Family Health Insurance Guide

A PRACTICAL GUIDE TO FINDING AFFORDABLE HEALTH INSURANCE FOR YOUR FAMILY. BROUGHT TO YOU BY HEALTH INSURANCE FINDERS.

One of the most important decisions you will make for your family involves providing them with adequate health insurance.

Families that have proper health insurance are more likely to receive preventive medical care resulting in early diagnosis and treatment of illnesses before they become serious. Family health insurance also provides a family with financial security in the event of an unexpected illness or injury.

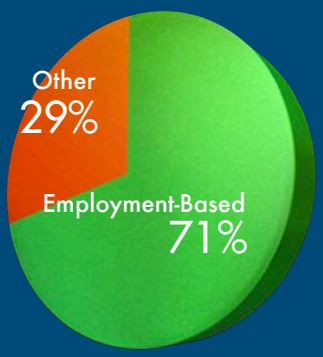
How This Guide Will Help

In this guide, you will find tons of useful tips and advice on how to shop for and find the best health insurance coverage to meet the specific needs of your family. We will address the many options available to you, including individual/family health insurance, group health insurance, separate child health insurance and state-sponsored programs that are available for low to middle income families. We will also address how to compare the many different types of health insurance, which will help you decide on the coverage that is best for your budget and specific health care needs. This guide will also provide tips of how to obtain multiple quotes from various insurance companies and agents, and how to best handle the hard-sell tactics that many people encounter when shopping for health insurance. And finally, you will find suggestions on how to best utilize your family health insurance once you have acquired coverage.

Inside:

In This Section:

Employment-Based Coverage as a Percentage of Insured Americans



No. of Insured Americans: 249.8 million
Source: U.S. Census Bureau 2006 statistics

Family Health Insurance Through Your Employer

Many people have the option of enrolling in the health insurance policy offered through their employer. This is referred to as a group health plan and is usually made available to all employees that work at least 30 hours per week for that company. Most group health plans provide the employee with the option of adding family members to their policy. Under such an employer-sponsored plan, each family member is considered a *dependent* of the employee. Insurance companies provide rate combinations for dependent coverage that are based on which family members are to be added to the policy. These rates are provided to the employer, who then informs the employee of the possible rate combinations, which include employee only, employee and spouse, employee and child, employee and children, and employee and family. The *employee and children* and *employee and family* classifications do not typically place a limit on the number of children. Under this rating system, the rates are based on having two children, so families with more children will pay less per child for their health insurance than a family with only two children.

Your employer will often give you several plan options to choose from, along with the rates and dependent options for each of those plans in the form of a premium chart. Along with the plan options and premium charts, you will be provided with the percentage or amount that will be paid by your employer and the amount or percentage that you will need to contribute. If possible, ask your employer or the insurance company to break this down for each family member you are considering adding as a dependent on your group health plan. This will make it easier for you to compare this option with others you are considering.

If you are fortunate enough to work for a company that pays 100% of your family health insurance, deciding which of your family members to include on your group health coverage will be simple. However, this is not usually the case and is even becoming less and less common as health insurance rates continue to increase. In most cases, an employer will pay the premium for the employee, but the employee may be required to pay the entire premium for any family member they wish to add to the policy. There are laws that require *employer contribution* toward the employee's health insurance premium, but these laws do not include dependent family members. An employer willing to make a contribution toward the premium of any of your dependents is doing so as an incentive and added benefit to your employment with that company.

Enrollment Guidelines & Open Enrollment

You must decide which family members to add to your group health plan when you initially enroll as a new employee. If you choose not to add a dependent at initial enrollment, you will need to wait until your employer's open enrollment period. Always ask your employer when their *open enrollment* date is, because this will be useful in helping you decide if you want to add your dependents during initial enrollment, look for other family health insurance options, or keep your family members on their current health plan.

Adding A Family Member

You may be wondering why you can't just add a family member whenever you want. Well, there is a perfectly logical explanation. Group health insurance is *guaranteed issue* to all newly enrolled members. This means that no employee or dependent family member may be denied enrollment on the group health insurance policy because of pre-existing medical conditions. If the insurance company allowed you to add your family members at anytime, most people would delay adding their family members to their coverage until they were in need of medical treatment. This would affect the overall healthiness of the group, which would force the insurance company to increase premiums to all persons insured under the policy.

When Is Your Company's Open Enrollment?

If your company's open enrollment period is only a couple of months away from your initial enrollment date, you are taking less of a risk in waiting to add your family members to your group health plan. The further away the open enrollment period, the greater the risk you are taking by not adding your family members during initial enrollment. It is never advisable to leave any family member without health insurance, but some families are forced to do so for financial reasons. There may be other options available for insuring these uninsured family members, which we will address in later sections.

Should You Cancel Your Current Family Policy?

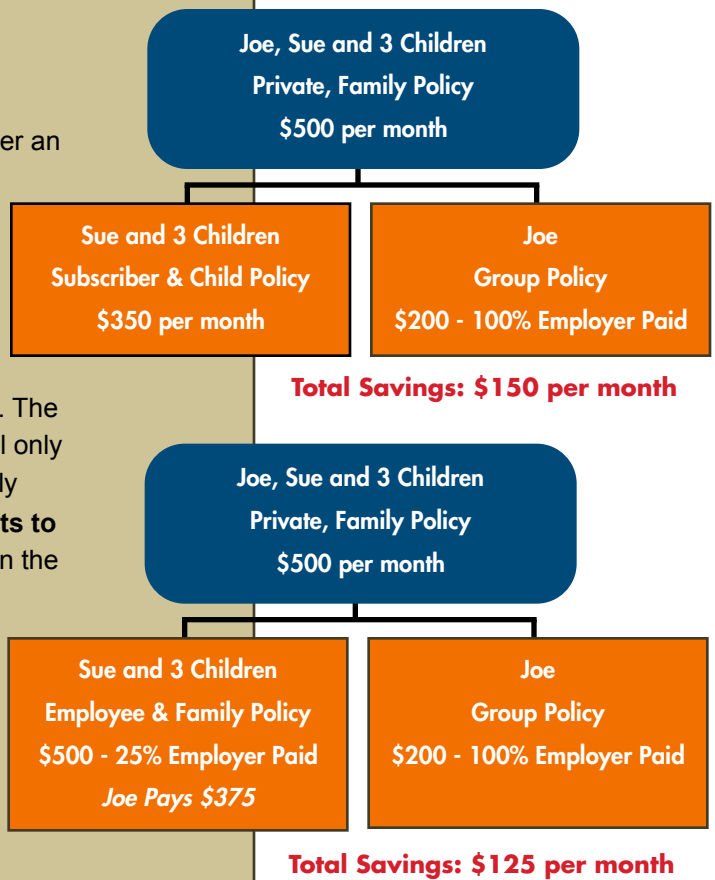
You may already have family health insurance at the time you are offered medical insurance by a new employer. Perhaps you have the family insured under an individual policy or you are covered under COBRA from the group plan of a previous employer. If this is your situation, you will need to decide if it is best to keep your family members on their existing health insurance or move them to your new group plan as dependents. In making this decision, there are several factors that you will want to consider.

Compare the Costs

First you will want to compare the cost differences between keeping your family members on their current coverage versus moving them to your new group plan. A big factor in this decision is the percentage that your employer has agreed to contribute towards your family's premiums. You will want to compare this with the adjusted premium from your current coverage. Remember that the premium for your current coverage will decrease if you are removed from the policy, leaving only your dependent family members. Most insurance companies will allow this to occur without having to re-apply for coverage or become subject to reset waiting periods. If you are the primary applicant on your existing policy, the insurance company should remove you and make your spouse the new primary insured member. Review the example below for a better understanding.

Example:

Joe, his wife Sue and their three children are all insured under an individual family health insurance policy. They are currently paying a premium of $500 per month for the entire family. If Joe is removed from the policy, the insurance company will adjust the rate to the "Subscriber and Child" rate and make Sue the new primary on the policy. In doing so, the new premium will drop to $350 per month. Joe is offered health insurance through his employer. The company will be paying 100% of Joe's premium, but they will only contribute 25% toward the dependent coverage for any family member. **Joe's new group health plan is similar in benefits to their existing coverage.** For employee only, the premium on the new group plan is $200 per month. For *employee and family* the total premium is $700 per month. The employer pays 100% of Joe's premium ($200) and 25% ($100) of the additional cost for adding the family members, which would leave Joe a balance of $400 (the $500 difference minus the $125 employer contribution). **Joe would save $25 per month by keeping his family on their existing health insurance.**



For other factors to consider in "splitting" coverage, review Section 5: *Using Multiple Policies*

Family Health Insurance Through a Private Health Plan

Families that do not have access to group health insurance through an employer must rely on a private health plan. There are many insurance companies in each state that offer private, individual health insurance. Insurance companies will publish different premiums for each of the classes (*see right*). The rates are often based on the age of the subscriber, who is called the primary applicant. *For this reason, you will probably want to make the youngest spouse the primary applicant when shopping for rates or applying for coverage*. In some states, this will not make a difference in premium because the insurance companies will consider the rate of each adult independently in determining the family health insurance premium. Ask your insurance company or agent how the rates are calculated prior to choosing your primary applicant.

Insuring Under Separate Policies

In some cases, it might make sense to insure your family members under separate policies. *You should especially look into this option if you and your spouse have only one child.* The insurance company may charge you the *family* rate if all three of you are included on the same policy. In this situation, you want to look at various rate combinations to determine which is the most cost effective and offers the lowest total combined premium. Here are the rate combinations to consider in this situation:

* Family
* Subscriber (Husband) and Child + Separate Single Adult (Wife)
* Subscriber (Wife) and Child + Separate Single Adult (Husband)
* Subscriber and Spouse + Separate Child Only

Multiple Plans Under One Family Policy

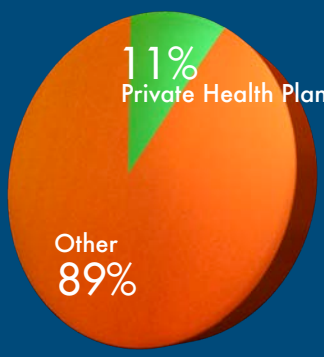
Some insurance companies that offer individual and family health insurance may allow you to select different plans and still remain under the same policy. This can be a convenient and cost effective option if you have family members with different health care needs. For instance, you may want just basic hospital coverage for the father, coverage with maternity benefits for the mother, and comprehensive coverage with preventive care benefits for the children. Not all insurance companies offer this multiple plan choice option, so ask you insurance company or agent if this option is available.

In This Section:

Premium Classes:

- Subscriber Only
- Subscriber & Spouse
- Subscriber & Child
- Subscriber & Children
- Family

Percentage of Insured Americans That Are Insured Under a Private Policy



No. of Insured Americans: 249.8 million
Source: U.S. Census Bureau 2006 statistics

Eligibility Requirements for a Private Family Health Plan

Depending on the state in which you reside, providing health insurance coverage for your family under an individual health plan may not always be possible. This is because the insurance regulations in most states allow the insurance companies to be selective about whom they approve for acceptance on an individual family health insurance policy. Although this may not seem fair, there is a logical explanation that supports this regulation. If families could obtain an individual heath plan at anytime they wanted, the majority of people would only obtain coverage when they needed it. This would mean that the insurance companies would only be insuring family members that were in need of medical attention, which in turn would dramatically increase the insurance premiums that must be paid by all.

Eligibility Guidelines Can Be Strict

Many families are often surprised at how strict the insurance companies can be in choosing who they are willing to approve for health insurance. What may seem like a minor medical condition to some people could easily result in a decline of coverage. This is primarily due to the high cost of health care and prescription drugs. Another factor is that many medical conditions can be directly related to risks associated with acquiring other, more serious medical conditions. Obesity is a prime example of this. Although a person may be overweight with absolutely no medical conditions, the insurance companies are concerned about the risks associated with obesity, such as diabetes and heart conditions. Most insurance companies have height and weight guidelines based on the body mass index. Insurance companies can reject an applicant if their BMI is above a level determined by the insurance company.

Not All Family Members May Be Approved

When applying for a private family plan, it is not uncommon for the insurance company to decline one or more family members and approve the other family members. They look at the health history and risk factors for each family member individually, even if they are all included on the same application and applying for the same health plan. When this occurs, you will need to decide if you wish to accept coverage for only the approved family members or try applying with other insurance companies that will accept all family members. You will need to consider your options for Splitting Family Members to More Than One Policy by obtaining rate comparisons for the family split options associated with the denial of a family member. If your family is currently without health insurance, it is always advisable to accept coverage for the family members that have been approved. You can always re-apply with a new insurance company and cancel your accepted coverage if you find a health plan that will insure all family members together. Do not cancel your recently acquired health care coverage until you have been accepted under a different health plan.

Rate-Up

Another possibility is that one or more family members may have a medical condition that results in a *rate-up*. This means that the insurance company views their medical condition as a risk, but not a substantial enough risk to fully deny that family member coverage. The insurance company may increase the quoted premium amount to offset the increased risk from insuring that family member. In this case, it is often beneficial to split that family member off onto their own policy so that the entire family premium is not affected by this rate-up.

What about uninsurable family members?

If you have a family member with a serious illness, they may be uninsurable through any private family health insurance plan. In this case, there may be government sponsored "high-risk" programs that will insure them. If the family member is a child, your State Children's Health Insurance Program (SCHIP) may be a viable option. Visit Section 3, *State-Sponsored Programs* for more information about SCHIP.

Consider Getting Short-Term Health Insurance

Another issue you will encounter if you plan on relocating your family, is the inability to apply for and obtain new health insurance in advance. With most health insurance companies, you must be a resident of the state in which you are applying for coverage. If you have not yet moved, this can pose a problem, especially if your current coverage becomes invalid the moment you move out of state. In this situation, consider purchasing a short-term health plan prior to your move. Most short-term, or temporary, health plans provide coverage nationwide and can provide your family with coverage for up to 12 months. This will allow you the time to shop and apply for health insurance once you become a resident of that new state. Not all short-term health plans are considered *creditable coverage* and may therefore not count toward having continuous coverage. You should inquire with the insurance companies at which you plan on applying to see if the short-term plan you choose is creditable.

Did You Know?

You can get quotes for all types of health insurance on healthinsurancefinders.com, including family and short-term health insurance. We offer access to a great selection of brokers and agents in your state so that you can shop for and compare multiple quotes.

Considerations When Relocating to a New State

One disadvantage of private family health insurance is that it is not usually portable to a different state. If you and your family relocate to a new state, you are most likely going to lose your current medical insurance and will have to find coverage in your new state of residence. This is because health insurance is state-regulated, so the laws that govern your current health plan may be completely different in your new state. Most major insurance companies, including Blue Cross Blue Shield, operate as separate divisions in each of the states where they offer insurance.

Research Regulations in the State Where You Are Moving

If you are considering relocating with your family, research the health insurance options and regulations in the new state before you make your final decision. Many families make the mistake of not considering the transfer or loss of their health insurance until they are well into the planning and moving stages. In situations where a family member requires medical attention for a pre-existing medical condition, a family may be unable to relocate due to their inability to replace their health insurance in the new state. Since some private health plans are portable, you first want to contact your insurance company to inquire about their policies regarding moving out-of-state.

State-Sponsored Programs for Families & Children

For families that cannot afford private or group health coverage, there may be state-sponsored programs available. These programs typically have income requirements related to the federal poverty income level, which may disqualify your family if the combined incomes are too high. There are, however, additional programs available that cater specifically to children and individuals who have been repeatedly denied health coverage because of a pre-existing condition. These programs are not available in every state and you should check with your state's Department of Insurance for availability and eligibility requirements.

Medicaid

Every state in the country has a Medicaid program that provides free or low-cost health insurance to families in lower income brackets. In most states, only families that have incomes at or below the federal poverty level will qualify for full Medicaid benefits. However, there are state programs that will provide health insurance to children, pregnant women, and the blind or disabled even if they are part of a family whose income exceeds federal poverty levels. Medicaid is a state regulated health care program and the regulations, qualifications, and optional programs may vary by state. Under Medicaid, your medical bills will be paid for by the government. In some cases, you may be required to make a small co-payment, but most services are provided at no charge to the family. Medical services are available from a limited number of health care professionals, local health clinics or county hospitals. Not all low-income families will qualify for Medicaid because other factors, such as your need for medical attention, may play a role in qualifying for assistance under your state's Medicaid program.

State Children's Health Insurance Program (SCHIP)

As part of the Medicaid program, many families that are not eligible for Medicaid may still qualify for state-sponsored heath care for their children. SCHIP is a state-sponsored program providing health insurance for children from families in low to mid income levels. Most states have a Children's Health Insurance

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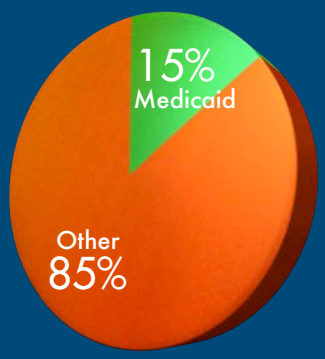
Percentage of Insured Americans That Are Insured Under Medicaid



No. of Insured Americans: 249.8 million
Source: U.S. Census Bureau 2006 statistics

Program, and the qualifications and family income guidelines vary by state. Each state that participates in SCHIP receives federal assistance. Money is allocated to the states based on several factors, including the percentage of children in that state that are without health insurance. Some states will allow children from families of any income to enroll in the program, but the families with higher income levels may be required to pay a monthly premium and/or higher co-payments for office visits and other covered services. Coverage is provided by private health insurance carriers in the state and most states have several carriers to select from depending on geographical location.

SCHIP provides health care for children under the age of 19 to families that are not eligible for Medicaid and do not currently have coverage. Coverage is focused on preventive health care and covers office visits, immunizations, hospitalization and emergency room visits. In most cases, there is no charge to qualified families. Due to the comprehensive coverage, no or low-cost premiums and the flexible income requirements, all families with children should review the State Children's Health Insurance Program available in their state.

State High-Risk Pool

In many states there are families that are able and willing to purchase their own health insurance, but are unable to do so because of a pre-existing medical condition. This may apply to one or more family members, depending on the eligibility guidelines of the various insurance companies in your state and the severity of the pre-existing medical condition. If you have a family member that is unable to be insured under the family health insurance plan due to their current or past medical history, you may consider looking into the options available through your state's high-risk pool. These are state-sponsored programs that provide an option of guaranteed coverage for persons that have been denied coverage through a private health insurance company and are without health insurance. These are by no means subsidized or low-cost health plans and any person enrolling in a state's high-risk pool will be responsible for paying the monthly premium for the health plan that they select.

The premiums for these guaranteed issue health plans are typically two times the rate that would be paid for similar coverage for a family health plan available to persons that are healthy. Coverage is offered through private health insurance carriers that are required to provide guaranteed coverage under state regulations. Not all states have laws that require guaranteed issue coverage or establish a high-risk health insurance program. If any family member is denied coverage when applying for individual health insurance, your insurance company should notify you of the availability of a high-risk pool in your state. You may also check with your state's Department of Insurance if you are uncertain about the availability of this guaranteed coverage option in your state.

Visit http://www.healthinsurancefinders.com/state-health-insurance.html and choose your state for more information about the options available in your state.

States Without High-Risk Pools:

Arizona
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Maine
Massachusetts
Michigan
Nevada
New Jersey
Ohio
Pennsylvania
Rhode Island
Vermont
Virginia
Wisconsin

For More Information of Your State's Health Insurance Programs:

In This Section:

Comparing Costs Under A Group Health Plan

If you are fortunate enough to have health insurance benefits provided to you through your employer, the comparison process is greatly simplified. Your employer has already done the comparison shopping for you and selected the insurance company or plan options that they feel best meet the needs of their staff. In some cases, your company may have a choice of plan options available to you through the same insurance carrier. In rarer cases, the employer may even have options available to their employees from more than one insurance company. Regardless of the options that are available to you, your choices will be considerably more limited than if you were shopping for private family health insurance.

Decide Who To Add Initially

You and all family members that you wish to add to your group health insurance policy will be eligible for enrollment on the same date. Your enrollment date will depend on the agreement that your employer has with the insurance carrier and is usually the first day of the month following your new hire waiting period. Most companies require that a new employee work for the company for a specific period of time before they can join the group's health plan. This can range from 0 days to 6 months, but is most commonly set at 90 days. Prior to your enrollment period you will be presented with the options available to you. You are not obligated to enroll yourself or any family member in the group coverage and have the right to refuse coverage altogether. You may also choose which, if any, of your family members that you want to include on the group policy as your dependents.

It is important to understand that if you decline to add any family member to your group policy when it is initially made available to you, there will be a waiting period before you can add them in the future. The length of this waiting period depends on your employer's "open enrollment" date, which is typically the anniversary month of when the group policy was first established. If your initial enrollment period is February and the group's open enrollment date is August, you will need to wait 6 months before you can add a family member to your group coverage.

Know Your Options

Once your health plan options are presented to you, it is time to choose the best option for you and your family. Under a group health plan, all family members must be insured under the same plan choice that is selected by the employee. You may not split family members on to various plans if more than one plan option is available to you. In choosing the right plan option you will need to compare your share of the cost for each plan option and compare that to the benefits offered under that plan. Your share of cost will depend on the percentage of the premium that is being paid by your employer for both the employee premium and the dependent premium. The percentage paid by the employer usually differs for the employee and any family members that are to be added to the policy as dependents. For example, an employer may agree to pay 100% of the employee's premium, but only 50% of the additional cost of adding family members.

In order to make the best decision for adding family members to your group plan, make sure that you receive a full premium break-down for all possible combinations for your family. This will assist you in determining if it is beneficial to insure your family under separate policies, as explained in the next section using multiple policies.

Compare Plans

If you have multiple plan options to choose from, your share of cost my be considerably higher on the more comprehensive plans, or your employer may only offer to pay a certain percentage for a lower cost plan, which means you will be responsible for 100% of the difference if you choose a plan that is more expensive than the standard plan that is being offered by the employer.

Example:

Let's assume that you want to add your entire family to the group health plan and your employer is offering you three different plan choices (right). Your employer pays 100% of the employee premium and 50% of the dependent premium.

Plan Options Offered By Your Employer:

Plan A - Employee Premium $100, Family Premium - $300
Plan B - Employee Premium $200, Family Premium - $600
Plan C - Employee Premium $300, Family Premium - $900

Your employer has further explained that they are offering Plan A as the standard policy option. You may upgrade your coverage, but you will be fully responsible for the additional cost (see cost break to the right).

Plan A:
$200 Paid By Employer / $100 Paid By Employee
This is calculated by taking 50% of the difference between the employee premium and the family premium. Your employer pays 100% of the $100 employee premium and only 50% of the additional $200 that would be required to add your family to the policy.

Plan B:
$200 Paid By Employer / $400 Paid By Employee
Since Plan A is the standard plan being offered, the employer contribution will not vary if you choose to upgrade your family to a more expensive health plan. You will pay the $600 premium, less the $200 employer contribution.

Plan C:
$200 Paid By Employer / $700 Paid By Employee
Since Plan A is the standard plan being offered, the employer contribution will not vary if you choose to upgrade your family to a more expensive health plan. You will pay the $900 premium, less the $200 employer contribution.

You should not need to manually calculate your share of cost for each plan offered to you, since it should be included with the employee benefits package presented to your prior to your enrollment eligibility date. If it is not clearly defined, ask your employer for a complete breakdown, using the options listed above. Make sure that your employer knows you are not sure which of your family members you want to add to the group's health plan and that your decision depends on the cost variances for the various combinations available to you. You will want to have this information available in order to determine if it is more beneficial to insure one, or all, of your family members under an individual health plan, instead of including them on your group policy.

Comparing Costs Across Private Plans

Determine Your Budget

The best way to find a health plan that meets the needs of your family is to first determine a monthly insurance premium amount that is affordable and then shop for the best plan in that price range. You will also want to make sure that the out-of-pocket maximum on any medical insurance policy would be achievable without causing severe financial hardship on the family. The annual out-of-pocket maximum is the maximum amount that you will contribute toward your health care costs in the worst case scenario. Once you have reached your out-of-pocket maximum, your insurance company will pay 100% of all covered medical expenses for the remainder of the calendar year. To determine if you are purchasing adequate health insurance for your family, add the out-of-pocket maximum to the annual premium total. Now, look at this amount and decide if this total possible expenditure would be attainable based on your current savings and income. If it is not, you need to find a plan with a lower out-of-pocket maximum or lower monthly premium. Keep in mind that the out-of-pocket maximum is often directly related to the premium amount, so it may be a challenge to find the right combination because as you lower the out-of-pocket maximum, you raise the monthly premium. The primary purpose of health insurance is to protect your family against financial disaster in the event of an unexpected illness or injury. If the health plan you are considering does not accomplish this, you are probably looking at the wrong plan.

Find the Right Company & Plan — Don't Be Intimidated by Agents

Once you have decided what a comfortable maximum is for your annual family health care costs, it is time to find the right insurance company and the plan that meets that budget. There are many sources online that provide health insurance quotes from multiple insurance companies. Other online sources will ask for your information and forward this to one or more agents that sell health insurance in your state. Many people are intimated by the prospect of having to talk with an insurance agent because they fear they will be forced to purchase something that they later regret. Don't be afraid, be smart!! Don't let an insurance salesman force you into purchasing a policy that you are not absolutely certain is a good health plan for your family. Don't rush into this decision and purchase the first policy that looks attractive. Do your research, find out about the insurance company, verify that your doctors accept the coverage and get a second opinion. Insurance premiums are determined by the insurance companies and these can't be modified by your insurance agent. So, once you decide which plan you want, there is no need to shop the cost of that plan with several agents. Purchase the policy through an agent that you like and have a good feeling about working with. We all know that insurance salespeople have a reputation for being pushy. Don't let them intimidate you. It is your decision, so you are in control. If you need to get rid of a persistent agent, simply tell them that you found a new job and your employer will be paying 100% of your health insurance through the group plan. That's an impossible objection for them to overcome and will work 95% of the time.

Consult With Your Doctor

While you are shopping for family health insurance, you will learn that most insurance companies have several different plan options to choose from. Your larger insurance companies should have a plan option that meets the financial and health care needs of just about every family. You may find it easier to first choose which insurance company you want as your health insurance carrier, and then find the best plan in their portfolio for your family's needs. If you have a regular family physician, trying asking him which insurance companies he accepts and which he prefers working with. Since the relationship between your doctor and insurance company is an important factor in efficiently managing your family's health care needs, his opinion is invaluable. Your doctor's office should be able to tell you which insurance companies are best about paying claims and authorizing treatments when necessary. Consult with each family member's physician in regards to their insurance carrier preference. You want to make sure that the insurance company you select has a relationship with all of your family doctors. Having access to the negotiated rates offered by participating in-network physicians can greatly reduce your family's out-of-pocket health care expenses and will also allow you to receive the maximum benefits offered under your health plan.

Splitting Family Members On Your Group Plan

When the company that you work for offers you medical insurance under an employer-sponsored health plan, they will often give you the opportunity to add family members to your coverage. In many cases, adding dependent family members must be done at the full expense of the employee. Larger companies may offer to pay all, or part, of the additional premium incurred when you elect to enroll family members. By law, they are not required to pay any portion of the premium for dependents, but they are responsible for paying a portion of the employee-only premium. The amount that the employer pays for the employee's health insurance is called the *employer contribution*. The balance is what the employee will be responsible for if they accept coverage and enroll as an insured member under the group health plan. This is called the *employee contribution*.

Compare Rates Based on Employer Contribution for Dependents

If your employer is generous enough to pay at least 50% of the premium for any family member, adding your family members to your group coverage will probably be the logical choice. However, you still want to compare your total employee contribution for adding family members to the other options available for providing your family with health insurance. If your employer does not pay any portion of the dependent premium, you will likely be able to save money by insuring your family members under a separate individual health insurance policy. Rates under a group health plan can often be more expensive than those offered for individual health insurance in the same market. This depends on the type of coverage that your employer is offering, the overall healthiness of your group, the average ages of the employees insured under the group plan, and the geographical location of those employees.

Separate the Cost for Each Family Member

Once you are provided with your group health plan options and rates, you want to separate the cost of insuring each family member under the group health plan. This will help you determine if more reasonable options are available on

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the individual health insurance market. Request that your employer provide you with a full breakdown of the various rate combinations. You will want to see your share of cost for the following options:

- **Employee Only** - The cost of insuring only yourself under the group plan and not adding family members. If your employer pays 100% of the employee only premium, this amount should be $0.
- **Employee and Spouse** - The cost of only insuring yourself and your spouse on the group policy, and not your children.
- **Employee and Child(ren)** - The cost of insuring yourself and your child or children on the group plan, and not your spouse.
- **Employee and Family** - The cost of insuring yourself and all dependent family members on the group

Having the rates for all of these possible combinations will allow you to determine your share of cost for each family member that you want to add to your group health plan. If you are just provided the "Employee and Family" rate, you will not be able to calculate the per family member premium. Use the formulas listed below to calculate your additional share of cost for each family member:

Formulas:

- **Spouse** = "Employee and Spouse" minus "Employee Only" premium
- **Child/Children** = ("Employee and Child(ren)" minus "Employee Only" premium) / (number of children)
- **All Family** = ("Employee and Family" minus "Employee Only" premium) / (1 + number of children)

Request Quotes for Individual Plans

You will now want to request quotes for individual health plans from various insurance companies in your state in order to compare those to the employee contribution amounts for adding family members to your group health insurance policy. Use the methods described in Splitting Family Members on Separate Individual Health Plans, to get the premium break down for the various family combinations available through an individual plan.

Consider the Out-of-Pocket Maximums

The annual out-of-pocket family maximum is another important factor to consider prior to deciding if it is best to insure your family members under your group policy or put them on separate individual plans. All health plans, be they group or individual policies, will have a family out-of-pocket maximum. View your group plan details to find out what this amount will be. All health plans will have a set individual out-of-pocket maximum and some plans will have a 2-member or 3-member annual out-of-pocket maximum for families. The out-of-pocket maximum is the most that you will need to contribute toward your deductibles, coinsurance and co-payments for medical services that are provided under your insurance coverage. Once you have reached your out-of-pocket maximum, you will be covered in full for the remainder of the year. If two or three family members reach this maximum (depending on your policy terms) all remaining family members will also be covered at 100% for the remainder of the year. It is not common for more than one family member to reach their individual maximums, but this is still a possible situation that you should consider prior to insuring your family under more than one policy.

There may be considerations other than cost that help you decide if you should add your family members to your group insurance, or insure them under individual policies. Some of these considerations are discussed in the next section.

Splitting Family Members Onto Separate Individual Plans

The monthly premiums for individual family plans are determined differently than group insurance premiums. Factors such as age, smoking, weight, pre-existing medical conditions and gender can determine the final rate of your family health plan. Some insurance companies may even break rates into groups, depending on which family members you want to insure (see the common rating groups to the right).

Advantages With Age Discrepancies

For Subscribe & Spouse and Family rates, the age of the youngest adult is often used as the basis for determining the premium. Since health insurance rates increase with age, this is advantageous when there is a significant age discrepancy between husband and wife. Many insurance companies group rates in 5 year blocks, such as 19-24, 25-29, 30-34, etc. Anytime the husband and wife fall into different age blocks, there is a premium benefit when the insurance company calculates rates based on the age of the youngest spouse. In this situation, it is almost always best to request that the husband and wife be insured under the same policy and it may reduce your monthly premium if you insure your child under a separate policy to avoid paying the family rate.

Only One Child in the Family

The most common scenario that would warrant obtaining two separate individual policies for your family is when there is only one child in the family. You will want to look at the rates for *Subscriber & Spouse* plus *Child Only* to determine if there is a reduction in total premium by splitting coverage in this manner. If the parents are in the same age band, you can also split coverage by obtaining one policy for *Subscriber & Child* and a second for *Subscriber Only*. If the parents are not in the same age band, you will lose the benefit of the lower premium of the youngest spouse by putting the adults on separate policies. Before splitting your three family members on to two separate policies, make sure that you are not increasing your total family out-of-pocket maximum by doing so (see *Consider Your Out-of-Pocket Maximums* on the previous page for more information on family out-of-pocket maximums).

Find Out How The Insurance Company Calculates Rates

Some insurance companies will calculate your total family premium by calculating the rate for each family member separately, and then adding them all together for the total. If an insurance company calculates family rates using this method, there is never an advantage to splitting coverage. To determine which method is used by an insurance company that you are considering, request a rate booklet or rate calculation worksheet from the insurance company or your insurance agent.

Common Rating Groups Used by Insurance Carriers:

Subscriber Only (Includes Child Only)
Subscriber & Spouse
Subscriber & Child
Subscriber & Children
Family

These classifications are often used by insurance companies to define rates.

In This Section:

There are certain advantages and disadvantages to each of your available options. Once you know and understand the pros and cons of each option, you can weigh your options more confidently.

Groups Pros at a Glance:

Employer Paid

Guaranteed Issue

Simplified Enrollment

Customized Plan Designs

Annual Rate Guarantees

Group Health Plan Advantages

Employer Paid

The best thing about group health insurance is that it is usually paid for, in part or in full, by your employer. Your employer may even pay for a portion of the premium for any family member that you wish to add to your policy. You should consider employer-paid health insurance as an income bonus, even though you are not required to pay income taxes on the value of this benefit.

Guaranteed Issue

Under a group health plan, you and your family members may not be denied enrollment on the plan because of a pre-existing medical condition. By law, the insurance companies are required to accept all eligible employees and their dependents under a group plan, regardless of their current or past health status.

Simplified Enrollment

The enrollment application required from each employee by the insurance company is short and simple to complete. You merely provide the insurance company with your personal information and a list of the family members that you want to include on your policy. If more than one plan is offered under your employer's group policy, you will need to choose which plan you are accepting. If you are enrolling in an HMO plan, you will also need to select a primary care physician for each family member at time of enrollment.

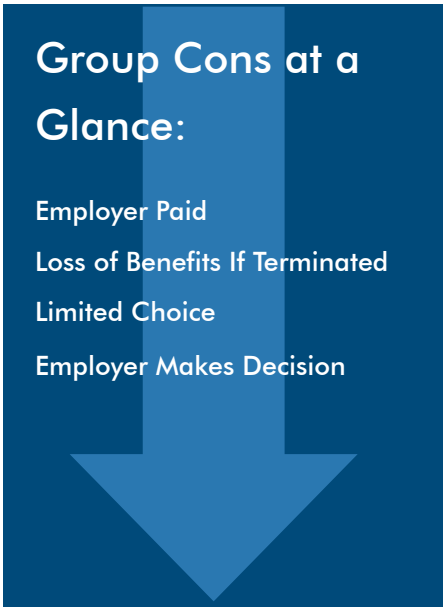
Customized Plan Designs

This benefit is often limited to larger groups of 100 or more employees. For larger groups, the insurance company may be willing to work closely with the employer to customize a health plan that best meets the needs of the company, the employees and the dependent family members. Customized plans may include benefits that are not typically found under individual health plans or group plans offered to smaller size companies.

Annual Rate Guarantees

The insurance company can only increase the rates to your employer once per year. This occurs during the annual open enrollment and your employer is given the chance to decide if he accepts these rate increases or decides to compare the new rates against other insurance companies.

Group Health Plan Disadvantages



Employer Paid

This is considered a positive benefit of group health insurance if you are the employee, but not so for the employer. If you are the business owner, the cost to you will be greater than purchasing separate individual insurance for your family, but you will be providing a valuable benefit to your employees that may make them more loyal to working for your company. As the employer, you will be able to determine the percentage of the employee premium that you are willing to pay, as long as it meets the guidelines of your state and insurance carrier minimum requirements. If you are considering setting up a group health plan for the primary purpose of providing health insurance to your family, keep in mind that you will need to offer this to all of your eligible employees and you will be responsible for paying a portion of the premium for those employees that choose to accept coverage.

Loss Of Benefits if Terminated

One of the more common concerns we hear from consumers is what happens if they have become ill and are no longer able to work. An unexpected lay-off or termination from your job may also result in the loss of your health care benefits. When this happens, you may be given the option to continue coverage for yourself and your family members under federal COBRA laws. This allows you and your family members to remain insured under the group plan for a specified period of time, but you will be fully responsible for paying the premium amount that was previously being paid by your employer. Federal COBRA only applies to companies with 20 or more employees. If you work for a smaller company, your state may have COBRA laws that also apply. You need to know and understand this prior to accepting group insurance through a smaller employer. If you do accept coverage under COBRA, it is only valid for a specific period of time, which is 18 months under federal COBRA regulations. Once your COBRA option expires, you and your family members may be left without health insurance. Finding replacement coverage for any family member with a pre-existing medical condition could be difficult and costly.

Limited Choice

When reviewing the family health insurance options offered by your employer, you may find that your choices are somewhat limited. There may be only one plan choice available to all employees through the same insurance company. You will have no choice but to accept what is being offered to you. Larger companies may provide more choices, but they will still be limited in comparison to what you will find when looking for private family health insurance. One of the biggest concerns faced with limited plan options is the availability of participating family physicians. If your family has a regular doctor that you wish to continue using, make sure in advance that he is part of the network of providers available through the health insurance company with whom your employer has group insurance. If you are able to enroll in a PPO plan, you may still be able to see this doctor, but your share-of-cost and co-payments will be considerably higher if he is not part of the insurance company's network.

Employer Makes Decisions

When you enroll your family in your employer's group health plan, you are at the mercy of any future decisions made by your employer. An employer may elect to no longer offer health insurance as an employee benefit. This occurs ever more frequently due to the increasing costs of health care and health insurance. Rates can increase to a level that the employer is simply no longer able to afford. Your employer may also change the insurance company and plan options at any time in an attempt to lower costs. You will have no choice but to accept coverage with this new insurance company, even if that insurance company does not provide the level of coverage you need for your family or is not accepted by your family physician. You can always elect to unenroll from the group plan, but this will affect your COBRA eligibility and make it difficult to find insurance for any family member that has a pre-existing medical condition.

Private Health Plan Advantages

Permanent Issue

Once you have enrolled your family in a private individual health insurance policy, the insurance company may never single you out and cancel your coverage. There are only two reasons why your insurance can be cancelled without your approval: 1) non-payment of premium and 2) fraud from false information provided on your enrollment application. As long as you have told the truth on the application and you continue to make your premium payments, you can keep your family insured for many years under the same policy and reduce the risk of being uninsured. Adults may remain on an individual health insurance policy up to the age of 65, at which time they become eligible for Medicare. Dependent children on a family health plan may remain on the policy until they have graduated from college. The eligibility guidelines for dependent children vary from state-to-state and may even vary from one insurance company to another. Many states are enacting or considering legislation that will extend the maximum age for dependent children insured under a family's health insurance plan. Check with your insurance company or agent to know the dependent age maximums in your state.

Greater Choices

In every state you will find a multitude of insurance companies that offer individual and family health insurance. Each of these insurance companies provides a variety of health plan options designed to meet the varying needs of the consumers in that state. When choosing to insure your family under an individual policy, the choices available to you will be so vast that you are likely to have a hard time choosing the right one. Refer to the section, Comparing Costs on a Private Health Plan, for tips on choosing the right plan.

You Make the Decisions

If your insurance company raises your rates, you have the freedom to find a different insurance company. If your insurance company does not provide you with the proper customer service, you have the freedom to find a different insurance company. If you doctor stops accepting your insurance, you can select a different insurance company with whom he participates. Regardless of the reasons, you are in full control of your family's health care needs when insured under a private family health insurance policy. The exception to this might be if a family member has developed a medical condition while insured under your current insurance. If the medical condition is one that would cause other insurance carriers to deny coverage, that family member may be forced to remain on the policy. Healthy family members may move coverage to another insurance company, without affecting the coverage and benefits of the family member that must remain on the existing plan.

Private Plan Pros at a Glance:

Permanent Issue

Greater Choices

You Make the Decisions

Private Health Plan Disadvantages

Lengthy Application Process

In all but a few states, individual health insurance is medically underwritten. This means that the insurance company will ask for the medical history for every family member to be included on the health plan for which you are applying. You will need to answer a series of health questions that apply to all family members. If any family member has any of the many conditions listed, the insurance company will want all of the details. When was the last office visit? Who was the doctor? What were the results of the last visit? Are follow-up visits required? To provide complete and accurate medical information for all family members could involve timely research.

Once the application is submitted, the insurance company may take a couple of weeks before they reply with a decision. The approval can be further delayed if the insurance company decides that they want medical records from the family doctor for any family member listed on the application. Medical records are often required if insufficient information is provided on the application or there is a concern about the accuracy and honesty of that information. Your signature on the application also acts as authorization for allowing the insurance companies to obtain and review your health history. If medical records are requested for any family member, you can assist in expediting the processing time by contacting your physician and explaining the urgency. Most doctors' offices are very busy places and they may not place a priority on a request from an insurance company for medical records. Your phone call asking for prompt attention is likely to considerably reduce the processing time.

Not Guaranteed Issue

With the exception of a few states, individual health insurance is not guaranteed issue. New York, New Jersey and Massachusetts are the guaranteed issue states in which this situation is not applicable and all individuals and families can get health insurance without medical underwriting. Other states are considering similar legislation in an attempt to reduce the number of uninsured residents. In those states that do not have guaranteed issue laws, the insurance companies selling individual health insurance can be selective about who they insure. On a family health insurance application, they can reject any family member based on health history, current health status and health risks due to obesity and smoking. If the insurance company declines any family member, they must provide the applicant with the reason for the decline. If medical records are requested, the approval process could easily be delayed 3 or more weeks. If all family members are healthy, and the application is complete, the approval could take only a couple of days. Family health insurance policies usually become effective on the first day of the month, following that date that the application was submitted.

Unexpected Rate Increases

Anybody that has had an individual health insurance policy is well aware of the unpredictability of rate increases. Although the insurance companies avoiding raising premiums for existing members whenever possible, it is often necessary for them to do so in order to maintain a profit and remain in business. Increases in prescription drug costs, health care costs and changes in state regulations are common causes of rate increases. These things all increase the operating and claims costs to the insurance companies, which are passed on to the plan members through periodic increases to your monthly premiums. This is an unavoidable occurrence that should be expected and estimated into your family budget. On average, family health insurance rates increase about 15% per year.

No COBRA or HIPAA Benefits

Individual family health plans do not meet COBRA or HIPAA requirements and can't be extended if you lose coverage. Keep in mind that individual health insurance is permanent issue and you can only lose coverage if you fail to pay your premium or commit fraud by lying on your application.

In This Section:

Know The Details of Your Policy

When you are shopping for family health insurance, the plan details that are available to you are just an overview of the full details of the policy. You are provided with a summary of benefits, but not all of the details of the policy. This may be available to you upon request, but is typically not provided until you have been approved for coverage and become a plan member. For group health insurance, the insurance company will send you the health plan details once you have enrolled in the group health plan. The plan details, also referred to as *evidence of coverage*, is a booklet that provides you with all of the details about the plan in which you are enrolled. This will include a list of all the medical benefits that are covered under your family health plan, but in much greater detail than a standard benefit summary.

Evidence of Coverage

The Evidence of Coverage booklet will usually be mailed to you along with your insurance cards upon enrollment in a new health plan. In many states, there is a *free-look* provision for all health insurance policies that allows you to cancel your coverage and receive a full return of your premium if you are not satisfied with the details of the plan, as provided in the Evidence of Coverage. Although the plan details can be confusing and tedious to read, always take the time to review these policy details within the *free-look* period. Knowing the plan details will help you to understand the requirements and benefits of your new family health insurance policy. This is essential in getting the most benefits from your new insurance.

Ask Questions

As you are reading through the policy details, highlight any section that you do not understand. Contact your insurance agent or insurance provider and ask them to provide clarification on any item in the plan details that is confusing to you. Pay close attention to maximum benefit limits, deductibles, exclusions, limits and additional fees for out-of-network care and pre-authorization requirements. The main reason that people become dissatisfied with their health insurance is because they did not take the time to read the policy details when they were provided. A denial of a claim because you did not follow the policy procedures and requirements can potentially cost you and your family thousands of dollars.

Consider Using Participating Health Care Providers

The policy details for your family health insurance plan will also clearly define the difference in benefits levels, deductibles and coinsurance between using participating providers and out-of-network providers. HMO plans will limit you to medical care from your primary care physician and his medical group. Most PPO plans will give you a choice of going to any physician you want, but the physicians that are part of the insurance company's network are the doctors that the insurance company prefer you use. These in-network participating providers are on contract with the insurance company to provide services at pre-determined negotiated rates. When you use these in-network providers, the cost to the insurance company is reduced and the benefit from the savings received by the insurance company is passed on to you.

Advantages of Using In-Network Providers

When your family uses in-network providers you will often have lower co-payments, deductibles, and coinsurance and share-of-costs based on the negotiated rates. You should request a provider directory from you health insurance carrier. This is a list of all doctor's and health care facilities within your geographical location that are contracted with your insurance company. Most insurance companies also offer online provider directories that are usually easier to use and more up-to-date. You can search these directories by location, specialty type or name. You may also contact your insurance company for assistance in finding a physician or specialist.

If you use out-of-network physicians, you will usually pay a higher coinsurance and will not benefit from the negotiated rates offered through participating providers. There may also be maximum benefit limits for out-of-network services. You will also be responsible for paying excess charges over the *usual, customary and reasonable* rates for the services that were provided to you. The insurance company will only pay their percentage on the fees that they deem to be reasonable. If you must use out-of-network providers, always inquire about their fees in advance and check with your insurance company for an estimate of how much they will pay toward the services provided. Compare those to your costs when using an in-network provider. You may be surprised at the difference in your share of costs and will likely be motivated to stick with in-network providers for future medical treatment.

Contact Your Insurance Carrier With Questions

Every insurance company has a customer service department that is available during normal business hours to assist you with questions about your family's health policy. They can assist with premium payments, plan descriptions, claims issues and health care provider searches. Do not hesitate to use this resource to your advantage. Prior to receiving medical care, contact your insurance company's customer service department to confirm that you are covered for this procedure and that the doctor you plan on visiting will provide you with the lowest possible out-of-pocket costs.

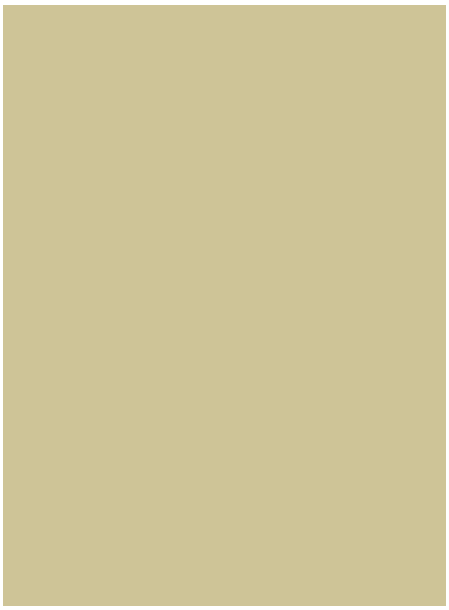
Keep Records

Whenever you contact your insurance company with questions about your family health plan, always ask for the name of the person you are speaking with. Record the name, date, time and inquiry into a journal. This may help protect you in the event that you are provided with inaccurate information. Although the customer service representatives of insurance companies are trained to answer your questions, there is no certainty that what you are told is accurate. If you are uncertain of the answer that you are provided, call back again and speak with a different customer service representative. If you receive conflicting answers from the representatives, ask to speak with a supervisor for clarification and then ask that the answer be placed in writing and mailed or emailed to you.

Get Your Broker or Agent Involved

If you have a health insurance agent or broker, also get them involved in finding out the answers to your questions or assisting with claims issues. Insurance agents will usually represent many clients with the same insurance company and may have special contacts within the insurance company that can assist in quickly resolving your issues or answering your questions.

Obtain Pre-Authorization When Necessary



When reviewing the plan details of your new family health policy, you may find mention of penalties or non-payment of claims for certain procedures that require pre-authorization. Not obtaining this pre-authorization for medical services needed for any family member can dramatically increase your out-of-pocket costs. Your plan details should clearly outline all procedures that require pre-authorization. If you have a family doctor that has scheduled your procedure, he will often handle the pre-authorization requirements with your insurance company or may even have the authority to grant this pre-authorization. However, it is always a good idea to contact your insurance company in advance of any scheduled medical procedure to verify that pre-authorization has been given. Ask for the claims number associated with this pre-authorization and, if possible, request a faxed copy for your records.

Glossary

Agent - A health insurance agent markets and sells health insurance to families on behalf of the insurance company. They typically work exclusively for one insurance company, but are not an employee of that insurance company. They are independent contractors who are paid a commission from the insurance company for each family that they enroll in that insurance company's health plan. The commission is usually a percentage of the total premium that you pay to the insurance company. Agents do not usually charge an additional fee for their service, so the family insurance premium you pay is the same as it would be if you purchased your family health insurance directly from the insurance company.

Basic Hospital Coverage - Some families are only interested in purchasing health insurance to cover major hospital expenses in the event of an unforeseen accident or illness. They are willing to pay the full cost of doctor's visits, prescription drugs and routine health care. The type of family health insurance that primarily protects against a "catastrophic" health care expense is called Basic Hospital Coverage. The premium for Basic Hospital Coverage is considerably less than more comprehensive family health insurance, thus allowing healthy families the ability to pay for the occasional expense of routine health care. This type of coverage may not be the most effective for families that have members with health issues or are at high-risk for medical conditions or the need for regular physician's care.

Broker - A health insurance broker is very similar to an agent, but they represent multiple insurance companies. A broker will work with his clients to help them shop the family health plans available from multiple insurance companies. Working with a broker saves you time from dealing with multiple agents and insurance companies. Since a broker represents multiple insurance companies, they should provide an unbiased and knowledgeable opinion on which insurance company best meets the specific needs of your family.

Claims - Whenever you or a family member seeks medical care while insured under a family health insurance policy, the treating physician will file a claim with the insurance company to seek compensation and reimbursement from your insurance company. When using participating providers, you are often unaware of this claims process because the doctor will collect from you in advance your share of cost and file the claim on your behalf. In some cases, usually when using non-participating providers, you may need to pay the doctor in full at the time of service and then file a claim with the insurance company for reimbursement of the portion of the costs for which the insurance company is responsible.

COBRA - In 1986, Congress passed a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA) that addresses the steps that must be taken by employers and insurance companies to provide continuation of health insurance coverage to any person that has been insured under the company's group health insurance policy and is no longer eligible due to loss of job, retirement or prolonged illness. Federal COBRA only applies to companies with more than 20 employees, but many states have mini-COBRA laws that place similar guidelines on smaller companies. The length of time you or a family member may continue being covered under the group plan will depend on several factors, including the size of the company and the state in which your family resides.

Comprehensive Coverage - A comprehensive family health insurance policy will provide a full range of benefits, including regular office visits, prescription drugs, out-patient surgeries, preventive health care, dental and vision benefits, and much more. HMO plans typically offer the most comprehensive coverage with the lowest out-of-pocket costs to the family insured under this type of plan.

Co-payment - Most family health plans will require you to make a small payment toward any medical services provided that is part of your health insurance benefits. This amount is referred to as your co-payment and represents the entire amount for which you will be liable, regardless of the amount billed to the insurance company by the doctor. Co-payments are most frequently required for routine office visits and prescription drugs and are paid directly to the treating physician at time of service.

Employer/Employee Contribution - If your family is insured under your employer's group health plan, the employer may offer to pay a portion of the total monthly premium required to insure all of your family members. Payment is made to the insurance company by the employer and any amounts that you owe toward your premium are collected from you by your employer. The amount that is paid by your employer and not collected from you is called the "employer contribution." The amount that you pay toward insuring yourself or any family member is called the "employee contribution." The employer contribution, combined with the employee contribution, equals the premium amount that is required from the insurance company for you and your family to be included on the group health plan.

Guaranteed Issue - Guaranteed issue means that the insurance company must accept and insure any person or family that applies for insurance and pays the required monthly premium. The most common example of this is group health insurance. If you wish to insure any family member under your group health plan, they may not be denied coverage by the insurance company, thus making the issuance of coverage "guaranteed." Other types of guaranteed issue coverage include COBRA, high-risk health plans and Medicare. A few states, such as New York, have legislation that requires all individual and family health plans to be offered on a guaranteed issue basis. Guaranteed issue does not always guarantee that the insurance company will cover all medical expenses. Pre-existing medical condition waiting periods may also apply to guarantee issue health plans.

HIPAA - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is federal legislation designed to protect the consumer's rights to health care access, portability, renewability, protect against health care fraud, and protect a patient's privacy. Under federal HIPAA regulations, every state must provide access to health care to families that have lost their group health insurance or exhausted their COBRA benefits and are uninsurable due to a pre-existing medical condition of a family member.

In-network - An "in-network" doctor of medical facility has a contract with the insurance company that provides your family with health insurance. They have agreed to charge special "negotiated rates" to any patient that is a member of a health plan offered by the insurance company with whom they are contracted. Each insurance company has an extensive list of in-network doctors and many doctors may be on the in-network list of many different insurance companies. An in-network physician may not be contracted under every health plan offered by the insurance company. For instance, a physician may wish to contract with the PPO plan members of an insurance company, but may choose not to be part of the HMO network of physicians.

Negotiated Rates - A negotiated rate is the amount of compensation that has been agreed upon between the in-network health care provider and the insurance company. Negotiated rates are only available when your family uses physicians or health care providers that are on contract with your insurance company, also referred to as "in-network" providers. Your family will also benefit from these negotiated rates because the amount that you pay toward your deductibles and coinsurance is based on the rate that is billed to your insurance company.

Open Enrollment Period - If your family is insured under an employer sponsored group health plan, you will have an annual open enrollment period, during which time you can add dependent family members to the policy that are not currently insured under your group health plan. You may also make changes to your health plan choices during open enrollment. The open enrollment period lasts for 30 days per year and usually occurs during the month preceding the annual renewal of the policy between your employer and the insurance company. If you choose not to enroll family members in the group plan during this 30 day period, you will need to wait another year before you can add them again.

Out-of-Pocket Maximum - The out-of-pocket maximum is the most your family will need to contribute toward deductibles and coinsurance during a specific period of time, usually the calendar year. Once you reach this maximum, the insurance company will pay 100% of the applicable medical expenses for the remainder of that specified period of time. For family health plans with more than one insured member, the policy may have a family out-of-pocket maximum, which when reached provides full coverage to all family members insured under the same policy. Co-payments and premiums do not

apply to the out-of-pocket maximum, and some covered services may also be exempt. The out-of-pocket maximum is usually increased substantially if you use non-participating health care providers.

Pre-existing Medical Conditions - This refers to a medical condition of any family member that existed prior to the effective date of your family's health insurance coverage. A pre-existing medical condition can result in a reduction of benefits or waiting periods that will lower the amounts that are paid by the insurance company toward treatment of this condition, quite often to zero. It is your responsibility to claim pre-existing medical conditions to your insurance company at the time you apply for family health insurance. Failure to do so could result in the cancellation of coverage for the family member that has this pre-existing condition that was not disclosed. The burden of proof is on the insurance company, but they have the right to request medical records to verify previous treatment or symptoms that suggest this medical condition existed prior to enrollment.

Premium - Maintaining health insurance for your family requires a monthly payment to the insurance company that is providing your family with health care benefits. This is referred to as your insurance premium and is usually required in advance of the month in which coverage is provided. Failure to pay the monthly premium may result in cancellation of coverage. Most insurance companies have a 30 day grace period on payment of premium.

Preventive Medical Care - This is any medical procedure that is done to possibly prevent further health problems. Preventive medicine does not treat an existing condition. A main purpose of preventive medicine is to look for signs or symptoms of other potential health problems or risks. Preventive medicine includes routine physical exams, blood tests, pap smears, mammograms, prostrate exams and well-child visits. Many insurance companies offer excellent benefits for preventive health care visits because they feel they can reduce costlier claims in the future if the doctors catch a potential problem in its early stages.

Waiting Periods - A waiting period is the length of time that you must be enrolled in your family health insurance plan before you are eligible for certain benefits. For instance, some family health plans may require that your family be insured with them for 12 months before you can receive maternity benefits. This is called a "12 month maternity benefit waiting period. Waiting periods are also frequently imposed on pre-existing medical conditions, depending on the type of coverage you have chosen and the type of coverage you had prior to enrolling in your new family health plan. During this waiting period, your family will be responsible for the full cost of health care for any treatment received for a medical condition to which this waiting period applies.