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Health Insurance

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Individual Health Insurance

As its name implies, individual health insurance covers only your (and your family's) medical expenses. Unlike group insurance, individual health insurance is purchased directly from an insurance company. When you apply, you're asked a series of medical questions and possibly given a physical exam to determine how much risk you present. Your risk potential determines whether you qualify for the insurance and how much it will cost.

Each state has its own regulations regarding insurance products, including criteria for acceptance or rejection of applications by the insurance companies. Ask your insurance agent or call your appropriate state department.

Getting covered

Most people purchase individual health insurance coverage through traditional insurers. Some managed health-care systems also provide individual coverage; in fact, some states require health maintenance organizations to offer it during a special open enrollment period each year.

To get individual health insurance, you can either contact the insurer directly or get in touch with your insurance agent. To make sure you're getting the best coverage for your money, get quotes from several insurance companies before you choose a policy.

Before the insurer issues you a policy, it will want to know everything about your personal health history. It's unwise to try to hide a pre-existing condition, since many insurers use information from the Medical Information Bureau to determine whether you're insurable. If the insurer doesn't want to cover a particular health condition, you might still be able to get a policy with an exclusion rider. But if the insurer later discovers that you withheld information to get the insurance, your coverage could be rescinded back to your application date, so you will have no coverage.

The benefits of individual coverage

In the event of illness or injury, individual coverage is infinitely better than being uninsured. Although you may think that you can do without health insurance, you are taking a major risk if you choose not to get it. An unexpected illness or serious injury can put you and your family in financial peril. Remember that once you develop symptoms, it's too late to apply for coverage.

With individual health insurance, you're directly in control of your own policy. You may be able to negotiate to have certain provisions included or excluded, and you can choose your deductible amount and co-payment percentage. Keep in mind, however, that your choices will affect your premiums.

The disadvantages of individual coverage

When you purchase individual health insurance, you're responsible for 100 percent of the cost. Individual insurance often doesn't provide as much coverage as group insurance in the same price range. Moreover, to make up for the insurer's increased risk exposure, individual insurance is more expensive than group insurance.

Individual health insurance coverage is much easier to come by when you're healthy. If you're already sick or have a history of health problems, you may find it difficult to obtain coverage. Group insurance, by contrast, is usually available without taking a medical examination or answering health questions.

What you should look for in an individual policy

Try to find a policy with a guaranteed renewability provision. The guaranteed renewability provision means that the insurer can't cancel your coverage if you become ill. As long as you continue paying your premiums, your insurance coverage continues. Your premiums may go up over the years, but they will rise for all policies in your

class, not just for your policy alone.

Be sure to check what's covered and when. Major medical coverage, which covers all hospital costs including rooms, emergency-room care, anesthesia, tests, X rays, and drugs, is preferable to hospital-surgical coverage, which covers only hospital and surgical services. Most insurance companies impose a waiting period before they'll cover pre-existing conditions. The shorter this period, the better. Three months to one year is standard; anything over a year is extremely undesirable. Most policies do cover outpatient treatment, although cosmetic and other truly elective surgeries are rarely covered. The easiest way to check what's covered is to look at what's not covered, by reading the Exclusions and Limitations section. You'll also want to check with your state insurance agency, since some states require nongroup insurance coverage to comply with a standard set of benefits.

You'll want to find a policy with the highest lifetime payout possible. Policies with unlimited payouts are less common these days, but anything less than \$1 million may be insufficient to cover you in the event of a catastrophic illness.

You'll also need to choose a limit for your out-of-pocket costs. Lower deductibles and co-payments mean that your costs will be lower if you actually do get sick, but you'll pay dearly for this protection. By agreeing to higher deductibles and co-payments, you can cut your insurance premiums dramatically. As long as you retain a reasonable out-of-pocket maximum, you shouldn't have to worry about your medical costs getting out of hand.

Finally, look for an insurer that's financially stable--one with an "A" or "A+" rating from A. M. Best, Moody's, or Standard & Poor's. It does you no good to have guaranteed renewable insurance if your insurance company goes belly-up.

Group Health Insurance

With group health insurance, a single policy covers the medical expenses of many different people. Unlike individual insurance, where each person's risk potential is evaluated to determine insurability, group health insurance allows all eligible members of the group to be covered by one policy, regardless of their age or physical condition. The premium for group insurance is calculated based on the characteristics of the group as a whole, such as average age and degree of occupational hazard.

When you apply, timing is everything

Many employers offer group health insurance as part of their employee benefits package. Other groups that may offer such coverage include churches, clubs, trade associations, chambers of commerce, and special-interest groups.

Although your individual health is generally not evaluated when you apply for group health insurance, you must apply during the specified eligibility period. For employer-sponsored health insurance, this is often the first 30 days of your employment or the first 30 days following your initial probationary period. For insurance offered by an association, this may be the first 30 days of your membership in the group. Both employers and associations may also have an open enrollment period each year, during which you may sign up for coverage, modify your existing coverage, or add dependents to your coverage. There are also time limits for adding dependents (e.g., within 30 days of marriage or the birth of your child).

The purpose of the eligibility period is to reduce insurance costs by preventing people from waiting until after they discover a health problem to sign up for coverage. If you fail to enroll during this period, the insurance company has the right to treat you as though you were applying for individual insurance. This means you'll probably have to answer extensive health questions and submit to a physical examination. The insurance company can then decide whether or not to insure you.

The benefits of group coverage

Under a group health insurance plan, the insurance company agrees to insure all members of the group, regardless of their current physical condition or health history. The only requirement is that group members apply for insurance within the specified eligibility period. Clearly, group health insurance is beneficial for those with chronic health conditions who otherwise might be unable to get individual insurance.

Group health insurance is somewhat less risky for insurers than individual insurance, since the risk is spread out among a larger number of people. Within a fairly large group, it's almost certain that the good insurance risks will equal or exceed the bad ones. Because only one policy is issued for the entire group, the cost of establishing and administering group coverage is lower than the cost of issuing an individual policy to each person. This means it generally costs less for you to purchase. And in many cases, your employer or association will pick up some or all of the premiums, making group insurance even more affordable.

The drawbacks of group coverage

In a group insurance situation, the provisions of the policy are negotiated between the insurer and the master policyowner (usually an employer or association). Therefore, you can't customize your policy. You don't have the freedom to pick and choose provisions, and your deductible amount and co-payment percentage are determined in advance. In some situations, however, you may be able to choose between two or more insurance plans.

What you should look for in a group policy

Sometimes you have to take what you can get, but if possible, look for an insurer that's financially stable--one with an "A" or "A+" rating from A. M. Best, Moody's, or Standard & Poor's. It does you no good to have a great

insurance policy if your company goes belly-up.

You'll also want to find a policy with the highest lifetime payout possible. Policies with unlimited payouts are less common these days, but anything less than \$1 million may be insufficient to cover you in the event of a catastrophic illness.

If you do have a choice between two offered plans, you'll want to think about the limits you set on your out-of-pocket costs. Also, most employer groups review and compare differences in the health policies they provide to their employees, so check with your benefits or compensation manager to get comparable information about the different plans and covered benefits offered. Many managed care companies and other insurance carriers will send you free marketing brochures about the plan benefits. Lower deductibles and co-payments mean that your costs will be lower if you actually do get sick, but you'll pay dearly for this protection. By agreeing to higher deductibles and co-payments, you can cut your insurance premiums dramatically. As long as you retain a reasonable out-of-pocket maximum, you shouldn't have to worry about your medical costs getting out of hand.

Making the Most of Your Group Health Benefits

For millions of Americans, group health insurance offers affordable quality health care. To get the most from this valuable benefit, you need to understand what you have, how lifestyle changes can affect your coverage, and what to do if your coverage doesn't meet your expectations.

Understand what you have

Get your plan's summary plan description (SPD) from your plan administrator. It gives a detailed summary of your plan—how it works, the benefits it provides, and how those benefits may be obtained or lost. Look for information on:

- Physician choice
- Accessibility of doctor's offices
- Deductibles
- Co-payment requirements
- Maximum out-of-pocket expenses
- Lifetime benefits
- Incentives for using the plan's network of providers
- Exclusions
- Waiting periods
- Prescription benefits
- Maternity benefits
- Dental and vision benefits
- Preventive care programs
- Member rights, including the right to appeal
- Quality reports and ratings from member-satisfaction surveys

Ask before you need it

Don't wait for a serious illness or injury to learn what to expect from your group health plan. Now is the time to find out. Take the time to learn the answers to the following questions:

- Do you need prior approval to visit a specialist?
- How does the plan define emergency care?
- How do you get care if you are outside the area?
- What hospitals are in the plan's network?

- Is there a time limit on hospital stays?
- Who decides when you will be discharged?
- Will the plan pay for follow-up care, such as nursing home care or home health care?
- If you have a serious medical problem, will the plan provide someone to oversee care and make sure your needs are met?
- Are second opinions required for surgery? If so, who pays?
- How do you get ambulance service?
- Is there an advice hot line to help decide how to handle a problem that may not require a doctor's visit?

Be proactive

Don't be afraid to ask your doctor questions, and insist on clear answers. If you're concerned that you won't be able to understand or follow a doctor's instructions, bring someone with you or take notes. Take responsibility for your own care. Consider:

- Lifestyle choices and changes you can make to lower your risks or prevent illness (e.g., losing weight)
- The risks and benefits of any tests or treatments
- How you would go about obtaining care after hours

What happens when you lose coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) allows you to purchase health coverage under your employer's plan if you lose your job, change jobs, get divorced, or upon the occurrence of other qualifying events. Coverage that you obtain under COBRA can last from 18 to 36 months, depending on your situation.

COBRA applies to most employers with 20 or more workers and requires your plan to notify you of your rights. Most plans require you to make an election for coverage under COBRA within 60 days of the plan notifying you. Follow up with your plan administrator if you don't get a notice, and make sure that you reply within the allowed time.

When you buy the insurance under COBRA, you must pay the full premium amount, plus administrative costs of up to 2 percent. If you were accustomed to sharing health insurance premiums with your employer, you may be in for a shock. However, if you or any family member have pre-existing conditions, you may not have any other choice, at least until you get into a new group plan. You must remember to pay your premiums on time, or you will lose your coverage.

The medical coverage under COBRA must be identical to the coverage you had before. However, employers may drop benefits such as dental care and vision care.

The American Recovery and Reinvestment Act of 2009 provides that, for involuntary terminations that occur on or after September 1, 2008 and before January 1, 2010, assistance-eligible individuals will only need to pay 35 percent of COBRA premiums for a period of up to nine months. The remaining 65 percent of COBRA premiums will be subsidized. However, this premium subsidy may need to be repaid in some cases.

As your lifestyle changes, so do your insurance needs

Review your group health insurance benefits and options when you:

- Get married
- Get divorced
- Have a new child
- Have a child who is no longer dependent on you
- Suffer the loss of your spouse

The information provided by your employer should tell you how you can change benefits or switch plans if needed.

Planning for retirement

Find out what benefits are available during retirement. Ask your employer's human resources office, union, and plan administrator. Check your SPD. Make sure that all sources agree about the benefits you will receive and if they can be changed or lost. After you have this information, you can make other important choices, such as finding out if you are eligible for Medicare insurance coverage.

What can you do if a claim is denied?

Your plan administrator has a limited time after you file a claim to tell you if you will receive the benefits. If that is not enough time, you must be notified within a specified time why more time is needed and the date you can expect a decision. Many states regulate claims processing and denial notification to members, so be sure to find out your insurance company's time frames for processing claims, issuing denials, and resolving appeals.

If your claim is denied, you must be notified in writing and given specific reasons why it was denied. If you have no answer in the allotted time, the claim is considered a denial, and you can use the plan's rules for appealing the denial. If you disagree with any claims decision or preauthorization denial, you can request an appeal.

It's important to understand how your plan handles complaints. Check your health benefits package and your SPD to determine who is responsible for handling problems with benefit claims. Keep records and copies of all correspondence.

What if you are unhappy with your health care?

If you are in a managed care plan, you can change your primary care doctor if you are unhappy with the relationship. If the plan itself does not satisfy you, you may be able to switch plans. If you are dissatisfied with the managed care plan but prefer to remain in the plan because you want to remain with your physician, file a complaint. You have the right to a fair and timely process for resolving your complaint. If you are still unhappy, speak to your employee benefits manager to help you match your needs with the available plans.

Stay informed

- Ask for a copy of the member handbook, sometimes called the evidence of insurance or evidence of coverage, to review coverage policies.
- Check to see if your plan has a right-to-privacy policy. Make sure that the plan requires your consent to release any medical information about you to outside agencies not involved with your direct health care or the administration of your health policy, especially your employer.
- Does your plan have a magazine or newsletter? Such a publication can give information on how the plan works and on rules that affect your care.
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Ask how you will be notified of changes in the plan's medical providers or covered services and prescriptions.

- Talk to your plan administrator to learn more about your policy.

The more information you have, the easier it will be for you to make quality health-care decisions.

Understanding Your Health Insurance Policy

There's no doubt about it—health insurance can seem complicated. A typical policy is filled with the kind of technical jargon that sends many of us into cold sweats. Fortunately, understanding the basics of your policy isn't as difficult as you might think.

Take the bull by the horns

Before you can begin to understand your health insurance policy, you need to know exactly what type of policy you have. Do you have your own individual policy, or do you participate in your employer's group health plan at work? Is your plan a health maintenance organization (HMO), preferred provider organization (PPO), or point of service (POS) plan? If you're not sure what type of plan you have, talk to your insurance agent or your benefits officer at work. In addition, it's always a good idea to carefully read your entire policy. Your own initiative and resourcefulness will go a long way toward helping you understand your policy. If you have any specific questions, don't hesitate to call your agent or ask your benefits person.

Get a handle on the standard coverage

With so many different types of plans and policies, there is no standard health insurance policy. The specific benefits, levels of coverage, and other policy features will differ among policies. But most health insurance policies offer certain basic types of coverage. A big part of understanding your policy involves familiarizing yourself with these key areas:

- **Hospital expense insurance:** This covers your room-and-board costs if you're hospitalized, as well as other hospital-related expenses (e.g., use of the operating room, X rays, drugs, lab charges). Some plans pay on an indemnity basis, meaning that the insurer pays a specific amount per day for a maximum number of days. Other plans simply pay a percentage of your total hospital costs.
- **Surgical expense insurance:** If you have surgery, this covers surgeons' fees and related costs (e.g., anesthesia, use of the operating room if not covered as a hospital expense, follow-up visits). Benefits are typically paid according to a set schedule, though some plans pay benefits that are considered "usual, customary, and reasonable" in a particular geographic area.
- **Physicians' expense insurance:** Sometimes called regular medical expense insurance, this covers visits to a doctor's office and a doctor's hospital visits. A typical policy specifies a maximum benefit per visit (e.g., \$25 or \$50), as well as a maximum number of visits per illness or injury.
- **Major medical insurance:** This is designed to protect you against costs associated with a major illness or injury. Fortunately, major medical coverage is usually very broad and often has a very high benefit limit (typically, between \$250,000 and \$1 million). Common items covered may include diagnostic services, nursing services, medical specialists' services, outpatient services, ambulance service, home health care, radiology and other therapy, dental treatment resulting from injury, and prescription drugs.

Ideally, your policy will combine all four of these types of coverage into one package (if not, you can probably purchase them separately). It's important to know exactly what coverage your policy provides in each of these areas.

Understand your out-of-pocket costs

No matter how good the plan, health insurance is rarely free, so it's important to know how much you'll be paying out of your own pocket. The most obvious cost associated with your policy is the premium. If you're covered by an employer's plan or other group plan, your premium will be lower than if you have an individual policy. How low depends on the characteristics of the group as a whole and what portion of the premium your employer or group pays. With an individual policy, your premium depends on your age, health, and other personal factors. Be sure

to plan on the possibility of premium increases down the road.

In addition to the premium, your policy may require you to pay these other out-of-pocket costs:

- **Deductible:** This is the amount (typically, an annual amount) that you must pay toward your medical costs before your insurer begins to cover you. The most popular deductible is currently \$250 or \$500.
- **Co-payment:** This is the amount that you'll have to pay each time you visit a health-care professional or buy a prescription (e.g., \$10).
- **Coinsurance:** This is the percentage of your medical costs that you'll have to pay after you satisfy any deductible (e.g., 20 percent); typically capped at a maximum dollar figure for out-of-pocket costs.

These extra costs can greatly affect the total cost of your policy, so make sure you know what they are. For example, if you take lots of medications, those little co-payments can really add up over time. Reading your policy should tell you everything you need to know about deductibles, co-payments, and coinsurance.

What else should you know?

Understanding your health insurance policy involves other things, too. There are a number of specific provisions and features that you should pay close attention to as you're reading your policy. These often vary among policies, and it would be impossible to list all of the things you might find. But here are some common provisions and features of many health insurance policies:

• **Limitations and exclusions:** Most policies provide limited coverage (or none at all) for certain things. For example, cosmetic surgery may not be covered. Your policy should clearly spell out all of its limitations and exclusions.

- **Stop-loss provision:** This provision limits your liability for your medical expenses. Typically, this means that you no longer have to make coinsurance payments when your expenses exceed a certain threshold. Common loss levels are \$5,000 to \$10,000.
- **Benefit ceiling:** Also known as the maximum lifetime payout, this provision specifies the maximum amount that your insurer will pay on your behalf. Keep in mind that your policy's benefit ceiling may be well below what many insurance experts recommend, which is a maximum of \$1 million.
- **Family coverage:** Many policies allow you to also cover your spouse and children, but your premium will be higher. Some policies with family coverage have a family deductible that must be satisfied before coverage kicks in for anyone in the family.
- **Riders and endorsements:** These are optional features that you can often buy to modify your policy's standard coverage or add extra coverage. If you'd like to better tailor your policy to your needs, ask your insurer what riders or endorsements are available and at what cost.

Limitations, Exclusions, and Riders

Like any insurance, health insurance can be complicated. Trying to understand the ins and outs of coverage can be like trying to crack an elaborate code. A big piece of the puzzle is getting familiar with policy limitations, exclusions, and riders.

What should you know about limitations and exclusions?

The trend in health insurance has been toward more comprehensive coverage. Each state has its own laws regarding health insurance, including what must be covered and what is allowed to be excluded. Still, it would be nearly impossible to find a policy that covers everything. Many policies provide limited coverage for certain types of illnesses, injuries, treatments, and procedures. These are known as the policy's limitations. More importantly, some things may not be covered at all. These are known as the policy's exclusions. Here are some common limitations and exclusions that you might find in a policy:

- **Pre-existing conditions:** A pre-existing condition is an illness or injury that began or occurred before you were covered under your policy. These conditions are sometimes excluded from coverage, but are often covered after a specified waiting period (e.g., six months with no treatment or six months on the plan).
- **Nonduplication of payments/coordination of benefits:** To prevent double coverage, many policies specify that benefits will not be paid for expenses that are reimbursed by other insurance companies. This provision limits the total payment of benefits to 100 percent of covered expenses.
- **Care covered by the Department of Veterans Affairs, formerly known as the Veterans Administration, or by workers' compensation:** This is to avoid double coverage.
- **Military duty:** This provision usually suspends coverage while you're serving in the military.
- **Alcohol and/or drug abuse treatment:** It's increasingly common now to find policies that cover this, as many states have mandated coverage.
- **Cosmetic surgery:** A common exception to this is cosmetic surgery required as a result of an accidental injury or congenital defect.
- **Dental expenses:** You generally need dental insurance, but some health insurance policies cover reconstructive dental treatment resulting from an accidental injury.
- **Alternative treatments:** These include chiropractic and acupuncture. This coverage is now becoming more common.

• **Experimental procedures:** This may refer to procedures that aren't yet fully endorsed by the medical community.

- **Infertility treatment:** Some policies that provide extensive coverage may cover this treatment, but most do not unless mandated by state law.
- **Organ transplants:** Some policies don't cover heart, liver, and kidney transplant procedures.
- **Vision correction:** Procedures like laser vision correction surgery are usually not covered.
- **Certain air travel:** You're generally covered while traveling on commercial aircraft, but you may not be for other types of air travel.

- War or acts of war that result in injury: This exclusion applies whether you're a soldier or a civilian.

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Injury incurred while committing a felony: Covering this would be like paying you for your criminal behavior.

- Injury or illness that occurs while under the influence of intoxicants or narcotics: The rationale is that you shouldn't have been using these substances in the first place.
- Self-inflicted injuries: The rationale for not covering these injuries is self-evident.

Limitations and exclusions can vary quite a bit among policies. The best way to find out what's covered (and to what extent) and what's not is to read your policy carefully and ask your insurer. The policy should specifically list all of the coverage limitations and exclusions.

What should you know about riders?

You can often customize a health insurance policy to your individual needs through a rider. A rider is a special provision that is printed separately and attached to your original policy. A rider can be used to make specific changes to your standard policy, or it can provide additional coverage over and above your standard coverage. A policy endorsement can accomplish the same goal—the difference is that an endorsement is actually incorporated into the body of your existing policy. Here are some common health insurance riders:

- Waiver of premium: Some policies may offer an optional rider that allows you to stop paying your premiums during periods of extended hospitalization. You resume making premium payments once you've left the hospital, but you typically don't have to pay back the premiums that you missed.
- Exclusion/impairment: This rider is used to specify a medical condition that might normally be covered but isn't because it's a pre-existing condition. Though the particular condition isn't covered, the use of this rider allows you to obtain coverage for other health-care needs when the excluded condition might otherwise make you uninsurable.
- Additional coverage: If your insurer agrees to provide you with extra coverage that's not included in the standard insurance contract, this coverage can be added with an optional rider. The rider spells out the details of the additional coverage.

Be aware that certain types of health insurance plans (e.g., employer-sponsored plans and other group coverage) may not give you the option of adding riders to your coverage. Or, depending on your health and other factors, your insurer may not be able to offer you the riders you're seeking. Finally, keep in mind that adding a rider to your policy for additional coverage generally increases your premium. You should weigh the extra cost against your need for the rider.

Tax Tips: Health Insurance

Your health insurance coverage probably came in handy several times over the past year. It all seemed so simple at the time--you paid a deductible, and your insurance usually kicked in the rest. But what do you do at tax time? Just what are you taxed on, and what can you deduct on your federal income tax return?

Your income taxes may be affected by two aspects of your health insurance plan--the premiums and the benefits. Here's what you need to know.

You don't include employer-paid premiums in your income

For tax purposes, you can generally exclude from your income any health insurance premiums (including Medicare) paid by your employer. The premiums can be for insurance covering you, your spouse, and any dependents. It doesn't matter whether the premiums paid for an employer-sponsored group policy or an individual policy. You can even exclude premiums that your employer pays when you are laid off from your job.

What if your employer reimburses you for your premiums?

If you pay the premiums on your health insurance policy and receive a reimbursement from your employer for those premiums, the amount of the reimbursement is not taxable income. However, if your employer simply pays you a lump sum that may be used to pay health insurance premiums but is not required to be used for this purpose, that amount is taxable.

In most cases, you won't be able to deduct the premiums you pay

The deductibility of health insurance premiums follows the rules for deducting medical expenses. Usually, the premiums you pay on an individual health insurance policy won't be deductible. However, if you itemize deductions on Schedule A, and your unreimbursed medical expenses exceed 7.5 percent of your adjusted gross income (AGI) in any tax year, you may be able to take a deduction. You can deduct the amount by which your unreimbursed medical expenses exceed this 7.5 percent threshold.

For example, if your AGI is \$100,000, then 7.5 percent of your AGI is \$7,500. If your unreimbursed medical expenses amount to \$8,000 and you itemize deductions, you'll be able to deduct \$500 worth of your expenses.

Unreimbursed medical expenses include premiums paid for major medical, hospital, surgical, and physician's expense insurance, and amounts paid out of your pocket for treatment not covered by your health insurance.

If you're self-employed, special deduction rules may apply

In addition to the general rule of deducting premiums as medical expenses, self-employed individuals can deduct a percentage of their health insurance premiums as business expenses. These deductions aren't limited to amounts over 7.5 percent of AGI, as are medical expense deductions. They are limited, though, to amounts less than an individual's earned income. The definition of self-employed individuals includes sole proprietors, partners, and 2 percent S corporation shareholders.

If you qualify, you can deduct 100 percent of the cost of health insurance that you provide for yourself, your spouse, and your dependents. This deduction is taken on the front of your federal Form 1040; the portion of your health insurance premiums that is not deductible there can be added to your total medical expenses itemized in Schedule A.

Your health insurance benefits typically aren't taxable

Whether we're talking about an employer-sponsored group plan or a health insurance policy you bought on your own, you generally aren't taxed on the health insurance benefits you receive.

What about reimbursements for medical care? You can generally exclude from income reimbursements for hospital, surgical, or medical expenses that you receive from your employer's health insurance plan. These reimbursements can be for your own expenses or for those of your spouse or dependents. The exclusion applies regardless of whether your employer provides group or individual insurance, or serves as a self-insurer. The reimbursements can be for actual medical care or for insurance premiums on your own health insurance.

Note that there is no dollar limit on the amount of tax-free medical reimbursements you can receive in a year. However, if your total reimbursements for the year exceed your actual expenses, and your employer pays for all or part of your health insurance premiums, you may have to include some of the excess in your income.

HMOs and PPOs: What's the Difference?

Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are types of managed care health systems that employ a network of providers to treat the medical needs of their members. Today, most people are covered by one type of managed care system or another, either individually or as part of a group plan through their employer. If you are given the opportunity to choose between HMO and PPO coverage, consider the following in determining which one best suits your needs.

How are health maintenance organizations and preferred provider organizations alike?

Both HMOs and PPOs maintain a network of doctors, hospitals, medical labs, and independent physicians' groups to provide and finance health care for members. Both attempt to reduce costs by applying specialized management techniques to limit what they regard as unnecessary or inappropriate medical procedures. Both also share the goal of reducing health-care costs by focusing on preventive care and general health promotion. But there are several major differences, including the following:

Selecting a physician

HMO: When you join an HMO, you choose a primary care physician (PCP), who is your first contact for all medical care needs. Your PCP becomes the physician who directs what care is given, how much care is given, and by whom the care is given. HMO members must choose a PCP from among the HMO network physicians. So if your longtime family doctor is not part of the HMO network, you'll have to choose a new family doctor.

PPO: PPO members do not have to choose a PCP and can refer themselves to any specialist in the PPO network. You can even go to a physician outside the network, but you'll pay a greater portion of the bill. So, although you're covered for services both inside and outside the network, there is financial incentive to receive care from the plan's preferred providers.

What if you need a specialist?

HMO: Your PCP provides your general medical care and must be consulted before you seek care from another network physician or specialist. This screening process helps to reduce costs for both the HMO and its members.

PPO: You are free to see any network specialist at any time. But if you go outside the network, your co-payment will run 30 to 40 percent of the physician's charges. And if you fail to get permission from your PPO to see a non-network specialist, you could end up paying the entire bill.

Getting health care outside your network can be tough with an HMO

HMO: HMO members typically receive all treatment from their HMO network physicians. However, your HMO will pay for care provided by a non-HMO physician in an emergency. You should notify your PCP as soon as possible to coordinate the care. Nonemergency out-of-network care generally isn't covered. But your HMO will pay for treatment when it is medically necessary and when the plan's providers are normally unable to offer that treatment.

PPO: PPO members are not required to seek care from PPO physicians, but there are strong financial incentives to do so. For example, the PPO may reimburse 90 percent of the cost for care received within its network, but only 70 percent of the costs for non-network care. Most PPOs give full coverage for emergency treatment regardless of where it is performed and who provides it.

Co-payments are handled differently

HMO: Instead of deductibles, HMOs often charge a minimal amount, known as a co-payment, for each treatment or doctor's visit. HMO members often pay a nominal co-payment of \$5, \$10, or \$20 for office visits, tests, and prescriptions.

PPO: Your co-payments amount to 10 percent of charges for care inside the network and 30 to 40 percent for non-network treatment. You are reimbursed for the remaining 90 percent of network care and 60 or 70 percent for non-network care. Keep in mind that co-payment percentages will vary among PPOs. To avoid paying large co-payments out of their own pockets, most PPO members choose to receive all of their health care within the PPO network.

HMOs have no deductibles

HMO: HMOs typically have no deductibles. Coupled with low co-payments, HMOs are able to minimize out-of-pocket costs. This is designed to encourage members to seek medical treatment early, before health problems become severe.

PPO: PPO coverage requires payment of an annual deductible. Once your expenses exceed the amount of this deductible, insurance coverage kicks in. On average, annual individual deductibles are \$200 for network care or \$250 for non-network care. The average family deductible is \$500 per year for either network or non-network care. The deductible amount is in addition to any co-payment.

Annual payment caps

HMO: There is typically no limit on the amount of health-care costs in a given year. These costs are usually minimal co-payments (typically at most \$20 per office visit or treatment), so your out-of-pocket expenses will probably be quite limited. But keep in mind that while some HMOs will cover specialized treatment from non-network physicians when the HMO itself doesn't provide such treatment, others will not. You could end up paying for this treatment yourself. Talk to your insurance carrier or your employer's plan administrator.

PPO: Health-care costs paid out of your own pocket (deductibles and co-payments) are limited to an annual maximum. Typically, your out-of-pocket costs for network care are capped at approximately \$1,200 for individuals and \$2,000 for families. If you are treated outside the network, you'll of course pay more. The maximum annual cap for non-network treatment is approximately twice the amount of network care.

So, which system is better for you?

Obviously, the choice depends on your particular needs. PPOs tend to be more flexible, but HMOs are generally less expensive. Because you don't need to get a referral before seeing a specialist, you might prefer a PPO if you have a medical condition that requires specialized care. But if ongoing out-of-pocket costs are a major concern, an HMO may be a better choice—there are no deductibles, and co-payments are typically lower. Contact your state's department of insurance for a list of approved providers.

POS Plans

You're not alone if you're feeling confused by health-care plans that offer you benefits with one hand and place restrictions on you with the other. Fortunately, the world of managed care has begun to loosen up. And point of service (POS) plans may be leading the way. A POS plan is a type of managed care health system that maintains a network of physicians, hospitals, medical labs, and pharmacies for the health care of its members. POS plans blend the provisions of two major managed care models, combining the low out-of-pocket costs of health maintenance organizations with the flexibility of preferred provider organizations.

A quick overview of managed care

Managed care systems were developed to provide health care to members at a reasonable price. Costs are controlled in several ways. One way is to limit medical procedures that the plan considers unnecessary or inappropriate. Many traditional health insurance plans, in contrast, generally pay for the medical expenses incurred by its members without imposing stringent cost controls. Another measure that managed care providers use to hold down costs is to subsidize prevention and wellness programs, such as smoking-cessation classes, health education classes, and memberships to fitness clubs. The healthier you are, the less need you may have for medical care.

Your primary care physician is the gatekeeper to further care

As a member of a POS plan, you'll be expected to choose a primary care physician (PCP) from a network of doctors sponsored by the plan. Your PCP acts as your main contact within the network and is responsible for most of the care you receive on a regular basis. In addition, your PCP is said to act as a gatekeeper by coordinating your access to specialists and other caregivers within the network. But you may go to physicians outside the network if you choose.

If you need a specialist, it's best to get a referral

If you develop a medical condition requiring specialized care, you must get a referral from your PCP before you seek care from a specialist or another physician within the network. This screening process helps to reduce costs for both the POS and its members. If your PCP doesn't provide the referral you feel that you need, you can go outside the POS network for treatment and see any doctor or specialist you choose without consulting your primary physician.

You can choose to go outside the network, but at a price

A POS plan allows you the freedom to seek care outside its network of providers. If you choose, you can even mix the types of care you receive. For example, your child could see a pediatrician outside of the network, while you continue to receive health care from network providers. Of course, you'll pay substantially more out-of-pocket charges for any medical care your family receives from a non-network provider--encouraging you to stay within the network, but not requiring it. When using health-care services within the plan's network, you generally pay no deductible and only a minimal co-payment. If you go outside the network, you'll likely be subject to a deductible and may have to pay a substantial portion of the non-network physician's charges.

You'll pay nominal co-payments for network care

Co-payments are usually minimal for POS network care, often running about \$10 per treatment or office visit. You always retain the right to seek care outside the network at a lower level of coverage. But substantial co-payments for care outside your POS network give you a strong financial incentive to stay inside the network for most or all of your medical needs. For example, your co-payment may be only \$10 for care obtained from network physicians, but you could be responsible for up to 30 or 40 percent of the cost of treatment provided by a

non-network provider.

There's generally no deductible for network care

When you choose to use network providers, there is generally no deductible. So, coverage begins from the first dollar you spend as long as you stay within the POS network of physicians. But an annual deductible must be met for out-of-network care. In most cases, you must pay a specified amount out of your own pocket before coverage begins. On average, individual deductibles are around \$300 per year for an individual and \$600 for a family. This deductible amount is in addition to your co-payments.

You should expect an annual cap on your out-of-pocket costs

Your annual out-of-pocket costs are generally limited to a maximum dollar amount stated in the policy. The annual limit on your health expenses for a POS plan, including deductibles and co-payments, is typically around \$2,500 for an individual and \$4,000 for a family. If you don't know what the cap on your annual payments is, talk to your insurance company or plan administrator.

Understanding Managed Care

If it's been a while since you've shopped around for health insurance, you may find that things have changed since the last time you tackled this chore. Not long ago, you could go to any doctor or hospital, and you and your insurance company would each pay part of the bill. Now, most health insurance policies are some form of managed care, with controls to contain costs.

Today, more than half of insured Americans are covered by a managed care plan--a plan that gives financial incentives to encourage you to use doctors who are part of the plan network. The better you understand managed care, the better you will be able to select the plan that best meets your needs and budget.

How do managed care plans work?

Insurance companies negotiate discounts with medical providers who sign up to be part of the managed care plan's network. In exchange, the providers get an instant pool of patients. The plans generally limit your out-of-pocket expenses for covered care. They usually require (or encourage) that you seek care from a specific list of contracting doctors, hospitals, and other providers. If you go out of the plan's network for medical treatment, you have to pay higher out-of-pocket expenses.

The goal of managed care is to provide health care that is:

- Cost effective
- In the best setting
- Of the highest quality
- Medically necessary
- Offered by the most appropriate provider

To increase the overall quality of care and reduce costs, many managed care plans require that you see a primary care doctor (family practitioner, internist, or pediatrician) before visiting a specialist. Your primary care doctor has the responsibility of knowing your complete medical history, making the initial diagnosis, and advising on further treatment.

Health maintenance organizations

Your primary care doctor is the gatekeeper who coordinates your health care and refers you to specialists

- You must use specific health-care providers and facilities to be fully covered
- You can go outside the network only if prior approval is given or for an emergency
- Nonemergency and elective admissions to the hospital require prior approval

You can go for emergency care wherever and whenever you determine you need it, without prior approval

- Some treatments and procedures require a second opinion
- Preventive care programs are available to keep you well

- Doctors are paid based on a capped or fixed-fee arrangement rather than payment for services given
- You do not have to file claim forms with the insurance company
- Screening tests for cancer and other chronic diseases are usually covered

Health maintenance organizations (HMOs) are considered the most restrictive because they offer you the least amount of choices. However, they tend to have both the lowest out-of-pocket costs and the least paperwork, and they promote general wellness programs to keep you healthy.

Preferred provider organizations

- Most preferred provider organizations (PPOs) do not require a referral from your primary care doctor to visit a specialist
- You will have higher out-of-pocket costs if you use providers outside the network
- Prior approval is required for hospitalization (except for an emergency) and some outpatient services
- Some treatments and procedures require a second opinion
- Emergency care doesn't require approval if you determine you need it
- Preventive care is not always covered
- Your doctors and hospitals are paid for services provided
- Your medical provider files the claim forms

PPOs are less restrictive than HMOs in your choice of health-care provider, but your out-of-pocket costs may be higher. The coverage provided for treatment and care is similar to an HMO.

Point of service plans

- There are financial incentives, such as lower out-of-pocket costs, to use network providers
- You can receive care from providers outside the network without prior approval
- If you go outside the network, you'll be responsible for filing insurance claims
- If your doctor refers you out of the network, the plan pays all or most of the bill
- Premiums are higher than those for HMOs or PPOs

Point of service (POS) plans are less restrictive than HMOs. They combine some features of HMOs and PPOs and have the highest out-of-pocket costs. So even though POS plans allow greater choice at the time the service is delivered, you'll pay more for your health care.

How do I select the plan that's right for me?

There is no perfect plan--you'll have to do some give-and-take. Some questions to consider:

- Do your current doctors participate in any plans?
- Does it matter that you might be limited to your choice of doctors and hospitals?

- What level of services do you really need?
- Would getting referrals to specialists be a problem?
- How much can you afford to spend?
- Are you willing to file insurance claim forms?
- What is the plan's rating on quality of care and member satisfaction?

What to ask before you buy

After you decide what benefits are important, you will be in a better position to compare individual plans. Plans differ with regard to out-of-pocket costs, services provided, and how easy it is to get those services. Although no plan will pay for everything, some plans cover more than others.

- Ask to see a network directory. Are your current doctors in it?
- Are you willing to change doctors if necessary?
- Are the doctors close to you accepting new patients?
- Does the plan use a local hospital?
- Who decides if you can go to the hospital?
- What is the plan's policy on pre-existing conditions?
- Is there a maximum lifetime benefit?
- Are preventive care services offered?
- What is the prescription drug policy?
- Are there limits on medical tests?
- What are the mental health benefits?
- Does the plan pay for any special services you need?
- How easily can you change primary care doctors?
- Are therapies such as acupuncture or chiropractic services covered?
- How easily can you get help over the telephone?

Whatever plan you choose, you will become a partner with your doctor and insurance company. Keep in mind that managed care plans make more money when they keep you healthy and out of hospitals, reduce the amount of care you receive, and stay within the budget set for each member's total medical care. It will be your responsibility to schedule physical exams and take advantage of other preventive care programs. Make sure there is a good match between what you think you need and what is provided.

Trends in Managed Care

If you're like most Americans with health insurance, you probably belong to some type of managed care health plan. Managed care has grown rapidly in recent years and evolved in certain ways. You may be wondering where it's heading.

Although patients are generally happy with the minimal paperwork and lower out-of-pocket costs associated with managed care, the emphasis on cost cutting has led to a certain backlash. Most states have enacted managed care consumer protection laws, and Congress has debated a patients' bill of rights. In addition, physicians have begun to unionize. The spiraling cost of prescription drugs is another issue that begs to be addressed.

While health maintenance organizations (HMOs) and other managed care delivery systems have concentrated on lowering costs, many of them have been socked by rising claims and pharmacy costs. Profits have declined. Consequently, some companies have merged, and others have withdrawn from particular states altogether. The challenge faced by lawmakers will be to safeguard patients' rights without driving managed care providers out of business.

What is managed care?

First, a little history. In the past, health insurance was usually provided by traditional fee-for-service insurers, such as Blue Cross/Blue Shield. You paid the health-care provider and submitted a claim to your insurance carrier. Then, after your deductible was satisfied, you were reimbursed for some or all of your expenses. You could go to a doctor or specialist (or emergency room) as many times as you wanted. However, these uncontrolled claims resulted in high loss ratios for insurance companies, which in turn caused them to increase health-plan premiums significantly.

Because the industry needed to lower and control costs, managed care became popular. Managed care is a strategy for containing or minimizing medical care costs while delivering appropriate medical care. In managed care, patients pay significantly reduced fees to see their primary care physicians, but they usually can't see specialists or other medical service providers without their primary physician's approval.

To contain costs, managed care companies exercise control by denying or allowing insurance coverage for certain procedures, promoting generic drugs in place of brand-name drugs, and encouraging wellness programs and preventive measures. In fact, some companies now send registered nurses to workplaces on a periodic basis to educate employees regarding weight loss and nonsmoking.

Changes in managed care

Managed care grew rapidly in the form of HMOs, which require that the primary care physician act as gatekeeper for further care. In response to the public's frustration at being unable to access certain providers without authorization, preferred provider organizations (PPOs) and point of service (POS) plans have arisen in recent years to allow members to use both in- and out-of-network doctors and hospitals. However, these plans have higher co-payments and deductibles when you go outside the network.

State consumer protection laws

Most states have enacted at least one law concerning managed care. These laws may:

- Mandate coverage for certain medical conditions or services
- Forbid financial incentives for physicians who limit care
- Prohibit gag clauses (clauses that forbid physicians from disparaging the health plan or suggesting treatment that the plan does not cover)

- Specify when emergency room care is necessary
- Provide for complaints/appeals of coverage decisions

Federal legislation

In recent years, Congress has considered the issue of patients' rights. Consumer groups, legislators, and the American Medical Association (AMA) have raised concerns about managed care and its effect on patients. Various bills have addressed information disclosure to patients, choice of providers and health plans, access to emergency services, participation in treatment decisions, nondiscrimination, confidentiality of health information, complaints and appeals, and consumer responsibilities.

Opponents of these bills argued that they were too costly, that they called for too much regulation, and that they made HMOs too vulnerable to lawsuits. Although Congress has not yet passed a comprehensive patients' bill of rights, this issue is popular with voters and will continue to be debated. The future probably holds some form of federal codification of managed care rights for patients.

Another hot issue involves prescription drug coverage for Medicare recipients. With the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare beneficiaries can now join prescription drug plans offered by private companies or insurers that have been approved by Medicare.

Unions

In recent years, many physicians' organizations (such as the AMA) have pushed for unionization of doctors. In fact, some unions have already sprung up. In large part, this movement has stemmed from the growth of the managed care industry. In explaining why they wanted to join a union, several doctors cited a loss in their decision-making authority and a drop in reimbursements from HMOs.

In an attempt to cut costs, some HMOs specify the number of patients doctors should see per hour and deny coverage for certain procedures deemed medically necessary by the physicians. Doctors, watched over by plan accountants, are encouraged to minimize the number of tests, referrals, and hospitalizations they order. In addition, physicians whose expenditures for patients are regarded as too high are sometimes dropped from the health-care plan. Expect the unionization movement to gain strength.

Where to Get Health Insurance

You probably recognize the importance of having adequate health insurance for yourself and your family. But are you aware of all your options, and do you understand them well enough to make the right choices? If not, a crash course in the most common sources of health insurance may be helpful.

Each state has its own laws regarding health insurance, including what types of coverage are available, and what options you have for purchasing it.

Group health insurance: a sweet deal

Group health insurance covers a number of individuals. The most common form is employer-sponsored plans that many companies offer as an employee benefit. In addition, certain associations may offer health insurance to their members. If you have access to a group health plan and are eligible to participate, you can sign up for the plan at certain times of the year. If the plan offers family coverage, consider enrolling your spouse and children; such plans can provide cost-effective health coverage for the whole family.

The cost of setting up a group plan is relatively low because one policy is issued for the entire group. Some of this cost savings is passed on to you in the form of lower premiums. Another factor that keeps premiums down is that the insurer bases your share of the group premium on the characteristics of the group as a whole (e.g., average age). Typically, there are no medical exams or probing health questions, so you won't be charged more if you're older or in poor health. And the cost to you may be even lower because many employers and groups pay all or part of the group premium.

Drawbacks? With most group plans, you have little or no freedom to customize the policy to your individual needs. That's because the specific policy provisions and other details are all worked out in advance between the insurer and the employer or group. Also, depending on your circumstances, your out-of-pocket co-payments and deductibles can really add up over time. And remember, you may find yourself without affordable health coverage if you leave your employer or group.

Individual policies: are they worth it?

Unlike a group plan, an individual policy provides health insurance coverage for only one person or family. You purchase one of these policies directly from an insurance company--there's no employer or other group acting as the middleman. An individual policy can serve as your primary source of coverage if you have no other health insurance options (or don't like the options you do have). The catch: You'll usually pay a lot more for coverage than you would under a group plan.

The cost of an individual policy typically depends on your age, health, medical history, and other personal factors. You'll probably have to take a physical exam and answer a lot of questions when you apply for a policy. If the company sees you as a high risk, the coverage that it offers you may come at a high price. You could even be turned down altogether if the company decides that you're uninsurable, depending on state laws.

But it pays to shop around because individual policy premiums can vary widely among insurers. And there are many companies that sell health insurance, giving you plenty of options to choose from. Another key advantage is that individual policies often allow you to tailor the policy features to fit your own needs. Finally, you can take your individual policy with you as your situation changes. You won't have to worry about losing the coverage when you quit your job, get laid off, or leave a group that you belong to.

COBRA: health insurance for a rainy day

You'll typically lose your employer-sponsored health coverage when you leave your job, and this can sometimes spell financial trouble. Fortunately, COBRA (the Consolidated Omnibus Budget Reconciliation Act) can help solve this problem. Under COBRA, employees and their dependents who have been covered by an

employer-sponsored health plan (in companies of at least 20 employees) are allowed to continue their coverage under circumstances that would otherwise cause them to lose it (e.g., a layoff or firing, divorce, or a reduction in work hours).

You may not need COBRA if you're going to work for another employer that offers a health plan. But the ability to continue coverage under your old plan can come in very handy if you're not returning to work right away. COBRA is not without drawbacks, though. Since you no longer work for the employer that has the plan, you'll have to pay your portion of the group premium entirely out of your own pocket (no more employer subsidy). Another disadvantage: COBRA coverage is typically limited to 18 months in duration, so it's only a short-term solution.

Medicare: help from Uncle Sam

The Medicare program was enacted into federal law in 1965 to provide affordable health coverage for retired people, regardless of medical condition. Most people become eligible for Medicare at the same time that they become eligible for Social Security retirement benefits. In addition, some disabled people and patients with end-stage kidney disease are eligible for Medicare. There are also separate eligibility requirements for Medicare Parts A and B, as well as special rules for certain government employees.

Medicare will cover many of your medical expenses during retirement, including inpatient hospital care, physician care, laboratory tests, and physical therapy. Without Medicare, many seniors would be unable to pay their major medical bills. Even those who could might be forced to dip into their retirement savings. And though you have to pay Medicare premiums once you're covered under the program, the out-of-pocket cost is very low compared with the benefits you get in return.

Still, Medicare coverage has gaps that often present a problem for retirees. To pay for deductibles and other out-of-pocket costs, most retirees need to supplement Medicare with separate Medigap insurance. Medigap policies are sold by private insurance companies and regulated by the federal government. There are 10 standard Medigap plans, but not all of them are offered in every state. The cost varies by plan, so weigh coverage against price when choosing a plan.

Medicaid: more help from the government

If you're older, blind, or disabled and have little income, you may be eligible for health benefits under Medicaid. Dependent children with financial need may also qualify. Medicaid is a joint federal-state health program that pays for a number of health-related costs, including hospital bills, physician services, home health care, and long-term nursing home care. Each state has its own Medicaid program that is based on broad federal guidelines and regulations. For details about your state's Medicaid program, contact the appropriate state office.

Comparing Health Insurance Plans

Perhaps you're starting a new job or trying to integrate employee benefits with your new spouse. Or maybe you're shopping for individual health insurance coverage. One of the challenges when comparing health plans is that many different types of plans are available, including indemnity plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service (POS) plans. If you are offered the chance to choose among different types of plans, you'll first have to decide which type best suits your needs. Then, you can begin comparing and evaluating policies.

Compare premiums

The premium may be the first thing you look at when trying to choose a health plan. Individual coverage can be expensive because the insurer takes on more risk by covering just one person. However, if an individual policy is your only option, you should compare the premiums charged by several different insurers. Even though companies all use certain information to price a policy (e.g., your age and health), premiums may still vary widely among companies. You can eliminate policies that cost more than you can afford. Also, try to get some idea of how much premiums will increase as you age and as the cost of medical care rises.

You should also look at cost when you're comparing group health plans. Even if two plans provide similar coverage, the group premiums may differ. That's because the premium in each case is based on facts about that particular group (e.g., average age). In addition, keep in mind that the employer or other group often pays all or part of the group premium. The less premium you have to pay, the more attractive the plan. Finally, find out how much it will cost to cover your family members under the plan.

Compare deductibles, co-payments, and coinsurance

These costs often vary widely among health plans, and some plans may not impose them at all. This is something to look at closely when comparing plans, because these additional costs can greatly affect your total out-of-pocket cost. The deductible is the amount that you have to pay toward your medical expenses before your insurance company begins to cover you. The co-payment is the amount that you have to pay each time you visit a health-care provider or need a prescription. Finally, coinsurance is the percentage of your medical costs that you have to pay after you satisfy any deductible that applies (not including any co-payments you're required to make). Consider the following questions:

- Will you have to satisfy an individual deductible, a family deductible, or both? What are the amounts?
- Do you have to satisfy the deductible annually, or every time you are hospitalized?
- Do different deductibles apply to different types of care? For example, you may have to pay a \$500-per-year deductible for hospitalization, but only a \$100-per-year deductible for doctors' visits.
- How much is the co-payment when you see your doctor for routine care? When you see a specialist? When you are admitted to the hospital? When you pick up a prescription?
- What percentage of your medical costs will you have to pay after you satisfy your deductible? A common coinsurance rate is 20 percent.
- What is your out-of-pocket maximum? To limit your liability, you may no longer have to make coinsurance payments once your medical expenses for the year reach a certain level (e.g., your insurer pays 100 percent of your annual expenses over \$10,000).
- Do you have the flexibility to change the amount of your deductibles and/or co-payments? Choosing higher amounts may help you lower your premium.

Compare coverage and features

It's equally important to assess each plan's coverage and specific features. Here are some issues to think about:

- What coverage exclusions apply? Specific types of illnesses, injuries, treatments, and procedures may not be covered at all under the plan. The plan should clearly state what these are.
- What coverage limitations are you subject to? For example, some plans impose a waiting period before you can be covered for pre-existing conditions. Like exclusions, limitations should be spelled out in the plan.
- Does the plan fully or only partially cover the following expenses: surgery, hospitalization, routine medical exams, diagnostic procedures, visits to a specialist, maternity care, immunizations, rehabilitation, and home health care? You'll find that the level of coverage often varies in each of these areas.
- Does the plan impose a maximum benefit ceiling, and if so, what is it? This means that there is a lifetime cap on the benefits your insurer will pay out on your behalf.
- How much freedom do you have in choosing your own doctors and health-care providers? For example, can you go outside your plan's network? Do you need referrals to see specialists?

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Does the plan require you to get approval from the insurance company for coverage of certain types of care? For example, if you're terminally ill, certain types of experimental treatment may need to be approved by your insurer.

- Does the plan offer any extras as part of the standard coverage? Some items that may be of interest to you are vision care, dental care, prescription drug coverage, and mental health coverage.
- Does the plan offer family coverage, as many employer-sponsored plans do? This can be very important if you have a spouse and/or children in need of health coverage.
- What optional riders and endorsements are available? Adding these features can allow you to tailor a plan to your individual needs.

For the best results when comparing plans, you should balance coverage and features against cost. This will allow you to determine which plan gives you the best overall value for your money.

Compare insurance companies

It's also a good idea to compare the insurance companies behind the plans--your satisfaction with a company may mean a lot over the long run. Here are some questions that may help you weed out insurers:

- Does the insurer provide good customer service? You want to speak to a knowledgeable, polite customer service representative when you call your insurance company. Unfortunately, busy insurance companies may keep you on hold for a long time before you get through to a representative. Look for a company that has a toll-free number and longer-than-average customer service hours.
- How does the insurer pay claims? Will the provider bill the insurance company directly, or will you be expected to pay the provider and then file a claim with your insurer? It may not matter much in terms of cost, but it's a lot more complicated if you have to fill out forms or pay upfront every time you seek health care. Also, check with your doctor to find out which insurers generally pay claims on time.
- Is the insurer financially stable? Make sure that the insurer you choose is financially sound and will be able to pay its claims. You can get information on the financial stability of most insurers from your

state's insurance department or from a firm that rates insurance companies (e.g., A. M. Best, Weiss, Moody's).

- If you're comparing group plans, are your coworkers satisfied with the plan they've chosen? Do they have trouble getting their claims paid?

Lowering the Cost of Health Care

America's spending on health care is growing faster than the rest of the economy. What are the reasons for this, and what can you do to lower your health-care costs?

Why is the cost of health insurance rising?

The main reason for premium increases is the growing cost of health care itself. On average, 90 cents out of every premium dollar is paid back in benefit payments for health-care services. Several factors are contributing to the rise in health-care costs:

- Increase in the average age of the population
- New medical technology
- High administrative costs
- More government regulation
- Oversupply of health-care facilities
- Overuse and misuse of medical services
- Prescription price increases and their increased use
- Tougher medical provider negotiations with health plans
- Consumer demands for easier and broader access to care
- The medical needs and demands of 77 million baby boomers
- Investors putting pressure on insurance companies to be profitable

What can you do to lower the cost of health insurance? Obviously, there are areas you have no control over. But there are some things you can do.

Become an informed consumer

Group insurance is less expensive than individual health insurance. If you can't get group coverage from your employer, investigate buying insurance through another group such as a fraternal or professional association.

If individual coverage is the only alternative, look at different types of plans. For example, if you need insurance for just you and your spouse, individual policies may be less expensive than a family plan. Research the benefits and options. Find out which best suit you and your family. Don't buy more insurance than you need. Many on-line resources are available to help you purchase health insurance. However, an insurance agent or financial advisor may save you both time and money.

You may be able to save money by self-insuring against routine medical expenses (i.e., paying routine medical expenses out of pocket) and buying major medical insurance to cover only costly illnesses or emergencies. If your cash reserve is large enough to pay for minor medical expenses, you should consider choosing a higher deductible. For example, increasing your deductible from \$250 to \$500 could significantly lower your insurance premiums.

Other ways to reduce premiums

- Avoid purchasing single disease policies
- Avoid duplicating any coverage your spouse may have from his or her employer
- Ask how much you can save by paying premiums annually

After you determine what you need, compare at least three companies for the best deal. Remember that the lowest price does not necessarily mean the best plan. Ask questions such as:

- What is the plan's history of premium increases?
- How much notice is given before a premium increase?
- How are deductible and out-of-pocket costs figured?
- What are the co-payment levels, and when are they charged?
- What is excluded?
- How long is the free-look period?
- Is the insurance company financially healthy?

Avoid plans that exclude pre-existing conditions. You may end up paying for a policy that doesn't cover you. If you have no choice, try to get one that covers the condition within six months or less.

Try to get quality and accreditation reports on the plans you are considering. Quality reports contain consumer ratings that outline how satisfied consumers are with the doctors in their plan and how well a health-care organization prevents and treats illnesses. Accreditation reports give information on how accredited organizations meet national standards, and often include clinical performance measures. Most employer groups can provide this information. Talk to your plan's administrator or customer service department.

Don't lie

Be truthful on the insurance application. If you make a minor error, such as your month of birth, there shouldn't be a problem. However, if you fail to report that you are a smoker, benefits could be denied for smoker-related problems that you might later develop. Worse yet, your policy could be rescinded, leaving you with no coverage at all.

Control your out-of-pocket costs

Avoid unnecessary surgery. Ask questions. If it's not an emergency, find out if there are alternative treatments. It is your responsibility to make sure that you are covered for certain procedures. If you choose an elective surgery, make sure that your policy will cover it. Do the benefits include hospital and doctor's fees? Some plans pay only one or the other.

Does the plan pay a percentage of the actual costs, or does it pay based on a set fee schedule? A plan that pays 80 percent of a fee schedule instead of 80 percent of the actual costs can end up costing you more out of pocket. Ask your doctor if he or she will agree to accept the insurance company's set fee. And ask about home health care for your recovery. Home care would be less expensive than a nursing home or hospital stay, and you'd be able to recover in the more comfortable environment of your own home.

Take advantage of tax deductions

Medical expenses are generally deductible to the extent that they exceed 7.5 percent of your adjusted gross income. Deductible expenses can include:

- Insurance premiums
- Prescriptions
- Doctors and dentists
- Hospitals and clinics
- Lab and X-ray fees
- Glasses and contact lenses
- Transportation for medical reasons

Work to continually save money

- Live a healthy lifestyle. For example, a smoker who quits can usually receive a premium reduction.
- Ask your insurance company about other discounts.
- Take advantage of free health screenings at local clinics, hospitals, and health fairs.
- Avoid the overuse of antibiotics.
- Watch your co-payments and out-of-pocket expenses to make sure that you don't overpay.

Each year, check the coverage of your policy. Make sure that it's keeping up with the changing needs of you and your family. Check rates when your lifestyle changes, such as moving to a new part of the country or getting married. When your children go off to college, look into college health plans. Some are subsidized by tuition and might save you money.

Reducing the amount of care you require will pay off. You will save money in out-of-pocket costs, insurance premiums, and lost time from work. But the greatest payoff will be a longer and healthier life.

Buying Short-Term Health Insurance

Should you care about a temporary gap in your health insurance coverage, even if you and your family are healthy? If you really think about it, any lapse in your health insurance could be devastating. Accidents--a fall off the ladder, a trip down the stairs--occur every day. Hospitals are filled with people who never expected to be there, and medical expenses paid entirely out of pocket can drain your family's finances.

Who needs a short-term health insurance policy?

A gap in your health insurance can pop up for many reasons:

- You changed jobs, and your new insurance doesn't become effective immediately
- You would like an alternative to expensive COBRA benefits
- You're between jobs and don't know when you'll work next
- You just graduated from college and are no longer covered under your parents' plan or student policy
- You lost coverage because of a divorce
- You're a seasonal employee
- You're an early retiree who is not yet eligible for Medicare

• You're planning a trip overseas, and your current policy does not cover expenses outside the United States

How does a short-term health insurance policy work?

Coverage periods range from 1 to 6 months. When the coverage period ends, the insurance stops. Some companies will allow you to renew your policy for a total of 12 months. If you still need coverage after that, you will have to go through the application process again and take out a new policy. There may even be a waiting period, such as 6 months, before you can reapply. If you had any illnesses or injuries during your previous policy's period, those now become pre-existing conditions, and you may not be eligible for new coverage.

Benefits vary depending on the policy you purchase, but they usually include:

- Doctor visits
- Diagnostic tests
- Hospital charges
- Complications from a pregnancy (but not pregnancy itself)

These policies are intended to cover unexpected illnesses and accidents--they're not designed to meet your permanent health insurance needs. They will not pay for preventive care, such as routine physical exams and well-child care. Short-term health insurance policies are generally not for individuals with pre-existing conditions diagnosed or treated within the last five years.

If you have ever been denied health insurance, you probably won't be eligible for short-term insurance, because a denial indicates that you probably have health problems. Maternity costs are not covered, and most policies will not insure you if any of your dependents are pregnant, whether they are applying for coverage or not. Additional

strict eligibility requirements vary from insurer to insurer.

In many cases, coverage is issued within 24 hours because all you have to do is answer a few basic yes/no questions, and physical exams are usually not required.

How much does the insurance pay?

Deductibles generally range from \$200 to \$2,500. After you pay the deductible, the policy pays a coinsurance, such as 50 percent or 80 percent. Some policies pay the coinsurance on expenses up to \$5,000 or \$10,000, then pay 100 percent of covered expenses. For example, if you have a policy with a \$500 deductible, 80 percent co-payment for the first \$5,000, and 100 percent thereafter, your out-of-pocket expenses for a \$25,000 medical bill would be:

Deductible	\$500
20% of next \$5,000	\$1,000
Total	\$1,500

How much does it cost?

You can buy a policy for you and any dependents between the ages of 15 days and 65 years. Premiums vary depending on the coverage you select and your age.

When comparing policies, make sure that you understand your potential out-of-pocket costs. Some policies require you to pay the deductible each time you are treated for a new injury or illness. For other policies, the deductible applies to the life of the policy.

Ask for the policy's definition of covered expenses. Some policies base their coinsurance on what they consider usual and customary charges. These are amounts charged for the same service by doctors within your area as determined by the insurance company. If your doctor charges more, your out-of-pocket expenses could be higher than expected.

Other benefits to look for:

- Deductible and emergency room co-payment waived if you are in an accident
- Continuation of coverage if you are in a hospital on the last day of your policy's term
- Refund of unused premium
- Lifetime benefits of \$1 million or more
- Worldwide coverage if you are traveling out of the United States

To reduce costs, choose a policy with a higher deductible. Consider 50/50 coverage instead of 80/20. However, make sure that you can reasonably afford the higher out-of-pocket expenses without ruining your financial plans in the event of catastrophic claims. Ask about a discount if you pay the premium in a single payment rather than in monthly installments. Try to buy insurance for the term you need. But don't cut yourself short--remember, these are nonrenewable policies. If you have to reapply for a new policy, you might not be able to get it.

Getting Health Insurance When You're Hard to Insure

If you're older and/or in poor health, you're definitely somebody who should have health insurance coverage. Unfortunately, you don't, and you're having difficulty getting it. All of the insurance companies you've applied to refuse to offer you coverage because they see you as too great a risk. They may even classify you as totally uninsurable. The good news is that you're not without options.

Shop around

In reality, few people are totally uninsurable. More likely, you're one of the "hard to insure." The variety of health insurance sources in this country means that most people have at least one option available to them. Most states have an insurer of last resort (e.g., Blue Cross Blue Shield) that must accept all applicants. If you do some research and diligently shop around, you may find an insurance company that's willing to assume your risks and sell you an individual health policy. Of course, depending on your health and other factors, the company may require you to pay a higher-than-average premium or offer restricted coverage to cover its risk of loss. If so, you must weigh the cost of the insurance against the potential benefits.

One additional note: Hard-to-insure individuals may feel tempted to lie or withhold information on an insurance application in order to get the coverage they desire. No matter how badly you need health insurance, don't do this. Not only is it unethical and illegal, but your insurance company generally has the right to immediately terminate your policy (and sue you to recover any benefits paid) if it discovers that you've been dishonest.

A new, more insurable you

The two primary factors that an insurance company looks at in deciding whether to insure you (and at what cost) are your medical history and your present health, both physical and mental. Although there's nothing you can do to change your medical history, you can take steps to improve your present health. Exercising regularly, following a better diet, and reducing your stress level all promote a healthier lifestyle. These steps can also dramatically improve your general health over a relatively short time and make you less of a risk. Insurance companies may then find you more attractive as a candidate for health insurance.

In addition, an insurance company considers other factors in determining insurability, such as your age, gender, marital status, income, occupation, and personal habits. Some of these factors are within your power to change, and certain changes may increase your chances of getting health insurance at an affordable rate. You could, for example, give up smoking or drinking. If you work in a dangerous occupation, you might consider switching to a less hazardous line of work.

Work it out through work

If you have no health insurance but work for a company that offers employer-sponsored group coverage, consider participating in the plan. If your employer doesn't have a group health plan, you might even consider leaving your present job and going to work for a company that does.

Group health insurance generally provides extensive coverage and may cost you little or nothing, especially if your employer pays all or most of the premium. Moreover, this type of insurance is ideal for hard-to-insure people who have difficulty obtaining individual coverage. When you enroll in a group plan, you generally don't have to take medical exams, answer a lot of probing questions, and undergo the other screening processes that are typically required before you can get an individual policy. This is because your portion of the group premium isn't based on personal factors about you--it's based on the risk characteristics of the group as a whole (e.g., average age).

COBRA

If you terminate your service with an employer, any group health insurance coverage you were receiving through that employer generally ceases as well. This is true whether you leave the job voluntarily or involuntarily. You may also lose employer coverage due to a reduction in your work hours. These events don't necessarily mean, however, that you have to go without health insurance or start shopping for individual policies. The reason: You are eligible for benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA) if your former employer had more than 20 employees.

The medical coverage you receive through COBRA is identical to the coverage that you had under your employer's plan, but you must now pay the full premium out of your own pocket. This can be expensive, but if you're not in the greatest health, it's better than being uninsured or trying to get an individual policy. The key for hard-to-insure people is that you can elect COBRA coverage without having to undergo any individual screening to evaluate your risk. COBRA coverage typically lasts up to 18 months, although this may be extended to 36 months in some cases.

Government benefits

Another way to get health insurance coverage is through government benefits. The three main sources of such benefits are Medicare, Medicaid, and the Department of Veterans Affairs (VA), formerly known as the Veterans Administration. These programs can be an excellent way to receive health insurance at relatively low cost, but you must meet the eligibility requirements and sometimes fund certain medical expenses out of your own pocket. In addition, some of these programs are not comprehensive and may need to be supplemented with other health insurance.

Medicare is a federal program designed to provide reasonably priced health insurance for retirees, regardless of medical condition. You generally become eligible for Medicare at the same time you become eligible for full Social Security benefits (currently age 65). In addition, some disabled individuals and people with kidney disease are eligible for coverage. Medicare is broken down into two parts, A and B. The specific eligibility rules, benefits, and costs to you will vary between parts A and B. It's important to realize that Medicare may not be enough after you retire, but supplemental insurance policies known as Medigap policies, sold by private insurers, can help fill the holes in Medicare's coverage. If cost is a concern, you can also choose to participate in a Medicare managed care plan. These plans, called Medicare Advantage plans, are health maintenance organizations offered by private insurance companies. If your income is limited, your state may help pay Medicare costs such as your premiums and deductibles.

Medicaid is a joint federal and state program that provides medical benefits to individuals who can't afford medical care, including elderly, disabled, and blind individuals, as well as needy dependent children. Each state has its own Medicaid program, and specific eligibility requirements and benefits vary from one state to another. In addition, Medicaid benefits depend on whether you are considered medically needy or categorically needy. However, certain core benefits (including coverage for hospital bills, physician services, and long-term nursing home care) are shared by most Medicaid programs.

In general, all veterans who served in the U.S. military (except those who were dishonorably discharged) qualify for VA hospital and outpatient care. However, some veterans may not have full access to such care. For specific information on eligibility and the types of benefits available, contact your local VA office or visit the VA website.

Planning a Family? Get to Know Your Health Insurance Policy

Congratulations! You've decided to start a family. Up until now, your health insurance has probably been adequate, paying for routine doctor visits and prescription drugs. But now that you're facing a lifestyle change, you must make sure that your health insurance policy will keep up with those changing needs.

Check your coverage

Some policies insure only spouses and dependent children. So, if you and your partner aren't married, you'll want to check your policy carefully. If coverage is an issue, and you don't plan on getting married, consider whether purchasing an individual health insurance policy is an option.

Don't wait until you become pregnant to look for that policy, though. The insurance company will know that you have a condition that's going to require treatment and care. In a worst-case scenario, something happens (e.g., a difficult birth, or a premature baby), and the baby ends up in the neonatal unit. So, whenever you try to buy insurance for a condition that already exists, expect the cost to be high.

Changing jobs? Be careful

Be careful about changing jobs. Federal law bars pregnancy from being considered a pre-existing condition. If you change health plans while you're pregnant, your new insurer can't deny claims related to your pregnancy. However, there are some exceptions:

- If you had no insurance, became pregnant, then got a new job that offered group health coverage, your new health plan would not have to immediately cover your pregnancy. You might have to sit out a pre-existing condition waiting period--a time that could be longer than your pregnancy--and in the meantime pay for your own doctor visits.

The law applies only to group health plans. If you have individual insurance and are pregnant, and then buy group health insurance, there could be a pre-existing condition waiting period. Also, if you move from one individual health plan to another individual health plan, you might not have coverage during a waiting period.

When will the baby's coverage start?

Usually, your baby will be covered from the time of birth. Even if you and your partner are not married, either one of you should be able to add the baby to an existing plan.

Find out what you have to do to add your baby to your health insurance policy. Some plans require you to add your baby within the first 30 days following birth. Other plans will waive the additional premium for the first 31 days if you enroll within 31 days following birth.

If you're adopting an infant, and the birth mother has no insurance, you may have to pay for prenatal care and the costs of childbirth. If you're adopting an older child, make sure that you know when your insurance policy will begin coverage.

What is covered before your baby is born?

Will the plan pay for the first prenatal visit during the first trimester of pregnancy? Does the plan offer a prenatal program to assist you in having a full-term baby and avoiding a problem pregnancy? Some plans provide prenatal

education, health screening to determine risk, and case management services to encourage a healthy delivery. Are services for any medical condition that may complicate a pregnancy covered? If your physician leaves the insurance plan while you're pregnant, does the plan's continuity of care policies cover the remainder of the pregnancy with the noncontracted physician if you're already in the second or third trimester?

What is covered during and immediately after birth?

- Is precertification required prior to hospital admission? If so, make sure you take care of it, otherwise you might have a problem with claim payments.
- What length of hospital stay is covered? Do vaginal and cesarean deliveries have different time limits?
- Is the baby's stay in the nursery covered?
- Does the plan pay for administering anesthesia, obstetrical procedures, and any assisting required?
- If it is necessary for your baby to be hospitalized past the normal time period, will a separate deductible and coinsurance apply?
- Will the policy cover any complications from a premature birth?
- What if there's a difficult birth that lands your baby in an expensive neonatal unit?
- Does your plan provide care before the baby leaves the hospital, including routine tests, nursery service, doctor exams, and circumcision?

After you bring your baby home

How easy will it be to get emergency care under your plan's rules? Babies are susceptible to illnesses and injuries. You don't want to have to wait for prior approval or drive past two hospitals while rushing your sick newborn to an approved medical facility.

Will the plan pay for transportation costs to the nearest facility to treat any special conditions? If so, is there a maximum amount?

Does the policy have a maximum amount it will pay for well-child care? Well-child care usually includes physical examinations, laboratory tests, developmental assessment, immunizations, and guidance necessary to monitor the normal growth and development of your child. How many years will it pay?

What if your adopted baby is born with medical problems you didn't expect? Will the policy cover pre-existing conditions if you're adopting an older child? Does the plan offer home visits for new mothers?

Understand your out-of-pocket expenses

Many policies have a family deductible, which is the maximum amount that the family as a group must pay before the coverage begins. Instead of multiplying the individual deductible by the number of family members, the family deductible is often two or three times the individual deductible, regardless of how many family members are covered. The same is true of your coinsurance cap.

Review your co-payments. With a new baby, you will be making more trips to the doctor and buying more prescription medicines. It might be worthwhile to lower your deductible and co-payment. Your insurance premiums will be higher, but your benefits will be greater. Do a comparison to see what will work best for you.

Maximum lifetime benefits

Although no one can forecast how much you might need during a lifetime, \$1 million or higher is the minimum you should look for. This may seem like an outrageous sum, but keep in mind that expenses from birth complications for mother and child can reach this amount.

Read your policy carefully and make sure you have the coverage you need. If you have questions, meet with an insurance professional. Understand how your policy works--what's covered and what isn't.

Health Insurance and COBRA: Sometimes You Can Take It with You

If you're like most Americans, you count on your employer for health insurance coverage. But what would happen to your health insurance if you suddenly stopped working or no longer qualified for benefits? No one can predict the future. It's possible that your company could lay you off or reduce your hours to part-time, your spouse could die, or your marriage could end in divorce. If something unexpected happened, you could be left without health benefits. And remember, buying private health insurance on your own can be pretty costly, especially if you're out of work.

Fortunately, there's the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA can prove to be a real lifesaver for you and your family when your health coverage is jeopardized. You may also benefit from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which took some further steps toward health-care reform.

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) may help you continue your health insurance coverage for a time

COBRA is a federal law designed to protect employees and their dependents from losing health insurance coverage as a result of job loss or divorce. If you and your dependents are covered by an employer-sponsored health insurance plan, a provision of COBRA entitles you to continue coverage when you'd normally lose it. Most larger employers (20+ employees) are required to offer COBRA coverage.

As an employee, you're entitled to COBRA coverage only if your employment has been terminated or if your hours have been reduced. However, your dependents may be eligible for COBRA benefits if they're no longer entitled to employer-sponsored benefits because of divorce, death, or certain other events.

Unfortunately, you can't continue your health insurance coverage forever. You can continue your health insurance for 18 months under COBRA if your employment has been terminated or if your work hours have been reduced. If you're entitled to COBRA coverage for other qualifying reasons, you can continue your coverage for 36 months.

- **Divorce:** If your former spouse maintained family health coverage through work (and works for a company with at least 20 employees), you may continue this group coverage for up to 36 months after the divorce or legal separation. You'll have to pay for this coverage, though. Your cost of continuing coverage cannot exceed 102 percent of the employer's cost for the insurance. COBRA coverage will terminate sooner than 36 months if you remarry or obtain coverage under another group health plan.
- **Company goes out of business:** Unfortunately, you may be out of luck here. If your company goes out of business and no longer has a group health insurance policy in force, then COBRA coverage will not be available. (A possible exception involves union employees covered by a collective bargaining agreement.)

Keep in mind that, whatever your circumstances, you'll have to pay the premium yourself for COBRA coverage--your employer is not required to pay any part of it. However, if you're eligible for COBRA coverage and don't have any other health insurance, you should probably accept it. Even though you'll pay a lot more for coverage than you did as an employee, it's probably less than you'll pay for individual coverage. You won't be subject to any health screenings, tests, or other pre-existing medical condition requirements when converting to a COBRA contract. Your COBRA benefits and coverage will be identical to those provided to similarly enrolled individuals.

The American Recovery and Reinvestment Act of 2009 provides that, for involuntary terminations that occur on or after September 1, 2008 and before January 1, 2010, assistance-eligible individuals will only need to pay 35 percent of COBRA premiums for a period of up to nine months. The remaining 65 percent of COBRA premiums

will be subsidized. However, this premium subsidy may need to be repaid in some cases.

The Health Insurance Portability and Accountability Act of 1996 expanded COBRA

In 1996, HIPAA expanded certain COBRA provisions and created other health-care rights. In many ways, HIPAA took a significant step toward health-care reform in the United States. Some of its provisions may affect you. The major provisions of HIPAA:

- Allow workers to move from one employer to another without fear of losing group health insurance
- Require health insurance companies that serve small groups (2 to 50 employees) to accept every small employer that applies for coverage
- Increase the tax deductibility of medical insurance premiums for the self-employed
- Require health insurance plans to provide inpatient coverage for a mother and newborn infant for at least 48 hours after a normal birth or 96 hours after a cesarean section

For example, assume you're pregnant and covered by a group health insurance plan at work. You decide to take a job at another firm. Under HIPAA, pregnancy cannot be considered a pre-existing condition for a woman who's changing jobs if she was previously covered by a group health insurance plan. So if you had insurance at your old job, you can't be denied health insurance coverage at your new job simply because you're pregnant.

However, many companies require you to be employed for 30 days or more before you become eligible for coverage. If you are nearing the end of your pregnancy, and that requirement poses a problem for you, you may be eligible for coverage under COBRA through your former employer.

The American Recovery and Reinvestment Act of 2009 provides Cobra subsidy

ARRA provided a government subsidy of 65 percent of the cost of COBRA coverage for employees (and their eligible family members) who lost their health insurance coverage due to involuntary termination of employment in 2009. This subsidy was to last for up to nine months. The Department of Defense Appropriations Act, 2010 extends the subsidy to February 28, 2010.

Archer Medical Savings Accounts

Would you like to reduce your health insurance costs, save on taxes, and put away more money for retirement? If you meet certain rules, an Archer medical savings account (Archer MSA) may be just what you're looking for.

What is an Archer MSA?

An Archer MSA is a tax-exempt trust or custodial account set up with a financial institution such as a bank or an insurance company. Contributions you make to the account can be used to pay for health-care expenses not covered by your health insurance plan.

Note: The Archer MSA program expired on December 31, 2007. After this date, no new Archer MSAs can be established, but Archer MSAs established before this date can continue to be used and receive contributions.

Here are some of the benefits of using an Archer MSA:

- You can lower your insurance costs
- Your contributions and any earnings or interest on those contributions grow tax free until withdrawn, and like contributions, will be tax free when withdrawn if used to pay qualified medical expenses
-

You can deduct your contributions on the front of your federal income tax return, even if you don't itemize

Archer MSA must be coupled with a high-deductible health plan

Typically, an Archer MSA works in tandem with a high-deductible health plan (HDHP). An HDHP has a higher deductible than most health plans (e.g., \$2,000) and has a maximum limit on the amount you must pay for covered out-of-pocket expenses.

The premiums for an HDHP are generally 20 to 50 percent lower than for a low-deductible health plan. If you are self-employed, they are tax deductible.

An HDHP must meet certain IRS requirements in order to be used in conjunction with an Archer MSA. In 2010, an HDHP must have the following limits to qualify:

Type of coverage	Minimum annual deductible	Maximum annual deductible	Maximum annual out-of-pocket expense
Individual	\$2,000	\$3,000	\$4,050
Family	\$4,050	\$6,050	\$7,400

Making contributions to your Archer MSA

Tax-deductible contributions to an Archer MSA can be made by you or your employer, but not by both in the same year. You must be covered by an HDHP for the entire year to deduct the full amount. Employer contributions are nontaxable to you.

There are limits to the amount that can be contributed to your Archer MSA. The maximum is 75 percent of your annual health plan deductible if you have a family plan and 65 percent if you have an individual plan. For example, if you have a family plan with a \$4,800 deductible, you can contribute up to \$3,600 each year. If it is an individual plan with a \$2,400 deductible, the most you can contribute is \$1,560.

Any contributions over the maximum are not tax deductible, and you will have to pay a 6 percent excise tax on those amounts. The other limitation is that contributions cannot be more than you earned for the year.

Withdrawing money from your Archer MSA

You can withdraw funds from your Archer MSA to pay for unreimbursed medical expenses. Some trustees furnish checks for you to write yourself. Others will give you a debit card that provides instant access to your Archer MSA funds.

You and your trustee are required to report distributions. However, you will not have to pay income tax on this money as long as it was used for qualified medical expenses such as:

- Ambulance service
- COBRA continuation coverage
- Dental expenses
- Doctor's office visits
- Emergency treatment
- Health insurance premiums while unemployed
- Hospitalization
- Lab services
- Prescription drugs
- Vision care (including eyeglasses)
- Chiropractic and acupuncture
- Wellness and preventive programs

If any part of the distribution was used for nonqualified medical expenses, such as premiums for your HDHP or elective cosmetic surgery, you will have to pay income tax plus a 15 percent penalty tax on that amount. There is no penalty tax if you are disabled, are age 65 or older, or die during the year.

Archer MSAs are portable and will remain with you even if you change employers. Any money not used each year for medical expenses will continue to grow tax deferred in the account. The investment option you choose will affect the rate of return you receive. As with any investment, make sure you understand the risks before you sign up.

After age 65, you can withdraw money from your Archer MSA to add to your retirement income. The withdrawals will be taxable, similar to a traditional IRA.

Choosing between an Archer MSA and an HSA

If you currently have an Archer MSA, you may want to look into establishing a similar type of savings vehicle, called a health savings account (HSA). HSAs, created as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, expand upon the benefits offered by Archer MSAs. Funds from an Archer MSA can be rolled over to an HSA, making it simple for you to switch from one type of account to the other. But before you do so, make sure you understand the differences between the two, including the following:

- Any eligible individual under age 65 who is covered by a qualifying HDHP can establish an HSA; only a

self-employed individual or an employee of a small business covered by a qualifying HDHP could establish an Archer MSA.

- The minimum annual deductible that applies to an HDHP used in conjunction with an HSA is \$1,200 for an individual and \$2,400 for a family (in 2010), lower than the minimum annual deductible that applies to an HDHP used in conjunction with an Archer MSA.
- Both you and your employer (if any) can contribute to an HSA during the same year; an Archer MSA does not allow contributions from both individuals and employers during the same year.
- You can contribute more each year to an HSA than to an Archer MSA. Annual contributions to an HSA are limited to \$3,050 for an individual or \$6,150 for a family (in 2010).
- If you reach age 55 by the end of the tax year you can make catch-up contributions to your HSA up to \$1,000; no catch-up contributions can be made to an Archer MSA.

Coping with Medical Bills

A single procedure or trip to the hospital can fill your mailbox with stacks of bills. These can come from hospitals, doctors, pharmacies, emergency rooms, labs, and many others. The stress involved with handling all of this paperwork can be almost as overwhelming as the illness or injury itself. If your medical bills start to pile up faster than you can pay them, don't wait for a crisis to occur before doing something about it.

Get organized

Don't throw anything away. Keep all receipts, insurance forms, bills, and anything else that relates to your medical care. Organize your bills so you can keep track of them. One way is to make a file for each provider. Inside each file, organize the bills by date of service. If you don't receive itemized bills, request them. Go over each bill when you receive it because errors are common. A simple mistake, such as the wrong computer code, can cause you much grief. Here are some things to check:

- Is your personal and insurance information correct?
- Were you charged twice for the same service?
- Were you charged for something you refused or did not receive?
- Is there anything that seems unreasonably high or questionable?

Don't ignore the explanation of benefits form

This form comes from your insurance company. It shows the medical service provided, date provided, how much your plan will pay, and how much you will have to pay yourself. If you don't understand what you owe and why, call your insurance company or agent.

What if you think there's a mistake?

Medical bills and the billing process can be complicated. If you think your doctor or hospital has made an error, here's what you should do:

- Contact the appropriate billing office. Give it a reasonable amount of time to correct a mistake.
- Don't refuse to pay a bill because you think it should have been paid by your insurance company. Most likely, any agreement you made with a hospital or doctor holds you responsible for payment, even if your insurance company doesn't pay.
- Contact your insurance company to review the claim. Explain why you think the company's wrong. If the company needs to do something, find out when it will get done. If you have to do something, make sure you understand exactly what and when it must be done. Get the full name of the person you spoke to, and send a letter confirming your conversation.
- Request a written explanation of denial if you're still unsatisfied. To save your credit rating, pay the bill yourself, or negotiate a payment arrangement with the medical provider. Then use the insurance company's appeal process as soon as possible to collect your money.

Suppose you just can't pay

If you're having financial problems and can't pay your medical bills, it's better to work directly with your medical provider. Contact the provider before it contacts you. Perhaps you can work out a payment plan.

Try to keep the bill from being turned over to a collections agency. You don't want to damage your credit report. If the bill does go to a collections agency, understand that the agency is not interested in hearing that the insurance company made a mistake. Don't expect the collections agency to call your insurance company. And don't expect your insurance company to call the collections agency. If your claim is denied, you will have to keep working with your insurance company until it's settled. In the meantime, write to the collections agency and explain the situation.

Collections agencies get paid only for what they collect. And they can get very aggressive for their clients. However, they must abide by laws that prohibit harassment and unfair practices. For example, if you tell a collections agency that you don't want to be contacted at work, it must stop calling you there. You can try to negotiate with the collections agency. You might be able to work out a long-term payment plan. See if that will stop the agency from reporting negative information about you to the credit bureaus.

In the meantime, don't let your health insurance coverage lapse. You may have recovered from your illness or injury and think you would be better off using those premium dollars to pay your medical bills. But if something were to happen again, your financial problems will only get worse. Furthermore, if you drop your current insurance and apply later for a new policy, your recent illness could be considered a pre-existing condition, which would prevent you from getting coverage.

Look for other ways to save on your health insurance premiums. Talk to your insurance agent about increasing your deductible or co-payments. Do you have a child in college? See if the college has a low-cost health insurance plan that would enable you to take your child off your plan.

Finally, do you have any secondary insurance coverage? A secondary plan might pay medical bills not covered by your primary plan. Your spouse's group plan may give you some benefits. Or if Medicare is your primary insurance, you may have a secondary policy through a retirement plan, another group plan, or an individual plan.

What to do next time

After all of your medical bills are paid, think about what you can do differently to keep from getting overwhelmed again.

- Understand your health insurance policy's rules and benefits
- Keep a record of where you received medical care and who gave it to you
- Keep a date chart of hospitalizations, lab tests, X rays, treatments, medications, and doctor's visits
- If you ask for incidentals, like a toothbrush, slippers, or cot for a family member, understand that you will pay for them
- If you don't know why a procedure or test is being done, ask

Vision Care Insurance

One of the many things you can get insurance for is your eye care. Vision care insurance is relatively new and has become more common in recent years. Here's a crash course on the basics.

What is vision care insurance?

Vision care insurance is insurance that provides coverage for services relating to the care and treatment of the eyes. It typically covers services delivered by an optometrist or ophthalmologist. Depending on the specific plan, some or all of the following services may be covered:

- Yearly eye exams
- Glasses (with an annual limit)
- Contact lenses and fitting (with an annual limit)
- Glaucoma screening

Some vision plans may provide more extensive coverage (e.g., certain eye surgeries), while others may limit coverage to "reasonable and customary" charges incurred during routine eye exams. Reasonable and customary charges generally don't include the cost of glasses and contact lenses. With some employer-sponsored vision plans, coverage may be even more narrowly limited to the medical treatment of certain eye conditions. This is rare, however.

How much does it cost?

Vision care insurance is generally available for a small, nominal annual premium, often as little as \$50 a year. What's more, your out-of-pocket cost may be even less if your employer pays all or part of the premium (as many employers do).

How does it work?

Vision care insurance may provide direct payment to the eye care provider for the services you receive. Or, you may be required to cover the charges out of pocket at the time of service and then file a claim for reimbursement. It depends on the specific plan.

Where do you get it?

Almost everyone who has vision care insurance gets their coverage through work. Employer-sponsored vision care plans may be self-funded or self-administered plans. Vision care insurance may also be part of your employer's group health insurance plan, or one of several options you can choose under your employer's cafeteria benefit plan. Commonly, an employer will purchase a group vision care insurance plan through a health maintenance organization, insurance company, or other organization that offers such plans.

Individual vision care policies are not typically available because they're generally not cost effective from an insurer's standpoint. If you don't have access to vision care insurance through your employer, you may have a difficult time obtaining this kind of insurance through a private, stand-alone policy. Some individual health insurance policies may include vision care coverage, however, or allow you to add it for a slightly higher premium.

Who should have it?

Anyone who has access to employer-sponsored vision care insurance should take advantage of it, because the benefits outweigh the minimal cost. If you don't have coverage and have no vision problems, you should probably just go without vision care insurance and "pay as you go" for annual eye exams. However, if your vision expenses are relatively high (e.g., glasses, contacts) and you don't have employer coverage, you may want to look into other ways of obtaining vision care insurance.

Dental Insurance

Tired of paying out of pocket every time you go to the dentist? Concerned about the health of your teeth down the road? Dental insurance may be the answer you're looking for.

What is dental insurance?

Dental insurance is insurance that provides coverage for services relating to the care and treatment of your teeth and gums. Typically, it provides coverage for some or all of the following dental services:

- Diagnostic procedures
- Semiannual checkups (including cleanings) and periodic X rays
- Procedures that restore teeth
- Oral and maxillofacial surgery (teeth extraction and oral surgery)
- Periodontics (treatment of bone and gum diseases)
- Prosthodontics (fillings, dentures, bridges, and crowns)
- Orthodontics (repositioning of the teeth)
- Oral surgery
- Root canal therapy

What does it cost?

Dental insurance is typically inexpensive. The annual cost is often less than you spend eating at fast-food restaurants over the course of a year. If you have employer-sponsored dental insurance, the cost to you will be even less because your employer probably pays all or part of the premium.

How does it work?

Dental insurance may provide direct payment to the dentist for the dental care and treatment that you receive. Or, you may be required to cover your dental expenses out of pocket at the time of service and then file a claim for reimbursement. It depends on the specific plan. The dental plan may also have a list of preapproved dentists, like a health maintenance organization.

With group dental insurance, deductible and co-payment features usually come into play, though the deductible may not apply to routine cleaning and oral examinations. In addition, you may have to pay a separate coinsurance percentage for orthodontia and certain other procedures. Most plans also place a limit on the total amount of dental benefits that you can receive each year. Finally, if you've just enrolled in a dental plan, be aware that there may be a waiting period before your coverage kicks in.

Where do you get it?

Dental insurance has become more common in recent years. Of the roughly 55 percent of Americans who have dental insurance, most receive their coverage through their employer. Employer-sponsored dental insurance may take the form of a health insurance plan that includes dental coverage or a separate dental plan. It could also be benefit choices under a cafeteria plan. Health insurance plans are usually limited to routine cleaning and oral

examinations. Separate dental plans usually cover additional dental procedures but place restrictions on amount and price of dental benefits for specific dental treatments.

Unfortunately, if you don't have access to employer-sponsored coverage, you will have a difficult time finding dental insurance. Despite the variety of dental plans available, plans for individuals are rare. Typically, an individual plan will not cover any orthodontia (braces). And dental coverage is seldom found in individual health insurance policies, except maybe coverage for accidental dental injuries.

This doesn't mean that you're out of luck if you're looking for individual coverage, but it does mean that your options may be limited. In fact, one of the few types of plans that's readily available to individuals is what's known as a dental discount plan, which isn't even a true insurance policy.

Who should have dental insurance and who shouldn't?

If your employer offers dental insurance, you should probably enroll in the plan because the benefits usually outweigh the cost to you. If coverage is not available through your employer, you should weigh your options carefully.

As mentioned, individual dental insurance is usually inexpensive but difficult to find. And there's no reason to throw even a little money away on insurance that you don't really need. Why pay monthly premiums, deductibles, co-payments, and so on if you have healthy teeth and rarely go to the dentist except for a yearly cleaning? If this is your situation, it's generally more cost effective to pay as you go for your dental expenses (referred to as self-insuring).

On the other hand, buying your own dental insurance might be a good idea if you've had a history of dental problems and expect to have more, if you smoke (which can cause yellowing and/or decay), or if you're over 40 (age-related decay). If any of these describes you, consider seeking out individual dental coverage.

Prescription Plans

If your doctor has prescribed medication for you recently, you may be well aware of the rising costs of prescription drugs. These costs can eat up a large portion of your budget, especially if you develop an illness (like diabetes) that requires regular medication.

Fortunately, most health insurance plans have provisions for prescription drugs. But many of them don't go far enough to protect you when you become ill and need medications. Prescription drug plans are insurance policies that cover the costs of prescription medications. If your current health insurance policy provides insufficient prescription drug coverage or none at all, you may want to consider a prescription drug plan.

Traditional prescription drug plans

Traditionally, prescription drug plans were a benefit found in your health insurance policy, whether offered through an employer-sponsored group health insurance plan or through a private policy. The benefit typically reimbursed a percentage of your costs for certain prescription drugs after an annual deductible had been paid. This type of coverage had a number of flaws, including:

- Patients had to pay 100 percent of the deductible before any of their costs were covered
- Patients had to pay for prescriptions out of pocket, then wait weeks or even months for reimbursement
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Patients still had to pay as much as 20 to 50 percent of their prescription costs, even after the deductible was met

- Many drugs, such as contraceptive prescriptions, were not covered at all
- Patients had to cope with cumbersome paperwork to submit claims
- The system was unmanaged and led to rising health-care costs

The insurance industry responded by developing a more managed approach to prescription drug plans that would minimize costs while satisfying consumers.

Managed prescription drug plans

In response to the needs of consumers and rising health-care costs, the insurance industry instituted many management controls, including:

- Computerized claims processing
- Use of prescription drug card programs
- Networks of prescription drug providers
- Mail prescription programs
- Cost-control methods through the use of generic drugs
- Education of doctors and patients about health care
- Computerized drug-use control and reporting

As a result of these changes, more prescription drug plans have moved to the use of a co-payment system where

the patient pays a fixed fee for each prescription filled (e.g., \$10), has no deductible, and handles no claim forms (claims are submitted electronically at the point of sale).

To decrease the cost of drugs, many health plans implemented a formulary, which is a list of preferred drugs that the plan has decided are the most effective and least costly pharmaceuticals to treat specific conditions. If your physician orders a nonformulary drug, there is usually a medical review process to determine if there is a comparable drug on the plan's formulary. If your physician agrees to the change, a generic or less expensive drug in the same class may be substituted.

Another result is that patient information (including details regarding potential drug interactions) is readily available through a computer database to pharmacists who are networked. There are some tradeoffs to this system, such as the inability of some patients to obtain more than a 30-day supply of a medication or take a high-priced brand-name drug. But overall, the managed approach to prescription drug plans has been effective.

Prescription drug plan as a separate insurance policy

To many, the term prescription drug plan refers to the coverage provided by your typical health maintenance organization or other health-care plan. But a prescription drug plan can also be a completely separate and distinct insurance policy. You might purchase such a plan if you had no prescription drug coverage at all, or if you wanted to supplement your current health-care plan. You might seek an individual prescription drug plan, or in some cases, your employer might offer a separate prescription drug plan. Here are some advantages of these plans:

- Prescription drug card programs are easy for employees to use
- Employees may get no benefit from their primary health plan if they never reach the deductible
- Processing claims is easier for the insurer, making coverage less expensive for enrollees
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Prescription drug plans may cover certain types of drugs not covered under the employer's primary health plan

It's important to understand what your health insurance plan covers. You can then decide whether you need a separate prescription drug plan to supplement your coverage.

Health Insurance for Travelers

You were having a great time on your vacation--until your toddler woke up from her nap with a fever. If you were at home, you'd take her to the pediatrician right away and rely on your health insurance to pay for her care. But what do you do now that you are miles away? Here are some things you need to know about health insurance while traveling.

Will your health maintenance organization make it across the country?

Your individual or group health insurance policy typically covers you and your family if you are traveling within the United States. Still, it's a good idea to check with your insurance company before you go. Make sure that you fully understand the coverage conditions, especially if you belong to a health maintenance organization (HMO) or preferred provider organization (PPO).

HMO members are generally required to obtain all treatment from HMO physicians, except in emergency situations occurring outside the HMO's treatment area (a strict definition of what constitutes an emergency may apply). Although PPO members are not required to seek care from PPO physicians, you'll have to pay more for care if you receive it from a non-PPO physician.

Some cards are not accepted everywhere

If you are traveling overseas, beware: Your individual or group health insurance may not cover you at all. Even if your policy does cover you, it may not provide the same benefits overseas as it does in the United States. For instance, some policies will cover only emergency medical care, while others will reimburse you or the medical provider for only a percentage of the total cost of treatment. Some policies will cover personal travel but not business travel, while others cover you only if you stay overseas for a short period of time (e.g., one to six months). Check the limitations of your policy carefully, and call your insurer's customer service or claims department to find out whether you're covered, and if so, which limitations apply.

Note: If you or your traveling companion is a Medicare recipient, you should be aware that Medicare does not provide coverage for medical treatment overseas.

Adequate health insurance--don't leave the United States without it

If your health insurance won't cover your family while traveling, consider purchasing a short-term supplemental health insurance policy from an insurance company, travel agent, tour operator, or cruise line. These policies typically include accident and/or sickness coverage. What's more, they're often combined with medical evacuation coverage, which pays all or part of the cost of medical evacuation back to the United States if you're traveling overseas (something that most basic health insurance policies won't cover). Policies usually offer a choice of deductibles and may be tailored to suit your needs. You can purchase these policies separately or as part of a travel insurance package that includes other types of travel insurance (e.g., trip cancellation, baggage protection).

Coverage, terms, and costs of supplemental health insurance vary widely, but it's relatively inexpensive because the coverage is limited. Before purchasing it, ask to see a copy of the policy and get the answers to the following questions:

- Does the plan pay the cost of medical care needed for sickness, accidents, or both?
- What procedures must you follow to see a doctor or go to the hospital?
- Will you have to get approval before you receive care?
- Does the policy pay medical providers directly, or will you have to pay and wait to be reimbursed?

- What are the deductible, co-payment, and/or coinsurance costs?
- What exclusions and restrictions apply?
- What is the maximum amount of coverage under the policy?
- Are translator services available?

Travel tips

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If you are traveling for an extended period of time, schedule checkups for all family members before you go

- Carry your insurance card with you--it usually has a phone number you can call to check on health-care providers, and you may need to show it before receiving health care
- If you belong to an HMO or PPO, bring a list of network physicians and hospitals in the area to which you are traveling
- Pack an adequate supply of prescription drugs in your carry-on luggage
- If you are traveling overseas, find out how you can refill prescriptions while you're there, and take prescription drugs in their original containers to avoid trouble at customs

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If you are traveling to a country where English is not widely spoken, have your physician's instructions translated, especially if you or a family member has a serious medical condition--this will help avoid treatment mix-ups

- Consider purchasing trip cancellation/interruption insurance that will reimburse you for any nonrefundable deposits you pay in case you can't go or must leave early--check policy exclusions first (some policies won't cover pre-existing health conditions)

Coping with Rising Prescription Costs

Why are prescription drug costs increasing more rapidly than other health-care expenses? Drug companies are spending more on research and development, and passing those costs along to consumers and insurance companies. Consumer demand for newer and costlier drugs is rising, and physicians are writing more and more prescriptions.

Insurance companies, state and federal governments, and health-care professionals are working to find a long-term solution. But until that happens, here are some ways you can reduce your prescription drug costs.

Eight ways to cope with rising prescription costs

- Talk to your doctor about the medications you are taking. Are there less expensive alternatives? Sometimes, generic drugs work just as well as their name-brand counterparts and older, less expensive drugs may have the same benefits as newer, more expensive ones.
- Make sure you understand your benefits if you have prescription drug coverage. What co-payment or coinsurance costs apply? Are any drugs specifically excluded from the plan? Becoming familiar with your prescription coverage will help you identify money-saving opportunities.
- Join a prescription drug discount program if your health insurance does not offer prescription drug coverage. In return for a low annual fee, you may be able to save a certain amount on each prescription purchase at participating pharmacies.
- Shop around. Prescription drug prices vary among pharmacies. Some pharmacies may even be willing to match a competitor's price if you ask.
- Order prescriptions through the mail if you routinely take certain medications. Often you can receive a long-term supply (e.g., a 90 day-supply) for the same co-payment that applies to a short-term supply (e.g., a 30-day supply). Ask your doctor for approval first, though.
- Look for coupons or special offers from pharmaceutical manufacturers. Check magazines, newspapers, and websites, to find them, or ask your doctor or pharmacist.
- Consider enrolling in a Medicare prescription drug plan once you become eligible for Medicare, or enroll in a Medicare Advantage plan that offers prescription drug coverage.
- Find out if there are programs in your state that can help you pay for prescription drugs. These may be available to disabled individuals, seniors or others with limited income and assets. Drug companies may also offer free or low-cost drugs to eligible individuals. Extra help with Medicare drug plan costs is also available to seniors who have limited income and assets.

Finally, never reduce your dosage or stop refilling your prescription to save money. Instead, ask your doctor about ways you can cut prescription costs without sacrificing your health.

Mental Health Benefits

When you think of health insurance, you probably think of coverage for prescription drugs, visits to the doctor, hospital stays, surgery expenses, and the like. But your overall health also includes your mental health, so don't overlook benefits that can help your outlook. Depending on the type of health insurance plan you have, coverage for mental health expenses may or may not be included. Review your policy with an eye for the following.

What are mental health expenses?

Depression, anxiety, and other mental disorders affect countless Americans. So do substance abuse problems. Treatment for these problems may include consultations with doctors, private counseling, group therapy, prescription medications, hospital stays, outpatient programs, alternative living arrangements, and other expenses.

Read your health insurance policy to determine whether mental health benefits are provided

Whether you have a private health insurance plan or participate in a group health plan at work, you'll need to read your policy carefully to find out what is and isn't covered. If your policy provides coverage for mental health care, consider the extent of that care. What types of benefits are provided? What do you have to do to get benefits, and how do you appeal decisions you don't agree with? There could be a different set of procedures for mental health care than for other forms of medical treatment in your plan. You should also pay close attention to treatments that are excluded from coverage and any limitations (e.g., hospitalization coverage for a maximum of 14 days).

Pay close attention to the types of mental health care providers and the approval process

Find out which mental health professionals are covered by your plan. Are social workers, clinical psychologists, and psychiatrists included? What if you choose a licensed professional not covered by the plan? Some plans will deny coverage if you go outside their network of providers.

You should also determine who'll make the decision regarding the type of treatment you'll need. You may need to speak with your primary care physician (PCP) or call a toll-free number to explain your situation. Must you get approval before seeing a mental health specialist? Find out how long it takes to receive approval for treatments, and whether your mental health care provider will have to request approval for subsequent treatments.

Continuity and coordination of your behavioral health and medical care are important, so it is to your advantage to include your PCP in your treatment for mental health issues. If your policy does not use the same network of providers for mental health and medical care, make sure that your physicians share information in order to carefully monitor medication usage.

In addition, look to your policy to determine how your privacy will be protected. For example, if your medical information is transmitted, stored, or used for any purpose as data, will anything that identifies you be removed to protect your privacy? Will the information be transferred to others or sold? If your policy is unclear or fails to address important issues, ask your insurance agent.

Group health insurance plans and mental health

Group health insurance plans are usually not required to include mental health coverage. However, some states do have laws that mandate this type of coverage. If your plan provides this type of coverage, federal law prevents the plan from placing annual or lifetime dollar limits on mental health benefits that are lower than the limits for medical and surgical benefits. For example, if your health plan has a \$1 million lifetime limit on medical and

surgical benefits, it cannot put a \$100,000 lifetime limit on mental health benefits. (This law does not apply to individual health insurance plans or to groups with fewer than 50 employees.) Some states have their own additional requirements.

Group health plans may put other restrictions on mental health benefits and still comply with the law. For instance, mental health benefits can have higher co-payments or a lower number of allowed treatments, as compared to medical and surgical benefits.

What to do if you need help

If you're concerned that you're suffering from a mental disorder, be aware that physical conditions may be causing your symptoms. Behavioral disorders can have a medical basis or implications for your physical health. Your PCP can help determine if your symptoms are related to a medical cause. Medically related causes for mental or behavioral disorders will be covered under your medical care policy.

Follow your policy's guidelines to get help. If your policy does not cover mental health benefits, check with your state department of public health for any publicly funded programs where you may be able to receive services for substance abuse or mental health. Also, many employers provide on-site counseling or reimburse external agencies to provide the service for their employees under their employee assistance program.

Many states require insurance carriers to provide mental health benefits, so find out if your state mandates behavioral health and substance abuse benefits. Be sure to take notes and get the full names of anyone you speak to at your insurance company. If you don't follow the insurance company's rules, you could have to pay for the appointment yourself.

Alternative Therapies

An increasing number of Americans are choosing alternative methods for health improvement and medical treatment. Why has there been so much interest in alternative therapies lately? Is this something you should consider?

What are alternative therapies?

Alternative therapies are diagnostic methods and treatments that don't usually conform to standard medical practice. Nor are they generally taught at accredited medical schools. The philosophy of many alternative therapies is to treat the source of the problem, not just the symptoms. The goal is to achieve a sense of well-being in the relationship between the mind and the body, even in the face of disease. What separates alternative therapies from conventional medicine is the belief that achieving and maintaining health is different from fighting disease.

Why the interest in alternative therapies?

Many alternative therapy users believe that traditional doctors fail to understand and practice preventive medicine. They also feel that these doctors do not communicate with patients and are too dependent on expensive tests. This lack of interaction that ignores the human side of medicine has increased the interest in alternative therapies. Other reasons include:

- The public's increased disaffection with traditional care
- A belief that managed care means less care
- People want to feel in control of their bodies
- People are seeking ways to relieve the symptoms and side effects of conventional treatments

What medical conditions have been treated with alternative therapies?

Alternative therapies have been used on patients with a wide range of conditions and disorders, such as:

- Allergies
- Anxiety
- Arthritis
- Back pain
- Cancer
- Depression
- Fatigue
- Headaches
- High blood pressure
- Insomnia

- Neck problems

What are the different types of alternative therapies?

Many therapies are well known, others are exotic and mysterious, and some are dangerous. A partial list includes:

- Acupuncture
- Chiropractic
- Diet/nutrition
- Energy healing
- Folk therapies
- Herbal remedies
- Homeopathy
- Manual healing methods
- Naturopathy
- Osteopathy

Do they work?

Many people claim they've been cured of colds, headaches, fever, asthma, or more serious illnesses as a result of alternative therapies. However, some conventional medical doctors say that these results are similar to experiments in which patients felt better after taking sugar pills. In addition, medical journals have reported studies on alternative therapies that describe their benefits, but most of these studies have been questioned by scientists for flaws in research methods.

Despite conflicting claims, the belief in alternative therapies is increasing. In fact, some hospitals and insurance companies are using alternative therapy doctors as primary care physicians.

How should you select a practitioner?

Look into the background, qualifications, and competence of any health-care practitioner you might use. There are various national organizations for alternative therapies that are probably familiar with your state's licensing and certification requirements. These organizations might even offer referrals and information about particular practitioners. But beware--they don't function as regulatory authorities.

Talk with other health practitioners and patients who have had experience with the practitioner you're considering. Find out if there have ever been any complaints. The main point to consider is whether the practitioner follows regulated standards for medical safety and care.

Meet the practitioner in person. Look at the conditions of the office or clinic. Ask about education, additional training, licenses, and certifications. What is the practitioner's approach to treatment and patients? Find out how the practitioner will communicate with you about technical aspects of the therapy, possible side effects, and potential problems. Ask how willing the practitioner is to cooperate with other branches of medical science, including referring patients to other practitioners for diagnosis or treatment when needed. Finally, look for a practitioner who is easy to talk to--you should feel comfortable asking questions.

Should you try alternative therapy?

Here are some questions to ask your practitioner:

- Is the therapy safe?
- Are the benefits greater than the risks?
- How does my medical situation compare with other patients who have used the same therapy?
- Is there any new research on the safety and effectiveness of the therapy?
- What are the side effects, expected results, and length of treatment?

Make sure to tell your practitioner about any alternative or conventional treatments you're receiving. This information may be used to consider the safety and effectiveness of your entire treatment plan. Also, talk with people who had similar medical conditions and received the same therapy you're considering. Try to find people who had success with the therapy as well as those who didn't.

Who pays?

Many alternative therapies are not reimbursed by health insurance, so ask your insurance company. You may have to pay out of pocket. To get a better idea of the costs, find out what other practitioners charge. Regulatory agencies and professional organizations also may provide this information.

What precautions to take

The use of herbal treatments has flourished. But be aware that mixing herbal supplements, especially with prescription medications, can spell trouble for you—even if the label says "all natural." Many herbs interact with drugs in ways that can increase or reduce their effectiveness.

Proper health-care management requires that your practitioner coordinate all conventional and alternative therapies to have a complete picture of your treatment plan. Discuss all issues about treatments and therapies with your practitioner:

- Tell your doctor and pharmacist about the vitamins, minerals, and herbal supplements you take
- Use one pharmacy to fill your prescriptions so all of your medications can be monitored
- Tell your doctor about your diet—it can change the way herbs and drugs work
- Ask about the hazards that might result from postponing or stopping conventional medical treatment

As an informed consumer, you should continue gathering information, even after you've selected a practitioner and an alternative therapy treatment.

Health Insurance for College Students

As your child prepares to head off to college, probably the last thing on his or her mind (and yours) is health insurance. But getting sick or injured away from home can be an unpleasant experience--more so if your child doesn't know his or her health-care options. You'll want to make sure that your child's health insurance is in place before you pack up the car. There are basically two ways to insure your child's health while at college: your family health plan or a health plan provided through the college.

Your family health plan

Most family health plans will cover your child until 20 to 24 years of age as a full-time student who's still dependent on you, regardless of whether he or she lives at home. If you have a traditional indemnity plan (i.e., one that provides coverage no matter which doctor you choose), then your child should be able to see any doctor near campus, and your insurer should cover a certain percentage of the expenses as set forth in your plan. The situation is more complicated when you have a health maintenance organization (HMO) plan and your child's college is not nearby. In this case, your child may need to schedule appointments with his or her primary care doctor during school breaks and other visits home. But it may be difficult or impossible for your child to visit his or her primary care doctor in an urgent situation.

If your child isn't covered under your family health plan because he or she no longer fits the definition of a dependent child, your child may be eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). This is an individual plan that's based on the benefits in your group plan. Under COBRA, your child will be eligible for coverage up to 36 months.

The college health plan

The other option is for you to purchase health insurance coverage through your child's college. Many colleges offer low-cost health plans for students that may even be less expensive than continuing coverage through your existing family plan. These health plans, though not as comprehensive as some policies, are usually enough to get by on, even if your child becomes seriously ill or has a major accident. The reason that these plans are less expensive than your own plan is the cap they place on total benefits paid (e.g., \$250,000). Make sure that you know what the maximum benefit is and that you're comfortable having coverage up to that limit.

The cost and level of coverage of college health plans can vary greatly from one school to the next. Plans are usually designed specifically for each individual college, and the health services available on campus and in the community often determine what coverage the college can offer. State laws may also play a significant role in the cost and level of coverage.

Questions for your college health plan

Because college health plans can vary widely in their coverage, you'll want to consider the following questions before you sign your child up:

- Is the plan an HMO, or can your child use any health provider?
- What services are offered free or at low cost in the campus health center?
- Is the campus health center open 24 hours? How is it staffed?
- Are emergency-room visits covered in all situations or only in specific situations?
- Does the plan cover your child when he or she is on vacation (e.g., spring break)?
- Does the plan cover your child during the summer?

- Are hospitals in the college area accessible and utilized?
- Does the plan include mental health treatment?
- What pre-existing conditions are excluded?
- Are there deductibles and coinsurance to be paid?
- What is the maximum benefit amount?

Health Insurance and Divorce

How will a divorce affect your health insurance coverage? During marriage, it's common for one spouse to maintain health coverage for the entire family through his or her group health insurance plan at work. After a divorce, coverage for the other spouse and the children could terminate. State and federal laws offer protection to families in danger of losing health-care coverage, especially to children. But it's important to re-examine your family's health insurance situation before a divorce occurs to avoid serious complications afterward.

Health insurance coverage can be included in a divorce settlement

Because health coverage is such an important benefit, some divorce decrees stipulate that a spouse who provided health coverage for the other spouse or family during the marriage must continue to provide such coverage following a divorce. This is especially true if the other spouse didn't work outside the home and has no immediate access to health insurance. Neither an insurer nor an employer can deny such court-ordered coverage when children are involved.

If you're the spouse who carries the health coverage, you may have to pay additional premiums to continue coverage for your ex-spouse and your children, depending on the policy provisions. Some group policies will routinely allow you to continue full coverage for your family even after your divorce. Of course, this may change if you later remarry and want to include your new family on your policy. In any case, the premium for a group family plan may be less expensive than single coverage for two adults.

If your family has individual health insurance

If the issue of health insurance is not included in your divorce settlement, you'll need to do some scrambling around if your ex-spouse is the insured on the family's individual health insurance policy. It's very possible that the coverage provided to you and your children could be terminated. Talk to your insurance agent to determine if you're still covered, and for how long. If you're still included in the policy, find out how much the premiums will be over the next 6 to 12 months. Also, begin looking into new health insurance for you and your children.

Secure health coverage for your children

Hopefully, you and your former spouse can work out an agreement regarding health coverage for your children. The child support section of the divorce agreement assigns responsibility for providing the children's health insurance. But if the noncustodial parent or that parent's insurance company or employer refuses to cooperate, federal law provides for a court order that secures your children's continued health insurance coverage. This court order, known as a Qualified Medical Child Support Order (QMCSO), stipulates that custodial parents have the right to obtain health insurance coverage for their children through the noncustodial parent's group health plan, if the noncustodial parent has such coverage. The children can't be denied access to the plan, although limitations can be placed on the coverage. The order will not require the plan to provide additional benefits not actually offered in the plan.

The QMCSO can require that policy premiums be deducted directly out of the employee's paycheck. Reimbursements for medical care are made directly to the custodial (nonemployee) parent, when that parent pays a provider. Also, the noncustodial parent can't choose a medical plan that is unsuitable for the children. If you're the custodial parent, get copies of your ex-spouse's medical plan, medical claims and election forms, the summary plan description outlining your former spouse's employee benefits, and the page designating the current insureds of the health plan.

Temporary coverage through your former spouse's employer

Temporary protection may be available through the Consolidated Omnibus Budget Reconciliation Act (COBRA). This federal law was designed to protect employees and their dependents at companies with 20 or more workers

from losing group insurance coverage as a result of job loss or divorce.

If your former spouse maintained family health coverage through work, you may (at your own expense) continue this group coverage for up to 36 months after the divorce or legal separation. Your cost of continuing COBRA coverage can't exceed 102 percent of the cost to the plan for providing identical benefits to an active participant. Be aware that you have the right to pay the premiums in monthly installments. Also, you must pay premiums on time or you'll lose your coverage. COBRA coverage will terminate sooner than 36 months if you remarry or obtain coverage under another group health plan. Certain governmental plans and church-sponsored plans are exempt from the act.

Several states have enacted their own laws that preserve a spouse's eligibility for health insurance after a separation or divorce. Some of these laws may provide you with rights more generous than those offered under COBRA, so check your state's laws first. Ask your divorce attorney or contact your state insurance commissioner's office.

Also, if you're over a certain age, it may be wise to purchase individual health insurance or to make sure your working former spouse maintains health coverage as part of the divorce settlement. Otherwise, when COBRA coverage terminates after 36 months, you may find that poor health in your later years presents an insurability problem or that the cost of coverage is exorbitant. In addition, the Health Insurance Portability and Accountability Act of 1996 may provide certain protection regarding pre-existing conditions.

Health Insurance in Retirement

At any age, health care is a priority. When you retire, however, you will probably focus more on health care than ever before. Staying healthy is your goal, and this can mean more visits to the doctor for preventive tests and routine checkups. There's also a chance that your health will decline as you grow older, increasing your need for costly prescription drugs or medical treatments. That's why having health insurance is extremely important.

Retirement--your changing health insurance needs

If you are 65 or older when you retire, your worries may lessen when it comes to paying for health care--you are most likely eligible for certain health benefits from Medicare, a federal health insurance program, upon your 65th birthday. But if you retire before age 65, you'll need some way to pay for your health care until Medicare kicks in. Generous employers may offer extensive health insurance coverage to their retiring employees, but this is the exception rather than the rule. If your employer doesn't extend health benefits to you, you may need to buy a private health insurance policy (which will be costly) or extend your employer-sponsored coverage through COBRA.

But remember, Medicare won't pay for long-term care if you ever need it. You'll need to pay for that out of pocket or rely on benefits from long-term care insurance (LTCI) or, if your assets and/or income are low enough to allow you to qualify, Medicaid.

More about Medicare

As mentioned, most Americans automatically become entitled to Medicare when they turn 65. In fact, if you're already receiving Social Security benefits, you won't even have to apply--you'll be automatically enrolled in Medicare. However, you will have to decide whether you need only Part A coverage (which is premium-free for most retirees) or if you want to also purchase Part B coverage. Part A, commonly referred to as the hospital insurance portion of Medicare, can help pay for your home health care, hospice care, and inpatient hospital care. Part B helps cover other medical care such as physician care, laboratory tests, and physical therapy. You may also choose to enroll in a managed care plan or private fee-for-service plan under Medicare Part C (Medicare Advantage) if you want to pay fewer out-of-pocket health-care costs. If you don't already have adequate prescription drug coverage, you should also consider joining a Medicare prescription drug plan offered in your area by a private company or insurer that has been approved by Medicare.

Unfortunately, Medicare won't cover all of your health-care expenses. For some types of care, you'll have to satisfy a deductible and make co-payments. That's why many retirees purchase a Medigap policy.

What is Medigap?

Unless you can afford to pay for the things that Medicare doesn't cover, including the annual co-payments and deductibles that apply to certain types of care, you may want to buy some type of Medigap policy when you sign up for Medicare Part B. There are 10 standard Medigap policies available. Each of these policies offers certain basic core benefits, and all but the most basic policy (Plan A) offer various combinations of additional benefits designed to cover what Medicare does not. Although not all Medigap plans are available in every state, you should be able to find a plan that best meets your needs and your budget.

When you first enroll in Medicare Part B at age 65 or older, you have a six-month Medigap open enrollment period. During that time, you have a right to buy the Medigap policy of your choice from a private insurance company, regardless of any health problems you may have. The company cannot refuse you a policy or charge you more than other open enrollment applicants.

Thinking about the future--long-term care insurance and Medicaid

The possibility of a prolonged stay in a nursing home weighs heavily on the minds of many older Americans and their families. That's hardly surprising, especially considering the high cost of long-term care.

Many people in their 50s and 60s look into purchasing LTCI. A good LTCI policy can cover the cost of care in a nursing home, an assisted-living facility, or even your own home. But if you're interested, don't wait too long to buy it--you'll need to be in good health. In addition, the older you are, the higher the premium you'll pay.

You may also be able to rely on Medicaid to pay for long-term care if your assets and/or income are low enough to allow you to qualify. But check first with a financial professional or an attorney experienced in Medicaid planning. The rules surrounding this issue are numerous and complicated and can affect you, your spouse, and your beneficiaries and/or heirs.



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