



CONSUMER ALERT

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HEALTH INSURANCE

Before purchasing any insurance policy, ask the agent specific questions about how the company handles issues related to the military deployment of their policyholders. Each company's practices can vary. Compare prices and the level of service across a few different insurance providers. By shopping around, you may be able to find an insurer who specializes in needs of service members.

Before you leave on a military deployment, check your policy renewal date and payment terms with your agent to ensure your coverage will remain in effect during deployment. If necessary, you may be able to renew a policy early or have your premiums paid by automated bank draft. Some insurance companies might also allow you to suspend certain coverage while you are deployed.



To help members of the military better understand their insurance needs, the National Association of Insurance Commissioners offers tips and considerations regarding auto, home, health and life insurance.

Special Considerations for Members of the Military

- Many reservists and National Guard members have health coverage for themselves and their families through an employer-sponsored health plan. Some may wish to continue that coverage, particularly for their dependents, during their active duty period. Talk with your benefits administrator to learn what will happen with your health coverage when you are called to active duty. While employers are not required to pay the cost of health coverage for you and your dependents while you are on active duty, some employers may choose to continue benefits at their current level.
- If you are on active duty for more than 30 days, you and your dependents should be covered by military health care. Dependents have medical and dental services provided through uniformed services facilities subject to availability and are eligible for health benefits from civilian sources through the federally funded TRICARE program, the triple option benefit plan available for military families, formerly known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). Contact your military unit for more information on these programs.
- Your right to continue health coverage under an employment-based group health plan is covered by federal laws. The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides health coverage continuation rights to employees and their families after an event such as reduction in employment hours. The Uniformed Services Employment and

Reemployment Rights Act of 1994 (USERRA) is intended to minimize the disadvantages that occur when a person needs to be absent from civilian employment to serve in the uniformed services. Both COBRA and USERRA generally allow individuals called for active duty to continue coverage for themselves and their dependents under an employment-based group health plan for up to 24 months. If military service is for 30 days or less, you and your family can continue coverage at the same cost prior to your short service. If the duration of your military service is longer, you may be required to pay one hundred percent of the full premium plus a two percent administration fee to continue this coverage for you or your family. You should receive a notice from your plan explaining your rights.

- The Health Insurance Portability and Accountability Act (HIPAA) may give you and your family rights to enroll in other group health plan coverage if it is available to you (for example, if your spouse's employer sponsors a group health plan). You and your family have the opportunity to enroll outside of the plan's official enrollment periods. However, to qualify, you must request enrollment in the other plan (for example, your spouse's plan) within 30 days of losing eligibility for coverage under your employer's plan. After this special enrollment is requested, the health care plan must provide coverage no later than the first day of the first month following your enrollment request. If you are on active duty more than 30 days, coverage in another plan through special enrollment can be cheaper than continuation coverage because the employer often pays a part of the premium. When considering your health coverage options, you should examine the scope of the coverage including: benefit coverage and limitations, visit limits, dollar limits, cost of premiums, cost-sharing (including co-payments and deductibles) and coverage waiting periods.
- An individual policy can be used for your family members. But speak with your agent as there is a war exclusion that might make coverage for the military personnel void. Should you purchase an individual military-focused policy, check with your agent to make sure it does not duplicate coverage for your family that could be obtained elsewhere.

Health Insurance Considerations for All Life Situations

As with other kinds of insurance, there are several types of health insurance.

Major medical plans typically cover a comprehensive array of healthcare needs, including doctors' visits, drugs and hospital care. These benefits can be delivered in several different ways:

- Indemnity plans – These major medical plans typically have a deductible – the amount you pay before the insurance company begins paying benefits. After your covered expenses exceed the deductible amount, benefits usually are paid as a percentage of actual expenses, often 80 percent. These plans usually provide the most flexibility in choosing where to receive care.
- Preferred Provider Organization (PPO) plans – In these major medical plans, the insurance company enters into contracts with selected hospitals and doctors to furnish services at a discounted rate. As a member of a PPO, you may be able to seek care from a doctor or hospital that is not a preferred provider, but you will probably have to pay a higher deductible or co-payment.
- Health Maintenance Organization (HMO) plans – These major medical plans usually make you choose a primary care physician (PCP) from a list of network providers. Your PCP is responsible for managing all of your healthcare. If you need care from any network provider other than your PCP, you may have to get a referral from your PCP to see that provider. You must receive care from a network provider in order to have your claim paid through the HMO. Treatment received outside the network is usually not covered, or covered at a significantly reduced level.

- Point of Service (POS) plans – These major medical plans are a hybrid of the PPO and HMO models. They are more flexible than HMOs, but do require you to select a primary care physician (PCP). Like a PPO, you can go to an out-of-network provider and pay more of the cost. However, if the PCP refers you to an out-of-network doctor, the health plan will pay the cost.

Limited benefit plans provide coverage for a particular healthcare setting, ailment or disease.

Here are some of the options that may be available to you:

- Basic Hospital Expense Coverage – Covers a period of usually not less than 31 days of continuous in-hospital care and certain hospital outpatient services.
- Basic Medical-Surgical Expense Coverage – Covers costs associated with a necessary surgery, including a certain number of days of in-hospital care.
- Hospital Confinement Indemnity Coverage – Covers a fixed amount for each day that you are in a hospital.
- Accident Only Coverage – Covers death, dismemberment, disability or hospital and medical care caused by an accident.
- Specified Disease Coverage – Covers diagnosis and treatment of a specifically named disease or diseases, such as cancer.
- Other Limited Coverage – You may purchase insurance covering only dental or vision or other specified care.

Additional coverage options provide added protection should you become disabled, require long-term care or enroll in Medicare:

- Disability Income – This coverage provides for weekly or monthly benefit payments while you are disabled after a covered injury or sickness.
- Long-Term Care Insurance – This policy usually pays for skilled, intermediate and custodial care in a nursing home, as well as care in other settings, such as the home, adult day care center or assisted living facility. The policy usually pays a fixed amount per day while a person is receiving care.
- Medicare Supplemental Coverage – The federal Medicare program pays most medical expenses for people 65 or older, or for individuals under 65 receiving Social Security disability benefits. However, Medicare does not pay all expenses. As a result, you may want to buy a Medicare supplement policy that helps pay for certain expenses, including deductibles not covered by Medicare.

The following are two types of health-related services that are NOT health insurance plans:

- *Discount Plans* – You may receive advertisements from plans offering discounts on healthcare for a monthly fee. These are not health insurance plans, and participants do not have the same protections as under licensed health insurance. Your insurance commissioner strongly recommends that you thoroughly investigate any plan promising deep discounts for a “low” monthly fee and weigh the benefits against the costs carefully.
- *Non-Licensed Risk-Sharing Plans* – You may receive offers to join a group or association that will take your monthly payments, put them in a savings account or trust with other participants’ money, and then help pay some of your health care costs, as needed. Such arrangements are **NOT** insurance and the participants do not have the protections available to purchasers of

licensed insurance plans. Your insurance commissioner strongly recommends that you thoroughly investigate such plans before joining.

Health insurance – whether provided by your employer or purchased independently by yourself – can be expensive. Here are some ways you can control your costs:

- If you're married and both spouses work at jobs that provide health insurance, compare these policies and their costs to see which one best fits your needs. Look beyond the monthly amount you must pay and closely evaluate covered services, co-pay requirements, deductibles and reimbursement levels so that you make the best choice for your family and your pocketbook.
- Many plans offer a menu of options. Regularly review your situation, and adjust your options to meet changing needs.
- Stay in-network as much as possible, making sure to obtain referrals as required.
- Many plans require pre-certification for certain tests and procedures. Know your plan, and make sure you comply with these requirements to avoid paying penalties.
- Hold onto all receipts for medical services. Even though your intent may be to always stay in-network, you never know when an accident, out-of-town emergency room visit or unexpected illness might cause you to incur out-of-pocket expenses that exceed even a high deductible.
- Check to see if your employer offers a flexible spending account. These plans, which allow you to set aside pretax dollars for medical expenses and childcare, are a good way to reduce your out-of-pocket medical costs.
- Finally, consider combining a high-deductible catastrophic plan with a health savings account (HSA). An HSA is a tax-sheltered savings account similar to an IRA, but earmarked for medical expenses. Deposits are 100 percent tax-deductible for the self-employed and can be easily withdrawn by check or debit card to pay routine medical bills with tax-free dollars. Larger medical expenses are covered by a low-cost, high-deductible health insurance policy. What is not used from the account each year stays in the account and continues to grow interest on a tax-favored basis to supplement retirement, just like an IRA. Employers are beginning to offer HSAs to their employees as a health insurance option.

Disability Insurance Considerations for Young Singles

When you're young, one of the last things on your mind is thinking about becoming disabled. However, statistics from the U.S. Census Bureau indicate that in 2000 a substantial portion of the nation's population — nearly 20 percent — had some type of long-lasting condition or disability.

If you are hurt in an accident or become seriously ill and you can't work for several months or longer, your bills will still keep coming in. Long-term disability insurance coverage can protect a portion of your income if something happens to you.

- Even if you are single and have no dependents yet, you probably have a family who would be affected if you became disabled. Family members might not be prepared financially to take care of you. You may want to plan ahead by looking into long-term disability coverage so you have enough resources to take care of yourself.
- Your chances of being approved for disability coverage while you're young and healthy are better than later in life. In addition, younger, healthier individuals typically pay lower disability premiums.

While health concerns may not be an issue for you at this stage, you still may be in a higher risk category for disability insurance, and therefore subject to higher premiums, if you participate in certain hobbies, like rock-climbing or sky diving.

Disability Insurance Considerations for All Life Situations

Most people are not prepared to deal with the possibility of becoming disabled and therefore unable to work. However, statistics from the U.S. Census Bureau indicate that in 2000 a substantial portion of the nation's population — nearly 20 percent — had some type of long-lasting condition or disability.

Being knowledgeable about disability insurance options before an accident or serious illness occurs can help ease the financial pain for you and your family.

For insurance purposes, disability is typically defined as the inability to work due to an illness or injury. The exact definition of disability varies markedly among different insurance companies and policy descriptions.

Understand the Basics

There are two main types of disability insurance: short-term and long-term.

Short-Term Disability Insurance

Some states require employers to carry short-term disability insurance for their employees. This type of coverage replaces a portion of the policyholder's salary for a short-period --typically from three to six months following a disability. The specific time period and percentage of replaced income varies with different policies.

Long-Term Disability Insurance

Long-term disability insurance coverage typically begins after the policyholder is disabled and unable to work for at least six months. It can extend for a specified number of years or until the insured retires or reaches the age of 65, depending on the policy selected. Though policies can be costly, being disabled for a long period of time can be financially devastating.

According to research by the U.S. Department of Education and the National Institute on Disability and Rehabilitation, the most common causes of long-term disability are heart disease, back injuries, and cancer, followed by anxiety and depression.

Consumers should not confuse disability insurance with workers' compensation – a benefit that employers are required to carry in most states for employees who are injured on the job.

The NAIC offers the following tips to consumers considering disability insurance:

- Determine how much money you'll need to cover all your critical expenses. Consider all your main monthly costs - mortgage payments/rent, food, utilities and transportation – and figure you will have additional medical costs tacked on due to your disability. Unless your investments and savings can maintain your current lifestyle for several years, you may want to consider purchasing long-term disability insurance, which typically covers about 60 percent of your

previous income (percentages vary per policy/company). Also, you'll need to decide how long you want benefits to last.

- Be aware that having a pre-existing health condition, such as a back problem or heart ailment, coupled with your age, could affect whether you'll qualify for long-term disability insurance and at what cost. You may be subject to a higher premium or be "excluded" completely from purchasing a policy based on your medical history.
- Typically, younger, healthier individuals pay lower disability premiums. If you purchase disability insurance at a young age and can get a "non-cancelable" policy, your coverage can't be cancelled and premiums can't be raised once your medical exam has been approved and your policy issued, assuming your premiums are paid on time.
- While a "guaranteed renewable" policy can't be cancelled, its premiums may be increased on the anniversary of the policy or when stated in the policy.
- Most long-term disability insurance stipulates a waiting period, such as 90 days, 180 days or one year before benefits are paid. The longer waiting period you select, the lower the premium.
- If you have disability insurance and become disabled, you'll need to fill out a claim form. Keep in mind that many insurance companies will require supporting documentation from physicians to verify whether and to what extent you are disabled, before paying out on a claim.
- Find out if your employer offers a group short-term and/or long-term disability plan. Typically, premiums from group plans are less expensive than individual policies. Also explore whether you can convert group disability coverage from your previous employer to an individual policy should you change jobs.

The federal government does offer long-term disability benefits through the Social Security Administration (SSA) under the following circumstances: *"...if you cannot do work that you did before and we decide that you cannot adjust to other work because of your medical condition(s). Your disability must also last or be expected to last for at least one year or to result in death."*

Contacting Your State Department of Insurance

You should contact a state insurance department if you believe you have encountered deceptive sales practices or you discover that the policy you purchased was misrepresented to you. The state you contact should be the state where you are currently listed as a resident, regardless of whether you are currently stationed in some other state or you are stationed outside of the United States . You may also contact your resident state insurance department if you have any general questions about insurance.

For more information regarding the Insurance Regulator in Washington, DC please contact: DC Department of Insurance, Securities and Banking, 810 First Street, NE, Suite 701, Washington, DC 20002, 202-727-8000.

This information was made possible by the National Association of Insurance Commissioners.