Life & Health Insurance Advisor

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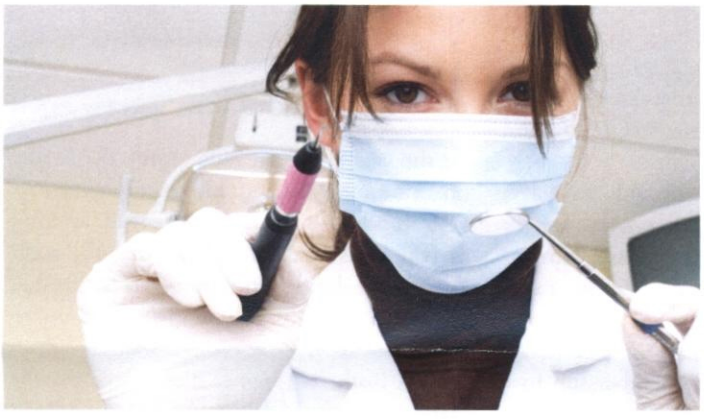
Good Dental Care = Good Health

People who receive regular periodontal (gum) care have fewer problems with diabetes, strokes and coronary artery disease. Evidence also shows that oral cancer, bulimia and other conditions, such as lung disease and low birth weight, are linked to oral health and are often first detected at the dental office.



Good dental care improves overall health. Regular dental visits can lead to an earlier diagnosis of disease and perhaps a decrease in your treatment costs. Dental insurance makes it easier to make regular dental care part of your wellness program.

When compared to medical coverage, dental coverage is quite affordable. Individuals can buy several different types of dental coverage.

1 Indemnity plans: These traditional fee-for-service policies let you select your own providers. The insurer pays either a percentage of the fee or according to a fee schedule. Policies have annual deductibles and spending caps.

Most policies cover 100 percent of the cost of preventive services after you meet the annual deductible. However, as in medical insurance, dental "fee for service" plans are becoming less common.

Insurers offer a variety of managed care dental plans, which help manage the cost and quality of care through a variety of delivery systems. These include:

2 Dental preferred provider organizations (PPOs): Under a PPO plan, the insurer assembles a network of providers who have agreed to accept a certain level of payment for their services. As with medical PPOs, dental PPO plans give you financial incentives to use these "preferred providers." For example, a plan might pay 100 percent of services by a preferred provider but only 60 percent of a similar claim submitted by a non-preferred provider (which may also be subject to higher deductibles). You would pay the uncovered portion out of pocket.

Don't rule out a PPO if you want to keep your cur-

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This Just In...

Life insurers make a significant contribution to the U.S. economy, and to the individual families who need it. The U.S. Census Bureau's 2011 Statistical Abstract lists those contributions for the country's 976 life insurers. Facts below reflect 2008 data, the most recent year for which complete data are available.

- **335 million: the number of life insurance policies in force**
- **$19,120 billion: the value of all life insurance policies in force**
- **$10,254 billion: the value of all individual life insurance policies in force**
- **$8,717 billion: the value of all group life insurance policies in force**
- **$59.9 billion: the value of all payments to life insurance beneficiaries in 2008**
- **$19.1 billion: policyholder dividends paid**
- **$69.6 billion: annuity payments**
- **$0.6 billion: matured endowments**

For more information on how life insurance can contribute to your financial security, please contact us.

Lose Weight, Save Money?

The link between lifestyle and health are becoming clearer every day. Individuals have more control over their health...and healthcare costs...than many realize.

Researchers have linked obesity and overweight to the following health conditions:

- Coronary heart disease
- Type 2 diabetes
- Cancers, such as endometrial, breast, and colon
- High blood pressure (hypertension)
- High total cholesterol or high levels of triglycerides (dyslipidemia)
- Stroke
- Liver and gallbladder disease
- Sleep apnea and respiratory problems
- Degeneration of cartilage and underlying bone within a joint (Osteoarthritis)
- Reproductive health

Moreover, the overweight and obese are more likely to become permanently disabled from injury than individuals of normal weight. Obesity makes surgery more difficult and wound complications more likely. It also leads to other conditions that increase the odds of complications, such as high blood pressure and diabetes, which increase the risk of blood clots and heart and lung complications.

How are your health and wealth linked? Consider the following facts:

- People who are obese spent 42 percent more for medical care in 2006 than did normal weight people, found a study by RTI and the U.S. Centers for Disease Control (CDC). This translated into extra annual costs averaging $1,400 for obese individuals.
- Obese individuals spend 77 percent more money for necessary medications than non-obese persons.
- The proportion of all annual medical costs due to obesity increased from 6.5 percent in 1998 to 9.1 percent in 2006, the RTI/CDC study found.

In addition, weight can affect your insurance coverage. Individuals who are overweight often cannot qualify for preferred or standard rates, so pay more for their coverage, while those who are obese might be declined. If you obtain coverage, most insurance companies regard obesity as a pre-existing health condition and will not cover related treatment. This could extend to certain health conditions linked to weight, including diabetes and hypertension.

Our medical and insurance systems have focused on treating illness rather than preventing it. However, some plans cover wellness and preventive care, because insurers know that good health translates into lower healthcare costs over the long term. If you have health insurance coverage already, check your plan to see if it covers wellness services such as nutrition counseling, weight loss and weight management programs.

If your plan does not provide coverage, you may be able to deduct the cost of weight loss programs as a medical expense. However, weight loss must be a treatment for a specific disease diagnosed by a physician (such as hypertension or heart disease). Deductible expenses include fees for membership in a weight reduction group as well as fees for attending meetings. You cannot deduct membership fees for a gym or health club, but you can deduct separate fees charged there for weight loss activities. You also cannot include the cost of diet food or beverages in medical expenses because they substitute for what you would normally consume.

If you have weight or other health conditions that prevent you from finding health insurance coverage, please contact us. Some insurers will cover substandard risks with policies that have limits on coverage, and many special programs exist to help for those who have problems finding coverage in the individual health insurance market. ■

ROTH— *continued from Page 4*

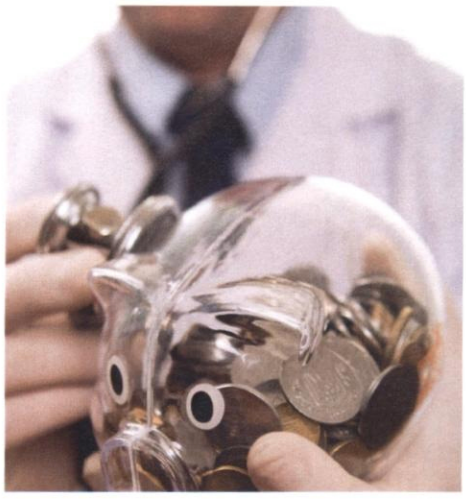
ter the year you turn 70½. Roth IRAs have no minimum distribution requirements, so your funds can grow longer. And as long as you have "taxable compensation"—such as wages, salaries, professional fees, taxable alimony and the like—you can contribute to your Roth IRA.

If a Roth IRA owner dies, a sole beneficiary spouse can combine the inherited Roth IRA with his/her own Roth IRA if he or she elects to treat it as his or her own IRA. Finally, Roth IRAs have estate tax advantages over traditional IRAs. If an IRA owner dies with funds left, the balance might be included in the estate. If your estate is large enough, this could subject your funds to estate taxes. On top of that, beneficiaries of traditional IRAs might also have to pay taxes on their withdrawals when they take distributions. Since you have already paid income taxes on your Roth IRA contributions, your plan's assets might be subject to estate taxes, but distributions to your heirs can avoid income tax.

For more information on Roth IRAs and other retirement plans, please contact us. ■

Partnership Programs Help LTC Buyers Conserve Assets

Many people don't realize that medical insurance and Medicare do not cover long-term care services. Medicaid will cover long-term care services for qualifying individuals. As a health insurance program for the needy, however, you typically must spend down your assets to qualify.



Buying long-term care (LTC) coverage through a Partnership Program-qualified policy can give you needed private insurance coverage, while allowing you to preserve more of your assets. Residents in all states except Alaska, Illinois, Massachusetts, Michigan, Mississippi, New Mexico, Utah, Vermont and Washington can access a Partnership Program.

How Do Partnership Policies Work?

Each participating state certifies LTC policies that meet the requirements for the Partnership Program. Most states require Partnership-qualified (PQ) policies to cover institutional and home services, be tax qualified, provide certain specific consumer protections, and include state-specific provisions for inflation protection. Often the only difference between a PQ policy and other long-term care insurance policies sold in a state is the amount and type of inflation protection required by the state.

Buying a PQ policy gives you the right to apply for Medicaid-paid long-term care services under modified eligibility rules. If you exhaust the benefits available under your PQ policy, you can apply for Medicaid under a special rule called "asset disregard." This allows you to keep assets that Medicare would otherwise not allow you to keep if receiving Medicare-paid LTC services.

In most states, the Medicaid asset threshold is $2,000 for a single person. This means you can only retain $2,000 worth of assets and qualify for Medicaid. Asset thresholds for married couples are typically more generous.

Under the Partnership Program, Medicaid will disregard assets equal to the amount of benefits you actually receive under your PQ policy. For example, if your Partnership-qualified LTC policy pays you $100,000 in benefits, you can retain $100,000 worth of assets over the state's asset threshold and still be eligible to receive Medicaid-paid benefits. Since PQ policies must include inflation protection, you could receive more benefits than the amount of insurance protection you originally purchased.

Let's say John, a single man, purchases a Partnership policy with a value of $100,000. Some years later the policy pays him benefits equaling $150,000, the policy's lifetime maximum coverage, adjusted for inflation. John eventually requires more long-term care services, and applies for Medicaid. If John had not bought a Partnership-qualified policy, he could keep only $2,000 in assets to qualify for Medicaid. He would have to spend down any assets over this amount. However, because John bought a PQ policy, he can keep $152,000 in assets and still qualify for Medicaid; the state will not recover those funds after his death.

Partnership programs help both individuals and the state. For individuals, it allows them to get and pay for the long-term care services they need without having to spend all of their assets. For the state, it can decrease the amount of Medicaid dollars used for long-term care services.

For more information on Partnership-qualified policies or long-term care insurance in general, please contact us. ■

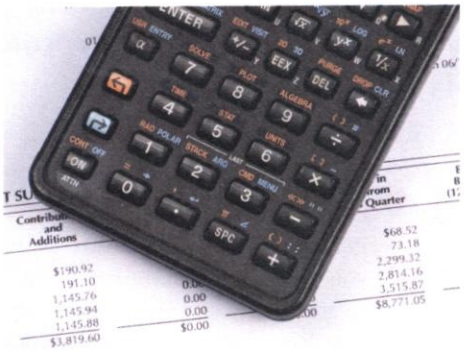
What You Need to Know Before Buying Partnership LTC Coverage

- If want to be eligible for an asset disregard if you apply for Medicaid, you must have a Partnership-qualified long-term care policy. Insurers often offer similar policies that are not qualified, so you will want to verify that your policy is certified by the state. Policies issued prior to a state Partnership Program's effective date will not be considered Partnership-qualified; however, you may be able to exchange a policy you previously purchased for one that is Partnership-qualified.
- Look for an agent who is specially trained to sell Partnership-qualified policies. States with Partnership Programs have additional educational requirements for agents who wish to sell Partnership policies.
- Note that eligibility for Medicaid is not automatic. You must still apply and meet the income, functional and general eligibility requirements of the Medicaid program in your state. The long-term care services provided by Medicaid vary by state and may not be the same as the services you are eligible to receive under your private Partnership long-term care insurance policy (for example, many state Medicaid programs do not pay for room and board costs in an assisted living facility, even if you are also receiving personal care).
- States that have Partnership programs are automatically considered to have "reciprocity" with each other and to honor the asset disregard you earned under a Partnership policy you purchased in a different state. However, states can "opt out" of this requirement at any time.

For more information on your state's Partnership program, or to find out if your state is planning to offer a Partnership program, contact the state's Department of Insurance. ■

The Grapes of Roth

A Roth IRA is an individual retirement plan that can be either an account or an annuity. Many of the rules that apply to "traditional" IRAs apply to Roth IRAs. However, Roth IRAs have some features that could make them preferable to traditional IRAs in certain circumstances. Read on for more information.



With a traditional IRA, you can deduct contributions from your income, subject to certain limits. Your funds also grow income tax-free. But when you make withdrawals, you will owe taxes on these funds at your current rate. With a Roth IRA, you make contributions with after-tax dollars, but you receive withdrawals tax-free. Tax-free withdrawals under a Roth IRA might make them a better option for some individuals, since taxes can take a big chunk of your funds, and you might not be in a lower tax bracket after retirement.

You can make contributions to a Roth IRA even if you participate in a qualified employer retirement plan, such as a 401(k). (You can contribute to a traditional IRA as well, but your ability to deduct your contributions begins phasing out at modified adjusted gross incomes, or AGIs, over $56,000 for single filers, and at incomes over $90,000 for married couples filing jointly for 2011.)

Further, traditional IRAs require you to begin taking minimum distributions, or withdrawals, after age 70½ or pay penalties. You cannot make new contributions in or af-

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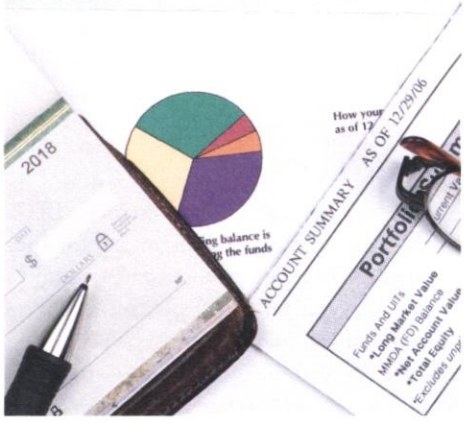

DENTAL—continued from Page 1

rent dentist. Most PPOs offer extensive provider lists; chances are good that your current provider accepts one or more PPO plans.

3 Dental health maintenance organizations (HMOs): HMO dentists agree to provide covered dental services to members in return for a periodic per-capita payment. Payments do not depend on the number or type of services rendered, and the HMO accepts the financial risk for providing covered services.

Most HMO plans require participants to use a member dentist for coverage, but some provide reduced benefits for visits to an out-of-network provider. A participant may have to pay a deductible, co-payment or amounts exceeding plan coverage levels. Dental HMOs might be less expensive than indemnity plans or PPO plans, but opponents say they limit choice and the way they pay providers gives them incentive to render only minimal treatment.

4 Dental point-of-service (POS) plans: HMO or PPO plans may offer a point-of-service option to allow participants to use out-of-network providers. POS plans usually offer lower benefits or reimbursement percentages and participants may have to do their own paperwork, including submitting bills to the insurer for payment.

5 Health savings accounts: If you have a health savings account (HSA), you can use it to pay eligible medical expenses. The IRS considers x-rays, fillings, braces, extractions, dentures and other dental treatments eligible expenses. It specifically excludes tooth whitening and cosmetic procedures that do not "promote the proper function of the body or prevent or treat illness or disease."

To qualify for an HSA, you must have a qualifying high deductible health plan (HDHP) and no other health coverage (with certain defined exceptions). Some HDHPs offer dental benefits as an option.

6 Discount dental plans: These plans are not insurance; instead, they provide discounts on dental care in exchange for an annual fee. For example, an individual may pay about $75 annually to save 15 to 50 percent on a variety of dental services, often including cosmetic procedures that most dental insurance plans exclude. Participants must go to a dentist who has agreed to offer services at a discounted price, and a dentist can refuse discount plans at any time.

These plans could save you money, but before enrolling, check whether the benefits are worth the cost. For more information on dental coverage, please call us. ■