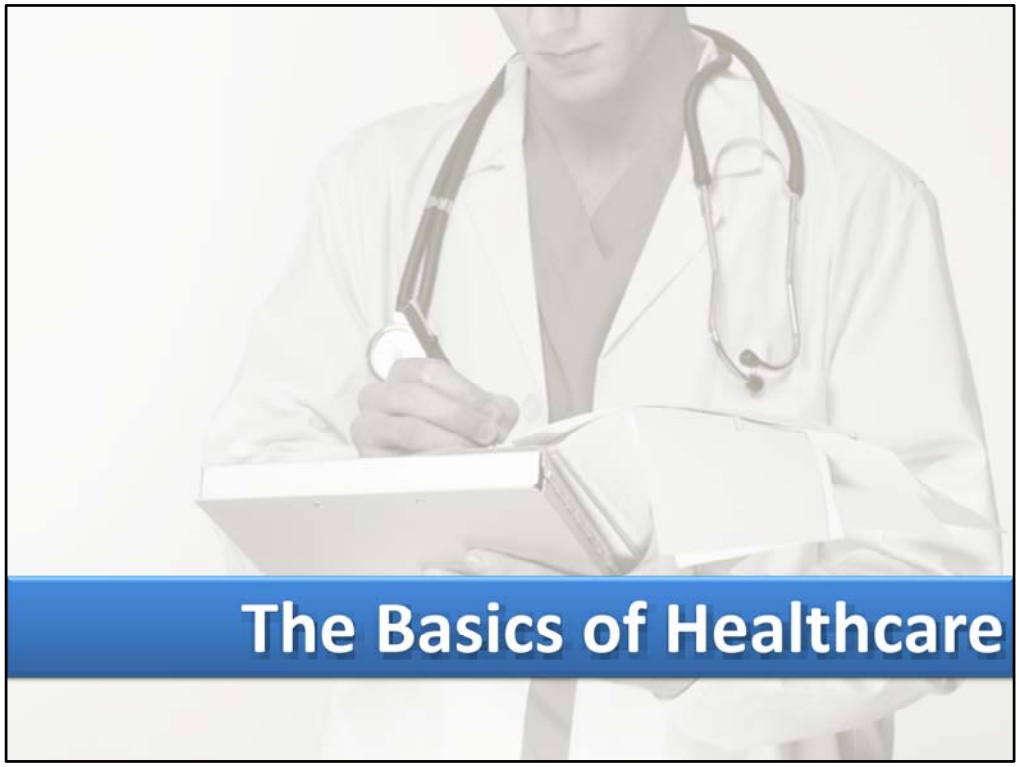
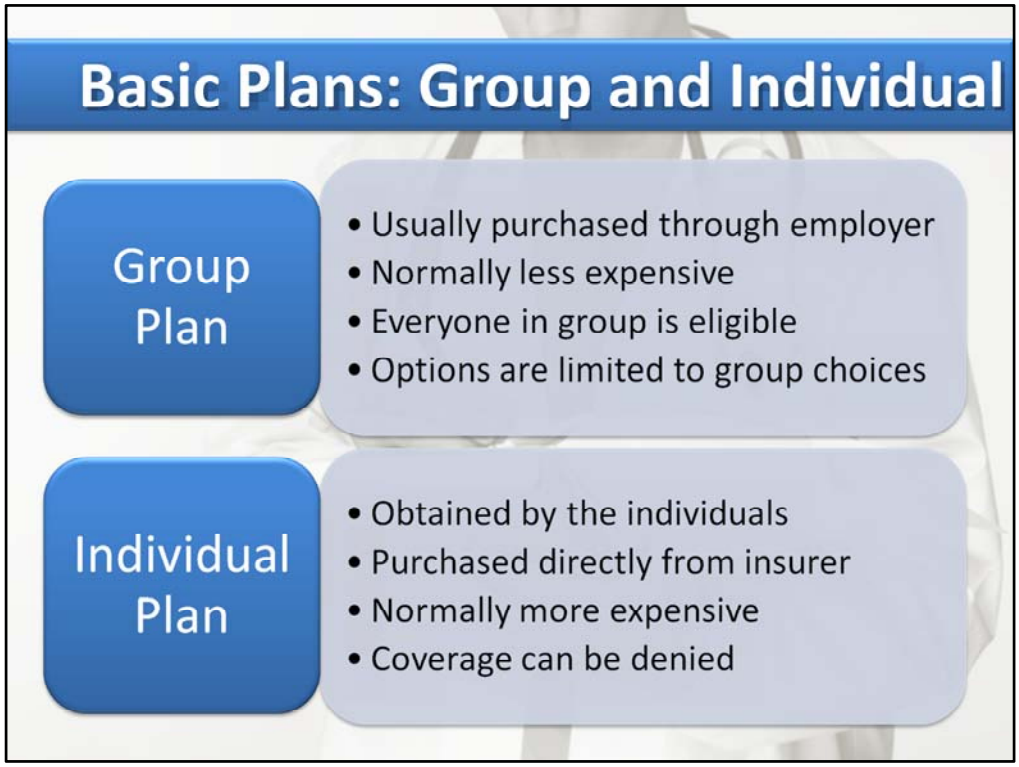


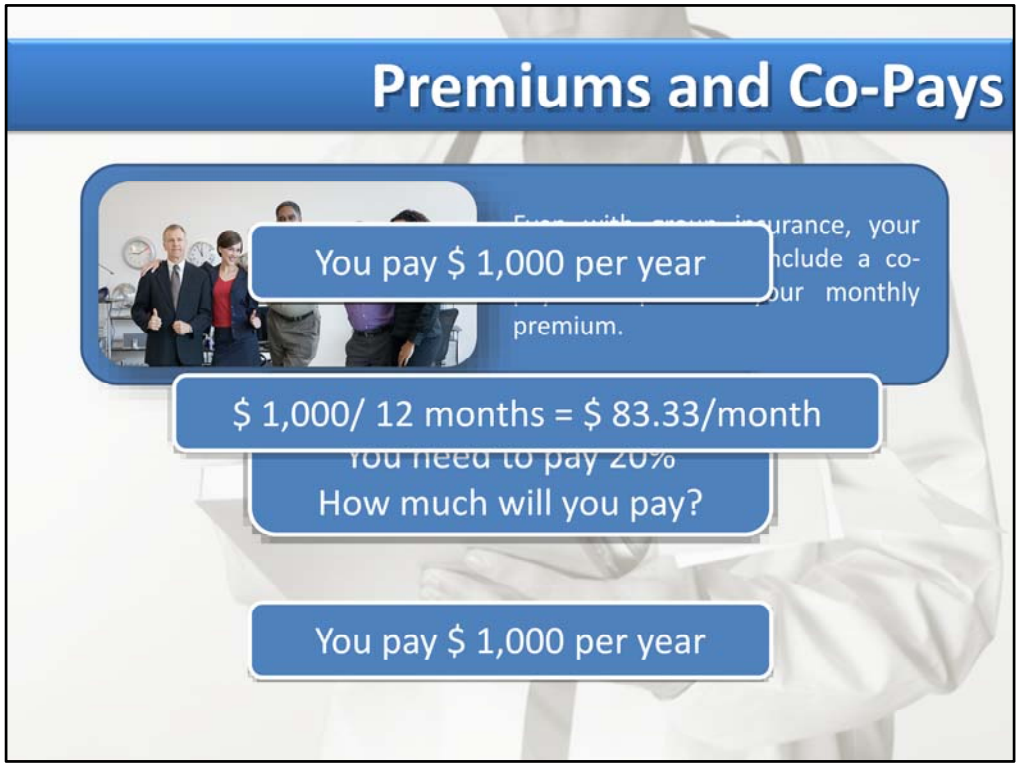
Sure, your mom and dad's health insurance policy might be covering you now, but at some point, you will be making your own choices about health insurance. When you are living on your own, who will provide you with health insurance? Will it be your employer, or the employer of someone else in your family? Will you be responsible for your own insurance plan and, if so, what types of insurance will be available to you?



Basic health insurance plans can be broken into two separate formats, group or individual.

Most insured Americans are part of group health insurance purchased through their employer or another organization – sometimes called a "group sponsor." With group health insurance plans, the insurance is provided by an employer for employees and the plans are normally less expensive than individual plans. Everyone who belongs to the group is eligible for insurance, even if an individual has pre-existing conditions. The options for health care are limited to what the group sponsor selects and the group sponsor can discontinue the insurance at any time.

The other format for insurance, individual health insurance is typically used by people who are self-employed or by individuals who do not choose to be enrolled in a company health insurance plan. Individual health insurance can be purchased directly from an insurance company and the company writes the policy for the individual's need. While individual health insurance is usually more expensive than group insurance, the insurance company may choose to offer discounts for individual's with healthier lifestyles. If an individual has a pre-existing condition, which is a condition that is present prior to the writing of the policy, coverage may be more expensive or may be denied by the insurance company.



Just because you are employed and your employer offers group health insurance, you may still be responsible for paying a co-pay when you need to go to the doctor. In addition, even under a group plan, you still pay a monthly premium for health insurance coverage. Let's look at an example of how much you might pay per month for your health insurance premiums.

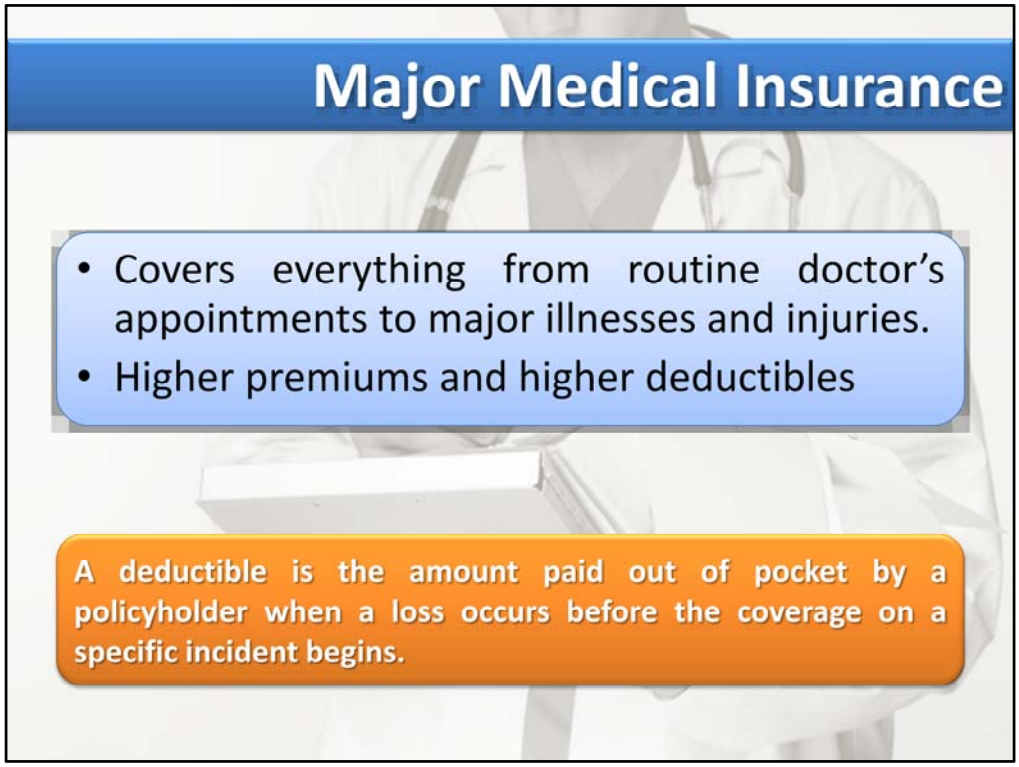
Let's say that you signed up for group health insurance that your employer offers. The total premium cost is $5000. The company will pay 80% of this premium, you must pay 20%. How much will you pay per year?
The answer is $ 1000.00/year

Don't worry! Most of the time this amount will be deducted monthly or semi-monthly from your paycheck. Therefore, you do not have to pay a huge amount at one time. If your portion of the premium is paid monthly, how much will your employer deduct every month your paycheck?
The answer is $83.33/month

Basic health insurance usually covers doctor's office visits, routine service like check-ups, and most hospital and surgical expenses. Furthermore, under a group plan, insurance companies typically cover the items shown here. Many of these coverage types can also be found in an individual plan as well. Individuals need to customize a plan according to their needs.

Insurance policies will vary. Therefore, it is very important that you understand the services that are covered and not covered by your plan. If you have questions about which services are covered, you should contact your insurance company to verify the information.

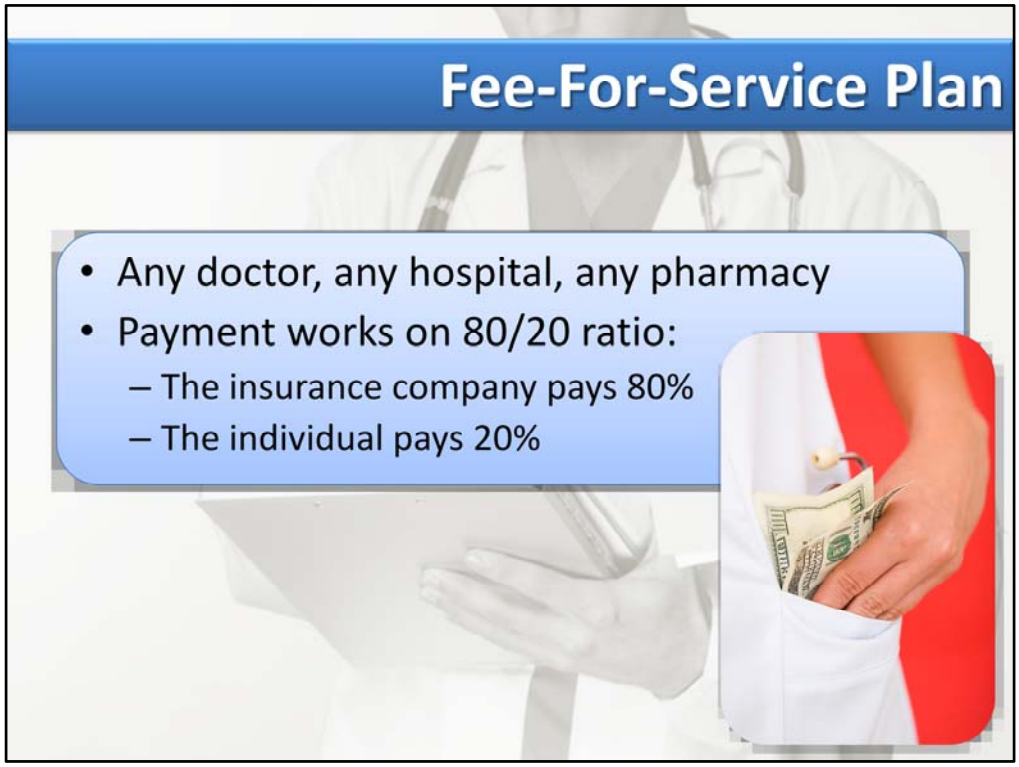
Generally, healthcare policies are designed to treat symptoms and cure diseases that affect its recipients. Therefore, procedures that are considered elective, or not necessary for the patient's survival or well-being, are usually not covered. Most of the items shown here are considered elective and an insurance policy's coverage of these items varies based on the company and policy.



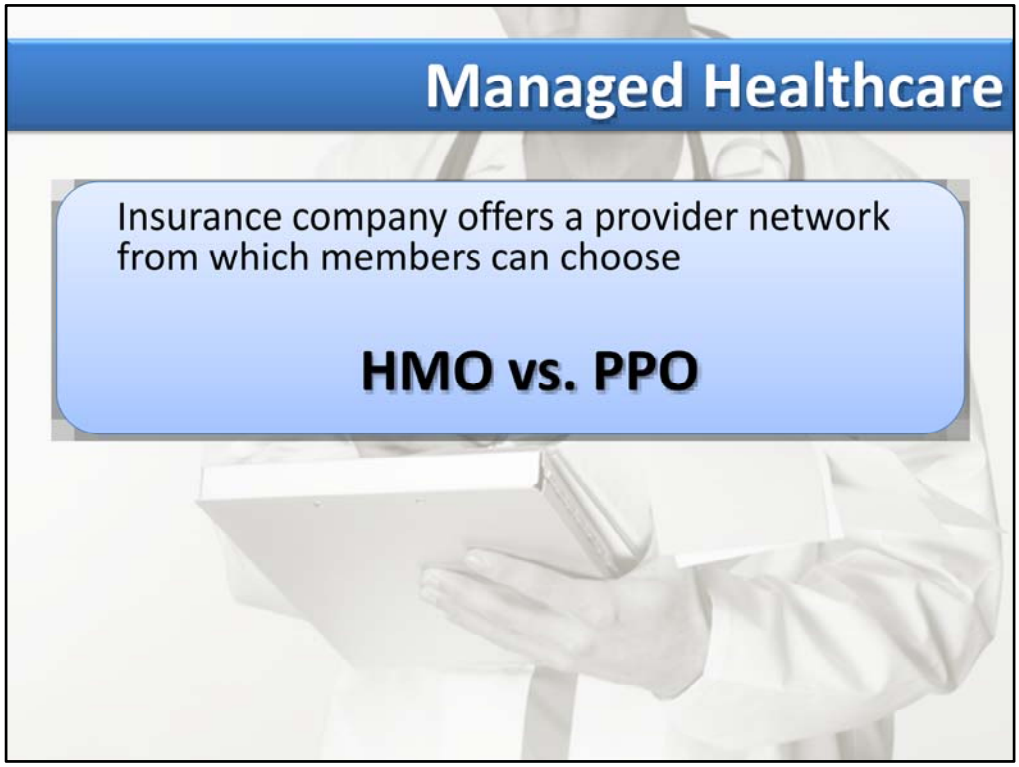
Major medical insurance covers everything from routine check-ups and doctor visits to major catastrophic illnesses or injuries. Basic health insurance may only help pay for some, but not all, types of medical services. Most major medical insurance requires higher premiums since you are receiving more coverage. Additionally, these policies will require a higher deductible before the insurance coverage begins for the individual. A deductible is the amount paid out of pocket by a policyholder when a loss occurs before the coverage on a specific incident begins.

Why would you need major medical insurance if you have basic health insurance? More than likely, there are limits on basic health insurance. One catastrophic illness or injury can deplete basic health coverage quickly and leave the sick or injured person responsible for paying the overage amount out of pocket.

There are many different types of health care plans. Let's look at some of the more common ones that you might encounter.

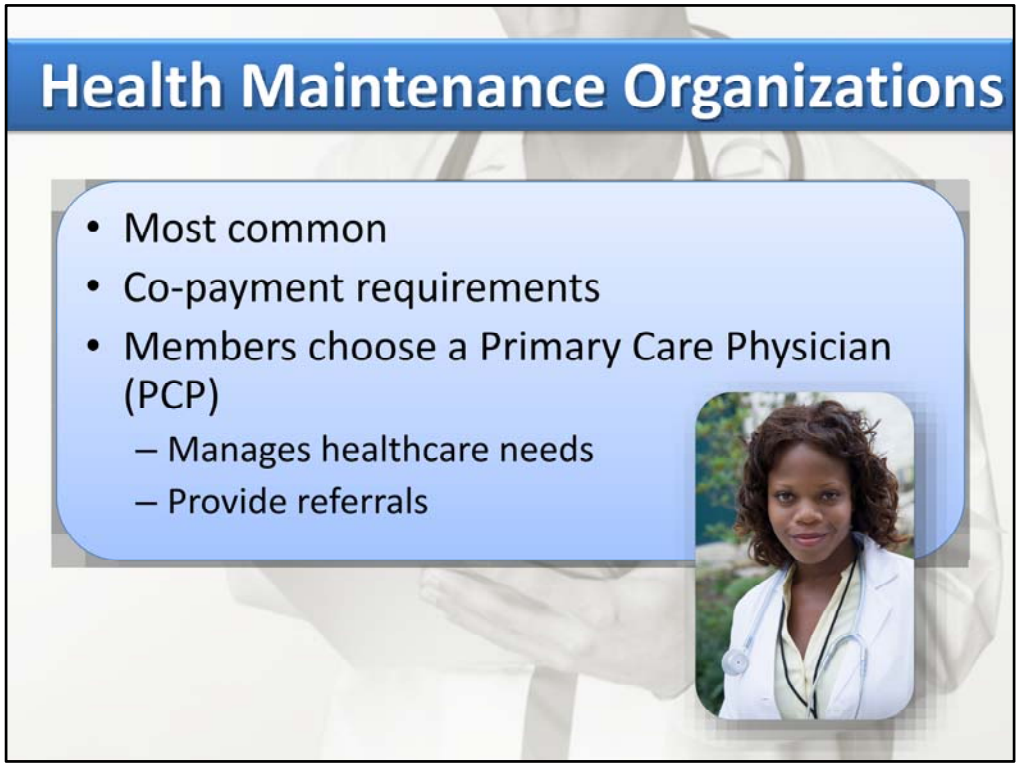


In a fee-for-service plan, members can go to any doctor, hospital, or pharmacy that you choose and the payment for services normally works on what is called a 80/20 ratio. When services are rendered, the insurance company pays 80% of the costs and the individual pays 20%. Fee-for-service plans can be very flexible, but can also be very costly.



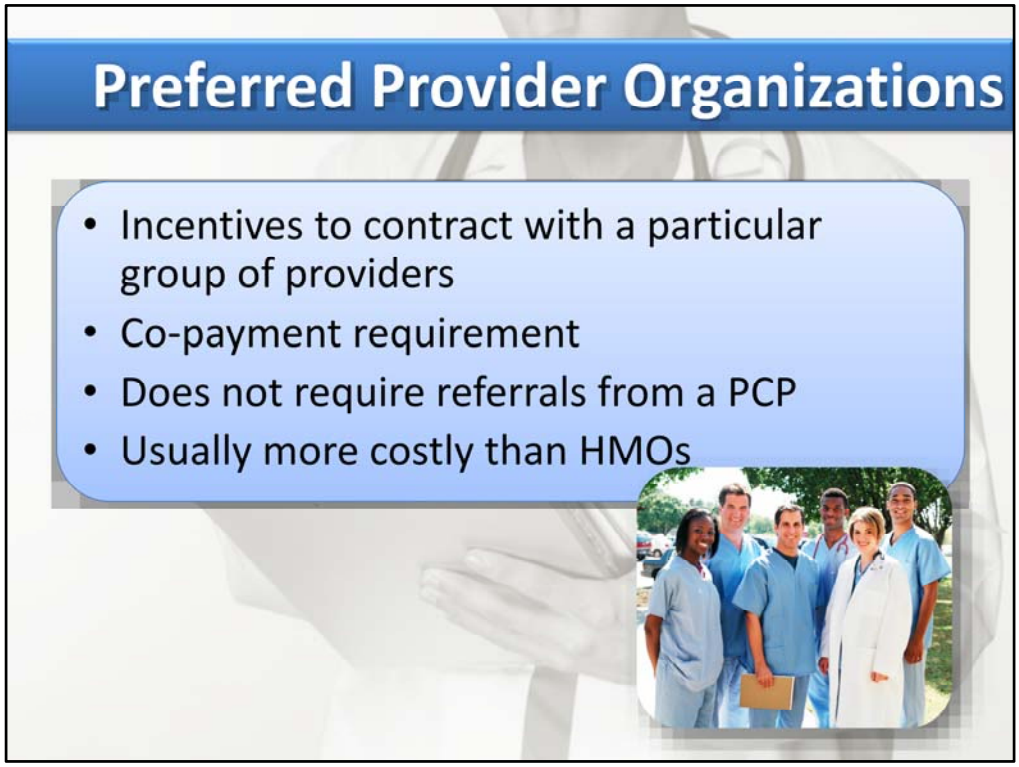
In a managed health care plan, the company will offer a provider network which allows the insured party to choose from only a select group of healthcare professionals. In all cases, except emergencies, you will need to choose you doctors from a list that has been approved by your healthcare plan.

Two managed healthcare options include HMO plans and PPO plans.



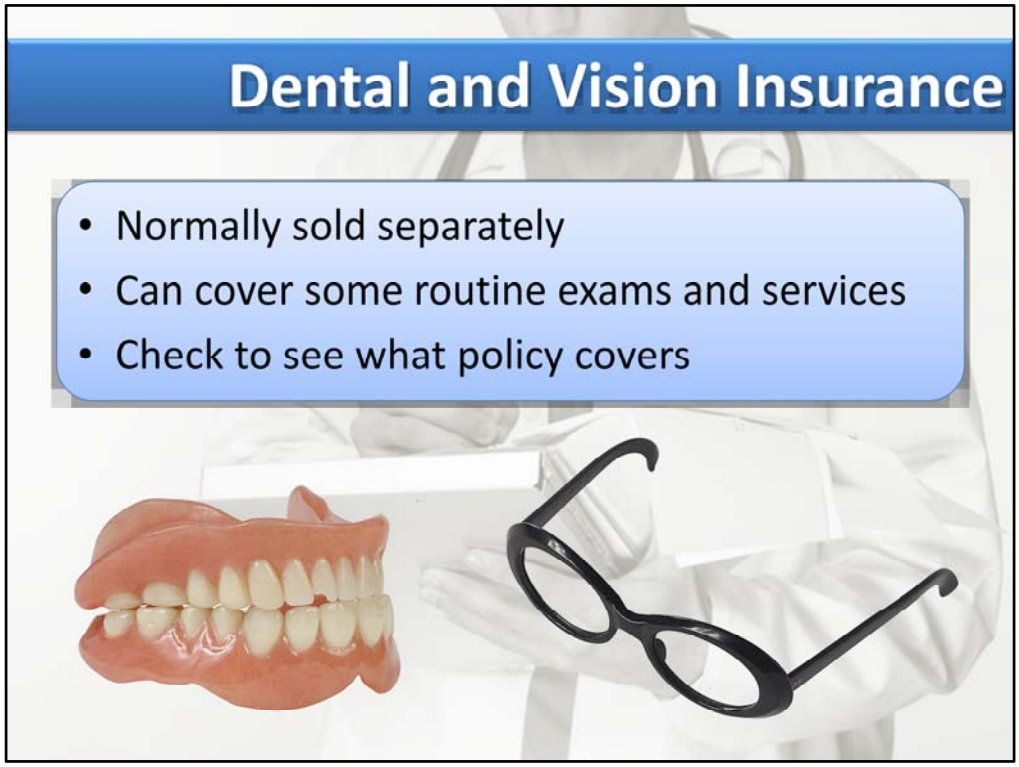
Health Maintenance Organizations, or HMOs, are the most common type of managed care plan. HMOs have co-payment requirements that the individual receiving the healthcare must pay. These plans allow insured parties to choose a primary care physician, or PCP, from a list of network providers. After a PCP is selected, this doctor is responsible for managing much of your other healthcare needs. HMOs also require that an in-network doctor provide any services in order for your healthcare claim to be paid. For example, you may need to obtain a referral from your primary care physician before you can go to the sports medicine doctor for a running injury. As with any other policy, read your contract or policy to find out exactly what is covered and what is excluded.

View the advantages and disadvantages of HMOs.



Preferred Provider Organizations, or PPOs, provide consumers with certain incentives if they contract with a particular group of healthcare providers. You will find many different types of PPOs. With a PPO, the member can visit any healthcare providers in their network and pay a co-payment. A PPO plan does not require referrals from a primary care physician if a specialist is in the network. PPOs can be more costly than HMO plans.

View the advantages and disadvantages of managed healthcare.



Dental and vision insurance are normally sold separately from basic health insurance. When you acquire your own insurance plan, you will need to check to see if these plans are available. Dental and vision insurance covers some costs of routine exams and other policy stated services. Each policy is different. Therefore, you will want to check the policy to determine what is actually covered when you visit your dentist or eye doctor.