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Family Dental Insurance

Types of Health Insurance Plans and Coverage for You and Your Family

Affordable Health Insurance

Having a healthy lifestyle does not guarantee that an individual would not get sick because no matter how good a person takes care of himself, unforeseen things can still happen. The healthiest person you know might wake up one day and find out that he has cancer. People are getting sick everyday, yet affordable health insurance is not available to all.

All individuals need affordable health insurance to protect from not only financial disaster but to also give peace of mind. The sad reality is that most people have habits that are detrimental to their health such as choosing unhealthy foods, cigarette smoking, lack of exercise and alcohol and drug abuse.

The salaries of people do not usually increase as quickly as health care costs do. The steep price of the advanced and highly technical medical diagnostic and treatment procedures ordered by physicians make people think twice about going to the hospital. They usually wait until the last minute to do so - by this time, the disease has progressed. This is the reason why affordable health insurance is desired and needed by everyone.

Affordable health insurance is a way of safeguarding oneself in case of illnesses or injuries. It assures us that should anything happen, affordable health insurance is there.

There are a lot of health insurance packages out there offered by various companies but one should choose the most suitable, most affordable health insurance coverage because not all packages offer the same. Some health insurance programs offer premiums that are lower than others. One should choose the affordable health insurance program and coverate that fits his current situation and weed out all the others.

In choosing affordable health insurance program, one should also take into consideration the time length required to pay the plan. There are some affordable health insurance programs that are applicable only for a fixed period, say 30 years. Other affordable health insurance programs extend until the death of the insured. Additional payments should also be considered in choosing for affordable health care programs.

Managed care plans are affordable health insurance are pre-arranged and work with hospitals. Some prefer this affordable health insurance. This type of coverage saves time and effort because they have doctors and hospitals affiliated with them. However, some prefer other affordable health plans that are flexible enough to allow them to seek treatment from their own doctors and choose the hospitals they like.

Be careful in choosing among the different affordable health insurance programs. Choosing the wrong one will waste money and time. Study all your different options and you will most likely find the one that works the best for you!

Group Health Insurance

In order to have a secured life, it is important to make sure that one has affordable health insurance. Not everyone can afford to be hospitalized in this day and age, what with the high cost of medications and diagnostic tests. It is therefore a puzzle why despite this, most people continue their habits that they know would be detrimental to their health in the long run. These include consuming fatty, unhealthy food, which leads to obesity in some individuals, cigarette smoking, excessive drinking of alcohol, lack of exercise and using prohibited drugs.

Following a healthy lifestyle does not automatically assure one of a disease and illness free life. No matter how good a person takes care of himself, unforeseen things can still happen. The healthiest person you know might wake up the next day feeling dizzy and weak, and discover that he is a diabetic. People are getting sick everyday, yet salaries are not increasing. Not everyone can afford individual health insurance but fortunately, some companies and organizations offer group health insurance.

Group health insurance policy is a policy that covers the medical expenses of many people, instead of just a single person. With a group health care insurance policy, all eligible people are covered regardless of age or physical condition. These group health insurance policies are usually more successful. Group members are not as scrutinized like those with individual health insurance programs.

The advantages of group health insurance include cheaper costs because the company can afford to offer low rates because there are many people on the plan. Many private employers also offer group health insurance. There are no physical exams or history forms to fill out.

In group health insurance, the insured can readily get maternity coverage. It also makes sure that all employees of a business have health insurance plans. Even those who were weeded out in individual health insurance plans can apply for a group health insurance plan. These are usually the people who have pre-existing medical condition.

The disadvantage of group health insurance over individual health insurance program is that their health care policy is not customized and the insured gets the same policy his group gets. Unlike individual health insurance program, the insured does not have the freedom to include or exclude provisions in group health insurance.

The choice is also limited because group health insurance plan is designed for the entire group and not for just one specific person. The insured in this group health insurance plan cannot choose the terms in the group health insurance policy. If one resigns and transfers to another employer, he also loses the group health insurance plan. Recently, there are some new group insurance plans that can be transferred to other employers but this is not the norm.

In contrast to group health insurance plan, individual health insurance programs give the individual a policy where most of his requirements and needs are fulfilled. These plans are customized and also more expensive than group health coverage. A group health insurance plan may give a much more generalized coverage to the insured but it is also much more affordable.

Anyone Want Health Insurance?

Health insurance is important to every individual because one never knows when he will need it. Due to the advances in modern medicine, medical diagnostic and treatment procedures are now a lot more expensive than before. Not everyone can afford the full cost of medical treatment, which could easily add up to thousands of dollars.

The tremendous increase of health insurance prices in recent years has been attributed to various health-related factors such as lack of regular exercise, unhealthy food choices, exodus of doctors away from poor areas and rural areas, alcohol consumption, cigarette smoking, the popularity of drug addiction, increased body fat leading to obesity and the sedentary life led by most individuals nowadays.

Health insurance coverage originated in 1694 by Hugh the Elder Chamberlen, who first thought of the concept of health insurance. In the late 19th century, health insurance was called disability insurance because health insurance was limited only to medical costs of such injuries that would potentially lead to disability.

Health insurance is a program in which the insurer pays the medical costs of the insured should the insured become afflicted with sickness due to diseases or accidents covered by the insured's plan. There are private organizations and government agencies who offer health insurance.

Health insurance is classified into private or non-government coverage or government-sponsored. A private health insurance is purchased from a private health insurance company and it is further classified into employment-based health insurance, which is offered through one's employment. "Direct-purchase" is a plan where the individual purchases the health insurance himself from a private company.

Private health insurance is controversial because the insurance company needs to remain solvent while the insured should remain in good health.

When the health insurance includes plans funded by the government, it is called government health insurance and it may be on a federal, state, or local level. This health insurance includes Medicare, Medicaid, military health care plans, state plans, and the State Children's Health Insurance Program (SCHIP).

Medicare is a government health insurance, which pays health care costs for those 65 years old and above. Medicaid is a government health insurance coverage, which helps families with dependent children, those who are disabled, blind people and the others who have disabilities and need health insurance. These two health insurance coverage programs complicate the current United States health insurance crisis because they unintentionally determine the price of medical diagnostic and treatment procedures.

The State Children's Health Insurance Program provides health insurance to children who are part of low-income parents not qualified for Medicaid while military health care is health insurance provided by civilians and the Department of Veterans Affairs (VA). Health insurance provided by some states for low-income constituents who have no insurance is called state-specific plan.

Individuals who wish to buy health insurance should first fill out a comprehensive medical history form that includes the history of smoking, the person's weight, the individual's past diseases and hospitalizations. This is used because individuals with pre-existing medical conditions are not eligible to that health insurance. Discounts may be given to applicants who are proven to be healthy, and who have no vices like smoking and drinking alcohol regularly.

Individual Health Insurance

Individual health insurance is important to everyone. People have no way of predicting what will happen to them next year, next week, tomorrow, or even the next minute. The world is full of uncertainties and sometimes it is inevitable that people get diseases that they cannot afford to pay for.

There are some diseases that prove to be very expensive for the average person. The average man's salary may not be enough to pay for the cost of his health care plus the household and school expenses he has to provide for. Due to this, many people feel there is a need for individual health insurance programs that would safeguard their future.

Individual health insurance is a program that offers them peace of mind. Those who have this type of individual health insurance program usually feel secure, knowing that should anything happen to them, they or their relatives would not need to worry about the steep costs of the medical diagnostic and treatment procedures.

The concept of individual health insurance originated after World War II, when the US government gave maximum benefits to its population. In 1950, Medicare, an individual health insurance program by the government, was launched for the needy people of the different states.

During the 1960s, Medical Assistance to the Aged was introduced which offered individual health insurance to the older population. Medicare and Medicaid programs were introduced in 1965. They were both individual health insurance programs by the government. The Medicaid individual health insurance program was provided by the Social Security Administration, while the Social and Rehabilitation Service was the government agency, which offered Medicaid.

There are many available individual health insurance program options and one should choose the type that would be appropriate for his needs. The traditional individual health insurance plan allows one to consult his own doctor and be hospitalized in the hospital of his choice. The HMO is a type of individual health insurance program that offers its own doctors and hospitals where the insured can consult for treatment and confinement. This type of individual health insurance program is limited by the availability of health care professionals. A new form of HMO allows insured to obtain health care from health care professionals and hospital that are not affiliated with them but the insured usually has to pay a certain amount because of this.

Individual health insurance programs give an individual a deal with most of his requirements and needs are fulfilled. Here, the insured purchases the individual health insurance program

directly from the company. The insured in the individual health insurance program is the one who chooses what he wants to be covered for.

In contrast to the individual health insurance program, the group insurance policies' single policy covers the medical expenses of many people, instead of just a single person. With a group health care insurance policy, all eligible people are covered regardless of age or physical condition. It is usually more successful.

Group members are not as scrutinized as those with individual health insurance programs. The disadvantage of group over individual health insurance program is that a group health care policy is not customized, and the insured gets the same policy as everyone else in the company. Unlike individual health insurance program, the insured does not have the freedom to include or exclude provisions.

Job Based Coverage vs. Individual Coverage

Many of us are fortunate enough to be employed by mid-sized or large companies that offer comprehensive benefits packages. These packages almost always contain job based health insurance coverage in addition to life insurance, long- and short-term disability, and flexible spending accounts.

Unfortunately, rising health insurance premiums are causing more and more companies to cut this important benefit, or they may require employees to dig deep into their pockets to share the mounting costs. Nonetheless, it has long been held that individual coverage is not the best route to go when job based coverage is available, but is this true?

Job based coverage may be just what the doctor ordered, unless it is too costly. Employee spending for health insurance coverage, deductibles, and co-pays has risen sharply, and there are times when individual coverage will actually cut the cost of insurance for an employee. For example, a single insurance customer in good health and without dependants to cover will be able to purchase less comprehensive coverage than a married consumer with children in the house.

Granted, many a job based plan offers a scaled back version of their plan, but realistically, these options still may cost more money since the financial insurance risk is spread out amongst the plan participants. An individual plan will only take the applicant's health care history and needs into consideration, and it may thus be a lot more cost-effective.

Individual coverage may be a wonderful idea, but it depends largely on where the individual lives! It is important to remember that individual health insurance coverage is regulated at the state level, and thus may vary widely from state to state. If a consumer lives in a favorably regulating state, then such a policy may be rather advantageous and offer a host of benefits.

If, however, an employee lives in an unfavorably regulated state, it might be wiser to stay with job-based coverage which is, after all, regulated by the federal government, and thus endowed with numerous protections for the worker. In addition to the foregoing, if a worker anticipates

a move to another state, this becomes an important consideration when opting for benefit portability or perhaps starting over with a new health insurance company.

Job based coverage is quite often somewhat limited in which selections the company will offer its employees. Usually, the plans that offer the most freedom are also the most expensive and thus the most likely to get cut by the company when the renewal date arrives. If an individual is happy with a more limited coverage option, then job based coverage will be adequate. Yet, if someone desires extensive coverage with the freedom to choose providers, and services offered, a PPO might be a good choice. If this is not available through the employer, then an individual plan will be most likely the best route to choose.

The important point to remember, however, is that PPO coverage is expensive, and thus a worker who has access to such a benefit from an employer will almost always be financially better by signing on with the job based plan, rather than seeking to purchase such a policy on an individual basis.

Workers with pre-existing health conditions will quite often enjoy the ability to sign up with an employer based plan rather than having to go through the waiting periods that individual plans will dictate -- if the worker can qualify as a new enrollee. Additionally, insurance premiums of job-based plans will not skyrocket because of any pre-existing condition, while an individual plan will take into account these conditions when selling a policy.

For this reason, if you or any dependants you wish to cover under your policy have pre-existing conditions, and you have the choice to sign on with job based coverage, it may very well be a fiscally sound move. It is obvious that there is no "one size fits all" template when it comes to individual insurance needs, and consumers will do well to not only shop around different plans in addition to their job based benefits, but also do some soul-searching prior to signing on for any coverage, so as to truly ascertain what the needs are and who may best fill them.

Medicaid and Medicare: What's the Difference?

Medicare and the Medicaid both fall under the umbrella of the Social Security Act. They were established in 1965 and sought to expand the budding safety-net for the elderly and the indigent.

Medicare's first and foremost goal was the creation of a system that would guarantee that the elderly population's medical care needs would be met. While Medicare originally limited its benefits to individuals aged 65 and older, in 1972 Medicare coverage was expanded to also include those individuals who are severely disabled and because of their disability entitled to at least 24 months of disability benefits, and also to include patients who suffer from the advanced stages of kidney disease that require dialysis or a kidney transplant. In 1973, the Medicare program was further extended to also include individuals who did not fall into any of the three categories previously mentioned, yet who wished to buy into it.

Medicare is a two-tier program that consists of a Part A and a Part B. Part A is the portion that deals with hospital insurance, while Part B is referred to as supplementary medical insurance.

Part A goes into effect automatically when a person reaches age 65 or enters the 25th month of disability benefits, while Part B requires an application process.

Hospital insurance allows for an unlimited lifetime benefit of inpatient hospital stays and up to 100 days of subsequent skilled nursing care per benefit period. Part A is not entirely free, and a co-payment is required. Hospital care benefits are extensive, and they include semi-private rooms, drugs, laboratory tests, and any medically necessary services, procedures, and supplies.

Skilled nursing care consists of the services covered by hospital care, but it also allows for rehabilitation therapy and appliances, such as oxygen tanks, C-Pap machines, apnea monitors, etc. In conjunction with skilled nursing care, home health care may be used without limitation. In 1983, Medicare Part A was amended to also include hospice care for terminally ill patients whose life expectancy was six months or less, and who have chosen to no longer receive conventional treatments for their illness.

Medicare Part B is an optional coverage that must be purchased and paid for with monthly payments on a regular basis. While it appears that Part B and Part A overlap, the supplementary medical insurance actually goes further than Part A in that it covers services such as flu vaccinations, ambulance services, blood for transfusions, and other services and products not covered under Part A.

It is important to note that Medicare does not cover custodial care for individuals in need of round the clock treatment or long-term nursing home stays. Additionally, dentures, dental care, glasses, hearing aids and prescription drugs are not covered.

Medicaid, on the other hand, sought to improve upon the medical care provisions that were available to those individuals who were eligible for public assistance. It is not an all-inclusive program, and a low income alone does not guarantee eligibility for the program benefits. In general, families who receive Aid to Families with Dependent Children (AFDC), pregnant women whose income falls below the poverty level, recipients of Supplemental Security Income (SSI) and adoption assistance are eligible to receive Medicaid benefits.

Medicaid has two loosely defined components that may or may not be available in each state. If a state has a "medically needy" component to its Medicaid program, it will allow individuals who may have more income than the poverty level, yet who are burdened by extreme health care expenses, to receive benefits. All states offer a "categorically needy" definition, and usually the benefits are more extensive than for individuals who take advantage of the "medically needy" program (if available).

Medicaid benefits will stop if individual eligibility criteria no longer apply. For example, if recipients of AFDC or SSI lose their eligibility to those programs, and if Medicaid coverage was received solely because of participation in those programs, then in addition to losing AFDC or SSI the individual will also lose Medicaid coverage.

While this could have catastrophic implications for a family, it is noteworthy that most states provide state-only programs that mimic Medicaid yet apply to those individuals who lose Medicaid eligibility, thus easing the transition.

Medical Coverage on Your Auto Policy

Car accidents can happen at any time to anyone. They can be devastating and cause unnecessary stress to everyone involved. If you are injured in a car accident the last thing you will need at that time is a problem with your medical insurance coverage. Insurance can be a tricky subject.

Sometimes it is hard to determine what is covered under certain policies and what is not. That is why it is a very good idea to invest in an auto insurance policy that includes medical coverage. Medical coverage on an auto insurance policy ensures that you will be covered for any injury resulting from a car accident. Most auto insurance policies that include medical coverage also cover injuries sustained from accidents you may be involved in as a pedestrian.

Most auto insurance policies that include medical coverage in the event of car accidents cover all passengers in your vehicle at the time of the accident. If you are involved in a car accident and have two or three passengers in your car at the time, all the medical expenses of yourself and your passengers will be covered by your auto insurance policy. It does not matter if the car accident is your fault or the fault of another driver, if you are involved in any type of accident where you have medical expenses due to the accident, those expenses will be covered.

Medical expenses can be considerably expensive since they may include everything from ambulance transportation to x-rays to surgery to an extended hospital stay. No matter what your injuries may be you can rest assured that you will not have to worry about them at the time of the accident. In addition, medical coverage can cover any additional expenses after your initial injuries have been treated.

If you require long term care following the accident, medical coverage can help with the financial expense of long term care. If you are left unable to care for your children for a period of time following the accident and must hire child care support, certain auto insurance policies that offer medical coverage can assist in child care finances due to injuries from an accident as well.

If you are not insured at the time of an accident, you will be left relying on other types of insurance. If you have health insurance you need to figure out what and how much is covered under your policy. Some health insurance policies only cover portions of medical expenses during major accidents where expenses can run high.

Oftentimes with health insurance, the insurance holder will also need to pay a co-pay when getting professional medical help. You may want to look into the price of emergency room co-pays, as they are often more than co-pays to a regular doctor's office. If you do not have health insurance then considering auto insurance that includes medical coverage is a must.

Car accidents are completely unpredictable. You and your family could be involved in a car accident at any time. Just because you drive safely does not mean someone else on the road will be driving safely. Even if the accident is not your fault, you will still face mountainous medical bills. Trying to pay them without any type of insurance will be an extremely difficult task that you do not want to be faced with.

Another medical coverage option that many auto insurance policies offer is personal injury protection. This option of medical coverage in the form of personal injury protection is not offered in every state but if you live in a state where it is offered it may be a smart choice for you. The difference between regular medical coverage in an auto insurance policy and personal injury protection coverage is that only those people specified to be covered in the policy will be covered in the event of an accident.

Instead of having any passenger in your vehicle being covered by your insurance, only those people who you have specified in your policy and who are in your car at the time of the car accident will have their medical expenses covered by your insurance. In some cases people do not want those who are not close family members being covered by their insurance. If this is the case then you may want to opt for personal injury protection, as it allows you to determine which individuals would be covered by your insurance policy in the event of a car accident.

Medicare Prescription Drug Assistance Drug program

Medicare's first and foremost goal was the creation of a system that would guarantee that the elderly population's medical care needs would be met. While Medicare originally limited its benefits to individuals aged 65 and older, in 1972 Medicare coverage was expanded to also include those individuals who are severely disabled and because of their disability entitled to at least 24 months of disability benefits, and also to include patients who suffer from the advanced stages of kidney disease that require dialysis or a kidney transplant.

It is important to note that Medicare does not cover custodial care for individuals in need of round the clock treatment or long-term nursing home stays. Additionally, dentures, dental care, glasses, hearing aids and most prescription drugs are not covered.

The small number of prescription drugs that Medicare Part B will cover up to 80% is limited to an injectable drug for osteoporosis, erythropoietin by injection for end-stage kidney disease, immunosuppressive drug therapy for transplant patients, some oral cancer drugs, and a few other drugs. Thus, if a Medicare recipient is not enrolled in the optional Part B coverage, these benefits will not apply. Additionally, patients will be required to pay an annual \$110 deductible for Part B services prior to Medicare's paying its agreed upon 80%.

The high cost of prescription drugs has long since been a major consideration for Medicare recipients, and many a patient is not taking prescribed drugs simply because they are too expensive. Unfortunately, the inability to obtain such needed drugs quite often negates the benefits received under Medicare provisions, and the program is seeking to remedy this situation by offering Medicare-approved drug discount cards to plan participants. In order to qualify for a drug discount card, an individual must participate in Medicare Part A and/or Part B, and not receive any prescription drug benefits through Medicaid.

Furthermore, benefits are sometimes curtailed if prescription drugs are covered (in whole or in part) through a current health insurance policy. Enrollment in a Medicare-approved drug discount card program is not free. As a matter of fact, costs may be \$30 per year. It is of vital importance that interested individuals do their homework and compare the card programs, as

each may not cover the exact same drugs, may not be accepted at a locally convenient pharmacy, and may not permit for easy mail-order refills.

Another way for Medicare recipients to receive prescription drug coverage is through the purchase of a, optional Medigap insurance policy, available from local insurance companies. Those individuals, who already own a Medigap policy that includes prescription coverage, may choose to not sign up for the new Medicare insurance coverage. However, new enrollees in Medigap policies who sign up after January 1, 2006 will no longer be able to purchase a policy that contains a prescription drug benefit.

The year 2006 will mark the beginning of a new Medicare insurance coverage for prescription drugs as well as the phase-out of the Medicare-approved drug discount card programs. The plan will not offer free prescriptions, but it will cover most often about half of the cost of prescriptions.

Additionally, this insurance coverage requires a fee-based subscription and enrollment must be completed by May 15, 2006. While it is still costly, this plan does guarantee that an individual will not pay more than \$3600 per year for prescriptions. Keeping in mind the growing numbers of Medicare recipients who are also borderline indigent, special plans are available for individuals who are unable to meet the deductibles, co-payments, or enrollments fees by substantially increasing the payment percentages and lowering the co-payment amounts.

Generally speaking, Medicare recipients who join the prescription drug plan will pay a monthly fee of about \$37. Also, they will pay the first \$250 in a calendar year for qualifying prescriptions. This sum is considered a deductible, and once it is met, participants will be liable for 25% of the costs of drugs per calendar year up to and including \$2,250. If a plan participant requires further prescriptions, any costs above \$2,250 will be the sole responsibility of the patient, unless the out-of-pocket costs reach \$3,600. At that point the plan will pay 95% of the drug costs.

State Insurance Pool: Can It Help You?

A "State Insurance Pool" is a ground-breaking program that secures insurance benefits for all individuals, even those who are considered to be high-risk by the insurance industry. Quite often referred to as "Guaranteed Access Programs," 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.

Previously, this determination meant that a person in need of medical care was denied health insurance coverage usually because of a pre-existing health condition. Sadly, it is the patient with such health issues who is in the greatest need of quality health care, yet quite often unable to afford the treatments because of the financial strain involved. Previously, this has led to interruptions in medical care for patients who had exhausted available COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) benefits, and were now unable to meet steep financial demands from care providers.

It is noteworthy that state insurance pools vary from state to state; however, they usually function within the confines of a state formed not-for-profit alliance, which is governed by a board of directors.

In general, this board has representative members from the insurance industry, individual insurance customers, and members of the specific state insurance department. Operating very much like a clearing house, the board enters into contracts with an insurance company, and then oversees the day to day operations of collecting members' premiums, receiving and paying out claims, and answering questions on eligibility for treatment.

While coverage is frequently comparable to the coveted 80/20 major medicals and outpatient coverage, prospective members may still be denied plan benefits because of perceived issues of being uninsurable, yet this limitation is often restricted to a 12-month period. Thereafter, acceptance is all but guaranteed.

While this is good news for patients seeking insurance protection, it is important to remember that this coverage, while state sponsored, 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 regulations, 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.

Quite often copies of rejection notices must accompany an application for coverage under the umbrella of a state insurance pool from state-licensed insurance carriers. Additionally, anyone wishing to take advantage of a state-run plan must be a resident of the state in which the plan is offered. In lieu of a rejection by an insurance carrier, an individual who can evidence 18 months or more of uninterrupted health care coverage and is considered HIPAA eligible will quite often qualify for pool coverage. Coverage for dependants is available as well.

In short, a state insurance pool is of invaluable help to anyone who has been denied health insurance because of pre-existing conditions or has exhausted the allotted time period of COBRA benefits, and needs assistance in receiving needed medical care without fear of exorbitant out-of-pocket expenses.

As of 2003, thirty-three states offered high-risk pools to their residents. Twelve states have chosen to opt out of these programs by providing alternatives. For example, the District of Columbia has contracted with Carefirst Blue Cross Blue Shield to have an open enrollment period where interested individuals may purchase coverage regardless of medical conditions, and enjoy full benefits after only a short two-month waiting period. Rhode Island and Pennsylvania have contracted with Blue Cross/Blue Shield to offer year-round enrollment for otherwise deemed uninsurable patients.

Interestingly, this health care concept has since been expanded to also apply to hurricane insurance. "Windstorm Coverage Pools" are an alternative for homeowners who are unable to purchase individual coverage for their residences. Homeowners in a few coastal counties of Georgia and New York are even to participate in pool coverage for wind and hail damage

through a program entitled "FAIR" (Fair Access to Insurance Requirement).

Understanding Temporary or Short-Term Health Insurance

There are a variety of reasons that you may find yourself in the market for temporary or short-term health insurance. You may have graduated from college and can no longer be covered on your parent's policy, but don't have a job yet that will provide coverage. You may have lost or left your job and now need health insurance coverage until you find a new one.

Or you may have started a new job and have to wait a period of several months before you are covered under their plan. Whatever the reason, going without health insurance coverage, even for a few months, can be a costly gamble. If you find yourself in this predicament, temporary health insurance coverage may just be the key to solving your dilemma.

What Is Temporary Health Insurance Coverage?

It's basically just what the name suggests. Temporary health insurance coverage offers you the opportunity to continue to be covered under a health plan for a limited amount of time, usually one to six months, although there are plans out there that will cover longer periods of time. If you find you will need to be covered for more time than you originally thought, some temporary policies can be extended past their expiration date, but you may want to consider getting a more traditional health insurance plan instead.

What Do These Plans Cover?

Temporary health insurance plans cover most of the same types of medical occurrences that permanent policies do, but there are some very important differences.

For one, these plans are usually strictly indemnity plans. Preventative treatments like check-ups, as well as dental and optical coverage are generally not covered. Pre-existing medical conditions and work-related injuries or illnesses are also not covered.

Your temporary health insurance policy will generally cover any emergency medical care you may need, prescription drugs, hospital and intensive care needs, lab and x-ray needs, ambulance care, and even some in-home medical care.

How Do I Get It?

Your first step should be to find an agent that specializes in temporary health insurance. Decide in advance how many days or months you need the coverage and when you want it to start. Pay attention to the 'exclusion' clauses in the policy and ask questions about any concerns you may have. Review the application and make sure all your personal information is correct before you sign anything. Also, remember to get a copy of all paperwork for your files.

The cost of the temporary health insurance plan will depend on the type of coverage you pick. To keep the cost down, you can choose to have a higher deductible with a 50/50 co-insurance

option rather than the more common 80/20 ratios. There are some extras that you may want to consider, though. With the high cost of prescription medicines, you may be better off buying the coverage rather than leaving it off.

The important thing is to read through the temporary health insurance policy carefully and make sure you are being offered the coverage you think you are paying for.

Individual vs. Family Health Insurance Plans

With the ever-growing cost of healthcare in the USA, finding the right health insurance plan that fits into your budget isn't always easy. Knowing what you need to accomplish with a health insurance plan and just who and what needs to be covered by it will help you to decide what type works best for you and your family.

Individual Health Insurance Plans

Okay, let's start with the individual health insurance plan and go from there. First, an individual health insurance plan is pretty much just what it says; it's a health plan for one person. For those who only have themselves to worry about, this is going to be your best option in the cost department. Individual plans can still vary a great deal in affordability, depending on what type of coverage you opt for.

A more traditional health insurance plan (called an indemnity plan) covers visits to whatever doctor you want to see and will cover whatever those procedures are that the said doctor prescribes for you. The cost can vary as to how much of a deductible you have and your out-of-pocket limit. Overall though, this is the more expensive type of individual health insurance plans out there but offers you the most freedom of choice.

Individual managed plans, like HMO's, are more cost effective but you do give up some of the freedoms that you have in the indemnity plan. You will need to see doctors on your approved list and any specialists that you need to see will need to be by referral. If your health care is primarily yearly check-ups and the occasional antibiotics, this is a plan that could work for you. It will cover health emergencies, there are just more hoops you have to jump through.

Both of these health insurance plans can include prescription and dental coverage at an additional cost.

Family Health Insurance Plans

Like the name suggests, family health insurance plans are for families and since these health plans are covering more than one person, the cost is going to be higher. As a matter of fact, the bigger the family, the bigger the price tag. Also, the ages, gender, and health choices, like smoking, from each family member will play a big part in just how much a policy like this will cost you. There are indemnity plans that are for families and they offer the same freedoms as the individual plans. This can be a real bonus when dealing with multiple people.

Family health insurance plans also come in the managed health care package and work pretty much the same way as the individual ones. The cost will be higher than the individual plan, but not as high as the family indemnity plan.

Group Insurance Plans

Many companies now offer their employees group insurance coverage, footing the bill for some or most of the premium. Since many of these companies now offer both types of health insurance coverage, how much you end up paying out-of-pocket will depend on which type of policy you choose.

Family Dental Insurance Plans

Family dental insurance plans are a huge factor when it comes to raising children with healthy smiles and good long lasting teeth. No matter what your brothers, sisters or parents teeth were like when growing up, your children may have different needs.

Keeping prepared for those times when a baseball knocks out part of a tooth, or when a toothache keeps your teen up all night, is all part of having dental insurance. Dental insurance is going to give you coverage not only for the yearly check ups but also for those times when the unexpected happens, which is often while a family!

Do you have dental insurance at work?

If you don't have dental insurance currently at work, you can get dental insurance online, through a number of reputable companies. The same companies that offer insurance plans to your employer offer private dental insurance plans as well. You can get coverage for your needs, or for your entire family dental needs. Your teeth play a major part in eating, drinking and in how you talk, caring for your teeth is important and reviewing all the information on dental plans will give your family a better healthy smile for the future.

Your can receive quotes online

If you are in search of family dental plans, you can find a huge listing of information online for your review. What you need to do is ask your local dentist if they accept the types of dental insurance you are considering. If you are considering an insurance that is not accepted by your dentist you will have to switch dental providers, which may not be what you really want. Look for companies that offer services and payments to dental providers and specialists in your own area. Compare coverage and prices for the final help in choosing a company you want to do business with.

Managed care

In seeking dental plans, you may want to think about a managed care plan. This is the type of plan that is not very expensive, but still offers you the basic benefits of seeing the dentist and getting the cleanings and needed attention from a dentist. A dentist is going to be very important through the many stages of your life, and your children's growing years, so if you are

on a budget, look for a managed care program for low cost needs.

Look for customer service

While choosing a dental plan, look for an insurance provider that offers you the best in customer services. Do they have a toll free number you can call? If you have questions, can you get them answered online with instant chat or do you have to leave a message on a service and wait for a return phone call? Look for some of the testimonials and methods of contacting customer service for every need.

Family Dental Insurance

Dental insurance is important for good health and for great smiles! Dental insurance is just like any other type of health insurance you might have, but it is for your teeth, and so that in case of problems in the future, you have the money and the access to the medical places to get your teeth and your mouth fixed. Dental insurance covers a variety of procedures, cleanings, and check ups.

The Dentist

Most all dentists will accept dental insurance. If you have never had any type of dental insurance in the past, but you have a dentist that you like to see all the time, you should inquire with your dentist if they accept the types of dental insurance you are inquiring about taking out. The dental insurance that you choose will not be expensive compared to the prices you see for health insurance. What can you figure on paying for dental insurance? You should figure if you were having your teeth cleaned about twice a year, you will pay that for your premiums.

What else does dental insurance pay for?

Every type of dental insurance is going to be a little different. Some will pay one hundred percent of your bills while others will pay anywhere from fifty percent and up. This is where your prices in dental insurance will differ. If you have a large family you might find that the insurance that pays the entire bill is best suited for your budget and price range, but if you are single you might only need an insurance that will give you coverage outside of regular visits that you can afford.

Dental insurance is going to cover having wisdom teeth out, having surgeries or having teeth pulled. It is important to have dental insurance so you can have these things done when needed without waiting. If you have a toothache, there is no worse pain for many people. If you have insurance you can make the appointment and not have to worry about what money you have to pay out. If you don't have dental insurance, often times the doctor wants a payment plan, or a payment upfront which can be difficult when on a very tight budget.

How to Choose a Dental Plan

Choosing a dental plan is going to be one of the easiest things, you have to do in life. What you

need to do is compare at least three different providers. If you have the time to review five, it will give you even better insight into what is being paid for and where you can go to the dentist.

You first what to choose a plan that offers coverage in your area. You don't want to have to travel fifty miles to see a dentist, as you will have to miss more work, and it can be costly to get to the dentist when needed. You then want to set a budget for your dental insurance. If you have just twenty dollars a month or ten dollars a month, you can find a plan that will fit your particular needs. If you have more you can spend on your budget for dental insurance, and you have a large family there are family dental plans for your review as well.

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