

Health Saving Account [HSA] and High Deductible Health Plan [HDHP] Producer Guide



Table of Contents

I.	HSA BASICS	2
	What is an Health Savings Account (HSA)?	2
	How does an HSA work?	2
	What are the advantages of an HSA?	2
	Who is eligible for an HSA?	2
	Which insurance qualifies for an HSA?	2
	How much can be contributed to an HSA?	2
	What is the tax treatment of HSAs?	2
II.	HIGH DEDUCTIBLE HEALTH PLAN BASICS	3-8
	Agent Licensing	3
	General Plan Eligibility	3
	Rates	3
	PPO Networks	3-4
	Pharmacy Benefits	4
	LabOne Select Program	4-5
	Case Submission	5-6
	Underwriting Process	6-7
	Market Conduct	7
	Premium Billing	7-8
	Administrative Procedures	8
III.	MY HEALTH SAVINGS BANK BASICS	9
	About <i>My Health Savings Bank</i>	9-10

This guide contains **general information** regarding administrative and product descriptions and is not state specific. This guide should be used in conjunction with underwriting guidelines.

Due to the constant changes in federal and state mandates on health insurance, it is important to keep current on laws enacted within your state and on a federal level that affect the life and health insurance industry.

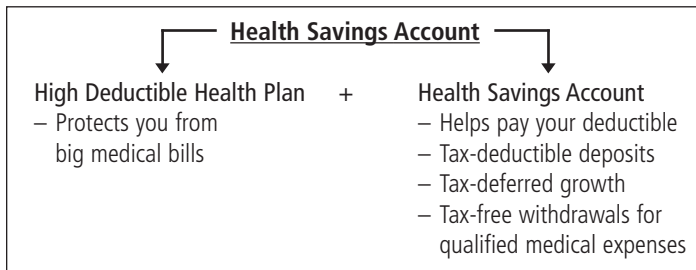
Please remember that no agent has the authority to change any benefits, to bind coverage with the insurance company or to promise a certain effective date. No statement made by any representative shall be binding if in conflict with the provisions of the policy. Nothing in this guide will waive or alter any of the terms and conditions of the policy; and if any discrepancies, misprints or changes of benefit occur, the policy will govern.

I. HSA Basics

What is a Health Savings Account (HSA)?

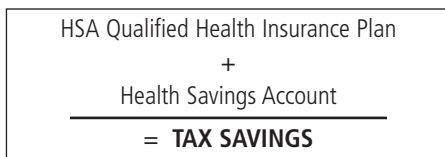
An HSA works like an IRA, except the money can be withdrawn tax-free to pay for qualified health care expenses. The consumer enrolls in a high-deductible health plan and then opens a savings account to cover current and future medical expenses. Deposits are 100% tax deductible up to the maximum contribution calculated each year. The money can then be withdrawn to pay for qualified medical expenses. The unused balance rolls over from year to year.

How does an HSA work?



1. Obtain coverage under a high deductible health plan.
2. Open a health savings account and save 100% of the health plan's annual deductible up to \$2,650 for individual coverage and \$5,250 for family coverage in 2005.
3. Use your health savings account to pay for your lower-dollar medical expenses, or those that are not covered by your health plan.
4. Once you meet the deductible, the health insurance covers your medical expenses as defined in the policy.

What are the advantages of an HSA?



Save money right away and in the long term:

- The HSA contribution to the savings account is 100% tax-deductible up to the annual maximum contribution.
- The savings account accrues interest on a tax-free basis.
- No tax penalty or tax payments when money is withdrawn to pay for qualified medical expenses.
- The high deductible health plan typically has a lower premium than those plans that have a lower deductible.

The consumer has the freedom to make some decisions:

- How much to contribute
- Whether to use the account to pay medical expenses or to save the money for future use

- Where to open the savings account
- Which HSA qualified high-deductible health plan to choose

The HSA is completely portable regardless of:

- Employer
- Age or marital status
- Employed or not employed
- Future medical coverage
- State of residence

Who is eligible for an HSA?

Everyone, not just the self-employed, with a qualified high deductible health plan (and not covered by another insurance plan) is eligible for a tax-deductible HSA.

Which insurance qualifies for an HSA?

For 2005, a high deductible health plan must have a minimum deductible of \$1,000 for individual coverage and \$2,000 for family coverage. The maximum out-of-pocket expenses for health care costs must be no more than \$5,100 for individual coverage and no more than \$10,200 for family coverage. Keep in mind that not all high-deductible health insurance plans are HSA-qualified even if they meet the requirements of deductibles and out-of-pocket limits.

How much can be contributed to an HSA?

Some HSAs require a small minimum monthly contribution. The annual maximum contributions for 2005 are as follows:

- For individuals, it is the lesser of:
 - a. \$2,650
 - b. The health plan's annual deductible*
- For families, it is the lesser of:
 - a. \$5,250
 - b. The health plan's annual deductible*

Note: If between the ages of 55 and 65, an additional annual contribution of up to \$600 can be made in 2005.

*If an HSA is started in the middle of the calendar year, the maximum contribution for the first year will be prorated based on the number of months in the HSA plan

What is the tax treatment of HSAs?

- At the end of each calendar year, a statement is sent showing the amount contributed to the HSA. This amount can be deducted provided it is less than or equal to the maximum allowable contribution.
- Like an IRA, HSA deductions can be taken even if one does not itemize their taxes.

II. High Deductible Health Plan Basics

Agent Licensing

- Agents must be licensed and appointed with the insurance company in the state where the applicant resides.
- We encourage agents to be licensed/appointed and trained prior to soliciting business.
- Agents can submit the appointment/contracting papers simultaneously with the new business submission in some states. Please check with your state's requirement.

General Plan Eligibility

- Must be a member of the association offering the high deductible health plan as a membership benefit.
- Minimum age is 16 and maximum age is 64.5—requirement to be a member of the association.
- United States Citizen, with a permanent U.S. residency or does not plan to live outside the United States.
- If the applicant is a student, clarify the address of where he/she is attending school. The student must be attending a school in a state where plans are available for sale.
- Individual and Association Group Major Medical Ineligible Occupation List (Subject to state mandates):

For attorneys and physicians consideration will be given if applying for an HSA-qualified plan; they are ineligible for all other plans.

- In order to consider an attorney, we will require an APS. If the applicant is a staff member of an attorney, we will require an APS.
- To consider a physician, we will require a paramedical exam. An APS will be required on the physician's family members. (Physicians include: Anesthesiologists, Dermatologists, Gynecologists, Neurologists, Obstetricians, Ophthalmologists, Orthopedists, Pathologists, Pediatricians, Plastic Surgeons, Psychiatrists, Radiologists, Surgeons, Urologists, Osteopaths and Podiatrists)
- Actors, Actresses, Entertainers, Escort Services, Strippers, Models and Stunt Personnel
- Airtraffic Controllers
- Asbestos and Toxic Chemical Workers
- Athletes (professional and semi-pro)
- Aviation (high-risk experimental or test pilots, aerial photographers, etc.) and Crop Dusters
- Bar and Tavern Owners and Bartenders
- Billiard Halls
- Circus and Carnival Workers
- Correctional Institute Employees
- Deep Sea Divers (professional skin, scuba and underwater excavators)
- Demolition, Explosive and Wrecking Workers
- Dock Workers (long shermen and stevedores)

- Drivers (Mining, racing, testing and explosive hauling)
- Fishing Industry (commercial, not returning to port each night)
- Government or Municipal Employees
- Halfway House Workers for Alcohol or Drug Rehabilitation
- Jockeys or Horse Trainers
- Logging and Mill Workers (to include tree trimmers)
- Massage Parlors (exception for certified massage therapists)
- Meat Packing and Slaughterhouse Workers (live animals)
- Migrant Workers
- Mining, Quarry and Foundry Workers
- Missionary Workers
- Musicians (except full-time concert, studio and symphony performers)
- Oil Rig, Oil & Natural Gas Workers and On or Off-Shore Drillers
- Pyrotechnists
- Rodeo Participants
- Structural Steel, Iron Workers and Steeple Jacks
- Tattoo Artist and Tattoo Parlor Owners
- Tunnel and Caisson Workers
- Unemployed (recently laid off, temporary unemployed, between jobs or medically disabled)

Eligible Dependents:

- Spouse (if not legally separated from the applicant)
- Unmarried child until the date the child attains age 19 including: (1) a legally adopted child or a child placed for adoption; or (2) a stepchild who permanently resides with the applicant or biological parent is applying for coverage
- Unmarried child age 19 or over who is incapable of earning a living due to mental retardation or physical handicap (proof of incapacity must be provided.)
- Unmarried child age 19 but under age 23 enrolled as a full-time student in an accredited school and is financially supported by the applicant. Age requirements may vary by state.

Rates

Contact your Field Manager for rate information and availability.

PPO Networks

When your client visits providers in the PPO network, they are protected from being billed for amounts above the reasonable and customary charge limits of their insurance for covered services. Since the PPO providers have agreed to negotiated charges, there will be no balance billing. We also apply PPO discounts before the deductible and coinsurance amounts are calculated, which can mean significant savings to them!

If individuals are obtaining healthcare service from providers who are not in their network, they will incur a greater out of pocket expense.

A PPO program offers freedom and flexibility.

- Choose between participating providers in a PPO network in order to receive in-network discount.
- Select providers who are either in- or out-of-network.
- Visit specialists without referrals.

Non-Network Negotiation Service (Part of the 24-Hour Care Coordination benefit—see the product sales brochure for more details).

If a PPO provider is not available within a reasonable distance from the insured's home, or if there is no provider within our network who performs the required service, your client can call **1-877-575-4207** or e-mail nonnet-exempt@ceresgp.com for assistance. We will help locate a non-network provider and attempt to negotiate the cost to help save them money. Our goal is to eliminate or reduce any balance billing to our insured.

Provider Locator Service and Directory

To locate in-network providers*, visit our website or www.ceres.pponet.com. Insureds can also consult their directory or call us toll-free at **1-877-575-4207** (available 24 hours a day, 7 days a week).

The PPO directory sent to the insured is a concise document that includes approximately 3,200 network providers, 90 hospitals and 90 ancillary providers located nearest to the individual plan member.

The directory does not contain hospital-based physicians—emergency room physicians, pathologists, anesthesiologists or radiologists. Information regarding these physician types is available on the provider locator.

To nominate a provider to a network, insureds should complete a Provider Nomination form. These forms are included in their customized provider directory.

*The directory and locator information is only as current as the networks have provided and we cannot guarantee that at the time, all providers' information is accurate. Networks submit provider data on a regular basis (generally monthly) to ensure the most up to date information is available to our agents and insureds. Every effort is made to ensure the accuracy of the information for each network. However, participating providers change regularly and vary from plan to plan. Insureds are responsible for selecting a provider currently participating in their network prior to receiving care. They should clarify each time with their provider's office prior to services being rendered that they are a participating provider of the network listed on their ID card. The insurance carrier is not liable for any losses, damages or uncovered charges resulting from the use of the provider locator website or directories or receiving care from a provider listed.

Administrative Procedures regarding PPO networks

- Insureds who move into a new state where the insurance company is currently doing business will be assigned to the new state's principle network. If there are multiple networks, The First Health Network* will be assigned. The insured can request the other network, simply by notifying the insurance company.

- Students will remain under their parent's network selection. The First Health Network has nationwide providers offering extensive coverage. If they have selected a local network, the student can take advantage of the travel PPO network National Preferred Provider Network (NPPN).
- The insured will be able to change networks, when multiple networks are available in a state, one time during a 12-month rolling period. This can be initiated through a phone call or by written request.

*Not available in AZ, MI and OH.

Pharmacy Benefits

The plan includes a Managed Indemnity Drug Card program, which offers preferred prices for both retail and mail order pharmacy drugs. After paying the preferred pricing at the pharmacy, the insured or the pharmacy can submit the prescription drug receipt to the insurance company and it will be processed subject to the deductible and coinsurance of the plan.

Our pharmacy program provider, Express Scripts, located at www.express-scripts.com, has a program that includes:

- 24 hour 365-day/year access to the Express Scripts Customer Service Call Center at **1-800-287-4526**.
- National network of over 56,000 pharmacies.
- Nationwide pharmacy locator available by contacting the Express Scripts Customer Service Call Center at **1-800-287-4526** or their personalized pharmacy website. For agents you can locate a pharmacy by going to the Pharmacy Locator at the insurance company website and following the instructions.
- Convenient home delivery of medications through the mail order service.

Express Scripts offers to their clients a personalized pharmacy website that has services designed for individuals.

Personalized pharmacy website services include:

- **Benefit Plan**—a detailed description of an individual's plan and coverage, including pharmacies in his or her network.
- **Prescription History**—an individual's personal record of his or her prescription history.
- **Online Mail Order Service Pharmacy**—individuals can save money by ordering prescriptions online through Express Scripts.
- **Drug Information**—get answers to specific questions about medications, including drug interactions, drug comparisons and more.

For an insured to register simply have them visit <http://member.express-scripts.com> and follow the simple instructions provided.

LabOne Select Program

The LabOne Select Program is offered* as voluntary, member-driven cost containment program designed to compliment the health plan. The LabOne Select program does not replace an

insured's existing lab benefits under the plan, it only enhances with reduced-cost laboratory testing.

The LabOne Select Program provides outpatient lab testing for covered services at reduced costs. Insureds will be responsible for any applicable deductible and coinsurance under the plan for any covered outpatient laboratory testing, but out-of-pocket expenses will be reduced when using LabOne. LabOne will submit the claim to the insurance company for processing in accordance with the policy provisions.

How does LabOne work?

LabOne is a fully accredited and certified laboratory in the Kansas City area. All an insured needs to do to take advantage of their LabOne program is simply show his or her LabOne Select card to the doctor and request that their specimens be sent to LabOne for testing.

Example of savings for a typical claim with LabOne

Lab Test	Typical Lab Charge	LabOne Charge
Basic metabolic panel	\$34.52	\$6.00
Lipid panel	\$63.29	\$9.88
Pap smear	\$41.75	\$13.56
PSA (Prostate Specific Antigen)	\$67.71	\$24.66

If the doctor's office is unable to collect the specimens, the patient can call 1-800-750-1253 to locate an approved collection site in the area.

How does an insured use the program?

The reduced-cost savings available through the LabOne Select program is not automatic. The insured under the LabOne Select program needs to make sure that they show their physician's office their LabOne card and request that their specimens be sent to LabOne for testing. If they do not have their LabOne card available, the provider may call LabOne directly for more information. The doctor customarily collects the specimens and calls LabOne for pickup. LabOne perform the tests and sends the results to the physician (usually within 24 hours).

The LabOne program savings apply only to the laboratory tests.

LabOne provides a LabOne card and other materials that provide instructions to the provider on how to send lab work or specimens to LabOne or how to locate a draw site. LabOne will submit claims for services directly to the insurance company.

What outpatient laboratory tests does LabOne process?

LabOne is able to process most diagnostic outpatient laboratory testing, provided a physician has ordered the tests and sent them to LabOne for processing. Outpatient lab work includes:

- Blood testing (e.g. cholesterol, CBC)
- Urine testing (e.g. urinalysis)
- Cytology and pathology (e.g. pap smears, biopsies)
- Cultures (e.g. throat culture)

Are there laboratory testing that LabOne can not process?

There are some tests that LabOne does not perform; these tests are indicated in the LabOne materials. LabOne is not able to process the following:

- Lab work ordered during inpatient hospitalization.
- Lab work needed on an emergency (STAT) basis and time sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests.
- Nonlaboratory work such as mammography, x-ray, imaging and dental work.
- Lab work performed by another lab.

LabOne Select Website

LabOne has a website available that supports the LabOne Select program at www.laboneselect.com. This website contains valuable information regarding the program and locating providers. The website contains information that will answer agent, insured and physician questions.

*The LabOne Select program is not available to insureds in the MAMCO/Berkshire Health Network.

Case Submission

- Contact your field manager for all appropriate forms and items that are required at time of submission.
- The applicant should not terminate prior coverage until written notice of approval is received and all requirements have been provided to the Home Office.
- Verify applicant's identity by reviewing driver's license, state ID or passport. (not applicable for electronic submission)
- Payroll deduction or list bill is available in some states; contact your field manager for further details.
- Application must be completed in full by the applicant. Applications must be complete in black or blue ink.
- All insurance applications must be signed and dated the actual date that they are completed.
- If a signature appears altered, the application will be returned to obtain a new completed enrollment application.
- Non-custodial parents—when a child considered for coverage does not live with the applicant, we require the signature of the parent/guardian or verify with whom the child lives.
- Applications received without a payment will not be processed. New Association applicants selecting to pay their premium through electronic fund transfer (EFT) are not required to submit an initial premium check at time of enrollment. A credit card is acceptable for electronic submission.
- Agents are required to submit all new business through their field manager for submission, unless authorized to do otherwise.
- The Home Office must receive all insurance applications within 21 days from the completion date and electronic applications within 24 hours.

- Once the case is submitted, the underwriter determines the final premium rates.
- COAST system can be accessed for inquiry on an application status.
- If there is a selection of networks, a network must be chosen at time of application. It must be listed on the application and quote.
- Review the underwriting guidelines (MAN-0044) for details on many conditions and ailments to determine if an application should be submitted or what the underwriting outcome may be.
- The agent has no authority to change benefits or bind coverage.
- If the insurance applied for is withdrawn, the insurance company's only obligation will be to refund the amount paid for insurance premium.
- Due to changes in federal and state mandates on health insurance, it is important that you keep current on the laws enacted within your state and on a federal level.
- This plan is not being sold or administered as an employee benefit plan, and the member's employer is not responsible, either directly or indirectly, for paying the premium or benefits.

Effective Dates

- If coverage is approved, the insurance company will determine the actual effective date of coverage, which may differ from the applicant's requested effective date.
- No insurance is in effect until a written notice of approval and the actual effective date is received by the applicant from the Home Office.
- The effective date will be the 1st of the month following underwriting approval. We will allow the 15th of the month on a request basis.
- The underwriting status report (USR) will reflect the possible effective date taking into consideration the outstanding information the underwriter is requesting. We will not backdate an effective date more than five days beyond the date the application is approved for coverage.

Underwriting Process

Verification

- The applicant indicates on their enrollment application convenient times they can be contacted for the verification call. It is important that you explain and support the verification process to your client.
- The phone call is recorded and is considered part of the application.
- The information obtained through verification is confidential and will not be released without the written consent of the applicant.
- The verifier will confirm the accuracy and validity of the information on the application, obtain any additional details which are needed and clarify any incomplete information.

- A verifier will attempt to contact each applicant by phone within 48 hours of when the application is received at the Home Office.
- The verification call will take approximately 10 to 20 minutes.
- If the applicant cannot provide a specific time or if the Verification Department is unable to contact the applicant they can contact the **Verification Department**. The phone number is on the enrollment application.
- The Verification Department is open Monday through Thursday 8:00 a.m. to 7:00 p.m. (Eastern) and Friday 8:00 a.m. to 3:30 p.m (Eastern).
- The enrollment application cannot be considered for coverage if the verification call is not complete.

Underwriting Case Status

- You will be notified of approvals, denials and additional requirements.
- Initial status requesting additional details will be sent to the field manager.
- The Underwriting Status Report (USR) is available on COAST.

Pending

- The application will be placed into a pending status for up to 45 calendar days from the date of receipt at the Home Office.
- If a complete response to the USR is not received within the 45-day period, the application may be closed for insufficient information. The USR reflects the time period.
- If all of the requirements are received after the file is closed, but no more than 60 days from the application completion date, the file may be reopened and the underwriter will notify accordingly.
- If all of the requirements are received more than 60 days from the application completion date but less than 90 days, it will be at the underwriter's discretion to determine the requirements to process the application.

Exclusion Riders

- May be used to exclude a specific medical condition.
- May be used to exclude a hazardous avocation.
- May be used to exclude a dependent.
- Rider must be signed and dated by the primary applicant prior to approval/issue of the case.

Medical Records

- Ordering of medical records is at the discretion of the underwriter and for certain medical conditions as noted in the field underwriting guidelines.
- The underwriter will request the medical records for an applicant through Source Access and will pay the associated costs up to \$70.
- If a provider requests a higher fee, the underwriter will then notify you and your field manager. If the medical records can be provided, you or the client can be reimbursed for up to \$70 with a receipt from the provider.

- The current medical record definition is records from a physician that has seen the applicant in the last two years.
- The underwriter will follow-up with Source Access 10 days from the request if we have not received. If there is any problem, they will advise.

Paramedical Exams

- Ordering of paramedical exam is at the discretion of the underwriter and for certain medical conditions as noted in the field underwriting guidelines.
- The underwriter will request a short-form paramedical exam, blood draw or urinalysis and will pay the associated costs.
- The examiner will contact the applicant to set up a time for the exam and handle all the paperwork.
- The examiner will provide the information to us electronically, therefore, eliminating mail delays.
- The Underwriting Status Report will indicate the date the exam was requested.
- This will enable you to explain to your client that an examiner will be contacting them to make arrangements to perform the paramedical exam.
- The underwriter will follow-up 10 days from the request if we have not received the report. If there is any problem, we will contact the agent to assist us in resolving the delay in completing the paramedical.

Denials

- A letter will be sent to the applicant, agent and field manager.
- If a check was submitted with the application, initial premium, administrative fees and association dues will be refunded to the applicant.

Rescission

- A rescission is a contractual remedy allowed to insurance companies when there has been material non-disclosure on the part of the applicant.
- A rescission puts all parties back in the same position they would have been if the health history had been disclosed on the application and coverage not issued.
- Rescission action is taken within the certificate contestable period.
- Premium payment is returned to the former insured, less any claims paid.
- The agent is charged back for any commissions paid.

Market Conduct

Accurate and complete applications are a requirement for your business: As part of your field underwriting responsibility, it is up to you to assure that the applications you submit to us are accurate, complete and true. Any health history disclosed to you must be indicated on the enrollment application, no matter what the condition may be.

With complete information and health history, we can make the best decision on risk selection and coverage approval or disapproval. If you're not sure whether you should submit a specific application, check our Underwriting Guidelines (MAN-0044). This guide provides details on many conditions and ailments, showing our underwriting practice for each.

You need to assure accuracy of the application not only for the Home Office, but also for yourself. Submitting inaccurate and incomplete applications can cause delays for your clients at claim time and can also have a serious negative impact on your contract with us and on your career in general.

If we find undisclosed health information through our telephone verification process or through medical records during the underwriting process, we will reject the application. The initial premium will be returned to the applicant. You will also receive a letter explaining that information materially different from that included on the application was discovered during the underwriting process from our Consumer Relations Department.

Agents who begin to develop a pattern of submitting incomplete or inaccurate applications or who are in some way committing fraud upon the company will have their contracts terminated.

The insurance company has the right to deny benefits or rescind coverage if any information on the enrollment application is incorrect, incomplete or untrue.

You can consult the Agent Code of Ethics & Procedures for a complete listing of requirements.

Premium Billing

Premium Payment and Billing Information

- When a billing statement is received, the total amount due must be submitted with the correct payment coupon and envelope to avoid delays in posting the payment or termination of benefits.
- If an insured selects the electronic fund transfer (EFT) payment process, a billing statement will not be generated unless the total amount due changes or the insured is also on a quarterly or semi-annual billing mode.
- A client can select the following dates for premium to be deducted through the EFT payment process: 1st, 10th, 15th or 25th of each month.
- An administrative fee for our services is added to each billing statement and is considered part of the total amount due.
- Administrative fee helps cover the cost of administering the health insurance plan such as preparation of billing statements, rating and actuarial studies, underwriting, claims processing, certificate materials and computer services.
- If payment is not received within 2 weeks of the due date, a reminder notice, including a payment coupon and envelope, will be mailed to the insured.

- If payment is not received at the time of the next month's billing statement is generated, the billing statement will also include a reminder message.
- If payment is not received within the grace period, coverage will automatically terminate. A letter will be sent to the insured explaining the termination and will contain information about applying for reinstatement of coverage.
- If a check is received after the grace period has expired, the check will be deposited and used to initiate the application for reinstatement process. Additional requirement will be requested through the field manager. If the member chooses not to apply a refund check will be sent.

Termination of Coverage

- A courtesy letter is sent approximately 40 days after the due date to the insured acknowledging the termination of coverage and information regarding consideration for reinstatement.
- A certificate of creditable coverage is also sent.

Reinstatement

- Individuals may be eligible to apply for reinstatement up to 90 days after the date of termination.
- Reinstatement is subject to approval, and coverage will not be in effect until advised of approval in writing.
- Reinstatements are subject to medical underwriting and rating, rider, or rejection may be determined according to risk.
- The reinstatement fee is \$15. If reinstatement is applied for more than three times, the fee increases to \$30.

Administrative Procedures

Adding Dependent Coverage

- For newborns and adopted children:
 - a. When a Member with Single coverage requests coverage for a newborn or adopted child, the following will apply:

In order to make coverage effective for a newborn or adopted child on the eligibility date, the Home Office must receive a written request from the Member to add the new Dependent within thirty-one (31) days after the eligibility date.

The eligibility date is determined as follows:

 - (1) for a newborn—the newborn's date of birth; or
 - (2) for an adopted child—the earlier of the date Placed for Adoption, or the date of legal adoption.

If a written request to add the newborn or adopted child is not received in the Home Office within thirty-one (31) days after the eligibility date, as indicated above, such Dependent will be considered independently and, if approved, the Home Office will determine the effective date of coverage.
 - b. When a Member with Dependent coverage requests coverage for a newborn or adopted child, the following will apply:

Coverage will be effective for a period of thirty-one (31) days following the eligibility date. In order for coverage to continue beyond this initial thirty-one (31) day period, the Home Office must receive a written request from the Member to add the newborn or adopted child within thirty-one (31) days following the eligibility date.

- c. The eligibility date is determined as follows: (1) for a newborn, the newborn's date of birth; or (2) for an adopted child, the earlier of the date Placed for Adoption, or the date of legal adoption.

If a written request to add the newborn or adopted child is not received in the Home Office within thirty-one (31) days after the eligibility date, as indicated above, such Dependent will be considered independently and, if approved, the Home Office will determine the effective date of coverage.

- Adding family members other than newborns and adopted children:
 - a. For a Member with single coverage, the Member must complete an Application. Each Dependent will be considered independently and, if approved, the Home Office will determine the effective date of coverage.
 - b. For a Member with family coverage:
 - (1) The Dependent will be automatically covered if a written request is received by the Home Office prior to the eligibility date (for example, the date of marriage). The effective date will be the eligibility date.
 - (2) If the written request is received by the Home Office within thirty-one (31) days after the eligibility date, coverage will be effective the first day of the month following receipt of the written request.
 - (3) If the Home Office is not notified within thirty-one (31) days after the eligibility date, the Member must complete an Application for the Dependent. Such Dependent will be considered independently and, if approved, the Home Office will determine the effective date of coverage.
- The additional premium charge for the new Dependent, if any, will be added to the Member's next premium statement and must be paid with that premium when due.
- No Dependent coverage will become effective for a Dependent before the Member's coverage is effective. Insurance for a Dependent confined in a Hospital or Extended Care Facility on the date that his or her coverage would otherwise have become effective, will become effective on the day after the final discharge from the Hospital or Extended Care Facility. This provision will not apply to a newborn Hospital-confined on his or her effective date.
- Following written approval by the Home Office of the Member's Application, the Home Office will determine the effective date of coverage for a Dependent who was previously rejected for coverage by the insurance company.

III. My Health Savings Bank Basics



About My Health Savings Bank*

My Health Savings Bank was created by the Bancorp Bank to provide HSAs and other banking services. Their goal is to provide a comprehensive HSA solution that meets all of your client's needs.

Advantages of My Health Savings Bank

Clients can choose to open an HSA with any of the companies providing accounts, but we think they will enjoy the following benefits of doing business with My Health Savings Bank:

Convenient:

- Apply online, by mail or by phone
- 24/7 Customer Service
- Full online account access to monitor deposits and withdrawals
- Options for contributions include direct deposit, E-Transfers and credit card
- Over 20,000 deposit locations nationwide
- Interest paid on account balances over \$1.00

Affordable:

- No fees to open an HSA
- No fees for the first 90 days
- No fees for HSAs when automatic monthly deposits selected
- No fees for HSAs with balances over \$2,500
- Free first order of checks
- Free HSA Debit MasterCard®

How to open an HSA

My Health Savings Bank has 4 easy and convenient ways to apply for a new account.

- 1) **Send in HSA Enrollment Form with Insurance application:**
After completing the insurance application, clients can complete an HSA application and submit it to the Home Office along with the health insurance application. The Home Office will fax the hardcopy HSA application directly to *My Health Savings Bank*. This makes it less confusing for both the client and agent as to where to send the forms when applying for a High Deductible Health Plan and an HSA.
- 2) **Enroll Online at www.MyHealthSavingsBank.com:**
After completing the insurance application, clients can visit www.MyHealthSavingsBank.com to complete the simple, online paperless enrollment secured application process.
- 3) **Paper Enrollment Directly to My Health Savings Bank:**
Complete the HSA application or download an application from www.MyHealthSavingsBank.com and send it directly to My Health Savings Bank via fax to 1-302-385-5121 or mail to My Health Savings Bank, 405 Silverside Road, Suite 105, Wilmington, DE 19809.

- 4) **Apply Over The Phone Directly With My Health Savings Bank:** *My Health Savings Bank* representatives are available to take an HSA application over the phone at 1-800-555-5157. To help expedite the application process over the phone, your client should have the following information available:

1. Name, address, phone number
2. Social security number or tax identification number
3. Drivers license number
4. Date of Birth
5. E-mail address

My Health Savings Bank will process the account application within 10 days of receipt and send them a welcome package that provides them important account information.

Contributing to an HSA

The annual maximum contribution is the annual deductible of the High Deductible Health Plan up to (for 2005) \$2,650 for single and \$5,250 for family coverage. However, this maximum is based on the full months the client qualifies. If the client does not qualify for the entire year (for example, if they were not covered by a HDHP the entire year) the maximum contribution will be a pro-rated amount. If the client and his/her spouse are between the ages of 55 and 65, there is an additional catch-up contribution available. In 2005 it is \$600 and it increases by \$100 a year until it reaches \$1,000.

The client has until April 15 of the following year to make contributions. The money earned on the HSA is 100% free from federal income tax while it is in the account. Also, after age 65, money withdrawn for any reason is only subject to normal income tax. If a spouse has been named as the beneficiary of the HSA then upon the death of the client, the HSA ownership is transferred to him or her without any tax due.

Paying Medical Bills Using the Money in an HSA

An HSA can be used to pay for qualified medical expenses such as doctor or hospital bills; or for any other purpose. If the amount distributed is used for qualified medical expenses, then the distribution is tax free. However, if not used for qualified medical expenses it's taxable and subject to an additional 10% tax unless the client is disabled or over age 65.

A qualified medical expense can be for the HSA owner, spouse and dependents but to qualify it must not be reimbursed by insurance. For example, doctor and hospital bills paid before the deductible of the High Deductible Health Plan is met are qualified medical expenses. Also, prescription drugs and certain non-prescription medicines qualify.

* *My Health Savings Bank* is owned by The Bancorp Bank, Member FDIC. Equal Housing Lender.

Record Keeping

With an HSA the client is responsible for the use of the account and may be required to show proof of expenditures to the IRS. When the client uses the HSA, they will need to keep track of all of their expenditures. *My Health Savings Bank* recommends the client designate a place to store all receipts so they are available when needed.

With *My Health Savings Bank's* HSA clients will be able to view all of their transactions using online account access. They are able to develop categories and classify transactions to easily track expenditures. For tax reporting, they will also receive a summary of the contributions and distributions that were made during the year.

When customers have questions about their HSA, please refer them to **My Health Savings Bank Customer Service Center** at 1-800-555-5157. Representatives are available 24 hours a day, 7 days a week. Or, they can visit the website at www.MyHealthSavingsBank.com for more information.



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