network.

Participants still do have the option of choosing to go outside the network, but when they do, their out of pocket expenses will be higher. Before the insurance company will contribute towards these costs, the person will have to first satisfy their deductible. And after that amount is met, the insurance company will pay a smaller percentage of the overall costs than it would pay had the participant chosen an 'in network' medical service provider.

So which type of plan is better--an Indemnity Care Plan or a Managed Care Plan? That all depends on the individual. Those who can afford the higher costs and place a high value on the ability to decide from whom they receive their medical care usually choose Indemnity Care Plans. Those who want more freedom of choice, but who also need to closely monitor medical costs are probably better off with a PPO.

Kaiser Family Plans

Kaiser family plans are available for anyone who is researching health insurance as an alternative to paying those high premiums. Kaiser plans involve a variety of different insurance actions all rolled into one. You can find insurance plans that will cover maternity, well child prevention, immunizations, skilled nursing care, hospice care, and even the medical equipment needed during sick care.

What are some of the other types of coverage you can get in your plan?

Some plans allow you to have fertility tests, small co payments of \$30 per doctor visit, \$10 prescription co payments, lab tests paid for in full or with small fee, mri, cat, and pet scans are covered up to 50% or 100% depending on the plan you choose, children's screening, women's screening, and out patient surgery is being covered by Kaiser family plans.

While there are always going to be moments in your life when you won't find yourself using your health insurance much, there are others where you are so glad that you had insurance to

cover those bills that it will well be worth your time and efforts to investigate the many types of insurance such as the Kaiser family plans that are available to you.

Why you need to consider purchasing health insurance

Health insurance is a basic benefit offered at many jobs, but with rising costs, many employers are not offering health insurance to their employees. If you like your job, and want to stay in that career, it is only going to make sense for you to purchase health insurance and not to wait for your employer to find health insurance for your family ñ this could take years. Look for a job you love, that you can get paid for doing exactly what you want, and then turn to private insurance companies to get the benefits you need at a price you can afford and then sit back and enjoy your life knowing you have great protection.

Children and health insurance

If you are thinking of starting a family or if you already have young children in your family you will find health insurance is a very important part of keeping up on immunizations, wellness checkups and for those times when you just don't know why they won't quit crying or why the fever won't go down. Get health insurance to protect your family now and well into the future with all the benefits that a doctor has to offer your family. Health care costs are constantly rising, if you don't have health insurance, you should be prepared to spend forty to one hundred dollars for every office visit, no matter how short it may be!

Understanding Managed Care Plans

Managed Care Plans are the most common form of health care coverage offered in the United States today. Unlike Indemnity Plans, where participants are free to seek medical attention whenever and wherever they feel necessary, Managed Care Plans are much more restrictive.

One of the reasons that managed care plans have become so popular is because employers are the ones footing the bills for most medical coverage. The cost associated with providing medical benefits to employees is one of an employer's highest expenses. So that they are able to continue offering medical benefits, employers need to select the most affordable health plans available and more often than not, it's the managed care plans that are the least expensive.

Managed Care plans work off the basic premise that health care costs can be better controlled by controlling access to health treatments and services. While this may be true and beneficial to the companies offering these plans, from a patient's perspective, it can be difficult to get approval for health care that goes beyond basic preventative care.

There are three main categories of Managed Care Plans: a Health Maintenance Organization (HMO); a Preferred Provider Organization (PPO); and a Point of Service (POS). Of the three, HMOs and PPOs are the most common. A brief summary of each follows:

A Health Maintenance Organization (HMO) plan is less expensive than a PPO and generally includes coverage for preventative care. Participants are required to pay a monthly premium,

and a nominal co-payment each time they see a doctor. They must be seen by medical care providers that are part of the HMO network. These medical care providers have an agreement with the insurance company to perform various medical procedures at a previously negotiated and reduced rate. Participants are required to select from this group of providers a Primary Care Physician (PCP) and must always see their PCP first. To be seen by a specialist, the PCP must initiate a referral.

The disadvantage of an HMO is that participants are forced to choose a PCP from the HMOs approved list of providers and sometimes, their 'preferred' doctor is not on the list. The HMO typically won't cover the costs of medical care provided by professionals outside the HMO network. And because an HMO network is limited in size, it often takes a long time to get an appointment with the PCP.

A Preferred Provider Organizations (PPO) is similar to a HMO, except that there is no need to first be seen by a PCP. Participants are advised to choose a medical professional from the PPO's approved 'network' but they don't have to and they don't need a referral to see a specialist. Should a participant choose to go outside the network, their co-payment will generally be higher, the percentage that the PPO pays for the medical care will be lower, and they will likely have to satisfy a deductible.

Although PPOs offer more freedom of choice, there are generally more costs involved in this type of managed care plan. These costs can be significant when participants go outside the network.

A POS or Point of Service managed care plan is somewhat like a hybrid. It offers more freedom of choice like a PPO, and a lower cost like an HMO. Participants must designate a PCP, but even then it is difficult to get a referral to a specialist. When participants stay within the network, paperwork is minimal, and so are co-pays. Plus, there are no deductibles. Although they might sound like the best of both worlds, POS plans aren't very popular.

Selecting the managed care plan that best suits your needs requires a careful analysis of each plan's coverage and should not be based on cost alone. Since coverage and additional costs differs greatly from plan to plan, take your time and don't be afraid to ask questions!

PIP: What Is It?

A good automobile insurance policy includes several elements: personal property liability, uninsured motorist coverage, collision coverage, bodily injury liability, comprehensive coverage and personal injury protection (PIP). Some of these elements are mandated by the state and others are optional. Collision coverage pays for damages to a vehicle when it collides with another vehicle or object, even if the policyholder is at fault.

Comprehensive coverage protects the policyholder in the event that his or her vehicle is stolen, vandalized, harmed by an act of nature or otherwise damaged. Both of these plans are always optional and very expensive.

The bodily injury and personal property liabilities are required by all U.S. states in one form or another; where the states differ greatly is in the minimum guaranteed payout that is set for each. For example, in Alaska, a driver is required to carry coverage that has a guaranteed minimum bodily injury payout of \$100,000. In Florida, a driver is only required to carry coverage worth \$10,000.

Elements of an auto insurance policy that may or may not be optional are: uninsured motorist coverage and PIP. Uninsured motorist coverage protects the policyholder in case he or she is involved in an accident with someone who is uninsured--it provides the coverage that would have been supplied by the other driver.

PIP, in the event of an accident, pays for the medical expenses and other miscellaneous damages incurred by the policyholder and his or her passengers (or if the policyholder is an injured pedestrian). Carrying PIP is mandatory in: Colorado, Delaware, Florida, Hawaii, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota, Oregon and Utah.

Who Needs PIP?

Even if PIP is optional in your state, you may still want to consider purchasing the coverage. In the event of an accident, PIP will pay approximately 80% (depending on coverage limits) of the costs of the policyholder and passengers. These costs include medical bills, lost wages and other miscellaneous expenses. PIP is a no-fault policy, so it will cover you and your passengers, even if the accident was your fault.

PIP, sometimes referred to as Medical Payment Insurance or Medpay, is a no-fault coverage for two reasons. First, the fact that fault does not have to be ascertained saves time and therefore allows medical payments to reach the injured parties as quickly as possible. Second, it saves everyone from the cost of lawsuits being filed in order to prove who is responsible for an accident and therefore responsible for the bills. The only time a PIP policy might allow for a lawsuit is in case of very serious injury or death.

Before you purchase PIP, go through your current policies and determine whether or not the coverage offered by PIP is duplicated anywhere else. For example, the cost of medical bills and lost wages may be recovered through an existing health insurance policy. If this is the case, then you may need minimal PIP or none at all.

Your driving behavior will also help determine whether or not you need PIP. Do you carry passengers on a regular basis? While your health insurance might cover your own medical expenses, it won't cover those of your passengers (unless they are family members who are on your health plan).

Ask your regular passengers about their own health coverage and its limitations. If they are uninsured or underinsured, you need PIP in order to cover them. That may not seem like such a fair deal (especially if you're the one driving an office car pool), but the safety of any passenger riding in your car is ultimately your responsibility.

How Much PIP Coverage Do You Need?

If you live in a state that requires PIP, then the minimum amount you must carry has already been decided for you. If you live in a state where PIP is not required, however, you might decide that you need the extra coverage anyway. How much coverage do you need? Well, to a large extent, that depends on where you are in life. If you are middle-aged or older, have good health insurance and liability policies, and then you will need minimal PIP coverage.

If, on the other hand, you are young, just starting out and still don't have much in the way of health and liability insurance, you will want to protect yourself and your future by carrying as much insurance as you can afford. This is especially true if you have young children or if you consistently carry others in your vehicle.

POS: What It Means

POS is a basic managed health care foundation in which one can attain lower medical costs in exchange for much more limited choices. Once you're in a POS health care program you will be asked to choose a primary care physician to monitor your health care. This physician will become your point of service within the health care network.

In the event that your primary care physician deems it necessary for you to see another doctor or specialist, he/she may make referrals for you outside the network but only the insurance company will cover a percentage of the cost. The paperwork for medical visits, which take place inside your network, is completed for you, but if you go outside the network you are responsible for filling out the paperwork and keeping very accurate records.

POS does give you some advantages that some people do like. Annual out-of-pocket costs are usually very limited. In today's world many people have limited resources set aside for medical costs so low out-of-pocket expenses will be a plus for many consumers. There is no deductible for network care.

This is another advantage people like a lot. With no deductible you don't have to spend a certain amount out-of-pocket before things start to get paid for. There is a deductible, however, if you go outside the network for care. You aren't limited to HMO providers only. This gives you the freedom of more choices for your health care needs, which is something we all strive for. Co-payments for non-network care are very high. This discourages going outside the network and promotes using more primary care providers in your network.

Your actual costs will only consist of a monthly premium and co-payment for health care services under the plan within the POS network. If you're still wondering which program is best for you a PPO, a HMO, or a POS, consider some of these questions. Are there a lot of doctors to choose from? No matter which plan you go decide on, a good selection of doctors is something you should consider before choosing a plan.

The prices of the health insurance premiums could very well be the most important question you may have. It won't do you any good to have health insurance if you can't afford to pay the

monthly premiums. Therefore this is a subject that needs great attention so that the right decision can be made. Coverage is another thing that should be looked into. Different plans have different coverage. Emergency room coverage can also vary by whatever plan you choose. Whatever plan you choose make sure it has the coverage you're looking for.

The hospitals that are available to you is something many people will rank high on their list of considerations. Having a place where you feel comfortable and trust the value of their service means a lot to most people. Hospitals can have a good reputation or a bad one. That's why choosing a hospital will play into which health care plan you choose. No one likes hospitals, but if you are comfortable at the hospital that is covered, it will certainly make for a more pleasant experience. So it is important to know which hospitals are covered by your health care plan.

Are their limits on the medical treatments and services a certain plan offers? There's really no sense in paying for a plan that won't let you use the services you really need. Isn't that the main reason we buy medical insurance so that we can use the services when we need them? Be sure to think about the services that you are most likely to use, and be sure to ask if those services are covered.

Consider non-network care. This is a very important part of any plan. Sometimes your physician may not be available. Be sure to find out how much more you would be responsible for paying to go outside your network and see a doctor. It can be quite costly with some plans.

POS plans have many advantages and many disadvantages. Looking over everything is something you must do before any decision is made. Looking through each plan will take some time and should always be done before you make that decision. You never want to rush into your decision.

POS plans are a little different than the others but lower costs and out-of-pocket expenses are some good reasons for choosing a POS plan. Whatever managed care you decide on, and the choices are many, it is important to remember that with each plan there are good parts and bad. You, as the consumer, must do your homework so you won't be disappointed.

PPO: What It Means

PPO stands for Preferred Provider Organization. These organizations have contract agreements with the insurance companies. A PPO's big advantage is the rules are a little more relaxed than an HMO, which means they tend not to be so restrictive. Fewer restrictions usually help the consumer, which is a good thing for you.

PPO's allow you to see whichever doctor you like. This is a huge advantage to many people, especially the elderly and those with young children. Repetition is very important to those with children and the elderly since they usually feel more comfortable going to a doctor they trust and will tend to be more open with that doctor or hospital. If the patient chooses an out-of-network physician, they will have to pay a higher out-of-pocket expense but doesn't need a referral to see a specialist.

Many times life's financial situations determine our choices and health care is no different. HMO's are a lot cheaper but if you want input into your healthcare choices and the services you will be receiving then the best choice is a PPO. PPO's give the consumer basically total control over his or her needs when it comes to their health.

PPO's were created originally to give a big group lower rates for health care coverage and to gain a growth in business for their organizations. Many reasons that PPO's have been so successful are the many things that they have been able to do within their organizations. A lot of times second guessing is never needed with a PPO, as more detailed information is available to PPO doctors. This helps cut down the costs for medical insurance for the group of a PPO.

Many PPO's were credited with reducing the rapid rise of medical expenses in the 1990's, however with expansion, a lot of PPO's joined each other to make larger companies, which doesn't necessary help the health care consumer. PPO's usually require insurers to pay a claim in a certain time frame to be eligible for the PPO discount. PPO's goal was to make things simpler but now it seems maybe the opposite is true. PPO's have great power in getting cheaper prices for their customers in the already complex health care system in the United States.

Let's now look at some common rules and questions many people have about PPO's. One of the most common questions people ask is "What if there isn't a provider in my area?" Under most PPO plans you are given the standard benefit for someone who is local. Prescription drug programs are covered in PPO's and have two different coverage options. One is to get them at your local pharmacy and the other is to search online and purchase them.

Many people don't realize, and this is probably one of the more important rules of a PPO, certain services must have prior approval before the service is rendered. One reason for this is that there is nothing more horrible than going through an operation and finding out after recovery that without prior approval no payment will be made. Doctor visits which use the co-pay option is another reason people love PPO's.

PPO's also have a yearly deductible which basically means even though you have a co-pay there is a certain amount you must reach before they PPO will start paying for the medical fees. Most PPO's will pay 80% of the medical bills as long as you use the in network physician. PPO's offer flexibility that other plans just can't offer you. Usually the overall premium is cheaper for PPO than it is for other traditional plans and also for health insurance. One important thing to remember is any work done outside the network will cost you a lot more money. It's best to try and find providers close to you or in the network.

So if you want to control more of your health care decisions then a PPO is probably one of the best choices for you and your family. PPO's are a natural choice for most Americans, it could be the best choice for you too.

Short-Term Family Health Insurance

Short-term family health insurance is needed for those who are between jobs, who are without

coverage for any length of time and for those who are in transition between other plans. Short-term health insurance coverage is available for as short as three months and up to a year. Short term insurance could be more expensive in some manners, but you are securing your finances in case something happens during that time when you don't have the full coverage your family had otherwise.

What is short-term health insurance?

Short-term health insurance is a plan that you purchase for just a few months. Short term insurance doesn't have to be something you pay a lot of money for if you are choosing a plan that covers just hospital visits and such. If you choose a short term plan that covers the major bills, or major illness factors you can still have the protection against those things that could happen in life without the worry about the what if's in life.

Perhaps you are between jobs, and your new health insurance doesn't kick in for six months, short-term health insurance gives you the coverage you need, during this time, without the worry about an accident occurring and using up all of your savings.

How do you obtain short-term health insurance?

Apply for health insurance as if you were going to purchase it for years, you don't have to tell the private company you are going to need it just for a few months, but you pay the premium for a few months and then cancel your insurance when you don't need it any longer. Some companies will offer certain packages for short term insurance, but you will have to compare the rates and coverage as well.

Generally, the rates are going to be higher because you need it just for a little while, but if you compare the other regular coverage you can apply for you may find your best savings in that manner. Read, compare and then purchase for the best decision making process when purchasing health insurance.

Three reasons to get short term insurance

Because you just never know when an accident could happen, you need some type of short term insurance. Cover those medical bills so you are not creating debt that you will have to worry about for years to come. If you never use that short term insurance, you don't have to worry about the money spent, because it could have always been worse if someone had an accident and needed stitches or needed a cast for a broken bone. Short term insurance is protection for your future.

Short term insurance is not a commitment for years to come, but just for a few months, so even if it is more expensive right now than what you could afford otherwise, you have to look at it, because you don't need to pay that bill forever each month. You have other insurance coming, so you know your medical bills will be covered in the long run. You don't have to stick with this company if you don't like them forever. Just get through this point in your life and good things will happen later as you start that new job, or you move to the new state or as you find other better health insurance.

Texas Health Insurance

The Birth of Texas Health Insurance

Texas has shaped and formed a new program called Texas Health Insurance that will help Texans get on the fast track when it comes to health insurance and human services. This was made possible through the merging and integration of 12 health agencies, transforming into four new departments under the supervision and management of Texas Health and Human Services Commission.

The aim and goal of Texas Health Insurance

Aside from providing a more attentive assistance to Texans' health concerns, Texas Health Insurance aims to lend a hand and facilitate in the lowering of administrative costs and to come up with fund generating projects that will directly derive more health services for the people of Texas.

Texans who would like to browse and get more information about Texas Health Insurance may visit other related Internet sites such as ñ Department of Aging and Disability Services, Texas Health and Human Services, Department of State Health Services, Department of Family and Protective Services, and the Department of Assistive and Rehabilitative Services.

Benefits from Texas Health Insurance

Each Texas Health Insurance holder is entitled to a Health Pool Benefit Plan. Texas Health Insurance features countless, great benefits like the calendar year deductible, the emergency care deductible, physician office visit co-payments and so on.

Another plus factor is that the Texas health insurance do not count the charges of prescription drugs for outpatients against their co-insurance maximums. And after the insured party pays the corresponding amount of the deductible from the policy, the policy will then pay the amount of the covered expenditures in excess of the co-insurance amount prior to policy limits.

However, in Texas Health Insurance dealings with the covered expenses from a preferred provider, the instance you have settled the coinsurance maximum, the policy pays a total of 100% of covered expenses from preferred providers for the remaining days in the Calendar year. On the other hand, if you are an insured party with a non-preferred provider, there will be no coinsurance maximum for the covered expenses.

Texas Health Insurance Policy will, in no event, pay more than the lifetime maximum for each insured party. The deductible amount chosen by the insured party may not be changed to a lesser amount after the policy is issued. One may request to upgrade and change to higher deductible if offered by the Texas Health Insurance but the insured party can only apply for that in a calendar year. The change made by the Texas Health Insurance will be effective on the first of the month following the date your written request is received or a later date upon request.

More, More, More!

Apart from this, enjoy the other great benefits from Texas Health Insurance such as: Intensive Care or Cardiac Care Unit with maximum of three times the average semi-private room rate, assistant surgeon or surgical first assistant with maximum of 25% of the surgeon's professional fee, Skilled nursing facility of 45 days in a calendar year, transplants of kidney, liver, heart, pancreas, lung, bone marrow, subject to a lifetime combined maximum benefit, plus the retail pharmacy co-payments for up to a maximum of 30-day supply on generic drugs, formulary drugs, and non-formulary brand name drugs.

Other Texas Health Insurance health pool medical plan benefits are: ambulance use, anesthesia, blood, acquired brain injury, home infusion therapy, genetic testing and counseling, use of medical equipment, breast reconstruction in connection with mastectomy, and other miscellaneous hospital services and supplies.

All About Travel Health Insurance

None of us want to think about all the things that can go wrong when we're on that much needed vacation, but the truth is, many things can. You could become ill while away, or you could even get sick right before the long awaited day has arrived and not even board that pre-paid cruise ship at all. Travel health insurance is set up to protect you from all the above-mentioned occurrences and many more but before you purchase this type of health insurance, you need to know what it is and just what coverage to look for.

What Is Travel Health Insurance And When Do I Need It?

Travel health insurance is an insurance policy that you can purchase prior to your departure that covers you for a variety of occurrences, whether medical or not, while you are away. This insurance can be pricy so you should take some things into consideration before you buy it.

If you are going on a short trip that only requires one round-trip airline ticket of \$250 then travel health insurance may be overkill. If you have booked a \$5,000 once-in-a-lifetime cruise well in advance, then travel health insurance begins to makes more sense. You need to decide if the cost of the policy is worth it.

What Should It Cover?

A good travel health insurance policy should offer you coverage for a number of things. First, you should be covered the entire time you are on your trip and at any destination. It should cover personal injury or death to you or anyone else named on the policy. It should cover the costs of all medical-related expenses you incur while on your trip. Travel health insurance policies can also cover you in the event you need to be evacuated due to a medical emergency.

Should you be visiting a third world country where medical experience and supplies are limited, make sure your policy covers any type of transportation to a more adequate country to receive proper medical care. If you travel often, you can purchase a multi-trip travel health insurance

policy.

Where Do I Get It?

First, check into the coverage you are entitled to under your regular health insurance plan so you don't end up paying more for coverage you already have. Once you know what you need, you can buy travel health insurance from your cruise line, travel agent, or an independent insurance agent. Although the independent insurance agents can be the most expensive, you don't have to worry about your cruise line going bankrupt and not honoring your travel insurance.

Unfortunately, things do and have happened and when they do happen without travel health insurance, they can be costly. So when that travel agent suggests travel health insurance to you, don't roll your eyes and assume they are just trying to get you to spend yet even more money. Pay attention and think about it. It may just be the best vacation money you ever spend.

Universal Health Care: What Is It?

Universal Health Care has been in the news lately and every political campaign usually talks about it somewhere down the line. Universal health care is getting health care for every living American no matter how poor, how rich or ethnic backgrounds.

Universal Health Care is one of the few services that haven't reached across the board of all American citizens. Universal health care would reduce the burden that is taxing our health care system, which is right now in crisis. We don't have enough doctors or nurses to staff our hospitals now.

A universal health care must meet certain requirements to work well in the United States. We must include the entire population, which would include men, women, children, and immigrants. No one should be without it. This program could be wide open to discrimination so we must make sure it runs smoothly and corruption isn't anywhere to be found. Access to care is a must. Many times people don't have ways to get health care. We must provide transportation to and from the medical facilities so they can receive the proper treatment.

A benefits package for universal health care is a must. Primary and specialty care must be included in the package. If we don't make sure we cover every aspect of health care we are doomed to fail. Most people can't afford health care and it has become a luxury for most rather than a necessity. A lot of consumers have been priced right out of it. We need to get universal health care so these consumers can get the health care they need.

Why is this important? Millions and millions of dollars are lost to workers being sick and not being able to do their jobs. Lost productivity hurts everyone involved. Fewer goods are manufactured thus increasing prices for the consumer. Health care is probably the most important subject in America today. Universal health care needs to be adopted and implemented by a single source. This will save a lot of heartaches and problems.

Poor health causes many problems that universal health care could stop. The poor struggle to pay for housing and other needs just to make it through everyday. This can lead to mental illness and the quick depletion of their resources and becoming homeless is the natural progression.

One number that people will find unbelievable is the amount of people without access to health care. Over 15 percent of Americans lack public or private health care. No universal health care puts public health at risk as untreated diseases can go unabated for years before the government can catch them. How many lives will we lose to this?

With insurance premiums skyrocketing one of the main reasons for this is; all the uninsured people who have to access free or low cost medical services. The only real way to recuperate the loss revenue by companies is to increase premiums to people who are now paying them. Universal health care would help control; costs and give everyone at least the opportunity to access health care. It should be a right of every American to have good health care.

Universal health care is something America has needed for a number of years now, so what's keeping it from happening? Many factors contribute to this and their really are no easy answers. Let's look at a few and see why we're one of the few countries without universal healthcare. Being a free country having universal health care would limit the amount of money doctors, dentists could charge everyone.

This would not make those in the medical community very happy to have their earning power limited. How many other industries do we limit what someone earns and you have to look what is a certain service worth that a doctor or lawyer does. Can we really tell them it's only worth this amount?

Universal health care has a lot of questions that probably will have to be answered before it will be universally accepted. Getting major health care providers on board is really the only way that it will work in America. I guess only time will tell if Universal health Care is what all Americans really want.

California Health Insurance

California health insurance is insurance that offers to pay the medical costs of the people of California should the insured should become sick of illnesses or get involved in accidents that are covered by the program's plan. The insured would pay the California health care companies premium in their preferred mode of payment.

Looking back, the concept of health insurance -- not just California health insurance -- started during the late 1600s when Hugh Chamberlen proposed this health insurance system. In the late 19th century, this was then called disability insurance because it included only the cost of injuries that had potential to make the person disabled and nothing else. Until the start of the 21st century, the California health insurance system covered only the insurance from disabilities. The other health care costs were paid for by the insured.

However, during the middle to the late 20th century, health insurance like the 21st century California health insurance system evolved into the recent health insurance plan which is fortunately more comprehensive and covers for preventive care such as consultations and regular check-ups as well as preventive diagnostic procedures such as mammogram for long-term diseases such as cancer which would save the California health insurance company a lot of money if diagnosed in their early stages.

California health insurance policies are beneficial because of the high percentage of morbidity in the state's population, which may be attributed to the bad health practices of the potential applicants to California health insurance programs. Obesity, alcohol drinking, cigarette smoking, and sedentary lifestyle should be blamed for the high percentage of the population that gets afflicted by these diseases. The California health insurance policies nowadays are more comprehensive and cover the cost of preventive, therapeutic, and emergency health care procedures. Some even extend coverage to therapeutic medications and out-patient follow ups.

California health insurance companies entice their clients by frequently mentioning the term "adverse selection," which is a description of the probability of an applicant seeking California health insurance to acquire illness later in life. Of course, there are diseases that you cannot prevent no matter how good you take care of yourself and the California health insurance companies are well aware of that.

California health insurance companies also assess the applicants, ask them detailed medical history as well as history of cigarette smoking and drug abuse, diseases and illnesses they have or may have acquired in the past. Those applicants for California health insurance policies with past history of long-term potential debilitating diseases that might cost a lot of money to the California health insurance companies are weeded out.

Because of modernization and advances in medicine and medical technology, the cost of health care has gone up. The California health insurance policies help the people of California by making expensive diagnostic and therapeutic procedures available, pay for emergency care, hospital stay, laboratories, medications, doctors' fees and even out patient care in some plans.

You are invited to pass this report along to as many people as you like, provided that you make no changes to it and that you give it away for FREE.

If you would like **your own Private Label Version of this report** and hundreds of others just like it on hot, high interest niche topics – all of which come complete with 5 custom cover graphics – [click here to visit our Niche Reports Resource](#).



WOW: Where Vision and Value Go Hand in Hand with Information & Opportunity!

Please click below to check out all of our entrepreneurial friendly sites and products.

=> <http://www.The-WOW-Experience.com>

Always something NEW on the horizon. Always something for YOU to use to grow your business!
That's what WOW is all about. Your success is our ultimate goal and our reason for growth.