Life & Health Insurance Advisor

PomeroyGroup
INSURANCE BROKERS & CONSULTANTS

3134 N. 7th Street, Phoenix, Arizona 85014 | (602) 265-8900 Main (602) 230-0398 Fax | info@pomeroygroup.com

Health Benefits Summer 2020 Volume 13 • Number 2

What the Coronavirus Taught Us

Wash your hands and check your health care benefits to see what's covered!

Because of the COVID-19 coronavirus pandemic we've learned a new term — social distancing — and relearned the importance of thoroughly washing our hands.

We've also learned the importance of understanding what tests, procedures and care are covered by our health insurance. In the beginning weeks of the pandemic, insurance carriers' call centers were inundated by calls from plan members wanting to know if their coverage would pay for the cost of a coronavirus test. Complicating the matter is that copays and deductibles vary depending on the type of plan. According to the Kaiser Family Foundation, the average deductible for single coverage was $1,655 in 2019.

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Stricter Standards Recommended for Selling Annuities

Brokers representing life insurance or investment companies — the two primary types of financial institutions offering annuity products — now must follow a stricter set of regulations.

The National Association of Insurance Commissioners (NAIC) approved a model regulation for insurance producers to follow when recommending annuity products to their clients. NAIC is the United States' standard-setting and regulatory support organization.

Annuities are financial products that offer individuals — usually retirees — a guaranteed

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During the crisis, many insurance companies have covered the costs of the tests, and the Trump administration designated the COVID-19 test as an essential health benefit. This meant that Medicaid and Medicare plans covered the cost of the screening. A few states, including New York and Washington, and some health insurers, waived copayments or deductibles for patients who needed to be tested for the virus. Some carriers waived the pre-authorization requirement for testing or for medically necessary covered services for members diagnosed with COVID-19.

For most individuals with insurance, treatment costs for the coronavirus have been the same as with the flu or pneumonia. Covered members must pay a co-pay for visiting the doctor, and if they are treated at a hospital, they must pay their deductible.

Where to Go to Learn About Your Benefits

One important lesson we can take away from this unprecedented experience is that you shouldn't wait until you're ill or a pandemic strikes to learn what type of health care benefits you have. You also don't have to just rely on calling your health plan's customer service line — which can unfortunately be a long wait during a time of crisis.

Remember, the more you know about what type of coverage you have and what it will cost, the quicker you can respond. Here are a few ways you can find out exactly what will be covered before — or if — you and your family become ill:

Member Welcome Kit

One of your most valuable sources of information is the welcome kit that is mailed to you when you enroll in a plan. Most welcome kits feature:

- ID Cards to demonstrate you have coverage
- Benefit information showing what services are covered
- Details about value-added benefits, such as wellness services or discounts
- Information on how to file a claim
- Pharmacy information
- The insurance company's phone numbers and emails
- Directions on choosing a provider in network if you have a PPO plan.

ID Card

Your ID card is not only your proof of insurance, it also gives providers information on what you will owe as a copay and where the provider should submit a claim.

If you didn't receive a card or have lost your card, call your insurer — their phone number should be on their website.

Login/Website

Insurance carriers provide login, or self-service sites for members to find out more information about their health benefit plans. Not only do these sites usually contain information about benefits, but they also may feature plan documents, claim payments and coverage dates. Some sites allow members to make changes in coverage and update address changes.

income stream. There are two types of annuities. Fixed annuities provide regular periodic payments. Variable annuities allow the owner to receive a larger cash flow when the annuity's investments are doing well, but less cash when the investments do poorly.

NAIC's strengthened annuity sales model law adds a best-interest standard that highlights four obligations: care, disclosure, conflict of interest and documentation. Brokers will need to provide extra effort and documentation to discover a client's financial situation, insurance needs and financial objectives. While agents can recommend products that provide them with a high compensation level, they must be able to show they made recommendations based on a client's best interest.

State insurance regulators now have the option of adopting the model regulation into their own insurance regulations.

Summary Plan Description

Plan administrators must offer covered members a Summary of Plan Document (SPD) which tells participants:

- What the plan provides
- How it operates
- When an employee can begin to participate in the plan
- How to file a claim for benefits.

If a plan is changed, participants must be informed, either through a revised sum-

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mary plan description, or in a separate document, called a summary of material modifications, which must be provided free of charge.

If you can't find a copy of your SPD and want one, you should make your request to the insurance company in writing.

Explanation of Benefits

After a medical provider submits a claim to your insurance company for services rendered, the insurance company will pay the claim and send you an Explanation of Benefits (EOB). This is a statement about your medical insurance claim. The insurance company usually mails the EOB to you, but it may also post it in the login or self-service website. The EOB looks like a medical bill — but it isn't. It explains what portion of the bill the insurance company paid to the health care provider and what portion of the payment, if any, is your responsibility. You should pay any portion of the medical expense not covered by the insurance company, such as a deductible or a copay, directly to the provider.

What Credit Insurance Can and Cannot Do

Credit insurance and credit protection can be prudent options for avoiding financial ruin

With credit card interest rates ranging from under 14 percent to more than 25 percent, you might wonder how long it would take to pay off a credit card making only the minimum payment. Investopedia points out that you would have to pay $200 a month for 11 years and five months to pay off a $5,000 balance at an 18.9 percent interest rate.

With that in mind, credit insurance and credit protection might seem like prudent options for avoiding financial ruin if you can't make a payment or if your credit card is stolen.

Credit insurance, also known as payment protection insurance, is an optional insurance policy you can take out on a specific loan or credit card account. The policy will pay the balance or make payments for you if you are unable due to disability, death or job loss. The average cost is about $1 for every $100 you owe, which is less than three percent of the balance owed for one card.

Credit card protection usually is free or low cost and covers everything from fraud to damaged purchases.

How Credit Insurance Works

Credit card companies often offer credit insurance for their particular card when you first sign up for the service. Coverage usually is offered for free for a specific time after which you are automatically enrolled and billed monthly unless you cancel.

There are four main types of credit insurance:

- **Credit life insurance:** Pays off your credit card if you die. You may not need this if you have enough life or disability insurance to pay off your debts. In addition, the monthly payments might cost more than a traditional life and/or disability policy. And, with a traditional life policy, your dependents would receive the remaining amount of the benefit after the debt is paid.

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- **Credit disability insurance:** Makes your monthly minimum payment for a specified time if you become medically disabled.
- **Involuntary unemployment credit insurance:** Makes your minimum monthly payment on the current balance if you are laid off or downsized.
- **Credit property insurance:** This is not credit card insurance. Instead, it is used to insure the property you used as collateral to secure a loan. It may not be necessary if you already have home insurance or personal contents insurance.

It might seem best to get all four types of insurance, but make sure you're not paying for coverage you don't need. Also, read the fine print. Credit life insurance often comes with age restrictions, waiting periods and pre-existing condition exclusions.

How credit card protection works

The major types of free credit card protection include:

- **Fraud protection:** Federal law ensures that you will be protected if someone fraudulently purchases an item or service on your credit card. You cannot be held liable for more than $50 in unauthorized charges, plus you will not be responsible for any charges if you report the card stolen before charges are made.
- **Purchase protection:** For certain types of items, if you pay with your credit card and your purchase breaks or is stolen within 90 to 120 days, you can get it repaired, refunded or replaced.
- **Price protection:** Many major credit card companies will reimburse you for the difference between the price you paid for an item and a sale price you find within 60 to 90 days.
- **Return protection:** Some credit card companies will reimburse you if you try to return a new, working item to a store within 60 to 90 days of purchase and the merchant won't take it back.
- **Travel insurance:** Credit card companies offer many different types of travel insurance, such as trip accident; trip delay/cancellation; baggage loss/delay; emergency evacuation; or emergency medical attention.
- **Rental car insurance:** Some credit card companies will reimburse you up to the cash value of the car for collision damage or theft for certain types of cars if it's shown that you were not intoxicated or driving recklessly. ■

Know Your Rights: How to Appeal a Denied Health Plan Payment

The first step is making sure the denial wasn't made in error.

Just because a health insurance company says it will pay only part of your claim, that doesn't mean you just have to accept the decision. You have the right to appeal — as long as you do so within the prescribed amount of time — usually 180 days of receiving a notice your claim was denied.

But first, make sure you understand why your claim was denied and what steps you need to take to properly appeal a decision. It pays to take the time to read your policy, check your insurance company's website or talk to customer service to better understand what your policy is supposed to cover. You also must understand the difference between a rejected appeal and a denied appeal.

A rejected appeal occurs when the claim could not be processed due to incorrect information. Rejected claims do not need to be appealed. You only need to correct the error on the health insurance claim form. Then resubmit it for the insurance company to reprocess the claim.

A denied appeal results when an insurance company does not approve payment for a specific procedure, test, or prescription. Some reasons your appeal may be denied include:

- Your health insurance plan does not cover that particular service or procedure.
- You have exceeded the coverage limits in your plan.

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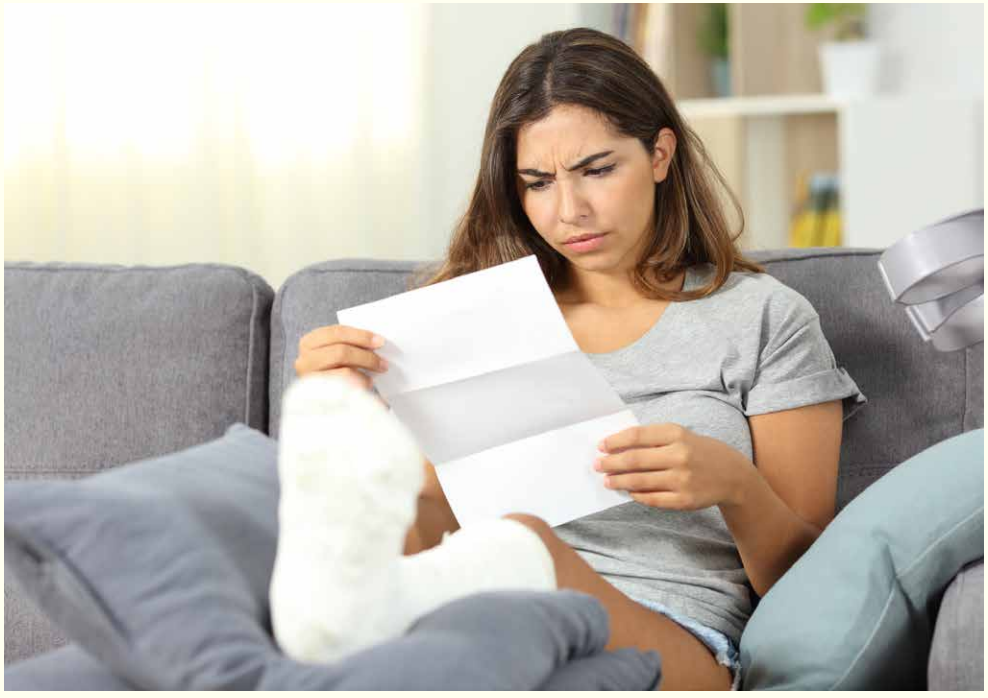
- The drug or therapy is not covered by your health plan.
- You may have used out-of-network services when your health plan requires "in-network" providers.

If you believe that none of these reasons applies to your claim, you can request an internal appeal, which will be conducted by the insurance company. If they reject your claim a second time, you can request an external appeal conducted by an independent third party.

Internal Appeals

You should receive an explanation from the insurance company about why your claim was denied and the steps you can take to appeal the decision.

Before calling an insurance company representative, find your policy information, the summary of benefits and the denial letter. Prepare a list of questions. Take notes and get the name of the person you're talking to and the date and time of the conversation. This might fix the issue if the claim was denied because of a simple error.



However, if your claim wasn't denied because of error, you must write the insurance company a formal letter asking them to reconsider the claim. Your letter should include:

- The service, treatment, or therapy that was denied and the reason for the denial.
- A request that they appeal the decision.
- The claim number.
- History of your medical condition or health problems.
- Explanation of why the treatment is or was medically necessary.
- Supporting information from your doctor, such as a letter.
- Evidence, such as medical records, X-rays and lab results.

Remember that you can ask for an expedited appeal if you or your doctor thinks the denial of your claim is life-threatening.

Independent External Review

You can ask for an independent external review if your claim is still denied after an insurance company internal appeal. Many states have an external review process. If they don't, the federal Department of Health and Human Services will oversee the review. Your explanation of benefits or the final denial of your internal appeal should have the contact information about who will handle your external review.

You must file a written request for an external review within 60 days of the date your insurance company sends you a final decision on your internal appeal.

How Life Insurance Companies Get to the Truth

Life insurance companies need honest answers to questions about your health to determine appropriate premiums and coverage levels. Some applicants are tempted to leave out or misstate information they don't see as important — or think will adversely affect their benefits.

Some of the areas people "fudge" on are:

- tobacco or drug use;
- depression;
- tickets for driving under the influence and moving traffic violations;
- cancer history;
- travel to dangerous locations; and
- income.

But insurers do their homework. To verify health and life insurance information, they can access the Medical Information Bureau (https://www.mib.com/facts_about_mib.html). (You can get a free copy of your record upon request.) They may also order a medical exam. Discrepancies between your application and their research could lead to a claim denial, higher premiums or policy cancellation.

Also, if an autopsy reveals application misinformation, the insurer could deny the beneficiaries' claim.

Fortunately, most applicants tell the truth!

If you're interested in getting life insurance coverage and are wondering if you'll qualify for a great premium and great coverage, contact your agent.

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