

Health Insurance overview for customers.

What does health insurance cover?

1. Treatment costs for illness that is covered under the terms and conditions of the insurance policy.
2. Treatment costs for accidental injuries (not self-inflicted).
3. In-patient treatment is the minimum required purchase.
4. Out-patient treatment is options for some insurance policies.
5. Treatment costs are consistent with generally accepted standards of medical practice in the country in which treatment is being received.
6. Treatment is clinically appropriate in terms of type, duration, location and frequency for that condition.
7. The insurance company will only pay for reasonable and customary charges. Costs should not be more than they would normally charge to other patients in the same area.

What does health insurance not cover?

1. Treatment costs for pre-existing conditions and related conditions (exceptions only if agreed by underwriters of certain insurance companies) (below items a. to f. are all linked together as if they are in one sentence).
 - a. Any medical condition or related condition for which you have received treatment.
 - b. Or medical condition that you had symptoms of.
 - c. Or to the best of your knowledge knew this condition existed.
 - d. Or sought advice for this condition.
 - e. Or taken (prescription or non-prescription) medication for treatment.
 - f. Prior to the start date of the insurance policy.
2. Accidents while intoxicated or under the influence of illegal drugs.
3. Most companies exclude treatment in the USA or limit it to life threatening emergencies and accidental injuries.

Two types of medical underwriting affecting pre-existing conditions:

1. Full medical underwriting policies
 - a. The majority of health insurers use this method for screening applicants.
 - b. Medical underwriting requires applicants to honestly disclose all their pre-existing medical conditions.
 - c. Underwriters will review applications and propose the exclusion wording for the customer to accept.
 - d. Only in some cases, can exclusion wording be revised at start of policy.
 - e. Exclusion wording has to be agreed on at the start of the policy, there is very little chance of changing this in the future.
 - f. Changes to exclusions have to be accompanied by medical reports that are acceptable to the underwriters. There is no guarantee that exclusions will be deleted or changed.
2. Moratorium underwriting policies
 - a. With moratorium underwriting, after 2 years of continuous cover, some pre-existing medical conditions will become eligible for benefit.
 - b. Many pre-existing conditions will never be covered by a moratorium policy, such as;
 - i. Diabetes.
 - ii. Hypertension (raised blood pressure).
 - iii. Hyperlipidemia (raised cholesterol levels).

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- iv. Ischemic heart disease.
 - v. Cancer.
 - vi. Thyroid disease.
 - vii. Auto-immune disorders.
 - viii. Arthritis.
- c. For a particular condition to be covered, it is required that in the first 2 continuous years of the policy;
- i. You did not have to consult any doctor for medical treatment,
 - ii. Or take any medication,
 - iii. Or suffer any symptoms for that medical condition,
 - iv. Or suffer symptoms for any related condition.
- d. If you experienced any of the above (listed in item c.), you will be required to wait another 24 months from the last date of treatment and must meet the criteria listed in item (c.) before being allowed to claim for the pre-existing medical condition.

Notes on health check-ups:

1. Any applicant aged 40 or more should agree to a voluntary medical check-up.
2. Applicants under the age of 40 do not need to take a check-up, but it is always recommended.
3. Check-up results do not have to be sent to the insurance company or broker. The customer keeps the results and only refers to them if there is a claim dispute.
4. Check-ups can be done at any hospital.
5. Check-ups are a valuable tool in helping the customer when there is a dispute in a claim with the insurance company in the first year of the policy.
 - a. Hypothetical situation. The customer is treated by a doctor that makes a mistake in diagnosis of the customer's medical condition.
 - b. If the doctor mistakenly declares the medical condition is pre-dating the start-date of the policy, the insurance company has to deny payment of the claim based on the medical information provided.
 - c. If the customer has the results of a medical check-up (taken at the start of the policy) and these results dispute the mistaken diagnosis of the treating doctor, the customer has a good chance the insurance company will agree to a second doctor's diagnosis to review the claim and pay.
6. The positive benefits of a check-up far outweigh the negative aspects. Annual check-ups are a part of normal healthy life. Early detection of a medical condition is always to the benefit of that person.
7. Avoiding medical check-ups will not help the customer. Check-up or no check-up; if the customer has a pre-existing medical condition, even if there is no medical record at a hospital, the insurance company has to rely on the results of the treating doctor to state when this condition was present. You are relying on the treating doctor to assess your condition. The treating doctor has to make an educated guess to when this condition first manifested itself. The doctor can easily make a mistake. A medical check-up eliminates the chance of a mistake.
8. It is next to impossible for a claim to be paid because of a combination of mistakes;
 - a. The customer was honestly and completely unaware of this pre-existing condition.
 - b. The treating doctor misdiagnoses when the medical condition first manifested itself.

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- c. The consulting doctor of the insurance company concurs with the misdiagnosis of the treating doctor.
 - d. Brokers that do not recommend medical check-ups to customers are misleading the customer into thinking a hidden (hidden from the broker and insurance company) pre-existing condition will be covered by insurance in the future.
9. A full check-up will include the following tests:
- a. Physical Examination
 - b. CBC Blood test
 - c. Fasting Blood Sugar
 - d. Cholesterol
 - e. Triglyceride
 - f. HDH and LDL tests
 - g. Kidney function tests; BUN and Creatine
 - h. Liver function tests; SGOT, SGPT. Alk. Phos.
 - i. Uric acid
 - j. Urine examination
 - k. Stool examination
 - l. Chest X-ray
 - m. EKG
 - n. EST
 - o. Abdomen ultrasound

Health insurance companies we cooperate with:

International companies

- 1. Global Health Asia
- 2. Aetna Global Benefits
- 3. William Russell
- 4. BUPA International

Local companies

- 5. IAG/Interglobal Insurance Co.
- 6. BUPA Health Insurance (Thailand) Co.
- 7. AXA Health Insurance P.C.L.

Differences between Thai health insurances and overseas health insurances:

International Health Insurances:

- 1. Higher overall benefit limits, anywhere up to 2 million USD.
- 2. Most companies have no traveling restrictions except for the USA. You are covered for everything except Pre-Existing Medical Conditions, anywhere in the world including Medical Evacuation costs.
- 3. All International companies adjust their premiums annually to compensate for continually changing medical costs and worldwide inflation. For well managed health insurance companies, this adjustment can range anywhere from Zero to 10%. For poorly managed companies, the increase can easily reach as high as 25%.

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4. The cheapest plan from any International company will pay for a normal private room in any hospital in the world. There are usually no limits for the room rates, just as long as the room rate is comparable to other hospitals in the same area.
5. International Health Insurance plans will pay ALL In-Patient expenses as long as they have been sent an invoice beforehand. It is important that you contact the insurance company before being admitted to the hospital and to make sure the hospital sends invoices to the insurance company to avoid unnecessary delays.
6. As long as you continue to pay the premiums before the due date, you are guaranteed renewal of your annual policy, Certain Insurance companies have limits on the maximum renewal age; others have no limits.

Local Health Insurances:

1. Cheaper overall premiums with corresponding lower coverage limits. Health cover benefits are very generous when compared to premiums charged.
2. Many plans include a range of sub-limits to costs of treatment, such as Surgeons Fees, Hospital General Expenses, Room and Board, Ambulance....etc.
3. Premium rates do not reflect the actual cost of insuring persons at each age group because premium rates are not adjusted annually to compensate for changing medical costs and inflation.
4. Renewal Premium rates are not guaranteed. If you are a healthy person with no claims, you can expect to pay the same premiums as other persons in your age group. If you are sick and have claims that have cost the insurance company money, your renewal premiums will be loaded by a percentage based on the size of the claims incurred by the Insurance Company. These loadings can range anywhere from 10% to 25% and are applied each year as a factor to the basic premium you pay. In later years, these loadings are compounded for each significant claim paid by the Insurance Co.
5. Renewal of your Local Health Insurance is not automatic. The policy is year by year. If the Insurance Company decides not to renew your policy, they have the right to refuse renewal. This is allowed by the Office of Insurance Commission.
6. Local Health Insurance companies include a 30 day waiting period at the start of the policy for illness claims. There is no waiting period for Accident claims. There is also a 6 month waiting period for a few medical conditions, see list below.
 - i. Benign or malignant tumor, cancer, polyps or cysts.
 - ii. Hemorrhoid.
 - iii. Hernias.
 - iv. Pterygium, pinguecula or cataract.
 - v. Tonsilectomy or adenoidectomy
 - vi. Stones
 - vii. Endometriosis.
 - viii. Varicose veins.
 - ix. Hallux valgus.
 - x. Ganglion.
7. Local Health Insurances have time limits on travel outside of Thailand; some companies limit you to 90 days travel each year.

Features common to both International and Local Health Insurances:

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1. You must be perfectly honest and disclose everything required in the insurance application. Hiding medical information is not to your benefit. If the insurance company finds out, they can either cancel your policy or deny paying claims.
2. All Insurance Companies abide by the same rules regarding Pre-Existing Conditions. Any claim as a result of a Pre-Existing Condition will not be covered. This applies even if you did not know about the Pre-Existing Condition and have never received treatment for this Pre-Existing Condition. Some insurance companies allow a 2 year grace period for pre-existing conditions. If in the first 2 years of the policy, you do not have a claim, take medication or need to see a doctor for that condition, you can ask the insurance company to cover it.
3. Other than Accidents, claims that occur in the first year of Insurance are always suspect. All Health Insurance companies are very cautious in paying for claims that occur in the first year because of the risk of being related to a Pre-Existing Condition. Therefore, it is in your best interests to have a Full Medical Checkup at a reputable hospital just before starting your health insurance policy. This Medical Checkup provides you with documented proof of your medical condition at the start of the Insurance Policy. It is the most important document that will help you dispute an insurance company's decision to deny paying a claim because it is related to a Pre-Existing Condition.
4. You must inform the insurance company anytime you change your address or change your job description.

How to use the health insurance:

Emergency situations:

1. Get Emergency treatment first. Call or have someone else call on behalf of you, the 24 hour Emergency number nearest to your location as soon as possible.
2. Give your name, policy number, telephone number and location.

Non-Emergency In-Patient & Day-Patient treatment:

1. Call the insurance company as soon as reasonable; or at least 24 hours before admission to the medical center. Some companies require 72 hours notice.
2. Provide your name, policy number, telephone number, and location of planned treatment, dates of treatment and the name of the Specialist / Doctor treating you.
3. When the insurance company has sufficient information to appraise the claim, written confirmation will be dispatched to you and the medical center will be paid directly.
4. If you should undergo treatment before obtaining confirmation from the insurance company, you may not receive a full refund for all expenses.
5. If the hospital fails to supply all required information and documents to the insurance company, you may have to pay first and claim back the medical costs later. Original documents must be sent to the insurance company to pay the claim.
6. Claims are processed faster if you call the insurance company prior to a claim.

Outpatient treatment:

1. Certain insurance policies include outpatient treatment; some only have limited outpatient treatment benefits.

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2. Go to the hospital for you outpatient treatment and pay the bills. Insurance companies will have their own claim form that has to be filled in my both the patient and the doctor.
3. Send the insurance claim form and original receipts to the insurance company for a refund.

Switching between different Health Insurances:

1. Choosing the best health insurance to match your needs is essential.
2. Moving between different health insurance companies each year to save on premium expenses is to your disadvantage. It is always advisable to stay with the same health insurer as long as possible.
3. As we get older, our bodies develop certain medical conditions. The older we get; the more medical conditions we accumulate.
4. Take for example the family that has chosen a cheaper health insurance plan because they expected to stay in Thailand. In the future, due to unforeseen reasons, they have to move away to a different country. The local health insurance will only provide them with temporary cover in the new country (usually 90 days). This family will have to apply for a new health insurance with a different company.
5. All new applications will have to declare pre-existing conditions. Certain conditions that were covered by the previous health insurance are now no longer covered. These conditions started during the previous policy year (when they were covered) but cannot be covered by the new policy because they exist at the start of the new policy.
6. Your family will not be given a discount on the premium due to excluded pre-existing conditions. Your premium rates will be the same as other policy-holders of the same age- group but your cover will be inferior to others because of declared (and undeclared) pre-existing conditions that are not covered.
7. All health insurance companies regard pre-existing conditions in a similar manner. Very few companies will give the customer the choice of cover on a few pre-existing conditions. These companies will cover a few declared conditions at a higher premium fee.
8. New applicants that fail to declare all pre-existing conditions on the application form risk either having their policy cancelled when the insurance company finds out at a later date or; if the insurance company is lenient, they will add exclusions to the policy to offset the undeclared pre-existing conditions.