Limited Benefit Frequently Asked Questions

Why are they called "Limited" Benefit (LB) plans?

Limited Benefit plans (also known as "Limited Medical" or "Mini-Med" plans) provide coverage that is generally less expensive than most Major Medical plans. Further, they are "guarantee issue," which means the consumer cannot be turned down for coverage, unlike many Major Medical plans. In order to make these plans affordable and accessible, the benefit payouts are less than typical Major Medical plans, resulting in greater consumer out-of-pocket expenses. The term "limited" is used to help differentiate these types of plans from Major Medical coverage.

Should I buy an LB policy?

The answer depends on a number of factors, from your health status (or that of members of your family), your budget (considering both premium and out-of-pocket costs) and your access to other forms of insurance. The first thing to understand about LB is that it is not Major Medical nor should it be ever considered a replacement for a Major Medical policy. It has been designed as an alternative for those consumers who cannot qualify and/or cannot afford a Major Medical policy. Generally, if you are young and healthy, a Major Medical policy will provide more coverage at less cost than a typical LB plan. Sometimes, by varying the benefits (having a bigger deductible, etc.), the premiums for a Major Medical policy can fit your budget. Before purchasing an LB policy, you should be sure that a Major Medical policy will not work for you. You should consult with a professional insurance agent on your coverage options before deciding on purchasing an LB.

I am being offered a membership in an Association; how does that work?

Many of AMLI's LB plans are offered by Associations as part of their mission to provide quality and relevant goods and services to their members. AMLI issues a group policy to an Association; the Association can then offer coverage under that policy to its current and prospective members. The Association generally packages the LB coverage along with other benefits and services (including other insurance policies, often at varying levels) in order to offer its membership an array of options. You may, of course, join the Association without selecting a membership level that contains an LB policy. Similarly, if you select a membership level that has an LB policy and want to terminate the policy, you can remain a member of the Association.

Can I buy an LB plan without going through an Association?

Currently, AMLI only markets LB policies through qualified groups.

I have a preexisting condition; can I get LB coverage?

Yes; however, you may be subject to a waiting period for claims related to your illness. For claims not related to a preexisting condition, upon enrollment you would be eligible to receive benefits. The "Preexisting Condition Limitation" means that if you have a condition, illness, disease or other health issue for which you needed treatment within 6 months leading up to your effective date of coverage, any claims related to this condition would not be covered for the first 12 months of coverage. After 12 months of continuous coverage, you would be covered for all eligible conditions. An exception to this is if you have a "Certificate of Creditable Coverage" and can present evidence that you were insured in a qualified plan up until your enrollment in the LB policy. If you had creditable coverage leading up to your initial enrollment, you would receive credit for the time for which you were covered under the creditable coverage against the waiting period in the preexisting condition limitation.

What does HIPAA Creditable Coverage Mean?

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the U.S. Congress in 1996; among its provisions are protections afforded consumers when switching health insurance plans. The objective of this provision is to prevent consumers from losing coverage for preexisting conditions solely as a result of a change in their health insurance policy. Major Medical carriers are not allowed to enforce a preexisting condition on any new enrollees if they have creditable coverage just prior to enrolling. The definition of creditable coverage can be complicated, but the general rule of thumb is that plans that provide coverage on a covered expense basis - which means that the benefit payment varies based on the amount billed by the provider - are considered creditable. Major Medical and most employer-sponsored plans are considered creditable. Plans that are pure indemnity, which pay a flat amount regardless of covered expense, are generally not considered creditable. Most, but not all, of the plans offered by AMLI are considered creditable because they contain plan design elements that qualify them as such. For these plans, should you decide to terminate your policy, you will receive a Certificate of Creditable Coverage to provide as evidence of your coverage for your new policy. For additional information you can refer to the following Web site:
http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html

I am eligible for Medicare; can I buy an LB policy?

AMLI's LB policies are not designed to coordinate with Medicare coverage. The federal government has regulated the types of plans that can be offered to Medicare beneficiaries and there are a great many insurance companies and agencies available that specialize in offering these plans that will be more suitable for you.

Can I get a policy just for a dependent?

A "dependent" can be the owner of the certificate if they are between the ages of 18 and 64 (21 to 64 in some states). Otherwise, you must enroll in some sort of family coverage to obtain the policy for your dependent.

What is my deductible and how do I determine my out-of-pocket expenses?

Aside from an Accident Medical Expense (AME) provision in some LB policies, there is no deductible requirement for you to meet before you can start being reimbursed for claims. However, the LB plan does not cap or limit your out-of-pocket expenses; it provides a fixed payment per occurrence. So, your out-of-pocket costs can vary greatly depending on the nature of the condition and the provider's charges. An LB plan will help defray some of your costs, but it does not limit the amount you can be ultimately charged beyond what the plan pays.

Is this a PPO plan?

The Limited Benefit plan is not a PPO plan. The payments made for most of the services are fixed and are not based on going to a network provider. The amount shown on the benefit schedule is paid, regardless of the provider's network status. While a network is not part of the LB plan, many of our policyholders offer participation in a Discount Medical Provider Organization (DMPO) as well as our coverage. Such DMPOs may help reduce your out-of-pocket expenses by passing along provider discounts.

Does AMLI pay the provider or do I?

You have the option of assigning the benefit to the provider or you can submit the claim on your behalf. By assigning the benefit, you agree to have the insurance company directly reimburse the provider on your behalf. Note that not all providers accept assignment and may require you to pay them and submit the claim on your own. Generally, if your group package is offering a companion DMPO and the provider is in network, the claim must be submitted on your behalf and AMLI will directly reimburse your health care provider. If the benefit amount is less than the provider's charge, you may be billed by the provider for the difference. If the benefit amount exceeds the provider's charge and the provider has been assigned the benefit, you will get a check for the difference. AMLI will always pay the total indemnity amount, even if it exceeds the provider's billed charges.

What is RBRVS and how does the surgical benefit work?

RBRVS stands for **Resource-Based Relative Value Scale** and it is **the methodology used by the federal government to pay physicians for care rendered to consumers with Medicare**. RBRVS varies by region but is generally well understood as a payment basis by the provider community. The payment is based on the address of the provider and the benefit covers the physician expense, not the facility. **AMLI's surgical schedule is based off RBRVS and usually pays each qualifying claim at some percentage of the schedule up to the aggregate annual dollar limit listed in your policy documents**. Please note that the percentage listed in your benefit schedule is not coinsurance; you are responsible for reimbursing the provider for the difference between the insurance payment and the provider's charges, or the discounted charge if a network was utilized.

Are all surgeries covered and how does the anesthesia benefit work?

An eligible surgery is a procedure that had anesthesia rendered by a licensed nurse anesthetist or anesthesiologist. Surgeries that did not have anesthesia provided or were provided by someone other than the two professionals noted above are not covered expenses. The anesthesia benefit payment is based on a percentage of the surgical benefit paid.

What does the plan cover or not cover?

Please contact your Association's customer service representative or insurance agent for a detailed listing of the plans exclusions and limitations.