

CALIFORNIA BROKER

VOLUME 33, NUMBER 10

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

JULY 2015

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Agents Are the Answer



by ERIC WILSON

IS OBAMACARE ALL IT IS SAID TO BE?

The great author and motivational speaker Zig Ziglar used to say he read the Bible and the *National Enquirer* every day because he had to know what both sides were doing. When we read stories about the Affordable Care Act, we need to know both sides of the story.

One of the stories is people are paying less for their health insurance than they were before the new law being enacted. This one I find interesting. We know that insurance premiums went up in 44 states. Some of the more affordable plans have a smaller network of doctors. The lowest priced Bronze level plans do not have adequate coverage for prescriptions for some people's needs. When the 2015 rates came out, the increase was less than expected. This was because the rates have to be filed for the following year early, around June.

The insurance carriers only had six months of claims history to project their rates for the following year. We also know insurance deductibles and out-of-pocket maximums went up with it. So insurance costs more than it did before the law. Many Americans qualify for what is called an "advanced premium tax credit," otherwise known as a subsidy. Depending on your income, you may get a subsidy, so you may be paying less even though the premium is higher. Since deductibles and out-of-pocket maximums are higher, even though you may be paying less, if you spent significant time in the hospital, it could cost more. Insurance carriers are now submitting their rates for 2016. They now have over a year's worth of claims analysis. Blue Cross Blue Shield of New Mexico has filed for an increase of 51%. In Tennessee, Blue Cross Blue Shield are asking for 36%. In Georgia, an insurance company is asking for 64%.

Another great debate is more people have insurance now than before the Affordable Care Act. This debate has no easy answer. The uninsured rate has fallen, but so has the unemployment rate. According to a recent Rand Research study, the largest gain in health insurance was in the employer market. As many as 9.6 million Americans got employer health insurance. Is that an effect of the law or the economy improving? The expansion of Medicaid also contributed to the uninsured rate. Some people question whether this should be counted. Medicaid is coverage provided by the state. It is not really insurance since there is usually not an insurance carrier. The State reimburses doctors and hospitals, but not at a rate as good as insurance companies do. Not every state chose to expand Medicaid. Those who are

new Medicaid recipients are counted as insured. It is estimated that about 6.5 million Americans were added to the Medicaid system. More people have enrolled in expanded Medicaid than through the health insurance marketplace. Between the Marketplace (health insurance exchange) and those who purchased off the Marketplace, a total of those gaining coverage was 5.3 million. The Congressional Budget Office (CBO) now estimates that 29 million to 31 million Americans will remain uninsured 10 years from now.

Many of the supporters of the law still profess that the ACA plans are more robust than the previous plans. I have not heard the proponents actually support these claims. The ACA plans focus on preventive care. The supporters say they have free preventive care. As we learned when we were kids there is no such thing as a free lunch. The cost of free is built into the premium. All health plans now have to have what are called Essential Health Benefits (EHBs). Most of the plans before the ACA had many or all of these benefits, though not necessarily required by law. Some of the others like mental health coverage or maternity varied by state. Many were optional benefits offered by the carrier. One that has been enhanced was the preventive care benefit in all plans offered without co-payment or deductible as previously mentioned, I would not say free.

While enhancing the essential health benefits is a nice idea, it comes with a premium. The more you require a plan to cover, the more it adds to the premium. The new ACA plans have higher deductibles. In many cases, they are twice as high as they were so you are more vulnerable at the time of claim. To try and offset the increasing costs, many carriers have shrunk their network of doctors and hospitals. The idea here is to pay them less per service, but drive more volume to the facility. So the thought that you could keep your doctor, may or may not be accurate. Many people have been forced to change doctors, or change insurance carriers.

Lastly, the *Wall Street Journal* cited a study from Moody's Investors Service showing that non-profit hospitals in the states that expanded Medicaid are not seeing more unpaid bills and more paying clients. Seeing more Medicaid patients and lower reimbursements does not make up for the reduction in reimbursements under the law. If hospitals have to go out of business, it won't matter how many Americans have insurance. ★

Eric Wilson is principal of Wilson Associates, a health care insurance company.

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	Bests	Fitch	S&P									
American Equity	A-	BBB+		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.25%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.70%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
*Effective 6/5/15. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG	S	2.15%** 2.00%** ^b	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000(Q&NQ)	1.5% age 0-75 .75% age 76-85
*CA Rates Effective 5/18/15. First year rate includes 1.50% interest bonus. a (\$100K or more); b (less than \$100K)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.25%** ^a 1.25%** ^b	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.00% age 0-85 1.00% age 86-90
*CA Rates Effective 6/1/15. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years.												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.70%*	5 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ) \$2000 Q	3.00% age 0-85 1.50% age 86-90
*CA Rates Effective 5/18/15. First year rate includes 4.0% bonus 1st year.												
American General Life Insurance Companies	A	A+	A+	American Pathway Flex Fixed 8 Annuity (Q/NQ)	F	4.00%* *(includes a 2% interest rate bonus for first year)	1 yr.	None	8%, 8%, 8%, 7%, 6%, 5%, 3%, 1% 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.20% age 0-75 1.70% age 76-80 1.20% age 81-85
*CA Rates Effective 4/13/15;												
Genworth Life & Annuity Insurance Co.	A	A-	A-	SecureLiving Rate Saver	S	2.70%* 2.45%	7 yrs. 5 yrs.	None None	9%, 8, 7, 6, 5, 4, 3 9%, 8, 7, 6, 5, 0	Yes	\$25,000 (NQ)	Varies 0-85 *Effective 6/17/15. Based on \$250K or more.
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.40%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 6/8/15. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.40%. For under \$100,000 first-year rate is 2.40%. Escalating rate five-year yield 2.25%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.65%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 6/8/15.. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.54%. For under \$100,000 first-year rate is 2.55%. Escalating rate seven-year yield 2.44%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.75%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 6/8/15. Eff. yield is 2.77% based on 1.75% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.75%. Surrender value interest rate 1.75%. Accepts additional purchase payments in first three contract years. COM12255												
Jackson Insurance Company.	A+	AA	AA	Bonus Max (Q/NQ)	F	3.20%*	1 yr.	None	8.25%, 7.25%, 6.50%, 5.50%, 3.75%, 2.75%, 1.75%, 0.75%**	Yes	\$5,000 (NQ) \$5,000 (Q)	6.00% 0-80 3.00% 81-85 1.50% 86-90
*Effective 10/6/2014. The first year interest rate includes any first year additional interest, if applicable. Interest rates in subsequent years will be less. **Each premium payment, including any subsequent premiums, is subject to the withdrawal charge scheduled as detailed.												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.65%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
**Rates Effective 6/1/15 for premium less than \$100,000 and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	2.05%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	
**Rates Effective 6/1/15 for premium less than \$100,000 and are subject to change.												
North American Co. for Life and Health	A+	AA-	A+	Boomer Annuity (Q/NQ)	F	6.57%*	1 yr.	None	15%, 14, 13, 12, 11, 10, 8, 6, 4, 2	Yes	\$2,000 (Q) \$10,000 (NQ)	7.00% (0-75) 5.25% (76-80)
* 6.57% First Year Yield reflects a 5% Premium Bonus in years 1-5, annuitization bonus after year 10. Penalties are waived at death. This yield assumes no withdrawals. The Interest Rate is based on current rates as of 6/4/15 and is subject to change.												
Reliance Standard	A+		A+	Eleos-MVA	S	3.30%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 6/9/15. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+		A+	Apollo MVA (Q/NQ)	S	4.25%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 6/9/15												
Symetra Life, Inc.	A	A+	A	Custom 7 (Q/NQ)	S	3.05%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 6/16/15. 2.55% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												



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THE EXPANDING WORLD OF ACA AUDIT & PENALTY ENFORCEMENT

How to Survive the Surge

by DENNIS FISZER

The first wave of audits enforcing compliance under the Affordable Care Act (ACA) ran its course in 2012. Since then, the risks have further elevated; now other government bodies that co-enforce the ACA are introducing audit activities of their own.

Government entities are working under inter-agency “memorandums of understanding” to communicate with each other about their audit findings. An auditor who notices a problem outside of their enforcement zone will often pass along tips about which organizations have compliance weaknesses.

There are three reasons for this new surge in audits. One, as the ACA funding gap grows larger, the government will become increasingly compelled to make up at least some of the shortfall by seeking penalty enforcement recoveries. Collecting additional revenue through enforcement has the key advantage of not forcing a political battle to authorize a tax increase. Two, audit concerns are further intensified given the staggering volume of new guidance that has been issued since the ACA’s enactment. Conservative estimates put the estimated ACA-related regulations past 25,000 pages. The complexity of these rules, the lack of detail on real world situations, and the scope of these requirements heighten the risk for compliance breakdown. Third, audit triggers can be activated easier than ever through an employee or participant complaint. Every enforcement agency now maintains an online presence, often including social media, which solicits the public to communicate with them about workplace issues they witness. Employers must ramp up their efforts to ensure compliance ahead of a potential audit.

SURVIVING THE SURGE

Avoiding or surviving an audit will require an understanding of which agency or agencies might be knocking at the door and which law they seek compliance for (see side bar on enforcement zones). Current Dept. of Labor (DOL) audits are targeting age 26 coverage, retroactive coverage take-aways or rescissions and those claiming grandfather status and waiting periods. The DOL has authority to assess penalties for numerous ERISA violations, including failures to file Form 5500, failures to respond to requests for information in a timely manner, and other breaches of fiduciary duty. These finding could lead to participant lawsuits and civil actions in addition to DOL penalties.

The Dept. of Health and Human Services (HHS) has become increasingly active pursuing Health Insurance Portability and Accountability Act (HIPAA) privacy and security audits. The Centers for Medicare Services (CMS) is an internal HHS agency with a long track record of aggressive audits for Medicare Secondary Payer violations. The IRS is now targeting ACA reporting and hours tracking as it determines plan eligibility.

SEIZE THE DAY—COMPLY TODAY

Audit failures can result in significant penalties for organizations sponsoring employee benefit programs. For example, the failure to comply with group health plan standards under ACA, HIPAA, PHS, COBRA, or other relevant laws can trigger IRS excise taxes of \$100 per affected person for each day of noncompliance. Even more troubling is that employers must self-report certain plan-related violations (and any excise taxes due) on IRS Form 8928. The failure to do so could lead to a separate set of penalties.

Today’s businesses—large and small—and across all markets should ramp up compliance efforts to ensure that they don’t hit roadblocks. This will require establishing internal protocols to optimally position a response to any agency’s inquiry. The more prepared and organized an organization is today, the more efficiently and swiftly a plan-related compliance audit can be avoided and/or resolved tomorrow. ★

Know the Enforcement Zones

Here is a short list of government agencies that are driving ACA-related compliance audits and the laws whose compliance they seek:

DOL

- ACA
- ERISA including Form 5500, plan documents, and summary plan descriptions
- HIPAA

HHS

- Summary of benefit coverage
- HIPAA privacy, security, and breach notification rules
- Medicare secondary payer through CMS

IRS

- ACA including reporting
- Misclassification of employees as independent contractors
- COBRA
- Employee benefit related tax issues, such as group term life insurance valuation, Cafeteria plan operations, and discrimination testing duties

Equal Employment Opportunity Commission (EEOC)

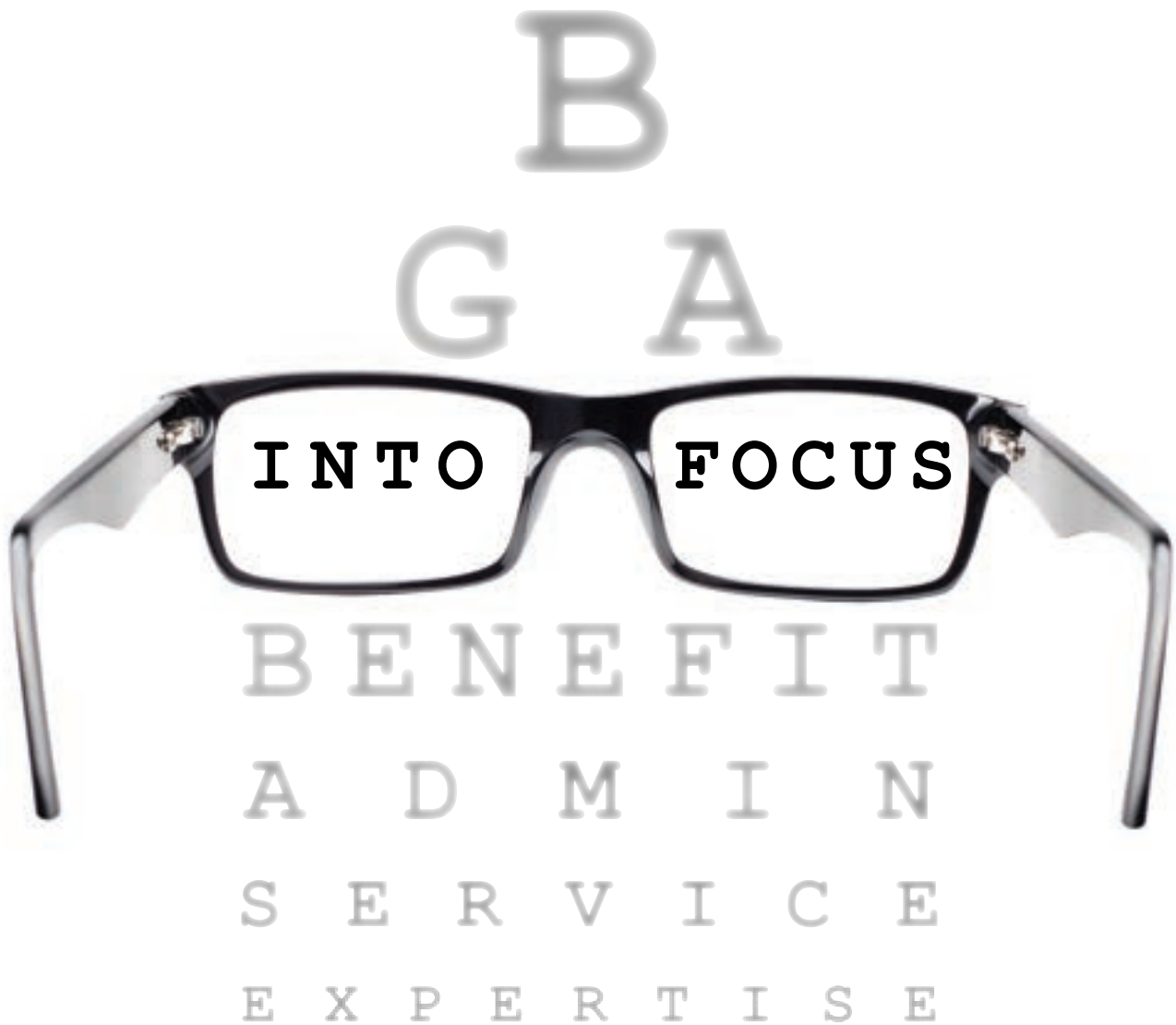
- Americans with Disabilities Act
- Age Discrimination in Employment Act
- Genetic Information Nondiscrimination Act

State Exchanges

A number of states are contacting employers to advise of potential ACA penalty assessment based on affordability problems as indicated by enrollees into a state exchange. Although states generally lack any power to enforce ACA penalties, many are corresponding with employers, and possibly also with federal agencies.

Dennis Fiszer is the chief compliance officer for HUB International Employee Benefits, Eastern Region and is a nationally recognized speaker on health care reform and the Affordable Care Act. He provides compliance and consulting services regarding health plans and other employee benefits. Dennis’ areas of expertise include COBRA, Health Insurance Portability and Accountability Act of 1996 (HIPAA), wellness programs, federal and state health care reform, employment and labor issues, ERISA, and the Family and Medical Leave Act. See more at hubinternational.com.

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Knowledge Insures a Difference



by **RENÉE-MARIE STEPHANO, JD**

His heart was ticking. So, too, was his time. Pablo Concepcion had to find a hospital that would enable him to receive a desperately needed heart transplant. Anytime soon would do. The 58-year-old Miami resident didn't want to wait any longer. He was a little worried that his deteriorating condition would not elevate him beyond the status of tens of patients like him waiting for the gift of life in the United States. So, Concepcion and his wife did what not many might do, but what government officials and healthcare interests in Puerto Rico hope many more may someday do: they boarded a plane from Florida for the island and a hospital that would perform heart transplant surgery.

Puerto Rico officials are banking on a steady flow of U.S. patients like this Miami truck driver caught in the cross hairs of the Affordable Care Act and others like him from points in the Caribbean and beyond. The idea is that the added patient volume will not only help to reverse the exodus of top doctors to the mainland, but will also stimulate a healthcare system that accounts for 20% of the commonwealth's economy.

Expectations are high. In the next three years, backed by an aggressive government marketing campaign, Puerto Rico hopes to create some 3,000 jobs and inject \$300 million into the island's economy. The Puerto Rico Medical Tourism Corp., an arm of the commonwealth's tourism structure, is reaching out not only to patients, but also to the healthcare operatives that service them. Humana and

Molina Healthcare have a presence on the mainland and the island. In the short term Puerto Rico is a promising destination to expand access to care for patients from the United States and eventually offer stable solutions to island inhabitants who are not required to follow most provisions of the Affordable Care Act, including the individual mandate.

Players with a stake in Puerto Rico understand that the island's healthcare dilemma won't be solved overnight. Too many doctors are asked to survive on Medicare and Medicaid reimbursements. Sixty percent of Puerto Rico's population relies on the government subsidies for healthcare.

TAX HELP

Until a formula can be worked out that reimburses doctors at a level consistent with their counterparts on the mainland, the Puerto Rico Medical Tourism Corp. is promoting tax incentives and exemptions to attract investors and foreign insurance companies to the island, and give doctors a break. Under Act 399, the International Insurers and Reinsurers Act of Puerto Rico, those that set up operations on the island and underwrite large policies for clients offshore, are exempt from corporate levies up to 4%; 100% of tax dividends paid and distributions; and property and premium tariffs.

The tax breaks are just a start. Proponents of Puerto Rico's entry into medical tourism say the enticements will play a

key role in making the metropolis appealing to foreign investors and patients from the United States—many of whom are Hispanic and have ancestral ties to the Caribbean region.

RAISING THE BAR

More than a few have embraced this strategy including Alberto Baco, Puerto Rico's Secretary of Economic Development and Commerce, who understands support for medical infrastructure and professional growth are another step toward keeping pace with the competition for entrepreneurial dollars and international patients. Hospital administrators, doctors and clinical staff took his cue earlier this year when they completed medical tourism training and certification processes.

Metro Pavia Health System, HIMA San Pablo and Ashford Presbyterian Community were among the providers that participated in the first round of Medical Tourism Association training that would certify some 35 hospitals to offer services to foreign patients. Another 20 hotels concluded related training to improve hospitality and travel operations for medical tourism patients and their companions.

Certification is by no means a small accomplishment, considering these forward-thinking service outfits were the first on the island to achieve such a distinction. Francisco G. Bonet couldn't agree more. The CEO for the Puerto Rico Medical Tourism Corporation says that training allows providers to provide quality care for international patients and build valuable relationships with insurance carriers and vendors that purchase health services indirectly.

The Cardiovascular Center of Puerto Rico and the Caribbean, where Pablo Concepcion received his new heart in San Juan, stood out from other healthcare providers in the United States because there wouldn't be much delay before treatment.

Carmen Concepcion knew very little about the clinic's doctors and staff; certainly nothing about the cardiovascular center's recent medical tourism certification. She knew only that she and her husband could not afford to wait for a heart transplant; that Pablo could barely walk much past his recliner without bending over out of breath; that the cost of surgery offered at the hospital in San Juan—far less than it would have been in the United States—would have to be acceptable even though their carrier would not extend coverage to Puerto Rico.

It all didn't matter, she insisted, as she watched Pablo Concepcion walk easily to the front door of their home where he greeted well-wishers upon his return to Miami. ★

Renée-Marie Stephano, JD, is president of the Medical Tourism Association, the first membership-based international nonprofit trade organization and think-tank for the medical tourism and healthcare industry. The MTA provides strategic development programs for destinations seeking to create sustainable and attractive programs for foreign direct investment. The MTA provides advisory services to investors interested in the industry and matches these financiers with medical tourism-related projects. Visit MedicalTourismAssociation.com for more information.

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2015: A SIGNIFICANT YEAR FOR HEALTHCARE

by JOSEPH BERARDO JR.

The new era in healthcare has shifted focus toward enhancing care and lowering costs. The growing emphasis on population health has prompted greater collaboration among providers as well as coordinated care models. These trends create new challenges and opportunities for employers, consumers, and healthcare professionals.

Many employers have already adopted cost-cutting strategies and are ready to respond to further developments, such as the rise in high-deductible health plans, increased demand for healthcare data transparency, growing adoption of self-insurance, and expanded reliance on high-performance networks for enhanced quality care at lower costs.

HIGH DEDUCTIBLE PLANS

More Americans are now covered by high-deductible health plans, and paying more out-of-pocket. The inability or unwillingness of many consumers to pay high deductibles is likely to compromise the bottom line of physicians, hospitals, ancillary services and pharmacies. Facing healthcare costs is the number one cause of bankruptcy in the country—a reality that is not buffered for consumers who have healthcare coverage.

TRANSPARENT DATA

In response to market pressures, healthcare leaders have made it a top priority for 2015 to improve population health management, according to a survey by Fierce Health. This will demand that patients will be able to participate more in their own care. Information plays an important role in this decision-making process for each stakeholder. Employers can use data transparency to structure benefits to encourage the purchase of the highest value healthcare services and healthcare coverage. Consumers can use price performance information to make informed decisions and choose providers who offer the highest quality care at the best value for their dollar.

For healthcare providers, providing transparent information requires a clear understanding of policy and guidelines (to avoid improper disclosure of protected health information,

for example). Organizations have begun to develop data collection and reporting mechanisms that meet the public reporting requirements of national and state initiatives. Individual organizations are also looking more closely at clinician performance and patient outcome data.

SELF-INSURANCE

With healthcare reform, more employers are finding it more cost effective to become self-insured. The key advantages over fully insured plans become evident when business leaders examine the potential for cost and utilization control, improved cash flow, flexible plan design and access to data and benchmarking.

When self-insuring, employers pay for individual employee health claims out of cash flow rather than as a monthly fixed premium to a health insurance carrier. Instead of paying premiums to insurers, they pay claims filed by employees and healthcare providers as they come in—paying strictly for services provided, with a relatively minor administration fee typically added if a TPA is involved. While self-insured employers assume direct risk for paying claims, costs are based on actual healthcare use among plan members. Catastrophic claims are covered by stop-loss coverage. This type of coverage serves as a financial buffer for the employer if an employee is found to have cancer or needs an organ transplant, for example. What's more, self-insurance is exempt from many of the onerous new federal health insurance taxes under the Affordable Care Act. Also, self-insured companies do not have to offer the government-mandated "essential health benefits," which enables them to tailor benefits to the needs of a company and its workers.

On the horizon, the Cadillac Tax is scheduled to take effect in 2018. This 40% tax is on plan fees over a set threshold paid by employers that provide high-cost health benefits to their employees. The concept is to reduce healthcare use and costs by encouraging employers to offer plans that are cost-effective and engage employees in sharing in the cost of care.

HIGH-PERFORMANCE NETWORKS

High-performance networks are exclusive groups of quality healthcare providers and health professional organizations recruited to serve a defined patient population. Limiting the number of providers can increase efficiency and lower costs. Providers are selected via sophisticated data analysis that identifies those with better outcomes, higher efficiency, and best practices.

High-performance networks, which have garnered considerable attention in the past few years, are gaining more interest in 2015. Health plans and employers anticipate that, by choosing the highest-quality providers, they can better meet the healthcare needs of plan members, improve individual outcomes and enhance personal satisfaction with healthcare coverage.

Some people call high performance networks "narrow networks," but the concept should not be perceived as one that simply limits choice. The model relies on a careful review of provider information and data to select providers who deliver quality care while keeping down costs for the high-performance network. Any apparent limiting is done to improve the network. This message must be communicated clearly so plan members understand and appreciate this thoughtful approach. Also, for these networks to be effective, they must work for every stakeholder so that plan members can get the most out of their provider network.

The key is for plan sponsors and members to gain easy access to complete, accurate, and current information about healthcare organizations, professionals, and services in their network. To ensure their long-term viability, it is important for plan sponsors to provide this information to providers, have network rosters online to help physicians refer patients, and give plan members and providers the tools to understand coverage and the basic concept behind the networks. ★

Joseph Berardo Jr. is CEO of MagnaCare, an administrator of self-insured health plans for employers in New York and New Jersey.

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Word & Brown founders John Word and Rusty Brown and all of the 600+ employees of The Word & Brown Companies congratulate our colleague, **Don Goldman**, on his new leadership role as the President of the National Association of Health Underwriters (NAHU).

We look forward to your transformational thinking as you take the helm of our industry's most important professional organization. Best wishes for success!

Don Goldman,

President of NAHU, and Vice President
of the Word & Brown University



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2015 DENTAL SURVEY

OUR ANNUAL SURVEY OF DENTAL INSURANCE CARRIERS IN CALIFORNIA

1. WHAT TYPES OF PLANS DO YOU OFFER?

Aetna: We offer the following dental plans:

- Aetna Dental Maintenance DMO plan, PPO, PPO Max
- Freedom-of-Choice Plan Design (offering members their choice of two dental plans)
- Aetna Dental Preventive Care, Aetna DMO Access, Aetna Dental Care Reward, Aetna
- DentalFund (our consumer-directed dental plan), indemnity, Vital Savings by Aetna, a dental discount program
- Aetna ValuePass Card

Aflac: Aflac Dental—voluntary insurance policy—has the simplicity of a Voluntary Individual Table of Allowances plan that pays a fixed benefit amount for each procedure, regardless of what the dentist charges.

Ameritas: PPO, indemnity, voluntary, non-voluntary, groups from two lives and up, individual, consumer driven and cost containment plans.

Anthem Blue Cross: Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company offer a comprehensive line-up of dental plans and products that include: PPOs and DHMOs for individuals, small groups, large groups and national accounts. We offer voluntary dental plans for small and large groups, and plans for Trust and Labor groups. Individuals and small groups who purchase our medical plans will be provided with pediatric EHB coverage. And, we offer “Anthem Extras for Seniors.” These plans complement Medicare Supplement plans and include a package of dental and vision coverage that offer extra preventive benefits.

BEN-E-LECT: BEN-E-LECT offers fully insured PPO, EPO, high deductible, pre-paid and self-insured dental plans for the group market. Employer-paid and voluntary plans with multiple network and out-of-network options down to the employee level are available to groups with as few as two lives.

BEST Life: In California, we offer employer-sponsored PPO and Indemnity dental plans to groups of two or more

employees enrolling. Voluntary PPO and Indemnity dental plans are available to groups of five or more employees enrolling. Custom dental plans can be offered for groups with 100 or more employees enrolling. Group term life and vision coverage are also available.

Blue Shield: Dental PPOs, to in-network only (INO) and HMO plans. For individuals/families, a dental PPO plan provides member copayments instead of the usual coinsurance percentages. Our dental HMO plan offers comprehensive benefits with pre-determined member copayments. Finally, our Duo plan offers members dental and vision coverage at a single price. Our plans can be sold with medical plans or on a standalone basis. For senior members, we offer two comprehensive dental PPO plans for Medicare supplement plan members. There is also a dental plus vision plan package option for Medicare supplement plan members. For groups, our dental PPO, INO and HMO plans are available on a contributory or voluntary basis, can be sold with or without Blue Shield medical plans, and are UCR- or MAC-based.

BRIGHTER: Brighter, an administrative services only (ASO) solution that reduces costs for self-funded employers and a savings-only plan for employees who don't want to purchase traditional coverage.

Cigna: The Cigna Dental Care (DHMO) plan, Cigna DPPO plan, Cigna Traditional indemnity plan and Cigna Dental Shared Administration. We also offer product features like Cigna Dental WellnessPlus, Cigna Dental Waiver Saver, and CignaFlex Advantage that enhance our plans. We also offer CignaPlus Savings, a discount dental program for retirees, part-time or seasonal employees, or anyone else not eligible for insurance coverage. All plans are available on a standalone basis. All plans except the CignaPlus Savings membership card are also available alongside medical and/or vision plans. Cigna also has three WellnessPlus features, which can be paired with DPPO or dental indemnity products. Individuals who get any preventive care in one plan year qualify for increased benefits in the following plan year. All plans are available on a contributory or voluntary basis. In addition to WellnessPlus, Cigna offers Cigna Dental Waiver Saver, where customers' Class 1 (preventive) services can

be waived for maximums and deductibles, providing an incentive for customers to seek preventive care.

Delta Dental: Managed fee-for-service, PPO and DHMO group dental plans; individual DHMO dental plans and group HMO vision plans. We also offer ACA-compliant small group and individual dental benefits to adults and children in many state exchanges throughout the country.

Dental Health Services: Dental Health Services specializes in providing prepaid dental benefits for groups and individuals. Plans are available for every size client. Customized plans are available for groups. We also offer PPO, EPO, and indemnity (reimbursement) products and ASO services for self-funded groups.

Guardian: Dental PPO (active or passive), Prepaid/DHMO, and indemnity plans are available on a voluntary or employer-sponsored basis. Dual and Triple Choice, Monthly Switch (between a DHMO and PPO), and administrative services only plans are also available. Guardian specializes in customized plans based on the needs and price points of the employers and employees. We also offer dental plans for individuals/families, both on and off Covered California, the state's insurance exchange. Consumers can purchase Guardian's dental plans directly from mydental.guardianlife.com.

Health Net Dental: Health Net Dental HMO (DHMO) plans and dental PPO plans cover most dental procedures. Dental plans may be purchased with a Health Net medical plan or on a stand-alone basis. In addition, the dental plans may be purchased as dual choice. Contributory and voluntary plans are also available.

HumanaDental: PPO, prepaid/DHMO, traditional preferred, and preventive plus plans available on a voluntary or employer-sponsored basis. Humana also has a robust ASO dental plan available in California.

Securian Dental: Group Dental PPO and Indemnity

United Concordia: United Concordia offers flexible fully insured PPOs and dental health maintenance organizations (DHMOs) plans. ASO funding arrangements are available based on client size. Most plans are offered on an employer-sponsored or voluntary basis.

Western Dental: Western Dental offers DHMO mixed-model provider panel comprised of (a) contracted independent, general dentist and specialists, along with (b) Western Dental employee dentist and specialists, who work in the company-owned Western Dental Centers. Western Dental operates general dentistry and orthodontic offices throughout Calif., Ariz., and Nevada.

2. HOW DO PLANS YOU OFFER FOR THE INDIVIDUAL AND/OR SMALL GROUP COMPARE IN RATES AND BENEFITS TO THE LARGE-GROUP PLANS?

Aetna: The key difference between Aetna small group plans and larger group plans is that small group plans are pre-packaged plan designs. While larger groups can select from an array of benefits, the packaged small group plans are comprehensive, yet price sensitive and make it easy for our customers to choose from plans that are competitive in the market. Aflac Dental rates and benefits do not vary based upon the size of the account.

Aflac: Aflac Dental rates and benefits do not vary based upon the size of the account.

Ameritas: Ameritas' small group and one-life group plans are rated by industry and are pooled in full or in part. Large groups are experience-rated, resulting in lower rates in most cases. Ameritas offers a wide variety of plan designs, regardless of group size, to meet the needs of our customers including rating flexibility. The pricing of our non-group individual plans will be higher than group individual because of the nature of the risk.

Anthem Blue Cross: There are different underwriting considerations for each business segment depending on the product offered. With our Dental Prime and Dental Complete plans, both small and large groups can customize benefits to fit their employees' needs.

BEN-E-LECT: The majority of BEN-E-LECT's plans compete very well in the large group market. The benefit design and structure of these plans remain consistent across the small and large group markets.

BEST Life: Rates vary by plan design, group size and employer contribution. Typically the larger the group, the lower the rates. However, we offer a lot of plan design flexibility for groups with 10 or more enrolling. Waiting periods for major and ortho services are waived for groups with 10 or more employees enrolling regardless of employer contribution. Some benefits are standard regardless of size. We offer a dental supplemental accident benefit on all of our dental plans. A child vision benefit is also standard on plans with orthodontic coverage. Other benefits vary by group size. Adult orthodontic benefits are available to employer-sponsored plans with 25 or more enrolling. Groups with 100 or more enrolling can customize benefits. Discounts for bundling, higher participation and new voluntary cases for groups of 10 or more enrolling are also available.

Blue Shield: There are different underwriting considerations for each business segment. Our ability to customize offerings for groups with more than 300 employees typically results in lower rates and more choices to meet the employer's needs. Group plans come in a range of deductibles and annual benefit maximums. Our individual, family and Medicare Supplement dental plans may vary in waiting periods, deductibles, and annual benefit maximums based on the plan selection. All dental plans include generous benefits, competitive premiums, and strong California and national provider networks that are available to all members; we don't differentiate our provider network for small groups or individual or family markets.

BRIGHTER: Our small group plans enable employees to reduce dental expenses for their families by an average of 30-50% without paying high dental premiums. So, in any given year they can often receive the same amount of care that they would through a large group plan and do so at a fraction of the cost they would have otherwise paid through premiums, deductibles and co-insurances.

Cigna: Cigna does not participate in the Small Group (2 to 50 employees) dental market, but does offer a series of standard group DHMO plan designs and individual and group DPPO/indemnity plan designs to accommodate our clients' needs. Cigna has two individual dental plan offerings in the

California; it includes an “Essential Health Benefits” compliant plan that is embedded in our medical plan offering as well as a standalone offering that is available with or without a medical plan offering. This individual plan is a DPPO offering that is very similar to our group plans aimed at businesses trying to control costs while offering employees a broad network. As for the group options, larger groups generally want more robust and flexible plans, while smaller groups gravitate toward standard offerings. We can custom-fit our group DPPO plans with a variety of cost-savings options for employers, such as missing tooth limitations, class shifting, low maximums, varying coinsurance, deductibles, waiting periods, etc. Our group DHMO plans start with basic coverage but also offer cost savings mechanisms such as specialty discount, alternate benefit provisions and other plans that have very rich, low-copay plans at the higher end of the cost spectrum, including plans with coverage for surgical implants and related procedures.

Delta Dental: While benefits offered to smaller groups are comparable to those offered to larger groups, larger groups have more options in terms of plan designs. Rates can be slightly higher for smaller clients and individuals, but Delta Dental strives to be competitive while balancing our financial risk. With individual DHMO plan benefits, we offer three different plan options—two for individuals and families and one customized for seniors. The individual and family plans offer a wide range of covered services. The senior plan is designed to offer services most utilized by this particular population.

Dental Health Services: Dental Health Services partners with its group clients on customizing dental benefits. Larger groups can have slightly lower rates as a result of efficiencies in administering them. All individual plans offer the same high-quality benefits and services at competitive rates.

Guardian: Guardian offers nearly the same plan options to small group employers as to large employers, plus an array of cost-reducing options. We also offer dental benefits through the California state exchange and through our direct-to-consumer website mydental.guardianlife.com.

Health Net Dental: DHMO plans offered to individuals provide a comprehensive schedule of benefits at a monthly fee that is slightly higher than rates quoted for groups. Small groups (two to 50 employees) have two comprehensive Health Net Plus DHMO and 3 DPPO plans from which to choose. Mid-market groups (51 to 250 employees) may choose from five DHMO plans and 16 DPPO plans. Mid-market rates are based on location, benefit plan chosen, employer contributions, and participation. Individual and small group rates are based on book rates. Risk evaluation is taken into consideration when underwriting larger groups (over 250 eligible employees).

HumanaDental: We offer flexible plan designs with a range of deductibles, co-payments, and out-of-pocket expense limits to meet the needs of small to large groups. We also offer large groups the additional flexibility to customize plan options. All our dental plans provide employees with incentives for preventive dental care, which promotes their overall health. Customers who see dentists participating in the HumanaDental PPO Network receive deep discounts. A vision discount program is included with all HumanaDental plans.

Principal Financial Group: We do not have individual dental plans. The only significant rating difference between our small and large group rates pertains to experience rating which is used on groups with 150+ employees. The benefits are the same for small and large groups.

Securian Dental: Small group rates are developed on a pooled basis. Large group rates are developed on a custom basis.

United Concordia: While larger clients have more flexibility in customizing benefit options than smaller clients, United Concordia offers an array of standard client products and options that provide small businesses and individual consumers with cost-effective, quality choices. To keep the small client premiums comparable to those found in larger clients, slightly higher deductibles, lower coinsurance percentages and lower maximums are more commonplace within this market segment.

Western Dental: Our individual and small group rates are a little higher for standard benefit plans. Customized benefits plans are available for large groups.

3. IS YOUR PLAN(S) BETTER THAN PREVIOUS INCARNATIONS? IF SO, HOW?

Aetna: We offer the following:

- Freedom-of-Choice Plan Design—packages our DMO plan with one of our indemnity or PPO plan options. Members pay one rate and can switch between the plans as often as monthly. It can be a lower cost alternative to a PPO plan.
- Aetna Dental Preventive Care—a low-cost PPO or indemnity plan covers preventive and diagnostic procedures from 70% to 100%. Members may also get reduced fees from dentists who participate in Aetna’s PPO network for non-covered services like fillings, adult orthodontia, and cosmetic tooth whitening.
- Aetna DMO Access—a fixed-co-pay DMO plan offers broader network access at a lower cost. There are no out-of-pocket deductibles for the member to pay and no claim forms to file. It also includes the Aetna Dental Access discount network, which gives members access to more dentists and discounts of 15% to 50% for non-covered services like bleaching.
- Aetna Dental Care Reward—By going to the dentist for preventive services in one plan year, Aetna will cover a greater percentage of coinsurance and/or annual maximum next plan year.

Aflac: The Aflac Dental plan is designed to increase the policy year maximum, which will satisfy both employers and employees.

Ameritas: We have released several industry firsts including a rollover maximum product; fully insured LASIK vision benefits; dollar reimbursement plans; combined dental/vision deductible, frequency and maximum plans; shared family maximum plans; \$5,000 maximum plans, and stand-alone hearing care benefits. Our newest individual plan release, vision, is very popular across the nation.

Anthem Blue Cross: Yes, our plans are significantly better than previous incarnations. Our Dental Prime and Dental

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Complete plans are open-access models that include the freedom to see any dentist—with lower out-of-pocket costs and in-network dentists. These plans are better than previous incarnations because they incorporate evidence-based benefit designs and claims processing guidelines, for greater savings and consistency with clinical oral health science, include a more robust California provider network, and automatically include access to the national Dental GRID, one of the nation's leading dentist networks, with dentists in all 50 states. The GRID is exclusively for customers of participating Blue Cross and Blue Shield plans. We also offer Anthem Whole Health Connection. With this program, we receive claims and clinical data from medical providers, vision care providers, dentists and pharmacists. We can create more complete health profiles that can be shared with their providers for members who have more than one of our products. In short, our new plans have better benefit designs and a larger network locally and nationwide.

BEN-E-LECT: BEN-E-LECT plans offer more employer and employee options than any other dental plan in the market. They can be written stand-alone or the employer may combine various BEN-E-LECT plans for a complete package offering PPO, DHMO and fully self-funded options.

BEST Life: Our current dental plans offer a lot more options compared to the dental plans we've offered in the past. We offer a MAC reimbursement option and all of our dental plans can be tailored to offer rich or lean benefits, depending on an employer's needs. We continually evaluate our dental plans to ensure the competitiveness of the benefits and our underwriting guidelines.

Blue Shield: We introduced four new group dental HMO plans and four new dental INO plans with a \$1,500 calendar year maximum. Compared to our existing dental HMO plans, our new dental HMO plans offer lower copayments to deliver a richer benefit to our members. The new dental INO plans offer a lower price alternative to our INO plans with \$2,500 calendar year maximums. In addition to new plan designs, all BSC plans include oral cancer screening coverage as a value-added benefit, which comes at no out-of-pocket cost to the member. We also offer enhanced dental services for pregnant women to all dental PPO plans. Pregnant women receive one additional routine adult prophylaxis, and/or one course (up to four quadrants) of periodontal scaling and root planing, and/or periodontal maintenance if warranted by a history of periodontal treatment. Treatment is payable at 100% of the allowable amount for in- and out-of-network.

BRIGHTER: Brighter has introduced the industry's first Proactive Remittance Organization (PRO) which is a dental care system enabled by our cloud-based platform that streamlines the interactions amongst members, providers and payers to lower claims costs through new efficiencies in benefits payments, network fee schedules, utilization review and group plan designs.

Cigna: The new Cigna Dental Care DHMO 09 Series of patient charge schedules (PCSs) includes many features and options from which to choose. This series provides a spectrum of schedules with multiple copay structures, so we can design the plan that meets our clients' needs.

Below is a summary of new features and enhancements that are available and only apply to the 09 Series of schedules:

- **Surgical Placement of Implant Coverage:** We offer coverage for surgical placement of implants and related procedures such as sinus augmentation, bone grafting, and cone beam CT x-rays.
- **Same Day, In office Services:** Members are able to take advantage of upgrading certain procedures which require material fabrications (veneers, crowns, inlays, onlays, and post and core) to same-day, in office service using CAD/CAM technology for a fixed copay.
- **Temporomandibular Joint (TMJ) Coverage:** TMJ coverage is now standard on our plans and coverages and includes an exam, diagnostic cone beam CT x-ray, and an orthotic occlusal device to treat TMJ.
- **Expanded Periodontal Maintenance Coverage:** We have expanded coverage for periodontal maintenance cleanings to four per year to increase our focus on prevention.
- **Additional Application of Fluoride and Fluoride with Varnish:** At a minimal copay, we allow additional applications of fluoride for those members who may need them.

Delta Dental: Most mid- to large-range plans offered by Delta Dental are customizable within basic parameters, and we incorporate changes in treatment standards and technology as they evolve.

Dental Health Services: Yes. Dental Health Services' plan designs are continuously evolving to emphasize the company's focus on improving the oral health of all its members.

Guardian: Guardian offers customized options to fit each employer's needs and budget. An example of this is Guardian Freedom, which is a lower cost dental option that gives members a choice of networks with access to providers in Guardian's premier PPO network, DentalGuard Preferred, or in Guardian's DentalGuard Alliance PPO, which offers even greater claims savings through a select pool of dentists. We also are focusing heavily on developing more voluntary options, a market that has grown tremendously as a result of the Affordable Care Act.

Health Net Dental: Health Net offers DPPO plans for small, mid-market and large groups. All of our DPPO plans include extra services for pregnant women in their second and third trimesters, including extra cleanings, scaling and debridement covered at 100% in and out of network and not subject to the plan's deductible. Our Mid Market Classic Plus DPPO Plans include MaxAdvantage, our rewards program that allows members to carry over a portion of their calendar year maximum into the next calendar year. Our Basic DPPO is a plan offering in- and out-of-network coverage for preventive, diagnostic and restorative procedures (oral surgery, endodontics, periodontics, major services and orthodontia not covered).

HumanaDental: Yes, we continually explore ways to offer more choices and flexibility for our customers. Please see next response.

DENTAL PRACTICE LOAN DI PLAN



When a bank lends money to a business, the lender will usually require the borrower to provide proof of disability insurance equaling the amount of the loan payments. The Dental Practice Loan Indemnification plan continues payments to the lender should the borrower become sick or hurt.

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Principal Financial Group: Our plan offers significant flexibility in plan design, optional coverage for cosmetic services, TMJ treatment, dental implant coverage, accident coverage, employee choice options and multiple price points. Employers can design any combination of plan options to meet their needs. In addition to our maximum accumulation feature, which allows members to carry over a portion of their unused annual maximum for use in future years, we also have a Preventive Passport feature. This feature allows for preventive charges to not accumulate towards the annual maximum.

Securian Dental: Yes, we have added greater flexibility.

United Concordia: In recent years we have done the following:

- Expanded our PPO network by 12,000 dentists to create our Alliance network.
- We re-credentialed our PPO network of dentists. Many now accept our discounted allowances for non-covered services and services over the annual maximum. Members can find which dentists have agreed to this cost saving measure, by looking at our website. The dentists are clearly noted.
- We launched Preventive Incentive®, which covers diagnostic and preventive services without counting them toward the member's annual maximum.
- Enhanced our employee oral health educational offerings.
- Introduced Smile for Health – Wellness, which offers enhanced coverage for members with diabetes and other diseases to clear away concerns they may have on the cost of treatment. This coverage is now standard with all plans. Smile for Health – Wellness also provides oral health education and program details for all members and targeted messaging to motivate those eligible for Smile for Health – Wellness benefits.

Western Dental: Western Dental Benefits Division recently launched the DHMO Series 7 dental plans. Our new plans offer an increase of covered procedures to include the availability of cosmetic alternatives and more orthodontic options for children and adults

4. WHAT RECENT CHANGES HAVE YOU MADE TO YOUR PLAN(S)?

Aetna: New DMO fixed co-pay plans that cover Implants were added.

Aflac: Along with an increased policy year maximum, Aflac Dental continues to provide a simple, no direct-cost option for employers to enhance employee benefits offerings. The Aflac Dental plan provides the ease of administration without the hassle of network restrictions, deductibles, precertification for treatment, or annual premium reviews.

Ameritas: Ameritas developed ACA-certified plans that are offered in most states. We also have developed our new Better Benefit product, through which certified pediatric dental benefits can be added to traditional dental plans. Pediatric dental claims are processed through both their traditional plan design and the ACA-certified design, and Ameritas pays the better of the two.

Anthem Blue Cross: We revised our Dental Net DHMO. Our new Dental Net DHMO plans cover approximately 300 procedures—approximately 62% more procedures than our existing Dental Net plans. In addition, our Dental Net network includes more than 10,700 general dentist and specialist access points in California.

And, we still offer our Dental Prime and Dental Complete products, which include modernized benefit designs, lower premiums, and a more robust dentist network locally and nationally. These plans include benefits such as dental implants, annual maximum carryover and composite fillings on all teeth. Plus, there are more options for out-of-network reimbursement, including the 90th percentile of FAIR Health. Voluntary plans are available with a minimum of five enrolled employees.

BEN-E-LECT: BEN-E-LECT has evaluated its Freedom PPO benefits portfolio and narrowed it down to four plans that have proven to be most beneficial to its members. By focusing on development of those four plans, BEN-E-LECT is now more able to create sustainable rates for its groups taking into account size and location. BEN-E-LECT has also eliminated the waiting period for groups and new hires on its employer-paid plans for added convenience. We have also added an EPO option to our portfolio which allows for even more cost savings and offers one of the strongest networks available.

BEST Life: We now offer certified-pediatric plans that meet or exceed ACA standards to complement our product offerings. So the great Dental solutions from BEST Life continue to meet the changing needs of our groups in California.

BRIGHTER: Brighter PRO maximizes the savings it generates through a transparent online marketplace so that members can easily shop providers by price and quality, participating providers can compete for more patients by improving their prices and quality scores, and payers can lower their claims by optimizing how and where members utilize their benefits.

Cigna: In addition to our response to question number three above: Cigna Dental Oral Health Integration Program: We have enhanced the program to reflect the latest medical and dental research. The program includes the following list of clinical conditions:

- Cardiovascular disease
- Cerebrovascular (stroke)
- Maternity
- Diabetes
- Chronic kidney disease
- Head and neck cancer radiation
- Organ transplants

The program also provides 100% reimbursement of co-pays and coinsurance on certain dental procedures associated with treating gum disease. Now, customers only need to register once (for each eligible condition) and their coinsurance/copays for qualifying procedures will automatically be reimbursed within two to three weeks from when we receive the claim from their dentist. For our DPPO products, we provide additional benefit flexibility including cost saving

capabilities with our dental code classification process through improved class shifting functionality.

Delta Dental: Delta Dental's mobile web functionality makes it easy for enrollees to access dental information from a smartphone. The online tools used most often have been streamlined so enrollees can get the information they need faster and easier. Enrollees can log on to the following:

- Search Delta Dental's online dentist directory
- Check benefits, eligibility, deductibles and maximums
- Search for benefits by keyword or procedure code
- Check claims status and claims history
- View ID card (pull it up at dentist's office)
- Go paperless by opting to "Receive Statements Online" under "My Account"

Our enhanced online dentist directory makes it even easier for enrollees to find a conveniently located dentist. The Find a Dentist feature at deltadentalins.com offers the following:

- Easier navigation and a cleaner display
- The ability to conduct a search using keywords, such as the name of a practice (as well as by the dentist's name)
- Faster narrowing of search results by specialty, language and gender
- Improved toggling between Delta Dental PPO, Delta Dental Premier and DeltaCare USA network results
- Access to our provider directory through our secure Online Services that pre-filters dentists to the network associated with the enrollee's plan

The SmileWay Wellness Program emphasizes preventive care, enhanced oral health communications and promotion of oral health through social media on Facebook (facebook.com/deltadentalins) and Twitter (twitter.com/deltadentalins) as well as LinkedIn and Google Plus. Our SmileWay Wellness Program is self-managed, enabling enrollees to determine their level of participation. It encourages users to review their habits and take our free cavity and periodontal risk quizzes, which will indicate their risk level based on oral health habits and lifestyle choices. In the risk assessment results, we encourage users to stay connected with us by signing up for customized communications based on their results. Delta Dental's online health risk self-assessment tool provides a structured set of questions that produces a risk-assessment score that identifies specific issues related to the individual's oral health. The intent of this risk-assessment tool is to inform the patient and his/her dentist of specific risk factors for oral disease and help guide preventive measures. Delta Dental offers dental-health articles and short videos. Enrollees can also subscribe to Grin!, our quarterly wellness e-newsletter.

Delta Dental offers online provider tools for real-time processing of certain claims and pre-treatment estimates (those that don't require clinical review, for example).

Dental Health Services: Dental Health Services' group plans are now available through Covered California.

Guardian: The College Tuition Benefit helps Guardian dental members pay for college. Employees covered by a

Guardian dental plan that includes the College Tuition Benefit earn Tuition Rewards that can be used to pay up to one year's tuition at one of over 340 private colleges and universities across the nation. Guardian is the only dental carrier to offer the College Tuition Benefit. We also offer dental benefits through the California state exchange and our direct to consumer website.

Health Net Dental: All of our Classic Plus, Classic, Essential Value, and Basic DPPO plans include extra benefits for pregnant members in their second and third trimesters.

HumanaDental: Plans in our new generation of products are available as voluntary plans, and to groups with as few as two employees. Our new plans offer an extended maximum benefit, in which members get 30% coinsurance on services rendered after they reach their annual maximum (implants and orthodontia excluded). Essentially, this means an unlimited annual maximum. In addition, no waiting periods for major services for voluntary groups with 10 or more enrolled open enrollment options, and orthodontia benefits. Updates include reimbursement options for out-of-network reimbursement: maximum allowable fee, or based on in-network fee schedules. Additional deductible choices, implant coverage, and acrylic filling coverage have also been added. Due to the connection between oral health and overall health, we have added, free of charge, oral cancer screenings to all of our products, excluding DHMO/prepaid plans.

Principal Financial Group: Our plan offers significant flexibility in plan design, optional coverage for cosmetic services, TMJ treatment, dental implant coverage, accident coverage, employee choice options and multiple price points. Employers can design any combination of plan options to meet their needs. In addition to our maximum accumulation feature which allows members to carry over a portion of their unused annual maximum for use in future years, we also have a Preventive Passport feature.

Securian Dental: Enhanced benefit plans. Escalating Annual Maximum and Lifetime Deductible options where available.

United Concordia: Along with our parent company and the University of Pennsylvania, United Concordia recently completed a study that showed treating gum disease can help reduce the cost of medical care in patients who have certain diseases or conditions.

As a result, we now offer our Smile for Health – Wellness coverage, delivering enhanced coverage for members with chronic conditions and periodontitis. By providing greater benefits for the full coverage of services, such as surgery, that eligible members may need to treat and control their gum disease, Smile for Health – Wellness clears away any concerns members may have on the cost of getting treatment. Smile for Health – Wellness makes it easy for employees to start saving employers money. An integrated communication and registration process is easily implemented that delivers:

- Oral health education and program details for all employees
- Targeted messaging to motivate those eligible for Smile for Health – Wellness benefits

5. CAN AN INSURED USE THEIR OWN DENTIST EVEN IF THEY ARE NOT ON YOUR PARTICIPATION LIST?

Aetna: PPO—We offer a national network of dentists. Each covered family member can visit any licensed dentist for covered services. When members visit dentists who participate in our network, their out-of-pocket costs are generally lower.

Aetna: DMO—Members must seek care from a participating DMO provider unless a state allows a member to seek out of network care. We make this easy by consistently offering the largest DMO network in the industry.

Ameritas: Insureds can use any provider, but they may incur additional out-of-pocket expenses.

Anthem Blue Cross: Members of our Dental PPO plans, including Dental Prime and Dental Complete, can see any dentist they want. However, members who choose a network provider generally experience lower out-of-pocket costs. Plus, members never need to file a claim when they see one of our in-network providers—the dentist files the claim for them. The DHMO plans are in-network only.

Aflac: Policyholders may use any dentist they choose since Aflac Dental does not have network requirements.

Anthem Blue Cross: Yes, they can with all of our PPO plans. Members who choose a provider, within the Dental Blue network, get the most savings in their dental costs. However, members can choose a non-Dental Blue dentist, but their out-of-pocket costs may be higher. The same is true for our traditional Prudent Buyer PPO dental plans. The DHMO plans are in-network only.

BEN-E-LECT: Yes, BEN-E-LECT's plans offer in and out-of-network coverage with multiple options for coverage and benefits. The members maintain complete control over the dentist they choose to utilize.

BEST Life: Yes. Both group and individual Dental products allow members to visit any dentist of their choice and receive coverage for services.

Blue Shield: Yes, dental PPO plan members can choose to go to any dentist, although their benefits will be covered at a higher percentage when choosing a network dentist, with less out-of-pocket expense.

BRIGHTER: Yes

Cigna: Cigna Insureds can use their own dentist in the DPPO and dental indemnity plans. However, there are no out-of-network benefits available with the DHMO plan or with the CignaPlus Savings dental discount plans (not insurance). Individuals can nominate their dentist to join our plan and if the dentist wants to participate and meets our criteria, he/she will be credentialed and added to the network. Additionally, the DPPO plan includes savings on most non-covered services (in states where allowed by law). Most of our DPPO network dentists offer their negotiated contracted fees to customers and their covered dependents for most non-covered services (in states where allowed by law). The savings also apply to covered services when an individual exceeds his or her annual maximum or other plan limitations, such as frequency, age or missing tooth. We are continuously expanding our network to meet the needs of potential clients.

Delta Dental: Delta Dental Premier enrollees can visit any licensed dentist for care, although there are advantages

to visiting one of more than 55,000 dentist locations for Delta Dental Premier dentists in California. Enrollees can go to any dentist, but they are only guaranteed to get in-network benefits and avoid balance billing when visiting a Delta Dental dentist. Delta Dental PPO enrollees also have freedom of choice, but can benefit from the protections associated with selecting one of more than 43,000 dentist locations for Delta Dental PPO dentists in California. PPO enrollees have access to both Delta Dental PPO and Premier dentist networks with different levels of savings.

DHMO enrollees must use a participating general dentist or approved specialist, except for emergency care. There are more than 5,800 dentist facilities for DeltaCare USA in California.

Dental Health Services: Members of Dental Health Services' prepaid and EPO plans choose their dentist from our select, Quality-Assured network. Members covered under Dental Health Services' PPO and reimbursement plans receive treatment from any dentist.

Guardian: Members covered under our PPO plans can visit any dentist; however, benefits may be paid at a lower coinsurance rate for non-participating dentists. DHMO members must choose a participating primary care dentist.

Health Net Dental: Our dental PPO plans offer members freedom of choice; members may receive services from any licensed dentist, but we will reduce their out-of-pocket costs by receiving services from a participating PPO dentist. Under Health Net Dental DHMO plan, members must use a participating dentist to receive benefits.

HumanaDental: PPO members can visit the dentists of their choice. Out-of-pocket savings are greater when members visit participating network dentists.

Principal Financial Group: Yes, our members can see any dentist even if the dentist is not on the participation list if they are enrolled in either our PPO or POS design. If a member is enrolled in our EPO design, network dentists must be seen for services in order to receive benefits under the plan.

Securian Dental: Yes.

United Concordia: Our Fee-For-Service (FFS) and PPO plans allow members to visit any dentist. However, out-of-pocket costs are lower when visiting a participating network provider. DHMO members must use network dentists.

Western Dental: Through the DMO plans, the member must use a dentist who participates in our network in order to have coverage.

6. IF THE DENTIST BILL EXCEEDS U&C, CAN THE DENTIST BILL THE PATIENT FOR THE DIFFERENCE?

Aetna: For covered services, network dentists are contractually prevented from balance billing above the negotiated rate. Non-covered services are also available for a discount in some states. Dentists who are not in our networks may balance bill members.

Aflac: Aflac Dental pays benefits based on a Table of Allowances and not on UCR. If the dentist's charge exceeds the benefit amount paid, the dentist may bill the patient for the remaining balance.

Ameritas: Ameritas PPO/First Dental Health (FDH) Networks: Ameritas PPO dentists and FDH PPO dentists are



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bound by contract not to balance bill the difference between their normal charge and PPO maximum allowable charges.

Anthem Blue Cross: There is no balance billing of patients above the dentist's contracted rate for covered services with our PPO plans, including Dental Prime and Dental Complete. Anthem Blue Cross participating provider contracts include negotiated fee agreements that prohibit balance billing above the contracted rate. A participating dentist may not balance-bill members for amounts that exceed the negotiated and contractually agreed upon fee. Members are not responsible for amounts in excess of negotiated rates unless services are not covered by the benefit plan. However, if a member visits an out-of-network provider, there is no contract and the provider can bill the patient for the difference. With our DHMO plans, the patient is only responsible for co-payments and charges that are applicable on set procedures according to benefit plan.

BEST Life: Members will not be balanced billed if they receive treatment from a contracted PPO provider. All our dental PPO plans offer a regional and national PPO network. Members can access their in-network benefits anywhere in the country and will not be balanced billed. Those who choose to visit a non-participating dentist may be balanced billed. Our 90th percentile UCR choice is a great cost-effective option for groups that have limited network access.

Blue Shield: No, in-network providers cannot bill members for fees that exceed the negotiated rate. Non-network providers, however, may bill for charges that exceed the plan's allowed amount.

BRIGHTER: Not if the dentist is participating on our platform.

Cigna: DHMO: Network general dentist and specialist contracts contain clauses that prohibit dentists from charging members any additional fee, surcharge, or other cost for services, other than applicable patient charges as defined in the patient charge schedule (PCS) or contract payment schedule for covered procedures. For services we do not cover, dentists may charge their usual fees. For certain orthodontic procedures, network dentists may charge incremental costs associated with optional/elective materials, including, but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances.

DPPO: Cigna's network dentists' contracts include language to ensure that members are only charged in accordance with the contracted fee schedule amounts. They are prohibited from balance billing members. Network fee schedules apply for covered services even after members have reached their annual maximums or exceeded frequency limitations, or if the applicable dental plan imposes missing tooth limitations or other similar limitations. For non-covered services, members are responsible for paying the dentist's usual fee or contracted fee for that procedure. Out-of-network dentists may balance bill the difference between the DPPO plan's payment and their usual charges.

Indemnity: We do not prohibit balance billing for our traditional indemnity plan coverage; dentists may balance bill the difference between the plan's payment and their usual charges. Members pay dentists at the time services are rendered and then submit claim forms to us, or dentists submit the claim forms directly to us for payment.

Delta Dental: Contracted dentists agree not to balance bill patients for services covered under the program for which the dentist has contracted service fees. Delta Dental holds its Delta Dental PPO and Premier dentists to their contracted fees when providing services to eligible enrollees.

DHMO enrollees do not pay more than their set copayment for covered benefits under the DeltaCare USA plan. Specialists are paid the difference for charges exceeding the enrollee's copayment for all preauthorized services. When an enrollee chooses a more costly procedure not covered under the plan, the enrollee is responsible for the difference in cost between the network dentist's usual fees for the covered procedure and the optional treatment, plus applicable copayment for the covered procedure.

Dental Health Services: No. Dental Health Services guards against balance billing for specialty claims and also has separate safeguards in place to protect members from other types of overcharging.

Guardian: Guardian's PPO dentists are prohibited from billing members for any difference between the billed fee and the contracted fee schedule amount, less applicable deductibles and coinsurance.

Health Net Dental: When receiving services from a participating PPO dentist, members cannot be billed any charge in excess of the maximum allowable charge established by the plan. If the member goes to a non-participating dentist, the dentist can bill the patient for the difference between the allowed amount for the plan benefit and the dentist's submitted charge.

HumanaDental: Members are encouraged to visit in-network providers to experience lower out-of-pocket costs. In-network providers have agreed to accept the amount listed on their PPO fee schedule as payment in full, less all copayments, coinsurance, deductibles and non-covered services. They may not balance bill for amounts that exceed their PPO fee schedule. Out-of-network members are responsible for any charges that exceed the maximum amount that Humana will reimburse for a specific service.

Principal Financial Group: Dentists cannot bill over the UCR/fee schedule allowance amount if they are part of our PPO or EPO networks. If the dentist is not a part of one of our networks, he/she can bill the amount over UCR.

Securian Dental: If the dentist is part of our network: no. If the dentist is not part of our network: yes.

United Concordia: Contractually, United Concordia participating dentists agree to accept our allowances as payment in full for covered services (less any deductibles and coinsurances or co-payments).

Western Dental: Since this is a managed care plan, members pay only the applicable co-payment listed on their benefit schedule. Members are financially responsible for non-covered procedures at a discount.

7. HOW DOES THE DENTAL PLAN PROTECT AGAINST OVERBILLING OR WAIVER OF CO-PAYMENTS?

Aetna: Our explanation of benefits shows the member's out of-pocket responsibility. Additionally, the vast majority of our network dentists accept the contracted amount for non-covered services and any services over the annual

maximum a copy is sent to member and provider. If necessary, the provider relations staff helps resolve any issues whether related to over billing, waiver of co-payments, or other issues.

Aflac: Aflac Dental does not have network requirements. If the dentist's charge exceeds the benefit amount paid, the dentist may bill the patient for the remaining balance.

Ameritas: The explanation of benefits automatically calculates the insured's portion of the bill to prevent these kinds of problems.

Anthem Blue Cross: With our Dental Prime and Dental Complete plans, we protect members against inappropriate billing through our provider contracts, claim review, and our continuous analytic monitoring of the treatment and claim submission patterns of each dentist that submits claims to us. For our DHMO programs, our quality assurance teams assess claims and providers regularly to ensure our DHMO members are getting the highest level of service and satisfaction.

BEN-E-LECT: Provider network discounts are applied automatically when a claim is submitted. We also make predetermination services available to inform members what their charges will be prior to receiving service. The members also receive an explanation of benefits which clearly illustrates network savings and patient responsibility.

BEST Life: We do this in several ways. 1) Provider network discounts are applied at the time a claim is processed. 2) Predetermination services are available to inform members what their charges will be prior to receiving service. 3) We provide easy-to-understand EOBs that clearly illustrate network savings. 4) We have educational flyers that inform members on how their dental plan works and why they should go to a network provider.

BRIGHTER: We track all utilization of the plan to ensure both the members and sponsor is billed appropriately.

Cigna: Balance billing for covered procedures is strictly prohibited for Cigna's network dentists. We counsel network dentists who do not comply. Continued balance billing may be referred to our Credentialing Committee for review of future participation in the network. Cigna monitors allegations of overcharging through enrollee feedback, surveys, and the dental network management staff.

For DHMO plans, the collection of copays is between the patient and the dentist. We encourage dentists to collect copays at the time treatment is rendered. For DPPO/Indemnity plans, it is illegal in some states for dentists to routinely waive deductibles. Since our group contracts indicate that Cigna is not responsible for any charge the patient is not required to pay, we may reduce our claim payment by the copay amount waived by the dentist. Our Special Investigations Unit may also contact the dentist and the patient for further information and has the ability to review claims on an ongoing basis.

Delta Dental: Delta Dental Premier and PPO dentists contract with us to establish acceptable fees as well as formally agree to certain protections for Delta Dental enrollees. Protections include no balance billing—contracted dentists cannot charge enrollees for the difference between their contracted Delta Dental fee and their submitted charge for a service, and

they may only collect the patient portion (copayment plus any deductible and/or amount over the annual maximum) at the time of service. Delta Dental dentists also agree not to unbundle a procedure that is on file with Delta Dental as one procedure. Waiver of plan copayments and deductibles is considered fraudulent and is handled by notifying the dentist of the violation and possible network termination. DHMO network dentists agree to be paid by Delta Dental on a guaranteed capitation basis. They also contractually agree to accept enrollee copayments as payment in full for covered dental procedures and not to seek additional fees. If a dentist consistently demonstrates a disregard for their contractual obligations with Delta Dental, their participation may be restricted or terminated.

Dental Health Services: Participating dentists' charts are audited on-site on an ongoing basis to ensure treatment is rendered in accordance with Dental Health Services' policies. In addition, plan members receive extensive patient education and tools to help them understand their plan benefits so they can question charges that may not be in compliance with plan benefits. Members are encouraged to contact the plan for assistance if they feel they are being overcharged.

Guardian: Guardian's PPO dentists may only charge members for any covered charges other than the deductible or coinsurance that may apply to the discounted fee schedule amount. Explanation of benefits statements sent to members specifically identifies the discounts taken and the member's responsibility.

Health Net Dental: Under our DPPO and DHMO plans, participating dentists are contractually prohibited from balance billing a member more than the maximum allowable charge or the contracted copayment amount. Practices are in place to discipline network dentists who attempt to bill members more than these contracted amounts. If it is determined that a participating dentist has overcharged a member, our Customer Service team will contact the provider on behalf of the member to confirm benefits and re-educate the office about proper plan collection from a member. If the provider refuses to comply with the plan design, the issue is escalated to the Professional Relations Department for follow-up with the provider. Depending on the circumstances, the issue could be escalated to our Quality Management Team, which follows state mandates for a full investigation, including the request for patient records from the office and a review by a dental professional. These investigations must be completed within 30 days and written communications are sent to the member and provider. If the provider still refuses to comply, our legal department would be contacted and steps may be taken to terminate our relationship with the provider. In these rare instances, it might become necessary for the plan to reimburse the member or provider depending on the circumstances and to ensure a positive member experience.

HumanaDental: The dentist and the patient get an explanation of benefits to ensure that the dentist does not overcharge or omit fees. The claims processing systems adjudicate the claim based on the contracted fee schedule. Waiving co-payments does not apply under a PPO.

Principal Financial Group: Provider utilization patterns are studied and issues are addressed as uncovered.

Securian Dental: We check every submitted claim systematically.

United Concordia: United Concordia participating dentists contractually agree to only bill members for applicable deductibles, coinsurance, or amounts exceeding the plan maximums. In addition, members receive explanations of benefits that clearly describe the services received and their financial responsibility. Additionally, the vast majority of our network dentists accept the contracted amount for non-covered services and any services over the annual maximum.

Members can also access the My Dental Benefits tool on our website (UnitedConcordia.com) to view their benefits and eligibility information, claim details, procedure history, maximum and deductible accumulations and more. Plus, United Concordia's responsive customer service representatives are available to assist members with questions regarding their benefits. Our Utilization Review area also analyzes thousands of claims each year to ensure the acceptability of treatment and quality of services. Our dental advisors and consultants also continuously review dentists' fees and practice patterns for statistical variation from their peers. Dentists who fall outside of the norm are targeted for education and additional monitoring.

Western Dental: Providers are bound by contract to accept the member's schedule of benefits. Members can also access the My Dental Benefits tool on our website UnitedConcordia.com to view their benefits and eligibility information, claim details, procedure history, maximum and deductible accumulations, and more. Plus, United Concordia's responsive customer service representatives are available to assist members with questions regarding their benefits. Our Utilization Review area also analyzes thousands of claims each year to ensure the acceptability of treatment and quality of services. Our Dental Advisors and consultants also continuously review dentists' fees and practice patterns for statistical variation from their peers. Dentists who fall outside of the norm are targeted for education and additional monitoring.

8. HOW MANY PROVIDER LOCATIONS DO YOU HAVE?

Aflac: Aflac Dental does not have network requirements. Policyholders may visit any provider they choose.

Ameritas: Ameritas/FDH Network: 85,946 California provider access points (60,353 Ameritas, 25,593 FDH); 20,404 California locations (12,794 Ameritas, 7,610 FDH).

Anthem Blue Cross: Our Dental Complete network includes more than 16,500 unique dentists and more than 41,800 access points in California alone. Our Dental Prime and Dental Complete members also have seamless access to the national Dental GRID, administered by GRID Dental Corporation. One of the nation's leading dentist networks, the Dental GRID has providers in all 50 states—with more than 98,000 unique dentists and more than 251,900 access points.

Additionally, Dental Prime and Dental Complete members have access to our international emergency dentist network, with 24/7 assistance with locating an English-speaking provider for dental emergencies in approximately 100 countries worldwide.

Our Dental Net DHMO network includes more than 10,700 provider locations in California to choose from.

BEN-E-LECT: BEN-E-LECT's dental plans utilize the Health Smart (Interplan), First Dental Health, Dentemax, PPO USA and Western Dental networks, which contain thousands of offices statewide.

BEST Life: We offer access to a regional and a national PPO networks—First Dental Health (FDH) and DenteMax. Our California network has more than 68,672 access points throughout the state of California. Our national network has more than 285,000 access points, which offers our members network access when they are outside of California.

Blue Shield: Members have network access to over 16,000 dental HMO and 25,000 dental PPO providers in California, and more than 218,000 providers nationwide. These are two of the largest statewide provider networks in the industry.

BRIGHTER: While Brighter can be used at any dentist, with discounts at over 190,000 Access Points nationwide, it is only available to employers with a significant portion of their employees located in Southern California as that is where we deliver the greatest savings and member experience.

Cigna: Across all specialties, Cigna has over 131,300 DPPO dentists nationally and over 20,500 in California. For DHMO, Cigna offers access to 14,226 locations on a national basis with 3,971 DHMO offices in California.

Delta Dental: Our networks offer access to more than 55,000 dentist locations for Delta Dental Premier, more than 43,000 dentist locations for Delta Dental PPO and more than 5,800 dentist facilities for DeltaCare USA in California.

Dental Health Services: As a prepaid dental plan, Dental Health Services has 951 general practice offices with 4,354 participating dentists and an additional 1,796 specialists.

Guardian: There are over 276,882 PPO dentist-locations across the country and more than 40,997 in California. We are one of the largest PPO networks in the state based on dentists. The DentalGuard Alliance PPO network has over 6,718 dentist-locations in California. For the DHMO, there are 45,523 locations across the country and 14,945 in California. Guardian's PPO network also includes dental offices in Mexico. International Assist, a value-added service available, provides dental members with access to dental care if needed while traveling outside of the U.S. In addition, a supplemental listing of out-of-network dentists, Out-of-Network Plus, provides Guardian members greater selection in finding an affordable dentist.

Health Net Dental: As of May 2014, our California PPO network includes 40,722 access points in 11,367 locations. Our California DHMO network includes 2,382 locations.

Humana Dental: Nationally, Humana has more than 215,000 provider locations. In California, we have approximately 30,000 provider locations.

Principal Financial Group: We have approximately 48,000 PPO provider locations and 25,700 EPO provider locations.

Securian Dental: More than 219,000 dentist access points.

United Concordia: To support our diverse product portfolio consisting of fee-for-service, DHMOs and PPOs, we maintain some of the largest dentist networks in the nation. Our largest network provides access to more than 96,000 dentists at almost 272,000 access points. In California alone, we have more than 16,000 providers at more than

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41,000 access points. Our DHMO network includes more than 2,615 primary dental offices and 1,765 specialists nationwide, with over 1,652 primary dental offices and 828 specialists in California.

9. CAN INSUREDS CHANGE PROVIDERS EASILY IF THEY ARE UNHAPPY?

Aetna: Yes, members in our PPO/indemnity plan can change any time and do not need to notify us. Members in our DMO plan can choose a new provider as often as once per month through Navigator, our online web tool for members, or by calling the toll-free telephone number on the back of their ID card.

Aflac: Yes. Policyholders can change providers at any time.

Ameritas: Ameritas PPO and the FDH Networks: Insureds can choose any provider at any time for procedures.

Anthem Blue Cross: Yes. Our PPO networks, including Dental Prime and Dental Complete, are open-access models: The member does not have to pre-select a dentist and can always see the dentist of his/her choice. DHMO members can change providers once a month.

BEN-E-LECT: Yes. Members may change providers at any time by selecting to use another provider. No further documentation or process is necessary.

BEST Life: Members may choose any dentist they desire without calling BEST Life to switch providers. We also provide immediate access to customer service who can assist members with selecting a provider.

Blue Shield: Yes. Dental PPO plan members have the flexibility to see in-network or non-network providers while dental INO members can only see network providers. However, dental PPO and dental INO plan members may change providers at any time without notice; Dental HMO plan members may change their primary care dentist as needed; changes will be effective the first of the following month.

BRIGHTER: Brighter members can choose the best dentist that matches their needs. Using our online dental shopping platform, members choose dentists based on location, ratings or price.

Cigna: DHMO: Members may transfer to a new dental office once a month and for any reason, as long as the member has paid his/her account, in full, at the office. Members can call our customer service department to speak with a representative, transfer using the online Dental HealthCare Professional Directory on myCigna.com or use our automated transfer option which can process transfers 24-hours-a-day. Transfers are effective the first of the following month. We suggest that members complete any dental treatment-in-progress before transferring to another dental office.

DPPO: Cigna DPPO members have the freedom to visit either a network dentist or any licensed dentist at any time. However, we do recommend that they complete any treatment-in-progress and pay outstanding balances full before changing dentists.

Indemnity: Cigna Traditional indemnity members have the freedom to visit any licensed dentist at any time.

Delta Dental: Fee-for-service enrollees can change dentists any time without notifying us. DHMO enrollees can change their contract dentist by contacting customer ser-

vice or online at deltadentalins.com. Requests submitted prior to the 21st of each month are effective the first of the following month. There are no restrictions in the number of times an enrollee can choose to switch dentists.

Dental Health Services: Yes. Members can change their dentist at any time by contacting their Member Service Specialist. Changes made before the end of the month take effect the 1st of the following month.

Guardian: Members covered under Guardian's PPO plans can change dentists at will, regardless of whether the dentists are participating or non-participating. Members covered under our DHMO plan may change dentists by using our on-line web tool, GuardianAnytime.com, or by calling our toll-free number. We also offer a dual choice monthly switch plan which enables members to switch between the DHMO and PPO as often as desired on a monthly basis.

Health Net Dental: With our PPO plan design, there is no need to select a primary care dentist or to obtain referrals for specialty care. Under our DHMO plans, members may change their primary care dentists once a month by calling Health Net Dental Member Services or via our on-line Web portal. The change is effective the first of the month, provided that the request is made by the 20th of the previous month.

HumanaDental: With the PPO plan design, the member can change dentists without notifying the dental plan.

Principal Financial Group: Yes

Securian Dental: Yes.

United Concordia: Yes, members can change PPO providers at any time without notice. DHMO participants may change dentists by writing or calling our customer service department and requesting a new DHMO provider, as long as there is no existing balance due to the current dentist or treatment in progress.

Western Dental: Our membership can change providers, on a monthly basis, by phone or in writing.

10. HOW DO YOU ENSURE THAT YOUR DENTISTS ARE AWARE OF THE BENEFITS OF YOUR PLAN(S)? DO YOU HAVE A WAY OF KNOWING IF THE DENTISTS ARE SO LICITING OR RECOMMENDING SERVICES THAT ARE NOT COMPENSATED FOR BY YOUR PLAN?

Aetna: Participating dental offices receive our helpful Dental Office Guide, which provides clear information about plan designs, policies, and procedures. We also offer a website specifically designed for dentists. The site includes real-time eligibility and benefits information, a 24/7 speech recognition system called "Aetna Voice Advantage." Also, our dental solutions team is trained to know what is important for provider service. Unusual treatment patterns may be discovered during our review of utilization reports. This usually results in an office audit that includes a review of patient files and general office practices. We talk with the dentist about the findings and develop recommendations for improvement where needed.

Aflac: Aflac has materials that may be provided to dentists with information on how to file claims and access on-line materials. A dedicated section on aflac.com provides dentists with claim forms and instructions, as well as online

access to verify policy benefit amounts. If the dentist has any additional questions, he or she may call Aflac's Customer Service Center toll-free at 800-99-AFLAC.

Ameritas: Providers can access individual plan information using the toll-free voice response system, the fax-back system, or our online benefit Website. We hope this educates both the provider and insured about covered benefits. If not, periodic surveys and automated utilization review mechanisms help provide a way to monitor issues regarding plan coverage misunderstandings.

Anthem Blue Cross: We inform participating dentists of plan benefits through a variety of communication vehicles. Dentists can access updated information on our Web site, through our interactive voice response system, directly from our provider relations and customer service representatives and through our provider mailings. Practice patterns of participating providers are continuously monitored and reported through monthly utilization reports and claims experience. We involve our dental director when we suspect over- or under-utilization patterns. In such cases, our dental director contacts the dentist to discuss findings along with a plan of action to help bring the practice within the standard.

BEN-E-LECT: The members are given material specific to the dentist to ensure benefits are understood. BEN-E-LECT also offers extended customer service hours with a department dedicated to assisting dentists with benefits information. BEN-E-LECT also has regular outside auditors review claims for this information in addition to scrub during time of payment.

BEST Life: Dentists may contact BEST Life for information about member benefits by calling 800-433-0088. We also have a fax back line dentists can use to obtain benefit information.

Blue Shield: We automate as many administrative processes as possible. Because administrative capabilities vary among dental offices, multiple approaches exist to facilitate dentist communication—from web-based applications to direct telephone contact—to ensure that all offices have access to critical dentist information and support. Communication channels available 24 hours a day, seven days a week, include the following:

- The Interactive Voice Response (IVR) system for eligibility verification and claims status inquiry. The IVR also provides fax-back capability for hard copy eligibility verification.
- A website enables eligibility verification; benefit confirmation and claims status inquiry.
- Electronic Claims Filing—We contract with a number of clearinghouses or trading partners to receive electronic claims submissions.
- Electronic Claims Payment—The capability exists to pay our providers electronically if they so choose. Claims are paid on a daily basis (Sunday-Friday). Network dentists can control costs and increase efficiency by submitting data electronically, using our website and interactive voice response (IVR) system.

BRIGHTER: Our dentists utilize our simple online platform to process interactions with our members so mistakes

are minimized. This also empowers us to track all recommended treatments and proactively remove providers that are over-utilizing (recommending unnecessary services) from being seen by our members.

Cigna: Our Cigna for Health Care Professionals website provides secure, 24/7 access to patient and claim information. This website provides one-stop online access to information that the dental offices will find helpful to manage day-to-day operations and increase operational efficiency. Our public website at cigna.com also provides an easy way for dental offices to access information about participating in the Cigna Dental Care (DHMO) or Cigna DPPO network. The network management staff communicates regularly with contracted dental office personnel by phone, bimonthly newsletters, site visits to provide information about regulations, practice management, patient satisfaction, policies, procedures, and high-level news about Cigna.



DHMO: The Cigna Dental Care Dental Office Reference Guides, Patient Charge Schedules (PCS) at a Glance and Specialty Referral Guidelines are provided to each network dental office on the plan. These documents describe the policies and procedures to administer the plan and assist members, the patient fees for each plan and the advantages of participating in the Cigna Dental Care network. These documents are available on an internet-based platform specifically established for dental health care professionals, on CDs or in print if requested.

DPPO: The Cigna DPPO Dental Office Reference Guide and fee schedules are provided to each network dental office on the plan. These documents describe the policies and procedures to administer the plan and assist members, contracted fee schedules for the dental office and the advantage of participating in the Cigna DPPO network.

Utilization Management: Our utilization management program includes reviews of claims, treatment plans and network dentist practice patterns. A utilization database, containing millions of claims and encounters from more than 140,000 dentists across the country, provides us with a comprehensive and statistically sound basis for establishing utilization norms. With the combined efforts of more than 40 network management professionals and our advanced systems capabilities, we are able to evaluate every network dental office and evaluate the number and type of services rendered against our utilization norms while easily identifying outliers.

Delta Dental: Detailed program information for all enrollees, including maximums, deductible and benefit levels, is available through a secure area of our website and through a toll-free telephone number. Additionally, Delta Dental issues a quarterly newsletter to network dental offices, which covers Delta Dental policy, industry news, seminars, new Delta Dental clients, tips on submitting claims and other useful information. We also issue a quality-related newsletter to participating dentists three times a year that provides useful information to help improve the quality and efficiency of the care they provide. In addition, Delta Dental provides Delta Seminars and Delta Day Seminars, as well as customized small training classes right in the dental offices to educate the dental staff on Delta Dental policies. Regular enrollee surveys seek information on various quality issues, such as services rendered that are not covered by the plan; services delivered as claimed; office cleanliness and appearance; and customer service.

Dental Health Services: We regularly provide on-site training, auditing, and service visits for our participating prepaid dentists. Additionally, each office gets a comprehensive manual and we monitor all services and treatments received by our members through monthly utilization reports.

Guardian: Dentists can access plan benefits online at GuardianAnytime.com or through their practice management system. All PPO dentists receive information about Guardian's plans through local network recruiters as well as email newsletters or mailings of pertinent information. Our claim system tracks and monitors each dentist's practice patterns for bundling, over-utilization, etc. We consult with dentists who are not meeting our expectations, and if they are unable to do so, we may discontinue their network participation. All offices

that join our DHMO network receive an orientation that fully explains the plan. Additionally, our DHMO Regional Network Managers periodically visit the offices to review the plan. Dental Offices submit encounter data of services provided to DHMO members, which is reviewed quarterly by our Quality Assurance Committee.

Health Net Dental: We educate our providers about our administrative policies, including guidelines on appropriate care. Providers are encouraged to submit pre-treatment plans for review in order to learn what procedures would be covered under the member's benefit plan and the level of reimbursement. In the process of reviewing pre-treatment estimates and in completed claims, we track and monitor each provider's practice patterns. Providers with aberrant patterns receive focused review, including statistical analysis and record audits, which may result in appropriate corrective action plans. Our Professional Network Relations Reps meet with providers to counsel them and to answer any questions about planning care for members. Our Internet portals provide real-time information to providers and members on their benefits.

Humana Dental: HumanaDental notifies dentists, according to their contract, of any new product 45 days in advance of introduction. Providers are encouraged to check eligibility and benefits prior to treatment. Through monitoring of member communications and through utilization review, we would become aware of any situation where a dentist may be recommending non-covered procedures on a routine basis.

Principal Financial Group: We provide online, telephone and fax service options for providers to verify benefits and eligibility. We encourage pre-determinations to be performed for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery.

Securian Dental: Dentists can verify benefits by calling our toll-free customer service phone number or via our web site.

United Concordia: Dental offices can confirm benefit coverage information on our website via "My Patients' Benefits," through our telephone interactive voice response (IVR) system, or by speaking to a customer service representative. In some instances, we also inform dentists of important benefit changes through written communications, via our quarterly newsletter, through a stuffer included with dentist checks and/or with an automated telephone call. Dentists can also reference benefit information using our Dentist Reference Guide, available on our website. Professional relations representatives are also available to provide assistance when necessary. We identify abnormal practice patterns through a comprehensive quality assurance process. United Concordia reviews thousands of claims each year to ensure the acceptability of treatment and quality of services. Advisors and consultants also review dentists' fees and practice patterns. Dentists who fall outside of the norm are targeted for education and additional monitoring.

Western Dental: Each provider is trained and given training materials to ensure that they are knowledgeable about Western Dental programs. Western Dental Services also monitors customer service inquiries and grievances in addition to reviewing utilization data supplied by each provider. ★

MARKETING SECRETS

OF A SUCCESSFUL DISABILITY INSURANCE SALESPERSON

by ART FRIES

This article will explain the most important area of selling insurance: getting in front of prospects. I'll be telling you about the various methods that enabled me to earn in the top 1% of those selling life/health insurance in the country.

One method was to go into office buildings and write down names and suite numbers from the building directory in the lobby. After getting back to my own office, I would find all the phone numbers. The next step was to have a phone day in which I called the attorneys in the building. I would tell the receptionist that I specialized in disability sales and would like to talk to the attorney. How you get past the secretary to the attorney I will leave up to you since there are many books and mentors who can lead you in this direction.

Your telephone approach changes once you do business with just one person in that suite. You say, "Henry Jones in your suite (or your firm) is a client of mine and he suggested that I might speak with attorney Jack Cohen. Would you put me through to him?" Then say to Mr. Cohen, "Henry Jones is a client of mine and I'd like to sit down with you on the same basis I sat down with him to discuss your disability insurance needs. Tell me, Mr. Cohen, do you have disability insurance? When was the last time you had your program reviewed?" I always looked to do business with attorneys in smaller firms or those who were sole practitioners." I stayed away from large firms because I did not want to talk to an attorney who was covered under a group disability plan.

SEEK THE ENDORSEMENT OF A PROFESSIONAL ASSOCIATION

If a client is a member of a local association, go to their monthly meetings. Offer to talk on a particular subject. Eventually you will be known as the expert in your niche. See if an insurance carrier would be willing to provide a discounted premium if you

submit an application on behalf of the association member. Then suggest to a board member that you would like to make a presentation that will offer their members a quality product as well as a premium discount.

You would like to be able to send a letter out to the members indicating your availability to discuss this product. If the board of the association accepts your offer, you should receive a membership list with addresses, telephone numbers and e-mail addresses. You should be given permission to call the members after you have sent out your initial letter or e-mail notification. A letter with a properly designed brochure can be an effective first step. In my case I became endorsed by a number of Bar Associations. The key to getting in the door was to call the attorney member and say that I represented their bar association with respect to their disability insurance needs. Doing business with a member gave me the opportunity to get referrals for other association members. Doing business with just one board member gave me the opportunity to do business with other board members.

EXHIBITING AT A CONVENTION

Larger venues tend to be more successful for securing interviews I would pay to be an exhibitor at a state association, which gave me the opportunity to be in front of a large number of prospective clients. Eventually, I didn't have enough time to follow up with all of the people I met at these events. I brought another agent with me and split the leads with him. I had a reduced split commission arrangement, whereby he would receive a much higher split. At the trade shows, I would do the following:

- Have a banner hanging behind my small booth, which said, "Art Fries Disability Insurance for Attorneys" with my telephone number, all in big bold letters.

- Provide a handout of high quality business cards, copies of articles I had written, and my bio.
- Provide a free gift imprinted with my name and contact number.
- Have business cards on the table.
- Have a hook. My opening line was, "Hi, Art Fries and I handle disability insurance for attorneys." I would ask, "Do you have disability insurance?" If they said yes, I would ask, "When was the last time you had your program reviewed? Would you have any objection to meeting with me after the convention on a non-obligatory basis? Do you have any medical history that you think would pose a problem in securing disability insurance (or more disability insurance)?"

If we established a need to meet, I would ask the attorney for their business card and say that I would be calling them within a week to set up a convenient appointment in their office. At one convention, a neighboring booth had three well dressed professionals who sat with their hands folded across their chests and failed to connect with anyone. At my booth, the other agent and I secured most of the leads because we made the effort to communicate.

I no longer actively sell insurance, but have used my selling skills and knowledge to carve an entire different niche, providing disability claim advice, mostly to professionals and high earners over the past 20 years. I hope you can use just one idea from this article to help you in your professional endeavors. It has been a pleasure sharing my ideas with you. ★

Art Fries is a disability claim consultant providing advice on a national basis in the U.S. He is located in Nipomo, California. He can be reached at 800-567-1911 or e-mail friesart@hotmail.com. The web address is afries.com.



Build Your Own

THE NEW MENU OF ANCILLARY BENEFITS: CUSTOM, BY DESIGN



by JASON T. ANDREW

What an exciting time to be in benefits. We are in a disruptive and evolutionary time in our industry. The experience of determining, pricing, delivering, and managing benefits has always been fascinating for me. It has also been frustrating.

The administration, selection and management of benefits are the pieces of the process that I typically find frustrating and broken. The relationships, consulting, advising, strategizing, and learning; those are fascinating, fun, and challenging. After all, we get the privilege helping people with some of the most important decisions during some of their most vulnerable times.

Technology, public exchanges, private exchanges, widgets, calculators, and algorithms all help facilitate the process. But, these tools don't replace the relationship, consulting, advising, and strategizing. They should absolutely reduce the fragmented way the industry has operated and make it smoother.

Within the new eco-system of private exchanges there is a movement toward a more personalized, custom consumer experience. Ancillary benefits, which have typically been the step-children of medical insurance, are now offered as a whole array of choice add-ons for insurance customers. More options become available to fill the gap as medical deductibles increase, employers reduce contributions, and administration becomes more consumer-centric. No longer are these fringe benefits. These ancillary benefits are quickly becoming

valuable retention tools that facilitate long-term satisfaction and care of employees and their families.

More employers will turn their attention to voluntary benefits and services over the next five years. These benefits will address four critical life needs: supplemental health, wealth accumulation, security, and unique personal interests or requirements, according to a recent Towers Watson report.

As a result of this, a number of carriers are making big moves into the business. AXA Equitable, for example, is offering a suite of benefit products scheduled to begin rollout in the United States in mid-2015, including group life insurance, dental and vision, short- and long-term disability, gap medical and hospital indemnity, and critical illness.

Hervé Balzano, a 15-year veteran of AXA S.A. France said, "While competitors struggle to adapt their legacy services and technology to the present, we have the advantage of building, from the ground up, a seamless platform that is unencumbered by the past and ready for the future."

This is just one example, and there are many others. However new companies entering the market and new exchanges propping up are not the silver bullets. There is a lot of room for innovation and change. The trend is not going anywhere. Big data information seems to appeal to carriers. Nerd Wallet, for example, just raised \$64 million. Last year, 30 million people used NerdWallet to get financial advice on a range of sub-

jects. The company offers comparison shopping tools on financial products including: healthcare, mortgages, life insurance, banking, credit cards, financial services and wealth management, small business tools, and college loans.

To remain competitive, employers are ready to offer a full menu of ancillary benefits, geared toward the consumer in product options and distribution. With the growth of options, the challenge is for the employers to provide an end-to-end process to build awareness of what options are useful to consumers and what these products provide. ★

Jason T. Andrews is co-founder and CEO of Limelight Health. Limelight Health, with offices in Silicon Valley and Redding, provides innovative cloud-based products to insurance agents. Previously, Jason was the founder of Stone Meadow Benefits & Insurance Associates. Prior to founding SMB, Jason worked as the managing producer at LHI (Lawson-Hawks Insurance Associates). He has worked as the lead consultant in benefit plans to over 30 public entities and union clients. Jason has advised numerous Silicon Valley startups. He serves on the Board of Napa Children's Health Initiative. He also serves as an advisor to "GoVoluntr," a startup that connects volunteers, non-profits and businesses together. Previously he was on the Silicon Valley Association of Health Underwriters board of directors and led a committee for the California Association of Health Underwriters, which was designed as a collaborative discussion between CAHU and HHS Region IX's Director, Herb Schultz, to provide feedback on key pieces of ACA and its impact to the California business community. Jason served for seven years as a minister for the International Churches of Christ and holds a degree in communications from Lewis and Clark College.



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Coverage is underwritten by American Family Life Assurance Company of Columbus. In New York, coverage is underwritten by American Family Life Assurance Company of New York.

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PET INSURANCE

*Bringing the **Excitement**
Back to Voluntary Benefits*



by **CHRIS L. MIDDLETON**

There is an important question that isn't asked enough among brokers trying to expand their client base: What is exciting about the services I offer? The question doesn't address the value of the service. It doesn't cover the importance of the products and policies that service provides. It does require an outside perspective. And that perspective is key in facilitating all the important brokerage advantages that the question does not address.

The average prospect is not going to find their inner passion ignited during a conversation about policy options. But try, in the middle of this chat, to ask a prospect about their dog. Then watch their eyes come back into focus. Watch as their body language opens up. Watch as they begin to gesture, to laugh, and to share. In essence, watch as they become excited.

If you doubt this sentiment, do a quick Google search. What do you think is the ratio of cat videos to earnest explanations of any insurance product? It's the relatable moments these products create that make pet insurance a valuable commodity among those who offer comprehensive insurance packages to their clients.

SEEING THE OPPORTUNITY

In the brokerage world, pet insurance is a niche property insurance product that acts as health insurance to dogs and cats. In a pet owner's world, it is piece of mind that another family member will have protection when the unexpected happens. This is an emotional connection that cannot be underestimated. Three in five Americans own a pet and, according to a recent Harris Poll, 91% of pet owners consider their animal to be part of the family. Even if intrinsically understood by pet owners, that connection has yet to be recognized and embraced in the larger insurance community.

There is a 1% penetration rate in the market for pet insurance across the U.S., and annual growth averages at above 13% since 2008. Popular knowledge of the industry is growing and indicates a coming tipping point in consumer demand for greater pet protection. This suggests an opportunity for an advantage in a large and varied subset of the American population without crowding from competitors. Leveraging these policies into an important tool for a growing brokerage is just a matter of applying it to the right situations.

The demand for pet insurance is tied to the demand for emergency care. Eighty percent of pet owners will need it during the life of their pet, resulting in annual medical costs of \$500 to \$1,000. About one third of pets will need some unexpected care within the next year. Severe illnesses and injuries can run up bills of \$8,000 or more. In the face of those quoted costs, pet owners will often choose economic euthanasia over significant debt. Avoiding that eventuality is a powerful driver.

The service is simple enough. Most pet insurance companies reimburse pet owners for at least 70% of sickness and injury treatment costs resulting from veterinary care. This can be for cancer, allergies, broken bones, or even digestive problems from eating socks. Optional coverage for wellness care, such as routine checkups and vaccines, is also available.



FINDING THE ADVANTAGE

Pets can also be a lead generator. Pet insurance purchasers have a stellar cross conversion rate with other policies, which should make them a coveted demographic.

Going to pet expos, dog parks, and adoption events is a way to meet passionate, concerned pet owners who are curious enough about the product to discuss other comprehensive options. These same prospects will not consider other comprehensive packages well-rounded without pet insurance once it has been put on the table.

After gaining a client this way, what better or easier way to cement the relationship than to send over a couple of dog biscuits and some pet insurance options with your welcome package? How about a Frisbee or other branded object that they will use during positive activities with their pet?

The pet conversation opens, and reopens doors. There is no struggle to find common ground when doing a friendly checkup with a client if they have a pet. They're eager to share exploits and, possibly, even the positive results of a covered trip to the vet. For brokerages that create or aggregate their own content to keep brokers and clients engaged, pet and pet insurance information provides a whole new avenue for social media, blog, and e-mail topics that will generate active engagement.

For other potential clients these policies can be the detail that puts one broker over the top. When your average client walks away from a discussion you can hope that they will remember the high points of the value added in your services, but you will know they remember the key points about protecting their furry family members.

BEING EVEN MORE COMPREHENSIVE

Brokers can take advantage of group discounts and the growing desire for pet insurance when working with institutional and group clients. Human Resources departments are reporting pet insurance to be one of the most requested voluntary benefits in recent years.

These benefits add up to a more robust offering to clients. For a relatively small piece of the larger insurance picture, brokers can stand out from their peers. It also gives further validation to claims of comprehensive coverage that competitors don't offer. The addition of a pet onto any policy will result in additional fees collected by the broker. Pet insurance agencies compensate per pet, per policy and, in some cases, for affiliate traffic just by placing a link on your website. But the additional fees mean little compared to the opportunities available to brokers trying to connect with people on a personal level. It taps into a tender vein of emotion that quickly expands a budding relationship between client and broker, building trust faster than traditional service. It's humanizing.

So we get back to the original question, "What's exciting about the products I offer?" We can say that it's exciting to hear clients tell us eagerly about their lives. To invite us in to hear their inside jokes and understand their family. It's exciting to create that bond outside of the normal conventions of commerce and see it help us help them. And it's exciting to know that the good will we build by protecting their family will be sustained with every visit to the veterinarian. It's exciting to know that we can help protect that which they hold dear. ★

Chris L. Middleton is the president of Pets Best Insurance Services, LLC, a national pet insurance agency for dogs and cats.

COBRA FAQs

for Employers—from the Department of Labor

Which Employers Are Required to Offer COBRA Coverage?

Employers with 20 employees or more are usually required to offer COBRA coverage and notify their employees of the availability of coverage. COBRA applies to plans maintained by private-sector employers and sponsored by most state and local governments.

Who Is Entitled to Benefits Under COBRA?

A group health plan is subject to COBRA if it has had 20 or more employees on more than 50% of its typical business days in the previous calendar year. Each part-time employee counts as a fraction of an employee. The fraction is equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.

A qualified beneficiary is covered by a group health plan on the day before a qualifying event and is an employee, an employee's spouse, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

The type of qualifying event will determine who the qualified beneficiaries are and time that a plan must offer the health coverage to them under COBRA. A plan may choose to provide longer periods of continuation coverage.

The following are qualifying events for employees:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct.
- Reduction in the number of hours of employment.

The qualifying events for spouses are the following:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct.
- Reduction in the hours worked by the covered employee.
- Covered employee's becoming entitled to Medicare.
- Divorce or legal separation of the covered employee.
- Death of the covered employee.

The qualifying events for dependent children are the same as for the spouse with one addition:

- Loss of dependent child status under the plan rules

What Benefits Must Be Covered Under COBRA?

Qualified beneficiaries must be offered coverage identical to what's available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan

(generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage). A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

Who pays for COBRA coverage?

Beneficiaries may be required to pay for COBRA coverage. The premium cannot exceed 102% of the cost to the plan for similarly situated individuals who have not incurred a qualifying event, including the portion paid by employees and any portion paid by the employer before the qualifying event, plus 2% for administrative costs.

For qualified beneficiaries receiving the 11 month disability extension of coverage, the premium for those additional months may be increased to 150% of the plan's total cost of coverage.

COBRA premiums may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The plan must allow qualified beneficiaries to pay premiums on a monthly basis if they ask to do so, and the plan may allow them to make payments at other intervals (weekly or quarterly).

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment must generally cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the date stated in the plan with a minimum 30-day grace period for payments. Payment is considered to be made on the date it is sent to the plan.

If premiums are not paid by the first day of the period of coverage, the plan has the option to cancel coverage until payment is received and then reinstate coverage retroactively to the beginning of the period of coverage.

If the amount of the payment made to the plan is made in error but is not significantly less than the amount due, the plan is required to notify the qualified beneficiary of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to co-payments and deductibles, and are subject to catastrophic and other benefit limits.

More details about COBRA coverage are included in the booklet *An Employer's Guide to Group Health Continuation Coverage under COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1986*. To request a copy, call EBSA toll-free 866-444-3272. ★

*Critical Illness Plans:***YOUR CURE FOR UNHEALTHY SALES** by JASON MEYERS

Every agent has a story to tell. In the senior market, that usually means visiting clients and prospects in their homes to discuss typical offerings such as health, life insurance, and final expense plans. Most health agents focus on health. Life agents sell life. But there's one product that eclipses these two areas: Critical illness. Demand is rising, and it could be just the medicine you need to boost your sales.

So just what is a critical illness plan? In most cases, this type of insurance provides a lump-sum payment or graded benefit following the diagnosis of any critical illness listed in the policy. Funds are paid directly to the insured (not doctors or hospitals) and can be used for any purpose. Some plans provide a per-day benefit for surgery or other procedures and can help stabilize household finances during an incredibly stressful time.

Many carriers are adjusting the structure and delivery of their products to meet both employer and employee needs, particularly as ObamaCare facilitates the greater use of high-deductible plans. Individual plans for the self-employed and small businesses are also seeing a rise in popularity. Some plans are available on a guaranteed-issue basis to employer groups with at least 100 employees.

WHEN LIFE INSURANCE IS NOT ENOUGH

According to a 2011 Genworth Life Jacket Study, 40% of Americans who have life insurance coverage don't think they have enough. And they're right. If a critical illness strikes while your client is still alive, proceeds from life insurance won't cover it. An accelerated death benefit rider may help cover some costs, but only if that client is terminally ill (in most cases). That's why many agents today are looking at presenting critical illness plans as part of a larger strategy for asset-protection rather than just a stand-alone ancillary solution.

A SILVER LINING FOR AGENTS

There are many critical illness plans available and some cover cancer up to age 85. Many plans also cover renal

failure, stroke, heart attack, or a combination of conditions. In most cases, a simple series of questions asked in the house can prequalify your clients for coverage.

Recent statistics show that one out of every two men will get cancer. For women, that number is one in three. As an agent, you already know selling health policies and life insurance to anyone over 65 is challenging. Health issues, underwriting, and cost all play a role in eligibility.

But, if you're already in the house discussing life or health plans, chances are that your clients haven't considered critical illness coverage as a way to protect their nest egg if unexpected medical treatments should arise from cancer or other conditions.

Plan payouts can be as high as \$70,000 in a lump sum per person. Other plans pay out in stages. Do your research and compare. There are some critical illness policies out there that will provide cancer coverage for smokers (at a much higher premium, of course, but creative plans do exist)!

ASK THAT CRITICAL QUESTION

Your ability to ask, "By the way, have you thought about critical illness?," is a good way to learn more about family health history and open the door to additional fact finding. Save the question for last in your presentation after you've closed a sale for something else. Ask about your clients' parents and other relatives. Do certain conditions run in the family? Usually, your clients will see the value of critical illness protection, but it's up to you as an agent to show them how having that extra money to fight unexpected illness can be a literal lifesaver.

Living proceeds from critical illness policies can also be used to pay for services often overlooked, such as temporary in-home care (especially when many seniors don't qualify for fully underwritten long-term care). Other uses for critical illness coverage include paying for expensive medications and treatments and keeping the household moving forward by covering utility bills, groceries, travel expenses, and other essentials.

THE FUTURE OF CRITICAL ILLNESS PROTECTION

Critical illness plans can change on a year-to-year basis, and some carriers are making it more difficult to qualify. Others are reducing lump-sum amounts. Overall, these plans continue to add value and can be leveraged by agents as a powerful and strategic tool when it comes to building sales and protecting clients.

The critical illness insurance sector is in a good overall state of health, according to last year's 13th-annual Critical Illness Insurance Market Survey, conducted by Gen Re in partnership with the National Association for Critical Illness Insurance (NACII).

Respondents predicted an average annual growth rate of around 10% for individual policies and about 14% for employer or group policies over the next three years.

KEEP THE CONVERSATION ALIVE

Building good rapport with clients and protecting their interests can usually be achieved with a simple conversation around critical illness. These plans are also well suited to younger individuals and couples with kids who may have a family history of certain conditions. It's a well-known fact in today's economy that one of the key factors leading to bankruptcy is unexpected medical bills.

For households worried about rising out-of-pocket costs and balancing health care with everyday costs, critical illness plans provide additional peace of mind. So, no matter who or what age your clients are, it makes sense to have a candid discussion about critical illness strategies. With the right plan and affordable premium in place, your clients will feel at ease knowing those what ifs won't become what nows. ★

Jason Meyers is Director, Western Office with Ritter Insurance Marketing (Ritter). He received his B.A. from San Diego State University and has been licensed in Arizona for more than 15 years. Ritter is a national Field Marketing Organization (FMO) that solves the distribution needs of more than 70 insurance companies in the senior health and life markets. Learn more at ritterim.com.

Booster Client confidence with CRITICAL ILLNESS INSURANCE

by **CARL JONES**

Today's brokers face a challenging environment as they seek to build their business and bring clients the products they need, especially among a dynamic regulatory climate. Fortunately, non-medical benefits can help brokers stand apart and provide clients with an innovative product they may not even know they need.

Critical illness insurance products are often overlooked as part of a comprehensive benefit offering. In fact, critical illness enrollment is the lowest among other benefits offered—including dental, life, vision, accident and health, according to a recent report released by Lincoln Financial Group. While critical illness insurance has lower offer and enrollment rates than other workplace benefits, its effectiveness in helping enrollees become more confident and prepared in covering health care costs down the road cannot be ignored. In fact, Lincoln's data found that critical illness enrollees feel significantly more secure about their financial future, more in control of their lives and experience a higher sense of optimism than non-enrollees.

THE GLASS IS HALF FULL—BUT THERE IS A CONCERN

This year, 88% of employees are optimistic about their future. Yet less than one in five feel very secure about their financial future, especially when it comes to health care. And only 18% feel very confident they could cover their current expenses in the event they suffer a major injury or illness, according to the survey. While today's employees remain positive in their ability to cover today's health care expenses, they feel these costs will make it difficult for them to retire.

Critical illness insurance is one of the non-medical benefits that can help bridge the gap between today's confidence and tomorrow's concern. This benefit can help enrollees weather some of life's major obstacles, including medical ones. Unanticipated medical bills from a major life illness or injury could set today's savers back—even to the point of bankruptcy in extreme cases. And when savings are depleted and cards maxed out, the research shows that many are turning to their retirement accounts in to fund their mounting medical bills. Critical illness insurance coverage can also include advantages that help with the concerns of every day issues—often without experiencing a critical illness event. Annual health assessments can help the insured measure their health, health risks, and quality of life. In addition, value added benefits can include travel assistance for treatment or pleasure and a personal health advocate that helps the insured and family members navigate the health insurance maze associated with treatment for any condition.

THREE BENEFITS OF CRITICAL ILLNESS INSURANCE

As today's brokers navigate the world of non-medical benefits, there are important factors to keep in mind and communicate when encouraging enrollment in critical illness insurance.

It Helps Combat Health Fears

Experiencing stress or a chronic illness is a major concern for employees. About half of today's employees identify cancer as their top health concern—a concern consistently ranked at the top among all generations, according to the study. In the event an enrollee is diagnosed with cancer or another major medical illness, critical illness insurance can give them the peace of mind that their expenses will be covered and loved ones will be cared for as they recover.

It Pays the Bills and the Mortgage

Modern medicine has come a long way in helping people survive major illnesses, such as heart attacks, strokes and cancer. But recovery takes time. Those who experience a major life illness will need time to recuperate, and may not be able to work or earn an income while doing so. While enrollment in health benefits can cover doctor's visits and many other medical needs, a lump sum payout from critical illness insurance can help pay the bills for the mortgage, food, and other everyday expenses that medical insurance doesn't cover. In fact, the lump sum pay out can be used for anything, thus supplementing health care costs of today and tomorrow.

Education Can Help Enrollees Make Informed Decisions

Lincoln's research suggests a lack of communication and understanding around non-medical workplace benefits, such as critical illness insurance, which could help employees feel more secure about their future. Communicating the importance of a benefits education program, and offering materials that can help clients further understand the benefits of critical illness insurance can help engage employers and employees alike in this innovative and low touch point offering. Many enrollees cite the expense and low perceived necessity of critical illness insurance as a reason why they choose not to enroll. Education can help improve understanding and enrollment numbers.

While not all of today's employers offer critical illness insurance as part of their total rewards offering, data certainly underscores the ability for this product and other non-medical benefits to help enrollees face their fears—particularly worries about health care down the road—with confidence. ★



Carl Jones is vice president of Distribution, West Region, for Lincoln's Group Protection business. Jones has over 14 years of experience in the insurance industry. Jones graduated from the University of Oklahoma with a Bachelor of Science degree in Marketing and MIS. He is an active volunteer and supporter of many local charities in the community and above all, values time spent with his wife and three sons.

5 Trends

THAT ARE CHANGING THE FACE OF LIFE INSURANCE SALES

by **BRIAN GREENBERG**

Some big changes are in store for the life insurance industry, such as living benefits and technology that speeds up the application process. Some clients are reluctant to explore life insurance because they think that the process will be long and drawn-out. Below are some great opportunities to offer easier, less expensive, and quicker life insurance options. But there are some pitfalls.

1. NO MEDICAL EXAM NECESSARY

Advisors are well aware that clients don't like taking medical exams. Some have difficulty working it into their schedules; some fear needles; and others simply don't want the hassle. The great news is that no medical exam policies are extremely successful. Consumers choose them overwhelmingly even when they are more expensive than traditional medical exam policies. Five years ago, we had one or two options to offer clients. In 2015, more than 10 companies offer these simplified issue policies.

However, maximum benefit amounts are often under \$400,000. One option is to get multiple no exam life insurance policies from different carriers. The great news is that we have seen the first company offering up to \$1 million in coverage for a no medical exam policy this year.

Another growing trend is instant issue/no exam life insurance. It's great for clients who seek the ultimate convenience. This past year, several companies have entered this market. The applications are completely digital, and underwriting decisions are offered within 24 hours. Make sure your clients are aware that the insurance company will pull their motor vehicle report, medical insurance bureau report, and pharmacy report. The pharmacy report will show all medications prescribed over the past five years.

The market for no medical exam life insurance is growing, so if you have not added it to your product offerings, 2015 is the year to do it.

While no-medical exam policies can offer quick approvals, they can also result in quick declines. Make sure that you know the underwriting guidelines for each carrier before applying. Any adverse health codes that lead to a decline are stored in the Medical Information Bureau (MIB) database. The MIB can alert underwriters to any errors, omissions, or misrepresentations on a new application. This mitigates an insurer's risk, which keeps prices low. The codes associated with a declined policy stay on your record, which can make it difficult to secure insurance from another company.

2. TECHNOLOGY-DRIVEN PRICE DROPS

Eighty percent of consumers do online research before buying life insurance, according to a 2013 study by LIMRA and the Life Foundation. Price comparison engines rank life insurance companies by premium cost, which means that companies are now competing head to head, especially in the term life insurance market.

For clients with older policies, 2015 is a great year to look for significant cost savings, especially if the client is in good health. Inform clients who have older policies that policy rates have been up to 70% lower since the mid-1990s. Driving this trend is direct competition, lower administrative costs due to new technology, and the fact that that people are living longer. In the term life insurance market, the fact people are living longer means higher profits for the insurance companies. Life insurance claims rates are decreasing, which means lower rates for consumers.

However, when consumers search online for life insurance, what's most often displayed is the preferred plus health-class. It is important to let your clients know that not everybody gets these low rates. The company with lowest displayed rate may not be the best option based on the client's health situation and history.

3. NEW LIVING BENEFITS

Hybrid life insurance policies with living benefits riders have seen double-digit growth over the past few years. Accelerated death benefit riders offer access to the death benefit when the insured is terminally ill. Now, we have options to add chronic care and critical illness riders.

The chronic illness rider allows you to use the policy's death benefit if you are unable to perform two of the six daily living requirements of bathing, continence, dressing, eating, toileting, and transferring. This is very similar to a long-term care policy. The critical-illness rider allows the insured to use the policy's death benefit in the case of critical health conditions, such as cancer, heart attack, stroke, a major organ transplant, end-stage renal failure, ALS, blindness, or paralysis of two or more limbs.

These are just two types of riders that life insurance companies are adding to hybrid policies. With the growing popularity of these policies, we can certainly expect to see more. Offering these policies is a great way for agents to provide long term care benefits without selling a separate policy. Clients like being able to take advantage of their life policies while they are still living. However, living benefit/hybrid life policies are still new. Make sure to examine differences among carriers. States regulators are still examining the fine print of these policies so expect these products to continue to evolve.

4. PAINLESS POLICY PROCUREMENT

Traditional paper applications are still available, but insurance carriers are finally moving toward more digital options. Many top carriers allow the application to be entered primarily online and completed by a paramedical examiner.

The no medical exam policies are even easier with complete online ap-

plication options. This is huge news for the once-antiquated life insurance industry. Agents can almost completely avoid snail-mail, which means faster policy procurement and much shorter underwriting times. Get yourself a nice scanner and a fast Internet connection to enjoy all the new time-saving tools. However, with technology come more security issues. Make sure your computer's anti-virus software is up to date, and only connect to the Internet on secure networks.

5. NO NEED TO MEET FACE-TO-FACE

Some insurance companies still require agents to witness client signatures, but the majority allow applications to be taken over the phone and signed for with digital and voice signatures, which is a huge time saver for agents. It is now easier than ever to take an application. In 2015, more agents are taking applications over the phone, especially for simple products like term life insurance.

Fifty percent of consumers prefer buying life insurance without a face-to-face meeting, according to a recent LIMRA report. Be sure to offer this new option for your tech savvy clients; it can mean a whole new sales channel for your practice.

Just because a policy is taken over the phone does not make it less official. Make sure to fully qualify clients before submitting business to avoid having clients get declined or rated. Also be sure to note on the agent report that the application was taken without meeting the client. It is always best to be transparent when dealing with insurance companies.

To take advantage of all these new changes, it is a great idea to brush up on your technical skills. Most of the changes are aimed at making life insurance purchasing easier. Life insurance is just one part of financial planning. The most valuable assets an agent can have are knowledge, experience, and strong ethics. ★

Brian Greenberg is president of True Blue Life Insurance. Greenberg is in the world's top one percent of life insurance and financial services professionals. He may be reached online at TrueBlueLifeInsurance.com.

EMPLOYEE BENEFITS GUIDANCE TOOL

MassMutual is launching a tool to help Americans make financial decisions about health care coverage, insurance protection, and retirement savings. Within minutes, MapMyBenefits provides personalized guidance to help employees prioritize their health care, insurance, and retirement benefits. It helps them make the most of each benefit dollar based on their life stage, financial goals and personal financial situation. For more information call 1-800-874-2502, option 4.

NO-COST CHRONIC ILLNESS RIDER

AIG is offering a no-cost chronic illness accelerated death benefit rider on three Quality of Life Insurance (QoL) products issued in California. The owner can accelerate some or all of their base life insurance benefit if they are certified as having a chronic illness, as defined under the rider. The money can be used for any purpose, including supplemental income, medical expenses, or long-term care. Coverage is reduced by the amount of the accelerated death benefit, which may also reduce premiums. Accelerated benefits can be paid in a lump sum, annually, for a fixed period of (not to exceed 24 months), or monthly payments for a fixed period (not to exceed 24 months). For more information, visit aig.com.

GROUP TERM LIFE

Voya Financial launched a group term life product. Enhanced features include a variety of coverage options for employees, and life insurance benefits that can be used to help cover everyday expenses including funeral costs, medical bills, mortgage payments, and college tuition. Through an optional rider, an insured employee may be eligible to receive a portion of their benefit if they should become permanently confined to a healthcare facility. This benefit can be paid on a monthly basis, providing a stream of income for an employee or their family. For more information, visit voya.com.

ACA COMPLIANCE TOOL

Infinisource is offering an Affordable Care Act (ACA) compliance tool. iSolved tracks and maintains data about employee status; dates and coverage in a single source. It can produce reports for ACA compliance. The iSolved ACA Checkup evaluates how employers' criteria may subject them to certain provisions of the law. For more information, visit infinisource.com.

ROLLOVER PERKS TO DENTAL MEMBERS

Anthem Blue Cross introduced a dental rollover feature for large employer groups and national accounts that select Anthem's dental plan. Employees can bring in maximum carryover amounts from their previous dental carrier and retain the balances they earned. Members who don't reach \$500 in claims get \$250 in credit for each year they meet this criteria, up to \$1,000. They can spend this credit on dental care (with the exception of orthodontia) in years when the member's annual claims exceed their plan's annual maximum. For more information, visit anthem.com.

CRITICAL ILLNESS INSURANCE

Transamerica launched of CriticalEvents—critical illness insurance that helps to ease the financial burden of a major health event. Features include the following:

- No lifetime benefit maximum
- No waiting period
- Easy enrollment options
- Payroll-deducted premiums
- Simple product design – no categories for critical illnesses
- HSA compatibility
- New recurrent benefit options
- New issue age, attained rate and composite rate options
- Claims can be submitted online

For more information, visit transamerica.com. ★



IN NEWS

IN CALIFORNIA

Group Calls for Laws to Stop Hepatitis Care Rationing

Those on the front lines of fighting viral hepatitis and HIV/AIDS urged lawmakers to overturn state Medicaid and managed care policies that block patients from getting new and effective hepatitis C treatments. The Center for Health Law and Policy Innovation of Harvard Law School documented system-wide insurance restrictions, such as only allowing only patients with advanced liver disease to get the new drugs; only allowing a small number of medical specialists to prescribe the drugs; and restricting access to patients who use alcohol and other substances or have an HIV co-infection. These exclusionary practices also apply to a number of private health plans, resulting in a series of lawsuits in California. These restrictions mean that only 5% to 6% of people with Hepatitis C are being treated successfully.

Specialists are calling on policymakers to pass state laws requiring insurance plans to follow evidence-based medical guidelines when covering Hepatitis C testing and treatment. These guidelines (published jointly by the American Association for the Study of Liver Diseases, the Infectious Diseases Society of America, and the Department of Veterans Affairs) support treatment in all Hepatitis C-infected people except those with a life expectancy of less than a year due to non-liver medical conditions. Advocates urge states to enact laws requiring Medicaid programs to offer first-line HIV medications and new Hepatitis C drugs on their formularies and to cap the co-payments for these therapies, ending system-wide practices by public and private insurers that restrict access to these drugs.

Veronica Miller, PhD, Executive director of the Forum for Collaborative HIV Research said, "While the cost of new

therapies is a legitimate topic, without testing and treatment there will be little hope of reducing the burden of Hepatitis C and bending the cost curve." Proponents say that expanded access to Hepatitis C testing and treatment is especially warranted now that the Centers for Disease Control and Prevention (CDC) is grappling with twin epidemics in the U.S. – Baby Boomers who are living with chronic Hepatitis C, and an explosion of acute Hepatitis C primarily occurring east of the Mississippi River in young adults who inject drugs. "It is a sad fact that public and private insurers are responding to these twin epidemics by restricting access to new Hepatitis C drugs that have been found to produce high cure rates, sometimes exceeding 90%, within 12 weeks of treatment. We urgently need coverage policies that are intended to stem the tide of Hepatitis C and reduce its societal burden," said infectious disease expert John G. Bartlett, MD, Professor Emeritus of Medicine in the Division of Infectious Diseases at The Johns Hopkins University School of Medicine. For more information, visit hivforum.org.

State Senate Clears Bill to Clean up Provider Directories

Senate Bill 137 cleared a major hurdle as it passed out of the Senate by a vote of 33-0. Senator Ed Hernandez, O.D. (D – West Covina), Chair of the Senate Health Committee, is author of the bill that would require health plans and insurers to post accurate health care provider directories on their Websites so that consumers will know if their doctor is part of a network before purchasing a health plan.

During last year's open enrollment period many people had a hard time determining which plans their providers were a part of; some felt misled by the plans they chose. The problem was so bad that Covered California had to take its provider search tool off-line. It has not been reinstated.

A recent report by the Kaiser Family Foundation indicated that comparing provider networks is the most common difficulty in the plan selection process across all coverage groups. "We don't allow other products to be sold with an inaccurate listing of ingredients...This

bill would make sure provider directories are accurate and standardized, so consumers can know what they are buying and make the right decisions,” said Anthony Wright, executive director of Health Access California. SB 137 would also require the provider directories to indicate if the provider or staff speaks any languages other than English.

Covered California Enrollees Struggle with Premiums, but Like Coverage

More than 40% of Covered California enrollees struggle to pay their monthly insurance premiums, but many are satisfied with their coverage, according to a survey by the Kaiser Family Foundation. Forty-four percent of Covered California enrollees had a hard time affording their monthly premiums compared to 25% of adults with employer-sponsored or other private coverage. More than one-third of newly insured respondents delayed or skipped care because of cost. About 25% of Covered California enrollees said their medical bills were higher than expected. However, 84% said they had no problems paying their bills.

Seventy-four percent of Covered California enrollees said their coverage was excellent or good compared to 88% of consumers with non-exchange private insurance plans. Ninety-one percent of consumers with exchange coverage said it was easy to get care from their normal source.

Western Dental Will Drop Denti-Cal Patients

Citing low reimbursement rates, Western Dental stopped taking new patients with Denti-Cal coverage at 13 more of its California offices. But returning patients with Denti-Cal can continue care in their existing office. Also, Western Dental will close one office in San Francisco. Western Dental is the state’s largest provider of dental care services to low-income families. Simon Castellanos, CEO and president of Western Dental said, “For more than 50 years, Western Dental has been able to serve all Californians, including those most in need and covered by the state Denti-Cal program. However, the extremely low funding and reimbursement levels for the state program have finally proven impossible to bear. We... are

hopeful that the Governor and Legislature will pass a budget that will enable more providers like us to maintain the oral care that so many California children and adults need.”

**HEALTHCARE
Study Finds That Pay-for-Performance Doesn’t Work**

A study published in the New England Journal of Medicine finds little evidence that pay-for-performance programs reduce hospital mortality. Under the Affordable Care Act, CMS must adopt a pay-for-performance program for hospitals nationwide. CMS responded by creating the value-based purchasing program, which provides financial incentives for high achievement and improvement in performance — an approach closely modeled after the Premier HQID. Researchers looked at the Premier HQID program over six years. Even among hospitals that were poor performers at baseline, there was only a weak and inconsistent association between participating in the program and reducing mortality.

Poorly performing hospitals did improve under the Premier HQID program, but the improvements were similar to those seen under public reporting alone, with the exception of pneumonia. Prior studies of the Premier HQID showed that the early gains in process quality had mostly dissipated after five years. The modest benefits were most perceptible for hospitals that were eligible for larger bonuses, were well financed, or operated in less competitive markets. For more information, visit nejm.org.

AMA Seeks to Improve Mental Health Coverage

The American Medical Association (AMA) is calling on Medicaid and private health insurers to pay for physical and behavioral health care services provided on the same day. “Treating people with physical and behavioral health conditions can be two to three times higher than caring for those without co morbid conditions. Yet research shows that coordinated care management of mental and physical health conditions can greatly improve health outcomes and could save upwards of \$48 billion annually in general



health care costs,” said Mary Anne McCaffree, M.D.

The AMA is also encouraging state Medicaid programs to include payment for behavioral health care services in school settings in order to identify and treat behavioral health conditions as early as possible. “Less than half of the 43 million adults identified with a mental illness and the six million children identified as suffering from an emotional, behavioral, or developmental issue get treatment. A key barrier... is cost. If we don’t take the necessary steps to ensure that integrated physical and behavioral health care [are] provided as early as possible, the lack of comprehensive services will continue to have devastating consequences for these people and the health of our society,” she added. For more information, visit ama-assn.org.

Mental Health Bill Reintroduced

Chairman Tim Murphy (R-PA) and Rep. Eddie Bernice Johnson (D-TX) reintroduced the Helping Families in Mental Health Crisis Act, H.R. 2646. The bill would do the following:

- Create an assistant secretary for Mental Health and Substance Use Disorders with mental health credentials within HHS. The assistant secretary would elevate the importance of mental health in the nation’s leading health agency, coordinate programs across different agencies, and promote effective evidence-based programs.
- Require the Assistant Secretary for Mental Health and Sub-

stance Use Disorders to make public all federal investigations into compliance with the parity law so that families and consumers know what treatment they have rights to access.

- Establish a National Mental Health Policy Laboratory to drive innovative models of care and develop evidence-based and peer-review standards for grant programs.
- Dedicate funding for the Brain Research Through Advancing Innovative Neurotechnologies Initiative.
- Require psychiatric hospitals to establish clear and effective discharge planning to ensure a timely and smooth transition from the hospital to appropriate post-hospital care and services.
- Provides additional psychiatric hospital beds for those with an acute mental health crisis who need short term (less than 30 days) immediate inpatient care.
- Support advances in tele-psychiatry to link pediatricians and primary care doctors with psychiatrists and psychologists in areas where patients don't have access to care.
- Require the Assistant Secretary for Mental Health and Substance Use Disorders to study and recommend a national strategy to increase the number of psychiatrists, child and adolescent psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, and mental health peer-support specialists.
- Include child and adolescent psychiatrists in the National Health Service Corps.
- Authorize the Minority Fellowship Program.
- Authorize, for the first time in federal law, the Recovery After Initial Schizophrenia Episode (RAISE), an evidence-based early intervention program.
- Reauthorize the National Child Traumatic Stress Network.
- Launch an early childhood grant program to provide intensive services for children with serious emotional disturbances in an educational setting.

- Provide incentives to states to offer community-based alternatives to institutionalization.
- Reauthorizes the Garrett Lee Smith Suicide Prevention Program, invest in research on self-directed violence, and authorize, for the first time in the statute, the Suicide Prevention Hotline.
- Extend health information technology for mental health providers to coordinate care with primary care doctors using electronic medical records.
- Establish an inter-agency Serious Mental Illness Coordinating Committee to organize, integrate, and coordinate the research, treatment, housing and services for people with substance use disorders and mental illness.
- Ends the decades-old prohibition on physicians volunteering at community mental health clinics and federally qualified health centers.

CDHP Enrollees Skew Older

A recent study by the Employee Benefits Research Institute finds that CDHP enrollees are more likely to be 45 to 54 than 21 to 34 in 2014. They are also more likely to be in households with \$100,000 to \$149,999. They are roughly twice as likely as people with traditional coverage to have college or postgraduate educations. For more information, visit ebri.org.

Americans Flock to Canadian Online Pharmacies

In a new survey of about 2,700 American customers, the Canadian International Pharmacy Association (CIPA) found continued demand for ordering prescription medications online from licensed Canadian pharmacies. About 64% of respondents purchase some or all of their health maintenance medications from a non-U.S. pharmacy due to lower costs. Another 22% said medications are not covered under their insurance plan.

Twenty-five percent said that a lack of money has kept someone in their household from filling prescriptions during the past year. About 30% reported having to skip doses, split pills, or take similar actions to restrict their use of prescribed medications because of high costs.

Customers reported spending an average of \$250 a month per prescription for a 90-day supply of prescription medications for personal use, and saving about \$246 (or 50%) per month by importing their medications from Canadian pharmacies.

Without this option, about 32% say they would only be able to fill some medications, and 1% would not be able to purchase any of their medications. Previous reports have highlighted the issue of patients going off medications or rationing and the resulting harm to health along with the costs to the health care system. Further, since many who import their medications from Canada are seniors on Medicare, non-adherence and the resulting health implications and costs are a burden to the American taxpayer. Eighty-six percent of those surveyed are 55 years or older. Additionally, 57% say their health insurance is self-funded and that they must cover the full costs of their medications. For more information, visit cipa.com. ★

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A man in a dark suit and tie is shown from the chest up, pointing his right index finger towards the text. He has a slight smile and is looking directly at the camera. The background is a blurred office setting. The entire advertisement is framed by a thick blue border.

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