

Risk Management: Health Insurance and Disability Income Insurance

A severe illness, or a number of minor ones in a short period, can destroy the family budget and bring on indebtedness. Medical costs present a major problem throughout the life span. However, with adequate health and disability insurance, the risk of possible financial disaster from a costly illness or accident can be largely avoided.

Looking ahead to the possibility of illness is unpleasant, and if your family is healthy at the moment, it may seem like “borrowing trouble.” But medical problems have a way of showing up when least expected, bringing the inevitable bills and the possibility of financial ruin.

There are hundreds of different policies and plans of health and disability income insurance available with almost as many different rates. This publication will help you review various plans so that you can choose the ones that will give the most protection for the price you can afford.

Cost of Medical Care

The cost of medical care is ever-increasing. Health insurance is becoming one of the most expensive categories of your financial plan. Even if your employer pays part or all of your health insurance premiums, he or she does so by paying you less in wages.

If you are making a financial plan for the first time and have not kept records of your expenditures in the past, you may not know your health care costs.

Some of the known factors that influence the amount spent on medical care are income, family size, education, and the age of the head of the family. What you spend will not be affected as much by where you live as by your

income level. Usually the larger the family, the more you can expect to spend on medical care.

Not all of your health care needs must be met out of your budget. Some free or nominal-fee services (such as immunizations and TB testing) are available from your local health department and from voluntary societies organized to combat diseases.

Determining Health Insurance Needs

Since you have no way of knowing ahead of time what to expect in the way of medical bills, a two-fold approach to fitting the cost of medical care into your family financial plan is best. First, plan to pay for the normal or routine cost of medical care directly out of income. These costs include items such as regular examinations, inoculations, general dental care, and first-aid supplies. Second, carry insurance to cover the unexpected—costly emergencies and serious chronic illnesses.

When determining your possible losses from an injury or accident, weigh the costs of direct medical care such as a hospital room, doctor’s fee, and lab work. Include the need for recuperative care and rehabilitation expenses. Remember the cost of lost income. Be aware of how large and unpredictable these costs can be.

Find out if you are eligible for other forms of insurance (other than health insurance) that will pay for health-related losses. Check into the medical payments coverage of your automobile policy. Consider government funded programs, such as:

- Medicare,
- Medicaid,
- veteran’s benefits, and
- Social Security disability income insurance.

The coverage from these sources is limited and not the topic of this publication. In most instances you will need to consider some other kind of health insurance. The next section describes the types available.

Types of Health Insurance Coverage and Policies

The term health insurance is a general name for a wide variety of insurance coverage that covers financial losses resulting from illness, injury, or disability. No one policy or plan provides coverage for all types of losses that can occur.

Group policies covering employees of a business or other organizations provide most health insurance coverage. Group coverage usually applies automatically to those employed by organizations that have group policies in force. People not covered by group plans buy individual policies that cover one person or one family. Individual policies are sometimes used to supplement the coverage provided by group policies and often are obtained from the same agents who handle the rest of a family's personal insurance needs. Group coverage is generally more economical than an individual policy.

There are five standard types of health insurance that cover the cost of treatment associated with an illness or an accident. They are:

- hospital expense insurance,
- surgical expense insurance,
- regular medical expense insurance,
- major medical expense insurance, and
- comprehensive medical insurance.

Supplemental health insurance policies are designed to fill the gaps in the coverage of the five standard health insurance coverages or to provide reimbursement in addition to that provided by the standard policies.

Supplemental policies usually are advertised directly through the mail or on television. Many of these policies are not all they claim to be and their prices are too high. Often they contain severe limitations on the coverage provided or the amount to be paid. Purchasers sometimes are unaware of the limitations until they request a reimbursement. The supplemental policies to buy with caution are:

- accidental death and dismemberment insurance,
- specific disease insurance, and
- hospital indemnity insurance.

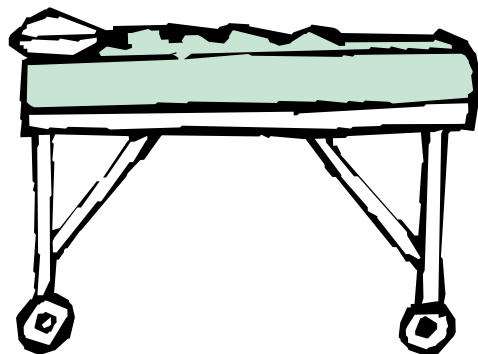
Dental insurance is a relatively new form of insurance mainly acquired through group plans. It covers your costs for dental care.

Disability insurance is the form of health insurance that covers your loss of income while you recuperate from an accident or illness. If you are a wage earner, it is essential that you buy disability insurance.

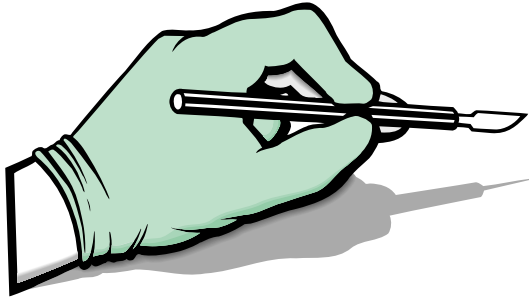
Hospital Expense Insurance

This kind of insurance covers the hospital's charges for room and board and may also cover additional expenses such as operating room fees, lab work, x-rays, and medications. A specific amount usually is allowed for each day in the hospital up to a limited number of days. Hospital expense insurance is the most basic form of health insurance available. Important things to consider when buying this kind of coverage are:

- number of days in hospital covered;
- amount policy will pay per day for board and room;
- amount policy will pay for additional services such as x-rays, lab work, and medication;
- waiting period for certain illnesses;
- amount of deductible, if any;
- exclusions or limitations in the policy; and
- provisions for renewing the policy.



Surgical Expense Insurance



Benefits for surgical care usually are paid according to a predetermined schedule of fees that states the maximum payment for each kind of operation. Fees for office calls made before and after the operation may be included. Benefits are not the same for all policies. Frequently, surgical insurance is bought in combination with the hospital policy. Evaluate a surgical expense policy by questioning whether:

- the benefits are in line with surgeons' fees in your community,
- the policy pays a cash or service benefit,
- the policy covers surgery only if you are hospitalized,
- the policy pays for services of a second surgeon or the anesthesiologist, and
- the policy has benefit limitations and exclusions.

Regular Medical Expense Insurance

Regular medical or physician expense insurance provides reimbursement for doctors' services other than those connected with surgery. Such policies usually include a dollar maximum per year, as well as a co-insurance clause and a deductible clause. Determine how adequate a policy is by comparing:

- what is covered,
- the deductible and co-insurance clause, and
- the limitations and exclusions.

Major Medical Expense Insurance

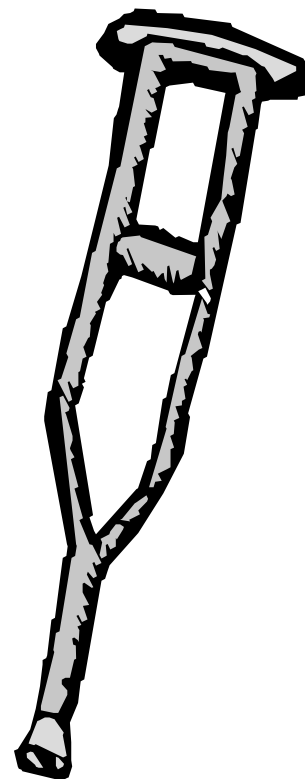
Major medical expense insurance is the most important type to have. Benefits provide protection against the large cost of serious accidents or expensive, prolonged illnesses. Major medical covers a broad range of medical services with a single policy by paying a major share of the cost of a treatment prescribed and

performed by a doctor, including hospital and surgical treatment.

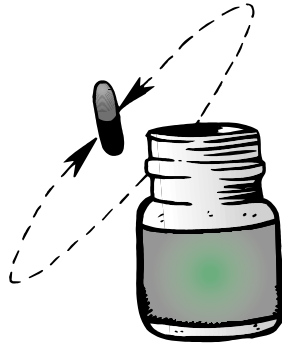
This kind of policy usually includes a large deductible, which can range from \$300 to \$1,000 or more, and a co-insurance provision that requires the insured to pay anywhere from 10 to 30 percent of a claim. This means that the insured pays a percentage of the total over and above the deductible portion of the expense. A stop-loss feature sets the maximum the insured must pay on a claim. This may be \$1,000 or more and substantially reduces the burden of the co-insurance feature. Usually, there is a maximum amount of benefits for each policy, which may be as high as \$1 million or more. Deductibles are an important way to reduce the premium costs of small claim handling and duplication of coverage.

Major medical coverage often is used as a supplement to a basic plan. It also may be combined into a single policy called comprehensive major medical insurance. Analyze a major medical policy by checking:

- the policy limits,
- the size of the deductible,
- the provisions of the co-insurance clause,
- renewability of the policy, and
- how maximum policy limits are computed.



Comprehensive Medical Insurance



This is a plan that combines the features of the basic (hospital, medical, and surgical) and major medical expense insurance plans. It generally has a deductible clause, a co-insurance provision, and stop-loss feature. Like major medical expense insurance, the maxi-

mum benefits usually are high. Determine the adequacy of a policy by comparing the features previously mentioned for other kinds of policies.

Accidental Death and Dismemberment Insurance

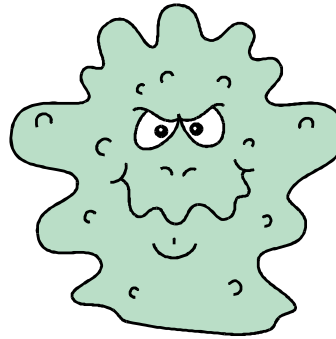


This policy covers reimbursement for medical costs resulting from accidents. An injured person might receive \$500 for the loss of a leg, \$1,500 for the loss of an eye and so on, with a maximum payment of \$10,000 if the insured dies.

Accident insurance is a poor insurance buy. A wiser strategy is to buy health insurance to cover the medical costs of accidents, disabil-

ity insurance to cover loss of income, and life insurance to cover loss of life.

Specific Disease Insurance



Specific disease insurance provides an unallocated benefit subject to a maximum amount for expenses incurred with the treatment of specific dreaded diseases, such as cancer. The limits on these policies usually are quite large and the premium is quite low.

These policies, like accident insurance, are a poor insurance buy. The likelihood of contracting the specified dreaded disease covered by the policy is small. You should buy a comprehensive policy that covers all kinds of diseases and accidents.

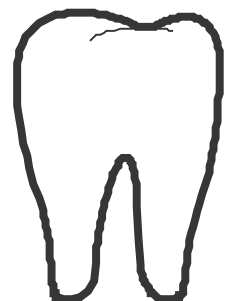
Hospital Indemnity Insurance

Hospital indemnity or income plans provide a stipulated daily, weekly, or monthly benefit during hospital confinement only. Be aware of misleading advertisements offering large payment figures. If a policy states that it will pay \$1,000 per month, in reality, it will pay only about \$33 per day.

Many of these policies do not start paying benefits until after you have been in the hospital for a number of days. The average hospital stay in the United States is less than 5 days. Chances are that you will not collect many benefits with this kind of policy. If you are unfortunate enough to be in the hospital for more than 5 days, you will find the settlement insignificant.

Dental Insurance

Dental expense insurance is a rapidly expanding kind of coverage that helps pay for normal dental care. Generally, it is available through insurance group plans, prepayment plans, and dental service corporations.



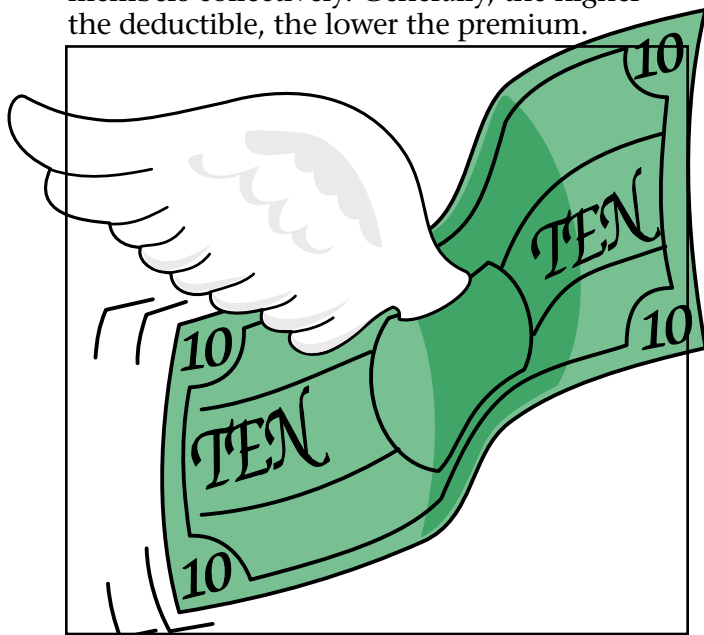
Under these programs virtually all forms of dental care may be covered, including oral examinations, x-rays, fillings, cleaning, extractions, inlays, bridgework, dentures, oral surgery, root canal therapy, and orthodontia.

The cost of dental insurance, like the cost of health insurance, is subject to many variables. Policy limits, deductibles, co-insurance clauses, and exclusions vary widely among policies. A common feature is a schedule of benefits for specified procedures.

Policy Provisions

Deductible and Copayments

The requirement in an insurance policy that the insured pay an initial portion of a loss before receiving insurance benefits is the deductible. It could range from \$100 to \$1,000 or more. This policy provision is designed to eliminate small claims. Check to see whether the deductible applies to each illness, to a particular time period, and to one or all family members collectively. Generally, the higher the deductible, the lower the premium.



The copayment is similar to the deductible in that it requires the insured to pay a specific dollar amount for covered expenses. Copayments are generally required if you are enrolled in a managed care plan. For example, you might have to pay \$10 for each office visit. The copayment differs from a deductible in that a deductible might require you to pay the first \$200 of medical expenses, while a copayment requires you to pay a certain amount for each medical expense.

Co-insurance Clause

The co-insurance clause is a policy provision in a health insurance contract by which both the insured person and the insurer share the covered losses under a policy in a specified ratio, typically, 80 percent by the insurer and 20 percent by the insured. The deductible is paid by the insured before this shared arrangement.

Usually a co-insurance cap or stop-loss feature limits the annual out-of-pocket expense made by the insured when meeting the co-insurance.

The following example illustrates a policy with a \$300 deductible, an 80-20 co-insurance clause, and a \$1,000 co-insurance cap. If you claim \$10,300, the insurance company will pay \$9,000.

To calculate responsibility, first, deduct the deductible, which is the responsibility of the patient, from the total bill. The 80-20 ratio is applied to the remainder of the bill. Any excess of the \$1,000 co-insurance cap is paid by the insurance company.

$$\$10,300 - \$300 = \$10,000$$

$$\$10,000 \times 80\% = \$8,000$$

$$\$2,000 - \$1,000 = \$1,000$$

The patient is responsible for the \$300 deductible plus \$1,000 of the total charges.

Policy Exclusion

Specific conditions or medical procedures may be excluded in a policy; this means that the policy will not provide benefit payments. Most policies exclude elective cosmetic surgery. Avoid policies that exclude treatment for mental illness or coverage for convalescent expenses, such as nursing home care required after major surgery.

Waiting Periods

The waiting period is the length of time the insured must wait for coverage by the insurance company. Policies that cover maternity benefits usually have a waiting period of 9 or 10 months.

Renewability

Renewability refers to a policy that guarantees the insured person the right to renew a policy by timely payment of premiums.

This contract usually is more expensive than one that may be canceled at any time. Avoid buying a policy renewable at the company's option because the company may cancel when you need the insurance the most.

Policy Limits

The maximum amount a policy will pay is the policy limit. These limits may apply to each illness, to the life of the policy, or to a calendar year. Computation per illness is best; computation per calendar year is second best, and computation over a lifetime is least desirable.

Benefit Payments

Benefit payments can allow a specified amount, a cash benefit, or a service benefit. The specified amount or flat dollar benefit pays you a stipulated amount for a loss. What you do with the money is up to you. Hospital indemnity plans offer an example of this form of payment.

Some policies pay a cash benefit for each covered health care service up to a set maximum. These policies include a schedule of benefits paid. If your costs are less than listed on the schedule of benefits, the reimbursement would be for that smaller amount. If your costs are more, the reimbursement will be for the maximum amount scheduled and you will pay the difference. Surgical expense policies offer an example of this form of payment.

When a health insurance policy states that it will pay all necessary and reasonable charges, it provides a service benefit. Service benefits are subject to a deductible and co-insurance clause. The payments under service benefit



contracts are generally made directly to the hospital or doctor. Major medical expense insurance typically provides service benefits.

Coordination of Benefits

Most insurance policies are designed to indemnify, which means “put you back in the position you were in before you suffered the loss.” They will pay no more than the actual financial loss suffered. This is maintained in health insurance policies through the coordination-of-benefits clause. This clause prevents you from collecting more than 100 percent of a loss and designates the order in which policies will pay benefits if more than one policy applies to the loss. The primary policy is the insurance policy that will be applied to the loss first. If the primary policy fails to reimburse 100 percent of the loss, the secondary policies will be applied in order, until the loss is paid fully or benefits are exhausted, whichever occurs first.

Convertibility and Portability

Should you have group health insurance through work and lose your job, there are steps you can take to protect yourself and your family until you find another job:

- First, find out exactly how long, or if, your insurance will continue after your last day at work. It may be 30 days, sometimes longer, depending on your employer's policy.
- Check to see how you can convert your group coverage to an individual policy, keeping in mind that the policy will be more expensive, but the waiting period and preexisting condition limitations will not apply.
- If your spouse is employed, see if you can receive coverage through his or her employer.
- If you would prefer not to convert your group coverage, and you are healthy and want complete protection, consider an interim or short-term medical policy. These policies frequently will insure you from 2 to 6 months, including payments toward hospitalization, intensive care treatment, doctor in-hospital visits, surgical expenses, miscellaneous hospital expenses, and convalescent nursing home care. Outpatient diagnostic x-ray

or laboratory procedures and ambulance coverage also are included. Most interim policies are effective immediately or within 30 days of purchase. Many may be reissued once during a 12-month period. As with other kinds of health insurance, you are advised to take the interim policy in which you absorb the small medical bills, while your insurance company handles the big ones. Choose a policy with as large a deductible as you can manage to lower your premium.

Sources of Health Insurance

You can obtain health insurance as an individual or as part of a group. A group health insurance policy is made available through a contract with an employer or other sources, such as associations.

In most instances, it is to a person's advantage to enroll in a group insurance plan. In many cases, an individual will be covered immediately and often may be insured regardless of physical condition. Also, the premiums generally are lower than for an individual policy. Many times an employer will contribute much of the premium or will at least offer the payroll method of deduction.

Individual (Private) Health Insurance

There are private insurance companies, nonprofit health insurance organizations, and alternatives to traditional health insurance (managed care plans). Managed care plans are rapidly evolving and variations continue to emerge.

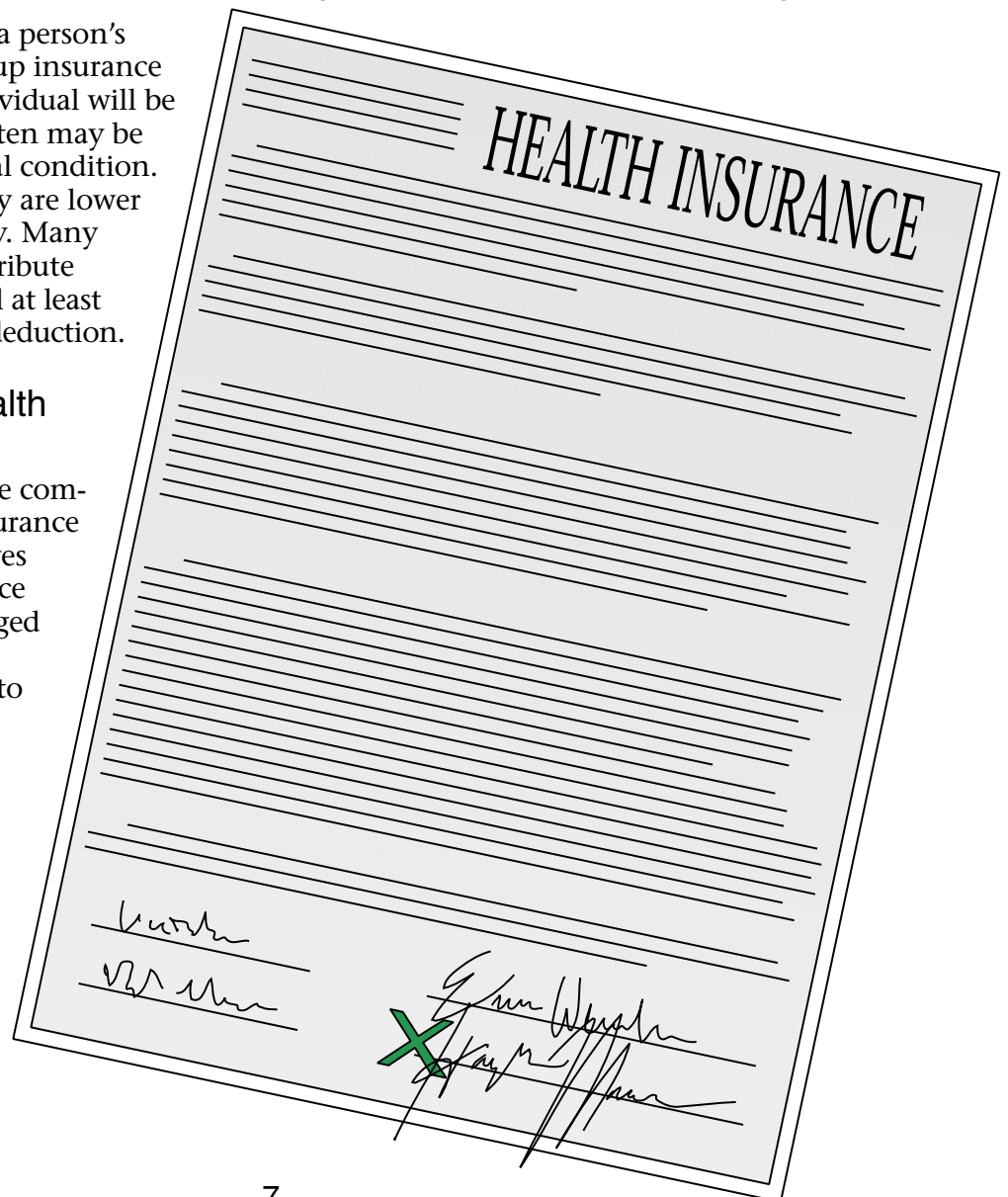
There are hundreds of private health insurance companies (e.g., Blue Cross/Blue Shield and Aetna) operating in the country, providing benefits for approximately one-half of the population. Individual or family policies may be bought through an agent or

directly through a company. An individual policy can be tailored to fit a particular need.

Private health insurance policies also are offered through magazines, newspapers, or by direct mail. Before buying a policy offered by one of these methods, compare the benefits with another company. You should be suspicious of companies that offer extremely high benefits for small premiums. Rarely will such advertisements mention the serious exclusions that drastically reduce benefits.

Managed Care Plans

A managed care plan is any health care plan that pays or reimburses for health care expenditures and exerts significant control over the condition under which health care can be obtained. The three best known forms of managed care are health maintenance organiza-



tions (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans.

Health maintenance organizations are health care providers that operate on a regular prepayment basis. Because they collect only the monthly fee, they have an incentive to keep costs and unnecessary procedures to a minimum. Generally, HMOs do not cover care provided by a physician who is not a member of the plan or who was not referred by the HMO.

For the set monthly fee, HMO members receive a wide range of services including regular checkups and other outpatient expenses, and sometimes dental care. When sick, the insured also gets most of the necessary health services. This includes a doctor's care, specialists if needed, lab work, x-rays, drugs, hospitalization, and surgery at no extra cost. Most HMOs require a small copayment of \$5 to \$20 for each office visit.

When hospitalized or in need of expensive medical care, the HMO pays the bill. Therefore, there is a financial incentive to keep patients healthy. HMOs that stress preventive health care are increasing in number.

Some insurers offer preferred provider organizations. These are groups of doctors, hospitals, and other health care providers who contract with the insurance company to provide services at a discount. PPOs provide their members with essentially the same benefits HMOs offer. However, unlike HMOs, PPOs do cover care provided by nonmember physicians. However, patients of nonmember physicians must pay a deductible and co-insurance, and may be responsible for any fee that exceeds the amount the insurer considers unreasonable.

Another variation of managed care is the point-of-service plans, which combine characteristics of HMOs and PPOs. POSs use a network of selected contracted, participating providers. Patients who receive care from a plan provider pay little or nothing. Medical care provided by out-of-plan providers will be reimbursed, but the patient must pay higher deductibles and copayments.

When You Decide to Buy Health Insurance

When you decide to buy the insurance, complete the application carefully. Some companies ask for detailed medical information. If they do, omitting specific medical information or submitting false information can be costly to you. The company can refuse coverage for an omitted condition for a period of time, or it may deny a claim and cancel your policy.

Pay by check or money order made payable to the insurance company, not the agent or anyone else.

You should be given a clearly worded summary of the policy. Read it carefully. By law, a health insurance policy must be written in nontechnical language (be easy to read), be in large print, and must have a disclosure statement and a glossary, which explains terms.

Companies must give you at least 10 days to review the policy. If you decide you do not want to keep it, send it back to the agent or company within 10 days of receiving it and you will get a refund of all premiums you paid.

The insurance company should deliver a policy within 30 days. If not, contact the company and obtain in writing a reason for failure to deliver. If 60 days go by without information, contact the Maryland Insurance Commissioner. The same schedules should be followed if you return the policy, but do not receive your refund.



Disability Income Insurance

Disability income insurance is more important for a wage earner to buy than life insurance. Statistics show that 8 out of every 10 people between the ages of 25 and 65 will become disabled for 90 days or more sometime during their lives. At age 35, your chance of a total disability of 3 months or more before age 65 is 33 percent. In fact, the likelihood of becoming disabled between the ages of 35 and 65 is twice the chance of dying.

Disability income insurance is a form of health insurance that provides payments for a specified period of time. The payments are for partial replacement of income lost by an insured person who is unable to work as a result of an illness, injury, or disease. It is important to note the waiting period, or stated time, between the period of disability and the start of disability insurance benefits, during which no benefits are payable.

The amount of the benefit may vary depending on whether the disability is partial or total, and the duration of the benefits may vary depending on whether the disability is the result of an injury or illness.

Total disability can be defined as “your complete inability to perform any and every duty pertaining to your own occupation” or “your complete inability to engage in any reasonably gainful occupation for which you may become fitted by education, training, or experience.” The first definition is more liberal than the second because it refers to your own occupation rather than to any occupation. Some policies combine the two definitions, using the first to satisfy the requirement for total disability during an initial stated period of disability (usually 2 years) and defining total disability thereafter in terms of the second definition.

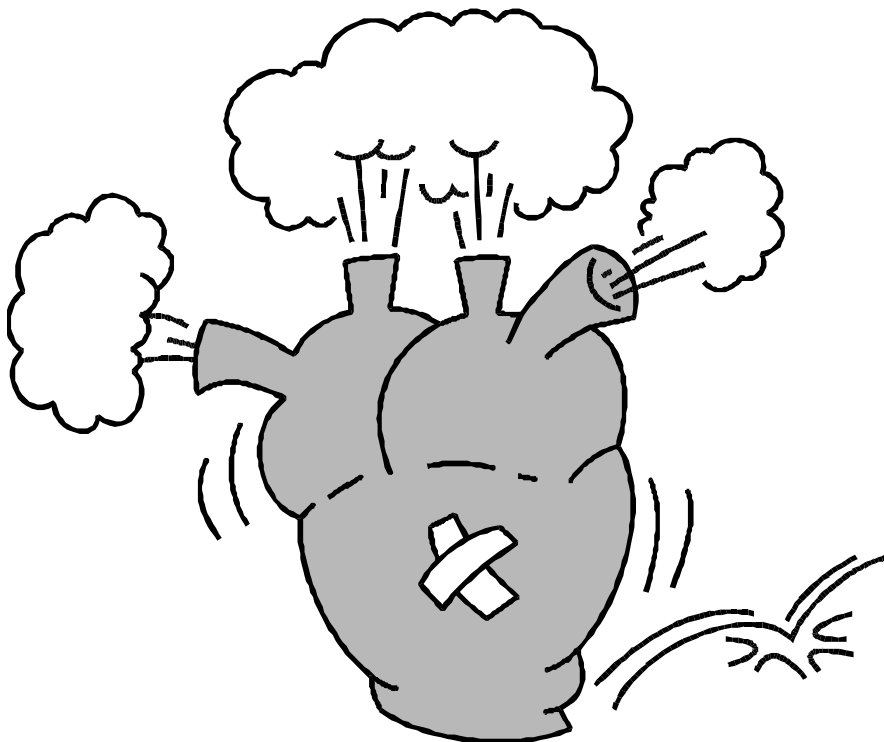
Partial disability is even more difficult to define than total disability. It usually is measured in terms of your ability to perform some of the important duties of your job. One policy defines it as “the inability to perform one or more, but not all, of the important daily duties pertaining to your occupation.”

A policy’s definition of disability heavily influences the probability of your qualifying as disabled. The more restrictive the definition, the less likely you will collect benefits. A liberal definition of a disability is desirable, although the annual premium will be higher per dollar of income coverage.

Disability income policies generally are divided into two kinds: those that provide benefits for up to 2 years (short term) and those that provide benefits for a longer period, usually 5 years or to age 65 (long term).

When determining your disability insurance needs, consider other sources of income available to you such as sick leave, worker’s compensation, Social Security, employer plans, credit disability on loans or home mortgages and other assets.

Buy disability income insurance with as long a waiting period as your budget will allow. This will lower the premium considerably. Buy a policy that is noncancellable and guaranteed renewable until you reach a certain age, usually 65. As with all health insurance policies, check the policy exclusions.



Some Final Tips

- Shop carefully before you buy health insurance. Policies differ widely in coverage and cost, and companies differ in service. Contact different companies and compare policies carefully before you buy.
- Do not buy more coverage than you need by trying to cover 100 percent of your costs. A single comprehensive policy is better than several policies with overlapping or duplicate coverages.
- Choose a comprehensive policy with a large deductible. The savings on premiums will be substantial. Set up a special savings account to cover the large deductible using the saved premium dollars.
- Increase the stop-loss feature of your policy to further reduce your premium costs.
- Do not buy insurance against named accidents or diseases. Get coverage against medical expenses from any cause.
- Do not lie on your insurance application. If you fail to mention a preexisting condition, you may not get paid when you need it.
- Do not try to insure against routine or predictable expenses such as checkups. Buy a policy that will reimburse you substantially for large expenditures.
- Check for preexisting condition exclusions that reduce or eliminate coverage for existing health conditions. Many policies exclude coverage or require a waiting period before covering preexisting health conditions.
- Do not be misled by the phrase “no medical examination required.” If you have had a health problem, the insurer might not cover you for expenses related to that problem.
- Beware of replacing existing coverage because you think it is out of date. Changing policies may subject you to new waiting periods and new exclusions. Consider adding to your present policy if necessary.
- On the other hand, do not keep policies that are inadequate just because you have been a customer for many years.
- Most policies have a limit (maximum) to the benefits they will pay. This might be expressed in terms of dollars or in the number of days for which payment will be made.
- Check your right to renew. Beware of policies that let the company refuse to renew your policy on an individual basis. Policies that automatically can be renewed offer added protection.
- Know with whom you are dealing. A company must meet certain qualifications to do business in Maryland. This is for your protection. Agents must be licensed and must carry proof of licensing showing their name and the company they represent. If the agent cannot show proof, do not buy from that person. A business card is not a license.
- Keep the agent’s and the company’s name and address. Write them down or ask for a business card.
- Take your time when buying health insurance. Do not let a short-term enrollment period rush you into a decision. Professional salespeople will not high-pressure you. If you question whether a policy offers sufficient benefits, ask the salesperson to explain it to a friend or relative whose judgment you respect.
- Insurance is cheaper if the premium is paid yearly. Any insurance plan where an agent collects at the door weekly or monthly will have higher rates for less coverage.
- Keep your insurance policy in a safe place at home. Keep a master list of all insurance policies and policy numbers in a safe-deposit box. If the policy is lost or destroyed, request a replacement policy

Some Final Tips (continued)

from the insurance company using the policy number from the master list.

- Buy insurance from a substantial, well-established company rated A or above by insurance rating services. This information can be found in your local library.
- Beware of health insurance sold through the mail or in television and newspaper advertising. Be particularly cautious if the policy has unique guarantees for the elderly, for veterans, or for dreaded

diseases such as cancer. Check these companies with the Maryland Insurance Commissioner and compare their offerings to those of a local, reputable company before buying.

- Report all problems to the Maryland Insurance Commissioner located in Baltimore. Contact the Maryland Insurance Commission, 525 St. Paul Place, Baltimore, Maryland 21202, 410-468-2000 or 1-800-492-6116.

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by

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Appendix A

Comparison of Health Insurance Policies

Company	Insurer 1	Insurer 2	Insurer 3
Policy Limits			
Hospital room (\$/maximum days)	\$_____ for _____ days	\$_____ for _____ days	\$_____ for _____ days
Surgical maximum	\$_____	\$_____	\$_____
Hospital extras	\$_____	\$_____	\$_____
Physician care	\$_____	\$_____	\$_____
Major medical maximum	\$_____ per _____	\$_____ per _____	\$_____ per _____
Deductible	\$_____ per _____	\$_____ per _____	\$_____ per _____
Co-insurance percentage	_____ %	_____ %	_____ %
Stop-loss amount	\$_____	\$_____	\$_____
Other policy features	\$_____	\$_____	\$_____
Renewability provisions	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Policy exclusions	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Waiting period for pre-existing conditions	_____	_____	_____
Annual premium	\$_____	\$_____	\$_____