

mPowerMed

Your empowered health insurance options

Producer's Guide *for use with*

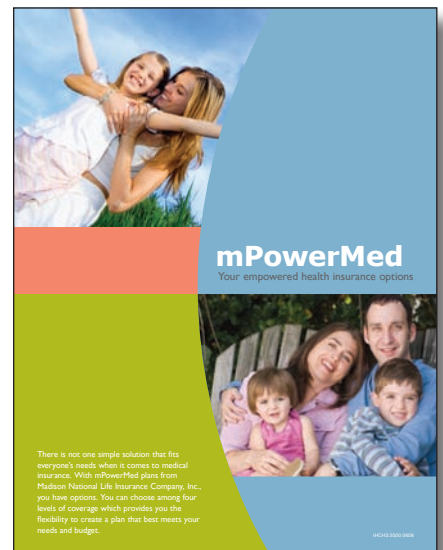


Table of Contents

| | |
|--|-----------|
| Important Addresses and Phone Numbers | 3 |
| Appointment and Contracting | 3 |
| Commissions | 3 |
| Communicating for America, Inc. | 4 |
| Eligibility of Applicants | 4 |
| Issue Ages for Individual or Family Coverage | 4 |
| Child(ren) Only Coverage | 4 |
| Adopted Children | 4 |
| Legal Custody | 4 |
| Resident State | 4 |
| Foreign Nationals | 4 |
| Overseas Travelers | 5 |
| Military Information | 5 |
| Medicare Eligible Individuals | 5 |
| Restricted Occupations | 5 |
| Underwriting Guidelines | 5 |
| Medical Underwriting Sources | 5 |
| Height and Weight Guidelines | 6 |
| Preferred Rating | 7 |
| Co-Morbidity Factor | 8 |
| Expectant Parenthood | 8 |
| Disabled Applicants | 8 |
| Unacceptable Health Conditions | 8 |
| Term Life Underwriting Guide | 9 |
| Submitting an Application | 9 |
| Checklist for New Applicant | 9 |
| Pre-Existing Conditions | 9 |
| Pre-Existing Conditions - 12/12/24 | 9 |
| Full Disclosure of Health Conditions | 10 |
| Underwriting Decisions | 10 |
| Issued as Applied | 10 |
| Exclusionary Riders | 10 |
| Empowered U/W Matrix | 10 |
| Rating | 13 |
| Higher Deductibles | 13 |
| Decline | 13 |
| Application Withdrawal | 13 |
| Requirements to Place | 13 |
| Pending Requirements | 13 |
| Exclusionary Riders | 13 |
| Premium Rating | 13 |
| Producer Kit/Delivery Certificate | 13 |
| Effective Dates and Billing | 13 |
| Effective Dates | 13 |
| Billing | 14 |
| Billing Modes and Options | 14 |
| After the Sale | 14 |
| Inforce Health Insurance Changes | 14 |
| Medical Claim Review | 15 |
| Rescission or Reformation of Coverage | 15 |
| Reinstatement of Coverage | 15 |
| Continuation | 15 |
| Turning Age 65 | 15 |

This guide was designed for the mPowerMed plans which are underwritten by Madison National Life Insurance Company, Inc. (MNL) and made available through select distribution partners nationally. It provides a general overview of the company's underwriting guidelines and procedures. They may not apply in every instance and are subject to change. Not all who apply for coverage will be eligible for and subsequently issued coverage. For additional information, please refer to the plan brochure, enrollment application, quoting tool or your producer's agreement.

Throughout this guide, producers/agents will be referred to as "you," Madison National's administrators will be referred to as "us" and Madison National will be referred to as "the Company."

Important Addresses and Phone Numbers

Underwriting and Inforce Administration

Insurers Administrative Corporation (IAC)

Underwriting

1173 W. Main St., Ste. E
Whitewater, WI 53190
866-472-6555
866-570-5234 Fax
uwind_wisconsin@iacusa.com

Administration and Billing

P.O. Box 37457
Phoenix, AZ 85069-7457
800-518-4510
602-678-4267 Fax
admin@iacusa.com

Claims

866-574-3260
602-395-0496 Fax
Agents can use the caclaims@iacusa.com email address for an elevated claims issue.

Clients can use the IAC customer service portal at www.iacusa.com to make changes to their contact information, review claims explanation of benefits (EOB), order new ID cards and much more.

Web site: <http://thinkihc.iacusa.com>. This Web site can be used to download forms, check underwriting case status, link to PPO directories and view promotional information.

For information on Communicating for America, Inc. contact:

Communicating for America, Inc. (CA)
112 E. Lincoln Ave. Fergus Falls, MN 56537
800-432-3276
218-739-3832 Fax
Web site: cabenefits.org

Appointment and Contracting

New Producers – Contact your Marketing Representative to determine licensing, appointment and contracting rules for the state(s) in which you do business prior to submitting any applications.

Before you sell your first case, you must have a current life/health insurance license for the state(s) in which you do business. You must be appointed by the Company and have completed a Producer's Agreement with Madison National. Some states allow producers to submit the required appointment request with their initial case submission. Contact your Marketing Representative to verify whether the state(s) in which you do business allow this procedure.

Producer-Required Forms

Prior to or upon submission of your first case, please provide us with each of the following documents, properly completed, signed and dated:

- Legible photocopy of your current state life/health insurance license(s)
- Certificate of Coverage for E&O Insurance
- Producer's Agreement
- Agent Requisition for Appointment form
- Appointment fee, if applicable

Non-Resident fees must be included with your contract for the state the appointment is being requested, along with any additional fees required for agency appointments. Contact your Marketing Representative if you have any questions about these fees.

Send or fax the required forms to your Marketing Representative for the mPowerMed plan.

After the company appoints you and executes the Producer's Agreement, you will be sent a completed copy of your Producer's Agreement for your records. If proper licensing and appointment procedures are not followed, submitted business may be closed out and initial premium submitted may be returned. If you are not appointed, no commissions will be paid to you.

Commissions

You will receive earned commissions, or may also receive advance commissions, subject to the terms and conditions of the Producer's Agreement. To continue to receive commissions, the case must remain inforce, the premiums must be paid and you must actively service the account.

For purposes of determining first-year commission and future years' service fees, administrative fees, premium rate increases (whether or not due to tobacco loads, medical loads, area rate increases and conversions) are not included. Commissions will be paid based upon the lower of the first modal premium or the current premium.

Communicating for America, Inc.

The Madison National individually sold major medical plans are available to members of Communicating for America, Inc. (CA). CA is a national, non-profit, non-partisan rural association founded in 1972 and headquartered in Fergus Falls, MN. Along with the endorsement standards that CA requires Madison National to abide by, the association membership provides the insured numerous benefits. For more information on CA and the benefits provided, please refer to the benefit guide or visit www.CAbenefits.org.

Eligibility of Applicants

Issue Ages for Individual or Family Coverage

Adult applicants must be 18 to 64 years of age. A spouse currently under age 65 is considered an eligible dependent. We do not recognize common-law relationships or domestic partners unless required by state law. Dependent children or stepchildren must be unmarried and under age 19*, or under age 25* if a full-time student at an accredited college, vocational school or high school. Full-time status is defined as actively attending at least 12 hours of class per week or attending the minimum hours of class the school considers as full-time status. For summer sessions, 6 credit hours are required if not enrolled for the following semester.

*May vary by state law.

Child(ren) Only Coverage

Child(ren) applying for coverage on a plan not to include a parent or legal guardian must be 2 months to 17 years of age. Newborn and adopted children can be added to a “child only” plan, subject to full underwriting. The youngest child to be insured must be listed as the applicant, and all other children listed under the dependent section of the application. A parent or legal guardian must sign the application and answer all medical questions of the children for whom coverage is being applied. Also, a parent or legal guardian must be the certificate/policy owner and the CA member. When children covered under such policies attain age 19 (or 25 if a full-time student), they can be issued coverage under their own individual plan without evidence of insurability and charged an adult rate if they reside in a state where the coverage is available. If issued their own coverage, they must become a member of CA.

Adopted Children

Coverage for adopted children begins on the date of placement with the insured. Placement means that the insured has physical custody of the adopted child and is the court-appointed guardian or has final adoption papers. The primary insured must notify IAC in writing within 31 days of placement to continue coverage. If notice and payment (if applicable) are not received within 31 days, the adopted child is subject to full underwriting.

Legal Custody

Dependents that do not meet the basic definition of an eligible dependent but who are in the legal custody of the insured may be considered for coverage subject to review of legal custody documents. Generally, temporary custody or powers of attorney are not considered sufficient legal documentation. There must be permanent custody documented by court order to qualify as an eligible dependent, except as otherwise mandated by state law.

Resident State

The mPowerMed plan being applied for must be available for sale in the applicant’s primary state of residence. The application must be signed in the applicant’s residential state or you must be licensed in both the residential state and the state in which the application was signed. Premiums are based on the rates applicable to the applicant’s primary state of residence and are adjusted to reflect changes in residence when they occur. Benefits are generally based on the owner’s primary state of residence.

If the owner of the certificate/policy resides in a different state than the applicant, you must also be licensed in the owner’s residential state. The resident state of the owner will determine the issue state. Therefore, benefits will be based, in general, on the laws applicable to the owner’s residential state. For example, an applicant resides in Iowa, the application was written in Nebraska and the owner resides in Montana. The producer must be licensed in Iowa, Nebraska and Montana and the issue state will be Montana.

Foreign Nationals

American citizenship is not mandatory under this plan as long as the applicant is a legal and permanent resident of the United States. A legal and permanent resident is defined as someone who is living in the United States on a full-time basis and who has been issued permanent Visa status with only an occasional stay outside of the United States.

We require a Social Security number only for adults who are applying for coverage. If an adult does not have a Social Security number, we can accept a copy of his/her green card or permanent Visa (see chart below) to validate residency.

The following Visa categories are acceptable to validate legal residency:

| Primary Applicant | Dependents |
|-------------------------------|------------|
| H-1 A Nurses | H-4 |
| H-1 B Professionals | H-4 |
| L-1 Intra-Company Transferees | L-2 |
| TN Trade “NAFTA” | TD |
| TC Canadians ONLY | TB |

Note: The Dependent Visa category is tied to the Primary Applicant category directly to the left of it. For example, if the primary applicant has a TN classification, his/her dependent(s) would have a TD classification.

Canadian citizens are exempt from the Visa and passport requirement of the Immigration and Nationality Act. To enter the United States, a Canadian citizen must be able to establish both identity and citizenship. Documents that may establish citizenship are: birth certificate, citizenship certificate and passport.

Overseas Travelers

Persons to be covered must not be planning or considering extended foreign travel nor live outside the United States for more than 3 months of the year. Dependents who are studying abroad are ineligible for coverage since they would be taking residence in a foreign country.

The mPowerMed plan excludes services received or supplies purchased outside the United States unless the charges are incurred for urgent care while traveling on business or for pleasure for a period not to exceed 90 days. Services and/or supplies used in connection with the urgent care treatment must be approved for use in the United States.

Military Information

USERRA does not apply. Coverage will terminate for the entire certificate on the last day of the month in which the primary insured is called to active duty. There is no reinstatement upon return from active duty; a new application must be submitted.

Medicare Eligible Individuals

Applicants who are already eligible to be covered under Medicare are not eligible for coverage under the mPowerMed plan. Individuals who are already covered under this plan prior to reaching Medicare eligible age may continue coverage. Benefits will be provided secondary to Medicare. The plan does not automatically terminate when the insured turns age 65.

Restricted Occupations

Applicants employed in any of the fields listed below are not eligible for coverage. Restrictions are applied only to the person(s) employed in a restricted occupation (*applicant and/or spouse, not children*).

- Adult Entertainment Workers (*actors, dancers, escort service workers, etc.*)
- Air Traffic Controllers
- Armed Forces Personnel
- Asbestos/Toxic Chemical Workers*
- Divers (*professional skin or SCUBA*)
- Explorers
- Explosive Workers
- Fire Fighters/Police Officers (*full time*)
- Fishermen/Crew (*not returning to port nightly*)
- High Risk Aviation (*crop dusters, test pilots, stunt or*

student pilots)

- Loggers or Logging Mill Workers*
- Masseuse (*not licensed or not certified*)
- Musicians (*not including symphony or orchestra*)
- Oil and Natural Gas Workers (*onshore and offshore*)
- Professional Motor Vehicle Racers*
- Professional and Semi-Pro Athletes (*golf and bowling accepted*)*
- Professional Rodeo Participants
- Pyrotechnists
- Roofers and Roofing Contractors*
- Structural Steel Workers*
- Underground Miners*

*For these occupations, underwriting will give individual consideration for business owners who do not participate in the normal duties of workers. This consideration is given on a case-by-case basis and is based on the size of the business owned and the likelihood the owner will perform the duties of the other employees in the event of a personnel shortage.

In those states that do not allow declinations based on occupation, a premium surcharge will be assessed.

In addition to the list of occupations above, the Company reserves the right to decline to insure any applicant engaged in certain extra-hazardous occupations or whose acceptance would, in their opinion, not conform to sound underwriting practices.

Underwriting Guidelines

Medical Underwriting Sources

We reserve the right to reject any application that, in our opinion, does not conform to sound underwriting principles. The Company depends on you to select acceptable risks and give complete information. Sources of information used in the underwriting process are as follows:

1. **Application:** Each question on the application must be specifically asked of the applicant and the answer recorded as given. It is never allowable for you to ask a general question such as, "Are you in good health?", and upon receiving a "yes" reply, answer all health questions with a "no" answer. Except in the case of children-only applications, **all answers must come directly from the applicant.** All paper applications must be completed in blue or black ink. It is not sufficient to answer questions with dashed or ditto marks. **If an error is made, the primary applicant should cross through the word or line with a single stroke, then initial and date the correction.** Under no circumstances should a health application be backdated.
2. **Health Questionnaires (Personal Interviews):** Health questionnaires are personal telephone interviews with the client. A health questionnaire is

ordered on all applicants that:

- are age 45 and older, if **not** replacing prior insurance **and** no doctor is listed on the application,
- are age 50 and older,
- are age 60 and older, if a doctor is **not** listed on application to order an APS,
- have a condition disclosed on the application without full details, or
- are children 2 years of age or younger.

Specific conditions can also warrant a health questionnaire. **You should tell every applicant that IAC may call him/her.** If we are unable to contact the applicant or need an updated phone number, you may be asked to intervene.

IAC utilizes TelMed of Whitewater, Wisconsin to perform the Health Questionnaire process.

All of these interviews are recorded for accuracy and to assure that appropriate customer service standards are maintained. The status of a pending telephone interview can be accessed using the Web site – <http://thinkihc.iacusa.com>.

3. **Attending Physician’s Statement (APS):**

Coverage may be considered for applicants who have various disclosed medical conditions, but an APS may be required. If an APS is needed, IAC will request it and pay the physician’s fee without asking you to obtain the records! **An APS is requested on all applicants over the age of 60 and all applicants age 50 and over who are not replacing prior insurance.** An APS is also ordered on any applicant that has a combination of at least two of the following three conditions: elevated cholesterol, obesity and/or tobacco use.

IAC utilizes Parameds.com for APS ordering. The status of a pending APS can be accessed using the Web site – <http://thinkihc.iacusa.com>.

4. **Motor Vehicle Report (MVR):** An MVR will be required if the applicant has 3 or more moving violations or any history of D.U.I. (driving under the influence) citations. MVRs can also be ordered at the underwriter’s discretion if s/he determines the applicant’s driving history will aid in making a decision on the case.

5. **Paramedical and Specific Tests:**

A paramedical includes testing of the applicant’s blood and urine. Vitals, including height and weight, are also taken at that time. The underwriter may also request an EKG. An examination, blood test and urinalysis will be required for all applicants ages 45 and over if not replacing prior insurance **and** have not seen a doctor in the past 2 years. These tests will also be required

for all applicants ages 60 and over who have not seen a doctor within 1 year of the application date.

Height and Weight Guidelines

The following *Height and Weight Tables* may be used as a guide to the eligibility of overweight individuals provided there are no other medical impairments. We may require a paramedical examination to confirm an applicant’s height and weight. If you have questions about heights/weights not listed on these charts, please contact the IAC Underwriting Department or your Marketing Representative for assistance. (The height/weight guidelines are different in the state of South Dakota. Contact your Marketing Representative for the South Dakota build chart.)

| MALE Height and Weight Table Ages 15 and Over | | | | | |
|--|---------|-------------|-------------|-------------|---------|
| Height | Normal | 20% rate up | 50% rate up | 70% rate up | Decline |
| 4' 10" | 100-174 | 175-191 | 192-208 | 209-226 | 227+ |
| 4' 11" | 102-178 | 179-196 | 197-214 | 215-232 | 233+ |
| 5' 0" | 103-181 | 182-199 | 200-217 | 218-235 | 236+ |
| 5' 1" | 105-183 | 184-201 | 202-219 | 220-237 | 238+ |
| 5' 2" | 106-186 | 187-205 | 206-224 | 225-243 | 244+ |
| 5' 3" | 109-190 | 191-209 | 210-228 | 229-247 | 248+ |
| 5' 4" | 112-196 | 197-216 | 217-236 | 237-256 | 257+ |
| 5' 5" | 115-202 | 203-222 | 223-242 | 243-262 | 263+ |
| 5' 6" | 118-207 | 208-228 | 229-249 | 250-270 | 271+ |
| 5' 7" | 122-213 | 214-234 | 235-255 | 256-276 | 277+ |
| 5' 8" | 126-220 | 221-242 | 243-264 | 265-286 | 287+ |
| 5' 9" | 130-227 | 228-250 | 251-274 | 275-296 | 297+ |
| 5' 10" | 134-230 | 231-253 | 254-276 | 277-299 | 300+ |
| 5' 11" | 138-236 | 237-260 | 261-284 | 285-308 | 309+ |
| 6' 0" | 142-240 | 241-264 | 265-288 | 289-312 | 313+ |
| 6' 1" | 147-248 | 249-273 | 274-298 | 299-323 | 324+ |
| 6' 2" | 153-253 | 254-278 | 279-303 | 304-328 | 329+ |
| 6' 3" | 158-261 | 262-287 | 288-313 | 314-339 | 340+ |
| 6' 4" | 163-269 | 270-306 | 307-333 | 334-360 | 361+ |
| 6' 5" | 169-275 | 276-313 | 314-340 | 341-368 | 369+ |
| 6' 6" | 174-282 | 283-320 | 321-348 | 349-377 | 378+ |
| 6' 7" | 178-290 | 291-330 | 331-359 | 360-389 | 390+ |
| 6' 8" | 182-296 | 297-337 | 338-367 | 368-398 | 399+ |
| 6' 9" | 186-303 | 304-345 | 346-375 | 376-407 | 408+ |
| 6' 10" | 190-308 | 309-351 | 352-382 | 383-415 | 416+ |
| 6' 11" | 194-316 | 317-360 | 361-392 | 393-426 | 427+ |
| 7' 0" | 198-322 | 323-367 | 368-400 | 401-435 | 436+ |

| FEMALE Height and Weight Table Ages 15 and Over | | | | | |
|--|---------|-------------|-------------|-------------|---------|
| Height | Normal | 20% rate up | 50% rate up | 70% rate up | Decline |
| 4'10" | 90-155 | 156-170 | 171-182 | 183-196 | 197+ |
| 4'11" | 90-160 | 161-175 | 176-187 | 188-199 | 200+ |
| 5'0" | 94-165 | 166-180 | 181-192 | 193-204 | 205+ |
| 5'1" | 96-170 | 171-185 | 186-198 | 199-209 | 210+ |
| 5'2" | 97-175 | 176-190 | 191-203 | 204-214 | 215+ |
| 5'3" | 99-180 | 181-195 | 196-208 | 209-219 | 220+ |
| 5'4" | 102-185 | 186-200 | 201-214 | 215-226 | 227+ |
| 5'5" | 105-190 | 191-205 | 206-219 | 220-231 | 232+ |
| 5'6" | 108-195 | 196-210 | 211-224 | 225-236 | 237+ |
| 5'7" | 111-200 | 201-215 | 216-230 | 231-241 | 242+ |
| 5'8" | 115-205 | 206-220 | 221-235 | 236-246 | 247+ |
| 5'9" | 118-212 | 213-228 | 229-242 | 243-256 | 257+ |
| 5'10" | 122-219 | 220-235 | 236-249 | 250-263 | 264+ |
| 5'11" | 125-225 | 226-242 | 243-258 | 259-271 | 272+ |
| 6'0" | 129-230 | 231-250 | 251-267 | 268-281 | 282+ |
| 6'1" | 132-238 | 239-257 | 258-275 | 276-289 | 290+ |
| 6'2" | 135-245 | 246-265 | 266-280 | 281-296 | 297+ |
| 6'3" | 138-250 | 251-270 | 271-285 | 286-301 | 302+ |
| 6'4" | 142-255 | 256-276 | 277-295 | 296-306 | 307+ |
| 6'5" | 146-260 | 261-285 | 286-300 | 301-311 | 312+ |
| 6'6" | 150-265 | 266-290 | 291-305 | 306-316 | 317+ |

| JUVENILE Height and Weight Table Ages 14 and Under | | |
|---|----------------|----------------|
| Ages 0 to 2 | | |
| Height Inches | Weight Minimum | Weight Maximum |
| 24 | 8 | 23 |
| 26 | 10 | 26 |
| 28 | 13 | 31 |
| 30 | 15 | 36 |
| 32 | 18 | 40 |
| 34 | 21 | 42 |
| 36 | 23 | 45 |
| 38 | 26 | 48 |
| 40 | 29 | 52 |
| Ages 3-9 | | |
| 30 | 18 | 40 |
| 34 | 22 | 44 |
| 38 | 26 | 54 |
| 42 | 32 | 64 |
| 46 | 38 | 78 |
| 50 | 46 | 94 |
| 54 | 56 | 111 |
| 58 | 66 | 128 |
| Ages 10-14 | | |
| 48 | 44 | 92 |

| | | |
|----|-----|-----|
| 52 | 54 | 108 |
| 56 | 63 | 126 |
| 60 | 74 | 144 |
| 64 | 87 | 166 |
| 68 | 100 | 186 |
| 72 | 113 | 206 |
| 76 | 126 | 228 |

Preferred Rating

A lower, preferred rating is available for qualified applicants. A qualified applicant is defined as someone that must:

- be the proposed insured or spouse (preferred rates are not available for dependent children);
- be age 18 or older, but not older than age 50;
- not have a condition that would result in a health exclusion rider or health rate-up at any level of benefit for the plan; and
- be able to appropriately answer the questions on the Application for Preferred Underwriting Classifications.

If applying for a preferred rating, the Application for Preferred Underwriting Classifications must be completed and submitted with the application. The applicant applying for a preferred rate must also be within the following build charts:

| Preferred Rating Height and Weight Table | | | |
|--|---------|--------|---------|
| Male | | Female | |
| Height | Weight | Height | Weight |
| 5'0" | 105-152 | 4'10" | 90-128 |
| 5'1" | 110-155 | 4'11" | 92-130 |
| 5'2" | 113-159 | 5'0" | 94-133 |
| 5'3" | 115-162 | 5'1" | 96-136 |
| 5'4" | 117-166 | 5'2" | 98-140 |
| 5'5" | 120-171 | 5'3" | 101-143 |
| 5'6" | 122-175 | 5'4" | 104-147 |
| 5'7" | 125-181 | 5'5" | 107-151 |
| 5'8" | 128-186 | 5'6" | 109-156 |
| 5'9" | 131-191 | 5'7" | 112-160 |
| 5'10" | 134-197 | 5'8" | 115-165 |
| 5'11" | 138-203 | 5'9" | 118-172 |
| 6'0" | 142-208 | 5'10" | 122-178 |
| 6'1" | 147-215 | 5'11" | 125-183 |
| 6'2" | 153-220 | 6'0" | 129-188 |
| 6'3" | 158-226 | 6'1" | 132-192 |
| 6'4" | 163-232 | 6'2" | 135-198 |
| 6'5" | 169-240 | 6'3" | 138-204 |

Co-Morbidity Factor

IAC considers applicants with more than one coronary risk factor to present a greater risk than the sum of medical loads for these conditions could address. As a result, underwriting will assess an additional premium load of 25% to applicants with two coronary risk factors and an additional premium load of 40% to applicants who have three coronary risk factors. Applicants with more than three coronary risk factors will be declined.

Underwriting considers the following conditions to constitute a coronary risk factor for underwriting purposes: hypertension (high blood pressure), elevated or treated cholesterol, obesity requiring a medical load and tobacco use. Any combination of two or more of these conditions will require a co-morbidity underwriting load or possible declination of coverage as indicated above.

Expectant Parenthood

No member of the family may be pregnant or be an expectant parent at the time the application is being written (whether or not applying for coverage). Current pregnancy is a medical condition that is **not** acceptable for applicants under the mPowerMed plan. Also, no family member may have received infertility treatment or have started the process of adoption within the 12 months prior to the application. This restriction applies to child-only plans as well.

Disabled Applicants *(may vary by state)*

Applicants who are currently disabled and/or receiving disability benefits are ineligible for coverage under the mPowerMed plan.

Unacceptable Health Conditions

(may vary by state)

Each person to be covered must qualify medically as determined in accordance with the Company's underwriting guidelines. Persons with serious existing health conditions may not qualify for coverage. Individuals who are contemplating surgery or hospitalization or who have undiagnosed ailments or symptoms indicating a potentially serious condition will not be accepted. Some conditions may be considered if there has been remission for at least 10 years.

Refer to the list below for unacceptable health conditions that would result in a declination of coverage. Please note that not every unacceptable health condition may be listed.

- Addison's Disease
- AIDS/ARC/HIV & other immune disorders
- Alcoholism, alcohol abuse
- ALS (Lou Gehrig's Disease)
- Alzheimer's Disease
- Amputation – disease related
- Aneurysm
- Angina Pectoris
- Anorexia Nervosa (within 2 years)
- Anxiety Disorders (selected)
- Aplastic Anemia

- Arteriosclerosis
- Atherosclerosis
- Autism
- Bechet's Syndrome
- Bipolar Disorder (within 7 years)
- Boeck's Sarcoid
- Bone Marrow Transplant
- Brain Tumor
- Buerger's Disease
- Bulimia
- Bypass Surgery
- Cancer – excluding skin cancer
- Cardiac Pacemaker
- Cardiomyopathy
- Cerebral Palsy
- Cirrhosis of the Liver
- Combined System Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Coronary Bypass Surgery
- Crohn's Disease (within 4 years)
- Diabetes
- Drug Abuse/Addiction
- Emphysema
- Endocarditis
- Epilepsy (Grand Mal)
- Fetal Alcohol Syndrome
- Gangrene
- Gastrionoma
- Gaucher's Disease
- Heart Attack/Disease
- Hemophilia
- Hodgkin's Disease
- Huntington's Chorea
- Hydrocephalus
- Juvenile Arthritis
- Leukemia
- Lupus Erythematosus
- Lymphoma
- Malignant Melanoma (within 5 years)
- Marfan's Syndrome
- Meneires Disease (within 3 years)
- Mental Retardation
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Myelofibrosis
- Myocardial Infarction
- Nephrosclerosis
- Organ Transplant
- Organic Brain Syndrome
- Pacemaker
- Paralysis
- Parkinson's Disease
- Polycythemia
- Polymyositis
- Porphuria
- Pregnancy/Infertility
- Primary Pulmonary Hypertension
- Prosthetic Heart Valve
- Psychotic Disorders
- Pulmonary Embolism
- Pulmonic Steriosis
- Renal Disease (ESRD)

- Scleroderma
- Sickle Cell Anemia
- Simmond's Disease
- Stroke
- Suicide Attempt
- Syphilis
- Ventricular Fibrillation
- Whipple's Disease

Term Life Insurance Underwriting Guidelines

The optional term life insurance benefit will not be offered if the primary applicant has any of the following:

1. Two or more co-morbidities which include the following: smoking, build, hypertension and hyperlipidemia;
2. A build load of 50% or more; or
3. Participates or engages in a hazardous sport or activity including private aviation.

Submitting an Application

Checklist for New Applicant

The following must be sent to apply for coverage:

1. **The Application:** The application can be faxed to IAC. A copy of the check is required with the fax if a direct billing mode is selected. After submitting an application via fax, send the original check to IAC. The original application does not need to be sent unless requested by the Underwriting Department.
2. **First Month's Payment:** If electing monthly credit card or bank withdrawal, the Monthly Automatic Payment Plan form must be completed and submitted with the application. The initial payment will be completed through the selected monthly payment arrangement. If electing a quarterly or semi-annual direct bill, a check made payable to MNL for the first month's premium must be submitted with the application. The applicant's payment must include the one-time application fee, administrative fee and association dues. Post-dated checks, checking deposit slips and agency checks are not acceptable. Premium checks are cashed when received.
3. **HIPAA Authorization for Release of Health Related Information:** This signed form is required with every application.
4. **Copy of the Premium Quote:** A copy of the computer quote calculated for the applicant will be requested if the system rates do not match the application. Premium rates are based on resident state. The effective date also determines the premium rate since rates change monthly based on a trend factor.
5. **Preferred Rating Questionnaire:** *(Optional)* This form must be completed and signed by those applicants (primary and/or spouse) applying for the lower, preferred rating.

6. **Monthly Automatic Payment Plan:** *(Optional)* If the client chooses to be billed via monthly bank draft or monthly credit card charge the monthly automatic payment plan section must be completed. Automatic payment is only available on a monthly basis and occurs on the 1st of each month.
7. **HSA Application and Custodial Agreement or HSA Attestation Form:** *(Optional)* Complete the HSA application and custodial agreement if selecting the Freedom HSA to accompany an HSA5 plan or HSA Attestation form if you intend to use a different HSA administrator with the HSA5 plan.
8. **Confirmation of Sole Employee Entity:** *(GA, KS, MI, NC, OK, TN, VA and WI)* In these states, a business check will be accepted by IAC only if this form is completed and sent with the application. The client must read and sign that he/she agrees to all the conditions listed on this form.
9. **Individual Health Plan List Bill Election Form:** *(Optional)* This form must be read and signed by the insured that is requesting his/her health insurance premium be included on a list bill.
10. **List Bill/Payroll Deduction Form:** *(Optional)* The employer or originator of a list bill must complete this form in order to create a billing to include more than one health insurance certificate/policy. **List bill availability varies by state.**

Additional forms may be needed based on state requirements.

Pre-Existing Conditions

Pre-Existing Conditions - 12/12/24

The policy defines a pre-existing condition as: a condition, whether physical or mental and regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was received within the 12-months immediately preceding the effective date of coverage.

A pre-existing condition will be considered a covered charge at the end of a continuous 12-month period following the covered person's effective date of coverage if no medical advice, diagnosis, care or treatment in connection with the injury or sickness has been received. Otherwise, pre-existing conditions will be considered covered charges after 24-months of continuous coverage, unless specifically excluded by the certificate.

Pre-existing condition definitions and time limits may vary by state. Contact your Marketing Representative for state-specific information.

Full Disclosure of Health Conditions

Health conditions that are fully disclosed in writing on the mPowerMed plan application will be covered from the effective date of coverage, provided the condition is not specifically excluded (except where prohibited by state regulation) by endorsement or exclusionary rider attached to the policy or certificate. Therefore, the pre-existing condition limitation will not apply to conditions that are fully disclosed.

Underwriting Decisions

After review of the application and all medical information, the underwriter will make one, or a combination of, the following decisions: issue the application as applied, offer an exclusionary rider, offer a rating on one or more applicants, offer a higher deductible or decline the application. The actual certificate/policy of insurance can be issued and delivered only if the applicant accepts the modified coverage within the allotted time frame by signing, dating and returning any required acceptance forms to IAC. Underwriting decisions and requirements can be found on the <http://thinkihc.iacusa.com> Web site.

- **Issued as Applied:**

An application that is approved exactly as applied for is a “standard” issue.

- **Exclusionary Riders:**

Coverage may be available for applicants with certain medical conditions if a medical exclusionary rider is issued for treatment related to that condition. Exclusionary riders are permanent and do not expire (may vary by state law). There is a maximum of three riders per applicant. If an applicant is offered an exclusionary rider, it must be returned or verbally accepted within 30 days of notification or the case will be closed out. The rider is mailed and posted to the Web site for you, the producer. Consideration to remove the rider may be given after coverage has been in force for at least 12 months. The certificate/policy holder must

request in writing that the rider be removed and provide medical records concerning any medical care or treatment relating to the excluded condition. Following are examples of medical conditions likely to require exclusionary riders:

- Allergies
- Phlebitis
- Arthritis, Osteoarthritis
- Endometriosis
- Ulcer
- Asthma
- Gall Stones, un-operated
- Back or Neck Disorder
- Glaucoma
- Bells Palsy
- Hernia, present
- Varicose Veins
- Carpal Tunnel Syndrome
- Joint Replacement/Knee Disorders
- Cataracts
- Menstrual Disorders
- Disc Surgery, within 5 years
- Migraine Headaches
- Ulcerative Colitis
- Ear Infections and Disorders, recurrent

Exclusionary riders may also be issued to exclude coverage for medical services incurred as a result of participation in a hazardous activity. For example, if the applicant participates in rodeo activities as a hobby (not on a full-time basis), the certificate/policy may or could be issued with a rodeo exclusion rider and medical expenses resulting from the activity would not be covered.

Empowered Underwriting Matrix

The conditions listed in the charts below will be accepted “standard” (without a rider or premium rate-up) if the selected plan deductible is at least the amount in the column heading. For example, under the \$5,000 deductible column, “Benign Prostatic Hypertrophy - minimal symptoms, controlled with medications” will be issued standard with a \$5,000 deductible or higher.

| \$1,500 Deductible Minimum | |
|--|--|
| Acne – No treatment in the last three months, no past or future treatments with Accutaine | Hypothyroidism – Controlled with thyroid replacement medications |
| Allergies – No other chronic respiratory conditions – with or without allergy shots | Indigestion, Gastroenteritis – Occasional attacks, evaluation fails to reveal cause |
| Anemia – Iron deficiency, present, mild, cause known | Lipoma – Small, asymptomatic, no surgery indicated |
| Anxiety Disorder – Situational, no counseling in the last 6 months. Rate or rider for medications only as needed | Mitral Valve Prolapse – Asymptomatic, incidental finding |
| Asthma – Mild, controlled with one inhaler. Empowered Underwriting is not available to smokers or children under age 3 | Menopausal Syndrome – Non-disabling, controlled with single medication |
| Baker’s Cyst – Present | Myopia – Un-operated, no other eye disorder |
| Bartholin’s Cyst – Present | Ovarian Cyst – Under age 45, single cyst, asymptomatic adequate investigation to rule out malignancy |

| \$1,500 Deductible Minimum <i>continued</i> | |
|---|--|
| Blepharitis, Blethorospasm Bursitis or Tendonitis | Pre-Menstrual Syndrome – Mild, non-disabling, controlled with one medication only |
| Condyloma Acuminatum - (genital warts) With recovery of at least one year, no other sexually transmitted diseases | Prostatitis – Single occurrence, recovered |
| Deviated Septum – Congenital after surgery | Ptergium Radiculitis – Single episode, complete recovery |
| Eczema (mild) Dermatitis, Keratosis or other mild skin condition | Sebaceous Cyst– Small, asymptomatic, no surgery indicated |
| GERD – Infrequent and stable | Sinus Tachycardia – Pulse rate to 100, no known coronary disease |
| Headaches or Migraines – Once evaluation and initial work up have been completed | Sinusitis – Chronic or acute, not current |
| Heart Murmurs – Discribed as functional, systolic grades i or ii only | Spinal Sprain or Strain – Single episode, complete recovery, no disc bulge or herniation |
| Hemorrhoids – Asymptomatic | Spinal Manipulation – Up to 12 visits per year, no underlying physical impairment |
| Hepatitis A and E – Complete recovery, normal LFTs | Urethritis – Acute, recovered |
| Herpes Simplex II – Genital, nor current Rx | Vaginitis – Complete recovery |
| Hyperthyroidism – 1 year post treatment with radioactive iodine, no goiter, no other thyroid conditions | Varicose Veins – Mild, asymptomatic, surface veins only, no surgery indicated |

| \$2,500 Deductible Minimum | |
|--|--|
| Acne – Currently treated, no Accutaine in past or anticipated | Labrynthitis – Stable, non-disabling, worked up with no evidence of neurological disease |
| Arteriosclerosis, Atherosclerosis – Mild, incidental finding on x-ray only. Ages 55 and over, no co-morbidities. | Marijuana Use – Once a month or less, no other criticisms, ages 25 and over |
| Attention Deficit Disorder - Controlled with meds, no counseling required or evidence of aggressive behavior. No anti-psychotic medications. | Meniere’s Disease – Stable, no serious underlying cause identified |
| Basal Cell Carcinoma – Single incident, recovered | Osteoarthritis – Up to age 50 at time of diagnosis, confined to a specific joint, no history of opioids, corticosteroid injections or hyaluronic acid injections |
| Blindness – From birth or caused by trauma only | Osteopenia, Osteoporosis – No symptoms, no other conditions |
| Bone Spur – Asymptomatic, no surgery required | Pilonidal Cyst – Asymptomatic or drained only with a complete recovery |
| Breast Implants – Not associated with cancer or breast disorders | Premenstrual Syndrome (PMS) – Mild or moderate |
| Carpal Tunnel Syndrome – Mild or resolved, no future surgery required | Pylonephritis, Pyelitis – Complete recovery |
| Chronic Otitis Media – Chronic, with or without ear tubes | Reynaud’s Disease or Phenomemom – Stable, mild to moderate |
| Conjunctivitis Dysfunctional Uterine Bleeding – Current, controlled with birth control pills | Reactive Airway Disease – Mild to moderate, non-disabling, controlled with inhaler |
| Diverticulosis – No inflammation, asymptomatic, incidental finding | Restless Leg Syndrome – Other neurological problems ruled out |
| Dysmenorrea – With normal Pap Smear | Sexually Transmitted Disease (Not AIDS or ARC) – Single episode, complete recovery |
| Gout – No history of kidney stones or other related impairments | Sleep Apnea – After successful surgery only, no coronary disease |
| Hernia – Not symptomatic, incidental findings only, not inguinal | Tuberculosis – Positive serology without disease manifestation, serology positive a minimum of 1 year |
| Irritable Bowel Syndrome – Mild, infrequent attacks, no evidence of colitis | Vertigo – Occasional, mild with work up to rule out underlying neurological disease |
| Kidney Stones – Single attack, pass spontaneously | |

| \$5,000 Deductible Minimum | |
|--|---|
| Anxiety – Moderate, over age 21 years | Orchitis – Recurrent, complete recovery |
| Basal Cell Carcinoma – Up to 3 episodes in past 2 years | Osteomyelitis – Complete recovery 6 months |
| Bells Palsy – Stable, not progressive | Paroxysmal Atrial Tachycardia – 2-3 attacks annually, no evidence of other heart disorders |
| Benign Prostatic Hypertrophy – Minimal symptoms, controlled with medications | Peptic Ulcer Disease – No malignancy of H-Pylori, complete recovery |
| Bunions, Hammer Toes – single foot only | Petit Mal Epilepsy – Work up to determine cause completed and no cause found, well controlled with infrequent episodes 1-2 year and complaint with meds |
| Cerebral Palsy – Ages 21 and over only, high functioning individuals only | Phlebitis – Superficial, no edema CR |
| Cervicitis – No erosion of the cervix noted | Polycystic Ovaries – No anticipated surgery |
| Cystitis – Chronic, non-interstitial only | Prostatitis – Recurrent, mild to moderate, present or CR |
| Chalazion Cholecystitis – One attack, recovered | Ruptured Ear Drum – Mild to moderate hearing loss |
| Chronic Fatigue Syndrome – Stable, non-disabling only | Sciatica – No herniation or bulging disc |
| Deafness – From birth or due to trauma only | Spinal Manipulation – Maintenance only, no indication of back or spine disorder |
| Depression – Moderate, over age 21 years | Spinal Strain or Sprain – Chronic, no herniated or bulging discs, not disabling |
| Diverticulitis – Single episode, no surgery required | Subluxation – Chiropractic treatment only, no evidence of herniated disc or bulging disc or disability |
| Erectile Dysfunction – No known coronary issues | Tourette’s Syndrome – Mild |
| Fibrocystic Breast Disease – No malignancy suspected | Tremor – Benign, non progressive, not attributed to Parkinson’s Disease or other diagnosed neurological disorder, thorough neurological work up performed |
| Fibromyalgia – Stable, non-disabling only | Tuberculosis – With disease manifestations, complete recovery 2 years |
| Mental Retardation – No physical impairment, no Down’s Syndrome, IQ of 60 or greater | Tumors – Class 6 or 7 excised, complete recovery 2 years |
| Neuritis – 3 or fewer episodes in the past 2 years | |

| \$10,000 Deductible Minimum | |
|--|--|
| C-Section Birth – No other complications | Hypertension – Controlled with 3 medications, well-controlled, no co-mobid conditions, one medication is a potassium supplement |
| Cataract – Un-operated, no imminent surgery | Lupus Erythematosus – Discoid, not systemic, stable or in remission for 2 years, worked up to rule out tumors or lesions, best cases only |
| COPD or Emphysema - Mild, incidental finding only, no symptoms of airway disease or shortness of breath, 50% with \$5,000 deductible | Passive-Aggressive Personality Disorder – Over 21 mild outbreaks of disorder only, controlled with meds, compliant with meds, rate for drugs as needed |
| Corneal Implant – Stable, no problems for minimum of 2 years | Pregnancy Complications – multiple miscarriage, eclampsia, pre-eclampsia |
| Gouty Arthritis – Stable, not progressive | Rectocele, Cystocele, Urethrocele – Present, no surgery indicated |
| Grand Mal Epilepsy – Evaluated to rule out brain lesion or other known cause, stable without seizure for 2 years, compliant with medications | Retinitis Pigmentosa Tumor – Class 3, 4 or 5, complete recovery 2 years |
| Glaucoma – Stable, controlled with drops, no surgery anticipated | Renal Cyst – One kidney only, no impaired function of either kidney, incidental finding only |

The following guidelines apply when considering a condition for empowered underwriting on plans with a family high deductible health plan.

To calculate the deductible to apply to each family member:

- Divide the family deductible by 2 if the application contains between 2 and 4 applicants to obtain the allowable deductible for each individual family member.
- Divide the family deductible by 3 if the application contains 5 or more applicants to obtain the allowable deductible for each individual family member.
- Utilize the individual allowable deductible to determine if a condition is eligible for deductible underwriting utilizing the empowered underwriting matrix above.
- The individual allowable deductible must be at least the amount of the minimum deductible allowed for empowerment for the condition in question.

Examples:

1. A family of 2 applies for a plan with a \$2,500 family deductible. The deductible is divided by 2, leaving each family member with a \$1,250 allowable individual deductible. Since the minimum deductible considered for empowered underwriting is \$1,500, no special consideration is allowed.
 2. A family of 7 applies for a \$10,000 family deductible plan. The family deductible is divided by 3, leaving each family member with a \$3,333 individual allowable deductible. In this example, each family member is eligible for empowered underwriting consideration for any condition that requires a minimum deductible of \$1,500 or \$2,500.
- **Rating:**
An application can be approved with a rating. A rating will increase the premium of the certificate. The minimum rating issued on an applicant is 5% and the maximum is 100%, increasing in 5% increments. Common medical impairments that usually warrant a rating include elevated blood pressure or a build that falls outside the height/weight guidelines.
 - **Higher Deductible:**
In order to lower the Company's risk on a certain individual, the underwriter may offer the applicant coverage with a deductible higher than initially requested. Increasing the deductible may also be a way to lower a rating and therefore keep premium as low as possible (*see the Empowered Underwriting Matrix above*).
 - **Decline:**
In the event that the underwriter feels that more than three exclusionary riders or more than a 100% rating are needed, the application will be declined. Certain health conditions will be declined upon receipt of the application due to the severity of the condition. See above "Unacceptable Health Conditions" for a list of these declined conditions.

Please note: if the applicant is a HIPAA Eligible Individual in a Federal Fallback state, we cannot decline coverage.

Application Withdrawals

In order to withdraw an application, either you or the applicant must submit a written request to discontinue the underwriting process. The submitted premium will be returned to the applicant. If the applicant wishes to re-apply at a later date, a new fully completed, currently dated application and new application fee will be required.

Requirements to Place

Pending Requirements

Correspondence for pending requirements is published on <http://thinkihc.iacusa.com> and an e-mail notification is sent to you. Requirements must be received within 60 days of application date to avoid closing the case.

Exclusionary Riders

The rider must be signed by the primary applicant and returned to IAC or must be verbally accepted within 15 days of notification before the case can be placed in force. An electronic/faxed copy of the rider is acceptable.

Premium Rating

If a case is rated, the applicant must accept the premium rating by signing an amendment. Coverage can be placed in force once acceptance is given and if 85% of the required premium has been paid.

Any premium shortages due to a rating are balance billed to the insured.

Producer Kit/Delivery Certificate

All issued certificates and ID cards are mailed to you, or the insured, as selected on the application. Any outstanding delivery requirements must be completed and returned within 30 days of the date they were mailed.

Effective Dates and Billing

Effective Dates

The applicant may request a plan effective date of either the 1st or 15th of the month. IAC must receive the application for insurance on or before the requested effective date. IAC will honor the effective date requested if they can approve the application within 15 days of the requested date.

If the applicant is replacing coverage, it may be in his/her best interest to elect an effective date of the 1st of the month following approval and keep his/her current coverage in force until notice of approval is received.

Please note: a requested effective date cannot be changed once the certificate are issued. You have up to 60 days to

submit all underwriting requirements based on the date the application was signed. After 60 days, the case will be closed out.

***** Never advise an applicant to cancel existing health coverage until approved by the Company and accepted by the client. *****

Billing

Premium is due by the 1st of the month. If a 15th of the month effective date and 1st of the month draft date are requested, IAC will generate a billing statement at the time of issue for a half-month premium to get the plan on the 1st of the month billing cycle.

Billing Modes and Options

The mPowerMed plan allows for automatic bank draft or credit card charge on a monthly basis or direct billing quarterly or semi-annually.

After the Sale

Inforce Health Insurance Changes

| Type of Change | Requirements | UW Required? | IAC Action |
|--|--|--------------|--|
| Name | Written request and legal documentation | No | Letter confirming the change, new certificate face page and ID cards will be sent to the insured |
| Address | Phone or written request | No | Letter confirming the change sent to the insured |
| Newborn Baby Addition | Written request within 31 days | No | Letter confirming the addition, new certificate face page and ID cards will be sent to the insured |
| | ----- Completed application if after 31 days | Yes | |
| Add a Family Member (other than newborn) | Completed application | Yes | Letter confirming the addition, certificate face page and ID card sent to the insured |
| Remove a Family Member (other than main insured) | Written request from the primary insured | No | Letter confirming the change, new certificate face page and ID card sent to the insured |
| Mode of Payment – from direct bill to monthly bank draft and credit card | Written request, Monthly Automatic Payment Plan form and voided check, if needed | No | Letter to notify of change and amount to be drafted |
| Mode of Payment – automatic monthly payment to direct bill | Phone or written request | No | Revised billing mailed |
| Lower Deductible | Written request from the primary insured with new completed medical section of the application | Yes | If approved, letter confirming the change, new certificate face page and ID card (if affected by the change). If declined, letter is sent notifying insured of decision. |
| Increase Deductible | Written request from the primary insured | No | Letter confirming the change, new certificate face page and ID card (if affected by the change) |
| Add Outpatient Accident Rider | Written request from the primary insured | Yes | Letter confirming the change and new certificate face page sent to the insured |
| Modify Prescription Drug Benefit | Written request from the primary insured with new completed medical section of the application | Yes | If approved, letter confirming the change and new certificate face page. If declined, letter is sent notifying insured of decision. |
| Remove a Benefit Rider | Written request from the primary insured | No | Letter confirming the change and new certificate face page sent to the insured |
| PPO Network Change | Written request from the primary insured | No | Letter confirming the change and new ID card sent to the insured |

| Type of Change | Requirements | UW Required? | IAC Action |
|--|--|--------------|--|
| Request for Removal of an Exclusionary Rider or Rating | After 12-months coverage, written request from the primary insured and all medical records regarding the condition at the insured's expense | Yes | If approved, letter confirming the change is sent to the insured. If declined, letter is sent notifying insured of decision is sent. |
| Termination of Coverage | Written Request from the Primary Insured Note: Terminations are made effective on the 1st of the month following receipt of the request or the last fully paid month | No | Letter to confirm the termination and Certificate of Creditable Coverage sent to insured |

Adding or removing benefits or dependents, making plan changes, etc. are all effective on the 1st or 15th of the month depending on your selected effective date following approval and/or receipt of the request. You are copied on all correspondence.

Medical Claim Review

Claims received at IAC that are inconsistent with information provided on the application or may be subject to a pre-existing condition limitation are sent to Medical Review. When a claim is reviewed, the analyst will look at the original application, telephone interview, prior coverage and determination of HIPAA eligibility. Investigations will determine if the condition on the claim is a pre-existing condition or if there was a material misrepresentation in the application. You and insured will be sent correspondence providing the status of the medical review process.

Rescission or Reformation of Coverage

False or misleading information on the application may be the basis for rescission or reformation of coverage. Rescission voids the coverage back to the effective date. Reformation allows a rating to be applied or an exclusionary rider to be added to the policy back to the effective date. Be sure that the applicant completes the application accurately, including all answers to medical questions and height and weight information.

Reinstatement of Coverage

All premiums are due the 1st or the 15th of the month and must be postmarked prior to the expiration of the 31-day grace period to be accepted as timely. Reinstatement provisions allow for a single exception in a 24-month period, provided all premiums due are postmarked within 20 calendar days immediately following the expiration of the 31-day grace period. An application and all premium due is required to re-evaluate the health status of proposed insureds. Additional underwriting requirements may be requested at the time of reinstatement. Reinstatement will only be approved if the original underwriting decision is still valid. If a rider or rating would now be required to approve the case, the reinstatement will be denied. If approved, the reinstated coverage would be continuous from the original effective date. Reinstatement is not allowed for insureds that have submitted a written request to cancel coverage.

Continuation

Continuation of coverage is available to dependents that lose eligibility. A request for the dependent to continue on his/her own certificate must be received within 31 days of the status-changing event. If approved, the dependent will have the same benefits as the certificate from which s/he converted.

Turning Age 65 – Medicare Eligibility

A notice will be sent 90 days in advance of an existing insured turning age 65 and therefore, eligible for Medicare coverage. Individuals who are already covered under this plan prior to reaching Medicare eligible age may continue coverage. Benefits will be provided secondary to Medicare. The plan does not automatically terminate when the insured turns age 65.