CATASTROPHIC MAJOR MEDICAL COVERAGE

The origins of Excess Major Medical (EMM) coverage date back to the early 1970's. At this period in time, basic major medical coverage was beginning to gain a hold in the American market. These coverages were limited in scope, generally written on a per-cause basis with low maximum's, by today's standard. They were also primarily available through employers. A perceived need for a coverage that would cover "catastrophic" illnesses led to the development of the first EMM policies.

EMM coverage was marketed to the members of professional and fraternal associations, as a way of increasing insured protection and alleviating the fear an insured would have to liquidate assets should they suffer a catastrophic illness. Original plan designs had relatively low deductibles by today's standards and over the years these have been increased as medical costs have escalated. Also, the traditional EMM plan was designed on a per-cause basis not only because early basic major medical plans were also designed this way, but because this design positioned the coverage as protection against true catastrophic situations which, for the most part, are related to a single illness or accident.

Benefit periods were also different than we see in current plans. They were generally longer; 7 to 10 years since the exposure to the insurance company was not as great due to less sophisticated medical treatment. These again have been shortened over time with the most common being a three-year benefit period.

The marketing success of EMM programs diminished over time due to the change in the basic major medical market. Although the persistency of inforce business remained excellent, the sales of new business lagged. It is felt that this was primarily due to the emergence of true "comprehensive" major medical coverages with low deductibles, low or no co-payments and lifetime maximums of $1 million or more. These have generally been referred to as indemnity major medical.

Over the past 5 to 10 years we have seen significant changes in health insurance, primarily driven by the need to address skyrocketing medical costs. The major change has been the emergence of managed care programs, either in the form of HMO's or Preferred Provider arrangements. Most of these programs limit, to some degree, the insured's choice of medical providers, either by providing coverage only for in-network care, or by providing significant financial disincentives if an insured goes outside their network. In addition, some managed care programs have either tightened or eliminated benefits that were usually covered under indemnity programs, again as a cost containment measure.

As a result of these changes, we feel there is an increased need for an Excess Major Medical product in the voluntary insurance market.

The Option Med Plus product could be thought of as one that provides an indemnity wrap-around to a managed care product. It provides two distinct protections to the insured that they don't have in their basic program. The first is traditional excess. In the event of a catastrophic claim, various medical charges not covered under the basic plan because of deductible, co-insurance, internal benefit limits or if the claim exceeded the person's underlying maximum benefit, would be covered by the excess program. The second would be to provide coverage in situations where the managed care plan restricted the member's choice. Assuming the deductible threshold has been exceeded, the plan would return these choices to the member, either by removing the additional disincentive or by providing full coverage in the event the managed care plan had very tight restrictions.

Perhaps the best example would be when an individual faced a serious medical situation and desired to use a non-network Center of Excellence for treatment. Depending upon the underlying coverage, it is possible the insured would be faced with a large out-of-pocket expense.

While the exact benefits would be determined on a claim-to-claim basis and would vary based on the details of each case, in many situations the Excess coverage will remove this financial hardship and allow the member to have the desired treatment choice.

Currently, the majority of the American public is covered under some form of managed care program. It has been estimated that almost the entire population will be covered under such programs by the end of the decade. We believe that a relatively inexpensive product that provides additional protection and choice is well positioned in today's market.

EXCESS MAJOR MEDICAL COVERAGE

Sample Illustrations

Following are examples of benefit calculations for varying service types based on the per-cause EMM policy.

Example 1: Claimant insured under a Comprehensive Major Medical plan, which conforms to Base Plan requirements *($500 ded./80%* x $10,000)

A	Incurred	Base Plan Allowance	Base Plan Paid	USL Allowance	USL Deductible	USL Paid
Hosp Private Room 2/1-2/10/97 (10 days@ $450)	4,500	4,500	3,200	3,500 (10 days @ $350 ASP)	3,200	300
Hosp Misc 2/1-2/10/97 (10 days @ $1,900)	19,000	19,000	17,800	19,000	17,800	1,200
Surgery 2/1/97	4,000	3,500	3,500	3,700	3,500	200
6 OfficeVisits	900	900	900	900	900	0
Total	28,400	27,900	25,400*	27,100	25,400*	1,700

* In this instance, the amount paid by the Basic Plan exceeded the $25,000 deductible, so United States Life benefits are reduced by Base Plan payment. USL's $1,700 payment reduces the claimant's out-of-pocket expense to $1,300.

Example 2: The following examples show a Managed Care plan as the basic carrier. A $20 co-pay applies to each office visit.

B	Incurred	HMO/PPO Allowance	HMO/ PPO Paid	USL Allowance	USL Deductible	USL Paid
Hosp. Rm/Board 2/1-2/10/97	4,500	1,000	1,000	1,000	1,000	0
Hosp. Misc 2/1-2/10/97	19,000	9,500	9,500	9,500	9,500	0
Surgery 2/1/97	4,000	1,500	1,500	1,500	1,500	0
6 Office Visits	900	600	480	600	600	0
Total	28,400	12,600	12,480	12,600	12,600	0

In this example, the USL allowance is the same as the cash value of the HMO/PPO service, since the claimant is not financially responsible for amounts exceeding the HMO/PPO plan allowance.

The total HMO/PPO payments are less than $25,000, so eligible charges are applied towards the member's 'cash' deductible. Claimant out-of-pocket = $120 (office visit co-pays).

C	Incurred	HMO/PPO Allowance	HMO/PPO Paid	USL Allowance	USL Deductible	USL Paid
Hosp. Rm/Board 2/1-2/10/97	4,500	4,000	4,000	4,000	4,000	0
Hosp. Misc. 2/1-2/10/97	19,000	17,000	17,000	17,000	17,000	0
Surgery 2/1/97	4,000	3,500	3,500	3,500	3,500	0
6 Office Visits	900	700	580	700	580	120
Total	28,400	25,200	25,080	25,200	25,080	120

In this example, HMO/PPO payments exceed $25,000, so USL benefits are reduced by Base Plan benefits, rather than taking a cash deductible. Again, the insured is not financially responsible for amounts over the HMO/PPO contractual agreements, so these are not eligible under the USL plan either. USL's payment of $120 reduces the insured's out-of-pocket to zero.

Assuming the Basic Plan (HMO/PPO plan) provided services with a value of more than $25,000, as illustrated in C, and the insured used a Non-Network provider, the USL Excess Major Medical plan would provide coverage as follows:

Basic Plan reimbursed at 90% of covered lab services
Average semi-private room rate is *$50.00* per day

D	Incurred	Base Plan Allowance	HMO/PPO Paid	USL Allowance	USL Deductible	USL Paid
Hosp. Rm/Board 10 days*	8,500	0	0	8,.500	0	8,500
Hosp. Misc. 10 days	6,375	0	0	6,375	0	6,375
X-Ray/Lab	375	200	180	200	180	20
Nursing x 5 days	2,000	0	0	1,500	0	1,500
Total	17,250	200	180	16,.575	180	16,.395

*Used Non-Network provider, so charges were denied by basic carrier.