



This FAQ document is regularly updated and available at www.assuranthealthsales.com

Advantage Agent incorporates new products, services and tools that make selling individual medical insurance faster, easier and more profitable. Here are answers to the most commonly asked questions.

General

Some services and tools are not available to me. When will I have access to all of them?

Watch your mail. We'll let you know when new tools are available in your state.

New Individual Medical Product Portfolio

Where is the new portfolio available?

The new portfolio is available in all states where we market IM products except CT, MN, NV and UT. It will be available in these remaining states as each state approves.

Are there new applications for the new portfolio?

Yes. You'll find the new applications on Find A Form at www.assuranthealthsales.com. Remember, when you quote and submit using EASE at www.assuranthealthsales.com, you'll always have access to the most up-to-date products and rates—and you won't need to worry about forms.

Are the rate guarantees available on the new plans?

Yes. All plans have an initial 12-month rate guarantee. The 24-month rate guarantee (and 36-month buy up) apply to:

- MaxPlan and CoreMed: \$3,500 or higher deductibles
- OneDeductible: \$3,750 individual — \$7,500 family or higher deductibles
- SaveRight HSA: \$5,100 deductible

Note: Internal replacements and expiry conversions do not qualify. The 24-month rate guarantee is not available in KS, MN, MS, NM, ND and OR.

There are several new brochures. What is the purpose for each?

Use the Individual Health Insurance Portfolio brochure for training, or if you like to show your clients how plan features compare. It provides information on all available plans including a comparison chart.

The HSA Plans brochure provides vital information for those considering an HSA—it's a great tool for explaining the benefits of an HSA plan. Use the Individual Health Insurance Portfolio brochure in conjunction with the HSA Plans brochure—the pages of benefits, optional features and provisions in the larger portfolio brochure are an excellent complement to the high-level plan descriptions in the HSA Plans brochure. Use the appropriate single-plan brochure for MaxPlan, CoreMed or RightStart if your approach is to show your client only the plan you think is right for him or her. These brochures are designed to stand alone—each includes plan-specific benefits, plan design options, optional features, provisions and exclusions.

Where do I find information on state-specific mandates or benefits?

All state-specific product, mandate and benefit information is available on our State Variations form, which you'll find on EASE, quoting software and Find A Form at www.assuranthealthsales.com.

Why are benefits and exclusions for the RightStart and SaveRight HSA plans sometimes different than those for the other plans?

New contract language is being used for MaxPlan, CoreMed and OneDeductible plans. Contract language for RightStart and SaveRight HSA (formerly RightStart HSA) is not changing. However, these popular and familiar plans are being reintroduced alongside the new and improved MaxPlan, CoreMed and OneDeductible plans.

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What happened to the Traditional (Indemnity) Plan?

To simplify the portfolio, and provide more affordable plan options, the Traditional Plan design has been discontinued. Three more affordable plans are still available without a PPO network: RightStart, OneDeductible and SaveRight HSA (formerly RightStart HSA).

There are two “HSA Plans.” Why is only the OneDeductible Plan available without an HSA?

The OneDeductible Plan is popular with both: 1) those who want an HSA and 2) those who like the one-deductible-for-everyone-and-everything concept. When you quote the OneDeductible Plan, you must indicate whether or not the applicant intends to establish an HSA. If you indicate an HSA will be established, the deductible and out-of-pocket maximum are subject to annual adjustments, which ensure that the plan remains HSA-compliant.

SaveRight HSA (formerly RightStart HSA) was designed for those who want an HSA but need an insurance plan with a lower premium. When you quote SaveRight HSA, the HSA indicator defaults to indicate an HSA will be established. It's important that your SaveRight HSA applicants understand the potential for annual deductible and out-of-pocket maximum adjustments. SaveRight HSA plans are subject to these adjustments, whether or not the insured completes the process of establishing an HSA.

What is the difference between the OneDeductible family plan deductible and the family deductible maximum on the other plans?

For the OneDeductible Plan, the entire deductible can be met either collectively or by any one member of the family. For example, if the family has a \$5,700 deductible and one insured has an accident with medical bills totalling \$7,000, the deductible is satisfied for the entire family. If another person in the family has a claim later that year, he or she has no remaining deductible to satisfy. In the contract, this deductible is defined as an “integrated” deductible.

On the other plans, the family deductible maximum is satisfied collectively by at least two insureds (at least three insureds for RightStart). For example, if the family has the CoreMed Plan with a \$7,000 family deductible maximum, that amount is comprised of two individual deductibles of \$3,500 each. If an insured is in an accident with medical bills totalling \$7,000, that person will satisfy his or her individual deductible of \$3,500 (with the balance applied to the coinsurance out-of-pocket maximum). When a different individual in the family has a claim, it applies to a separate \$3,500 individual deductible. Once the \$7,000 family deductible maximum is satisfied collectively by two or more insureds, the entire family's claims are subject to coinsurance.

For Behavioral Health benefits, why does coinsurance under OneDeductible apply to the out-of-pocket maximum, but not under the MaxPlan?

Under the MaxPlan, the intent is that the benefit be separate from the plan coinsurance and out-of-pocket maximum. MaxPlan Behavioral Health benefits are always subject to the deductible, 50% coinsurance and the \$2,500 benefit maximum.

However, since the OneDeductible Plan is HSA qualified, all covered expenses paid out of pocket must apply to the total out-of-pocket maximum. This means the 50% coinsurance applies toward the out-of-pocket maximum and, once the coinsurance maximum is reached, any additional benefits up to the \$2,500 benefit maximum are paid at 100%.

What are the eligibility requirements for dependents?

A covered dependent no longer needs to be a full-time student to continue coverage under his or her parent's / guardian's plan. However, age limits and other restrictions do apply at the time of application.

- An unmarried dependent can apply for coverage on a parent's plan through age 18 or, if the dependent qualifies as a full-time student or is disabled, through age 23. Some state variations exist; please refer to the state variations document.
- A covered dependent may continue on a parent's policy as long as he or she is unmarried and primarily dependent on his or her parents for financial support. An appropriate rate will be charged.
- A covered dependent is eligible to convert to another plan (due to divorce or the death of the primary insured, or if he or she no longer meets the eligibility requirements).

Please encourage your customers to notify us of changes that could affect the eligibility of their dependents.

Why would anyone select a \$10,000 Maternity deductible?

Without the Maternity Benefit, routine maternity expenses are not covered—meaning that no discounts are applied, claims are denied and bills are due to the provider in full.

With the Maternity Benefit, routine maternity expenses are covered—meaning that claims are eligible for all available discounts, applied toward the deductible and paid once the deductible is satisfied.

Access to discounts—that's what clients are buying when they select the Maternity Benefit with a \$10,000 deductible. This option is available for approximately \$8 each month. National averages for maternity costs (retail price) are \$7,394 - \$11,170 for the hospital charges and \$3,776 for the physician charges. The discounts your client receives on hospital and delivery bills can add up to thousands of dollars in savings.

What is the difference between the optional Maternity Benefit and the benefits for complications of pregnancy?

The Maternity Benefit covers routine maternity care services – prenatal care, delivery, postpartum care and routine well newborn services until the mother is discharged from the hospital. These services are only covered if the insured selects this option.

All insureds are covered under the regular plan provisions for some complications of pregnancy. The covered complications of pregnancy under each plan are outlined in the brochures.

When the Maternity Benefit is selected, are complications of pregnancy paid under that benefit?

Covered complications of pregnancy are paid under the regular plan provisions, not under the optional Maternity Benefit.

How does the maternity deductible affect Health Savings Account annual contribution allowances?

The optional maternity benefit is specific disease coverage offered in addition to the high deductible health plan. It has no effect on the amount that can be contributed to a Health Savings Account.

What is the Maximum Allowable Amount Provision?

The Maximum Allowable Amount provision of the contract applies to non-PPO plans and in instances when an insured with a PPO plan uses a non-network provider. It describes a number of methods used to determine the maximum amount of a billed charge that is considered covered. It encompasses terms such as contracted rate and negotiated rate as well as the concepts commonly termed reasonable/usual and customary charge allowance. When clients with PPO plans use network providers, exceeding the maximum allowable amount is never a concern. In any other instance, the insured is responsible for billed charges over the maximum allowable amount.

How is an emergency defined?

Emergency treatment is treatment, services or supplies for a sickness or an injury that develops suddenly and unexpectedly and if not treated immediately would: 1) endanger the person's life or 2) cause serious bodily impairment to the person.

Will the new products be underwritten any differently?

Many improvements have been made to the underwriting process—you may have seen them described in the BizBuilder newsletter. These practices will continue with the new portfolio.

Can a rating be applied to MaxPlan with the unlimited office visit copay?

Yes, you can now offer the unlimited copay option even when your client has a ratable health condition. However, the unlimited office visit copay option is sometimes removed with the addition of a rider or condition-specific deductible.

Are surgeries that are performed in a doctor's office subject to the CoreMed Facility Fee?

No. When applicable, the facility fee is applied to a bill from a medical facility. It will not be applied to a health care practitioner's bill.

HealthyDiscount Improvements

Do the HealthyDiscount Improvements apply to my currently insured clients?

There are no changes to the HealthyDiscount program available under the previous portfolio. The improvements apply only to the plans introduced in the new portfolio—on or after the first available effective dates—in the states that allow HealthyDiscount.

So, under the new portfolio, my clients could still qualify for HealthyDiscount even if they've had paid claims?

Yes,

- For the first three renewals
- As long as total paid claims have not exceeded \$500—all paid claims for all claimants since the effective date of the policy count toward this \$500, except claims paid for wellness services or claims paid under the optional Accident Medical Expense benefit
- When they attest to their continued good health by completing and returning the HealthyDiscount Questionnaire within 60 days following the renewal date

My Sales Link and My Web Page

Am I required to have a non-resident appointment to use a sales link and/or Web page?

Each state's rules and regulations dictate the circumstances under which an agent may solicit business. At a minimum, you must be currently licensed in the state in which you are taking the application for insurance.

Is the agent notified when a prospect requests a quote?

There is no automatic notification. However, you will find the quote when you go to Find/Save Quotes on EASE.

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Are all plans available through My Sales Link?

Not at this time. However, the link site will be enhanced later this year to allow for almost all plan variations.

In the meantime, to provide additional plans and options to your clients who want to apply online, use EASE to create a quote and then e-mail to your client a link that takes him or her to a Web site that displays the quote. The client can apply online and all your agent information is passed onto the application so you receive credit for the sale.

Can I still do business the “old fashioned” way?

We will continue to accept long-form paper applications and faxed Tele-App applications. And, for both, you may run rate proposals using the most recent version of quoting software.

Express Underwriting

What are the newly revised underwriting questions?

For the states in which the Express Underwriting process is currently available, you’ll find the questions on EASE or on the Tele-App form under Find A Form at www.assuranthealthsales.com.

If a client has a “yes” response to one of the underwriting questions, does he or she need to complete a paper application or TeleApp Part 1?

No, a “yes” response does not mean that you must “stop” the Express Underwriting process. You should provide any details and submit as usual.

Credit Card

What will the client see on his or her credit card statement?

The merchant description for each charge will be: Time Insurance Health Prem 1-800-553-7654

What happens if the charge is not approved by the credit card company?

If the charge is not approved (e.g., the client has reached the credit limit on the card), we will send a notice that the charge was declined along with instructions for making alternate payment arrangements.

What if my client’s credit card expires while the policy is in force?

When you set up the recurring credit card payment option, the information collected includes the card expiration date. If an expiration date is approaching, the insured will receive a letter requesting an updated expiration date or a new card number. The insured can call or write Premium Services to either provide the updated information or switch to another billing method.

Note: Recurring credit card payment is available in AZ, CT, KS, OH and NC.

List Bill

Do I need an active list bill account number to establish a list bill through EASE?

For most states (all except CO, DE, ID, KY, MD, MN, NC, OR, TN, VA and WI), it is not necessary to have a list bill account number to use EASE. Indicate a New List Bill payment mode with your first submission, and a list bill account number will be generated. For subsequent submissions, select Existing List Bill payment mode and indicate the list bill account number in the space provided. Then fax in the Employer Agreement.

Can an applicant (who is part of a group that has list billing established) apply through My Web Page using the list bill number?

Not at this time.

Can an employer make contributions to a Health Savings Account associated with an employee’s list-billed policy/certificate? Can employer contributions be pre-taxed?

Anyone may make contributions to an HSA that exists in conjunction with an HSA-qualified plan. Employers should consult their tax advisor regarding tax implications of contributing to employees’ HSAs.

Can premiums for list-billed policies/certificates be run through a Section 125 or Section 105 Plan?

No.