mPowerMed

Producer Guide

IHC Health Solutions
Independence Holding Group

This guide contains important information about the mPowerMed individual and family major medical plans which are underwritten by Madison National Life Insurance Company, Inc. (MNL). The plans are administered by IHC Health Solutions and, in most states, are only available to members of Communicating for America, Inc. (CA).

Included in this guide is a general overview of the company's current new business procedures and underwriting guidelines to help you, the producer, facilitate prompt review, processing and issuance or your new cases. The information provided is subject to change and is not guaranteed to apply in every circumstance.

Throughout this guide, producer/agents will be referred to as "you", and the plan administrator will be referred to as "IHC Health Solutions," "us," or "we." The insurance carrier may be referred to as "the Company."

For additional information about mPowerMed, MNL or CA, please refer to the following documents:

- Product brochure
- Enrollment application
- IHC's producer agreement
- Policy forms

State-specific benefits or regulations are not addressed in this guide. Please contact your IHC sales representative if you have questions about situations or topics not covered within this document.

Important Addresses and Phone Numbers

Underwriting and Inforce Administration—IHC Health Solutions

Underwriting
1173 W. Main St. Suite E
Whitewater, WI 53190
866-472-6555
602-674-9015 Fax
underwriting@ihcgroup.com

Administration and Billing
P.O. Box 37457
Phoenix, AZ 85069-7457
800-518-4510
602-906-4745 Fax
policyservices@ihcgroup.com

Claims
866-574-3260
515-316-6730 Fax
claims@ihcgroup.com

Customer Care and Retention Unit
888-206-5610

Communicating for America, Inc. (CA)

P.O. Box 677
112 E. Lincoln Avenue
Fergus Falls, MN 56537
800-432-3276
218-739-3832 Fax
memberbenefits@cainc.org

Producer Guidelines

Always provide the application with full information relative to the plan(s) you are presenting. Describe the benefits and requirements, including precertification, pre-existing condition limitations, exclusions, managed care, satisfaction of

deductibles, coinsurance and copayments. Contact your IHC sales representative if you have questions that are not answered by the brochure, policy forms, application or this producer guide.

You are not authorized to promise a specific effective date and you cannot bind coverage. You should always caution your applicant not to cancel any existing coverage until you have been notified by IHC Health Solutions that the application has been approved.

Appointment and Contracting

New Producers

In order to begin selling products available through IHC Health Solutions, you must be recommended through a general agent or IHC sales representative. In addition to becoming your point of contact for sales, service and training, this individual will assist you in determining contracting and appointment rules for the state(s) in which you do business.

If requesting appointment, you must have a current life/health license for each state in which you do business, be in good standing with the Department of Insurance and not have been convicted of a felony involving moral turpitude. If commissions are paid to an agency, some states require that the agency be licensed as well as the individual agent. Upon submission of your first case, provide your general agent or sales representative with the following properly completed, signed and dated documents:

- A legible photocopy of your current life/health insurance license(s) and, if applicable, a legible photocopy of your current life/health agency insurance license(s) for each state in which you do business
- An IHC Health Solutions Requisition for Agent Appointment form
- An IHC Health Solutions Producer's Agreement
- Compensation Schedule to Producer Agreement
- A Hierarchy Form

If you have requested an appointment without the submission of new business, we will not process your appointment request until new business is submitted. Please be advised that we will keep your appointment paperwork on file for 90 days from date of submission so we encourage you to submit new business as soon as possible to finalize the appointment process.

You will be notified when the insurance carrier appointment is completed and will be sent a copy of your executed Producer's Agreement. Until the insurance company completes your appointment, IHC Health Solutions may hold any commissions that are due.

Appointment /Administration fees

Resident and non-resident appointment fees, if applicable, for MNL will not be required when accompanied by new business. A $20 administration fee will be assessed annually.

Commissions

You will receive monthly commissions, as earned, subject to the terms and conditions of the IHC Health Solutions Producer's Agreement. Commissions are paid on the 7th of the month for premium that has been received and posted between the 16th and last day of the previous month. Commissions are paid on the 21st of the month for premium that has been received and posted between the 1st and the 15th of the current month, providing that the amount is greater than $25. Commission amounts less than $25 will forward to your next month's commission statement, subject to the same minimums.

If, for any reason, the company refunds premium on a policy you have written and been paid commission, you will be required to repay the commission amount received on the refunded premium. Such adjustments will be reflected on your commission statement.

To continue to receive commissions, the case must remain inforce, the premiums must be paid and you must actively service the account.

If you have any questions about commissions, please contact our commissions department at 800-920-7125.

Agent of Record Changes (AOR's)

If a case has not been inforce for 12 months an agent of record can be requested and processed, but the agent of record will not begin to receive commissions until the renewal of the policy. To grant first year commissions to the agent of record, a release letter from the original agent must be received. The writing agent can be changed on the case but the GA will remain the same for the life of the case.

A written request from the Insured is required for an individual case and it needs to contain the following items:

- Case name and number
- New agent name
- Insured's signature
- Insured's phone number
- It is recommended that the request be printed or typed

A written request from a company is required for a group case and the request must be submitted on the company letterhead and signed by the owner or officer of the company and needs to contain the following items:

- Case name and number
- New agent name
- Owner/officer signature
- Owner/officer contact information
- The agent contracting department will contact the insured or group and verify the change request. Once the AOR has been confirmed, agent contracting will send notification to the original agent and the new agent to advise when the change will become effective. The change is effective the 1st of the month following 30 days of the receipt of all necessary documents.

Eligibility of Applicants

All applicants must complete an application and qualify for coverage according to the plan's underwriting guidelines.

Issue Ages for Individual or Family Coverage
Adult applicants must be 19 to 64 years of age. A spouse must be 18 to 64 years of age to be 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 under age 26. Child-only coverage is not available unless required by state law.

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 IHC Health Solutions 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 major medical plan being applied for must be available for sale in the applicant's primary state of residence and you must be licensed in that state. Benefits and premiums are based on those appropriate for the applicant's primary state of residence. Premiums are adjusted to reflect changes in residence when they occur. Please remember – a current life and health insurance license is required in each state you market and solicit business. State of residence will determine the licensing requirements to be listed as the agent of record for a submitted application.

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. Foreign

nationals must have resided in the United States for a minimum of six months prior to applying for coverage and must have established medical care in 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:

Visa Type	Description of Visa
DV-1	Diversity visa lottery winner (also known as the Green Card Lottery)
DV-2	Spouse and/or Children of Diversity visa lottery winner
EB-5	Immigrant Investors
H-1B	Specialty Occupations
H-1B1	Chile and Singapore Free Trade Agreement
H-1C	Registered Nurses participating in the nursing relief for disadvantaged areas
H-4	Spouses and children of H-1 visa holders
IR-1	Immediate relative of US citizen, spouse
IR-2	Immediate relative of US citizen, unmarried child under age 21
IR-3	Immediate relative of US citizen, Orphan adopted by US citizen, adoption finalized outside the US
IR-4	Immediate relative of US citizen, Orphan adopted by US citizen, adoption finalized inside the US
IR-5	Immediate relative of US citizen, Parent of US citizen, US citizen must be at least 12 years old
K-1	LIFE Act (Legal Immigration Family Equity Act), fiancée of US citizen
K-2	LIFE Act, children of fiancée of US citizen
K-3	LIFE Act, spouse of US citizen, visa pending
K-4	LIFE Act, children of US citizen, visa pending
L-1	Intra-Company transferees
L-2	Spouse and children of Intra-Company transferees
TN	NAFTA professional workers
TD	Spouse and children of NAFTA professional workers
V-1	LIFE Act (Legal Immigration Family Equity Act), spouse of permanent resident, visa pending
V-2	LIFE Act, children of permanent resident, visa pending
V-3	LIFE Act, dependents of V-1 and V-2, visa pending

Overseas Travelers
Persons to be covered must not be planning or considering extended foreign travel nor live outside the United States for more than three 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. 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.

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 an 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.

Disabled Applicants *(may vary by state)*
Applicants who are currently disabled and/or receiving disability benefits are ineligible for coverage.

Ineligible Occupations
Applicants employed in any of the fields listed below are not eligible for coverage due to the higher risk they present to the insurance carrier. Restrictions are applied only to the person(s) employed in a restricted occupation (applicant and/or spouse, not children). This list may not include all excluded occupations and is subject to change. 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.

- Adult Entertainment Workers (actors, dancers, escort service workers, etc.)
- Air Traffic Controllers
- Armed Forces Personnel
- Armed Security Guards
- 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
- Pyrotechnic Operators
- Roofers and Roofing Contractors*
- Structural Steel Workers*
- Surrogate Mother
- Tattoo Artists
- 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 and the likelihood the owner will perform the duties of the other employees in the event of a personnel shortage.

In the states of Florida and Michigan, residents cannot be declined due to occupation, but applicants employed in an occupation listed above will be subject to a 45 percent additional premium assessment.

Underwriting
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. **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 at the underwriter's discretion and on all applicants that:

- 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
- applying with children 2 years of age or younger.

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

IHC Health Solutions utilizes RDM out of Whitewater, Wisconsin to perform the health questionnaire process. RDM can be reached (toll free) at 855-648-8722 Monday through Friday from 8:00 a.m. to 6:00 p.m. CST. 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 website – www.myihcgroup.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 at the underwriter's discretion. If an APS is needed, IHC Health Solutions will request it and pay the physician's fee up to $100. If the physician's fee exceeds this amount, we will ask the applicant to pay the remaining amount over $100. **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 age 50-59 that has a combination of obesity or tobacco use and high blood pressure or elevated cholesterol. The status of a pending APS can be accessed using the website – www.myihcgroup.com.

4. **Motor Vehicle Report** *(MVR)*
An MVR will be required if the applicant has three 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. **Please remind your clients that paramedical exams and tests require fasting.** The underwriter may also request an EKG. An examination, blood test and urinalysis will be required for all applicants ages 50 and over if not replacing prior insurance **and** have not seen a doctor in the past two years. These tests will also be required for all applicants ages 60 and over who have not seen a doctor and had lab work completed within one 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 IHC underwriting department or sales representative for assistance.

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+

MALE Height and Weight Table – *South Dakota Only*
Ages 15 and Over

Height	Normal Weight	Ratable Weight	Decline
4’ 10”	100-174	175-208	209+
4’ 11”	102-178	179-214	215+
5’ 0”	103-181	182-217	218+
5’ 1”	105-183	184-219	220+
5’ 2”	106-186	187-224	225+
5’ 3”	109-190	191-228	229+
5’ 4”	112-196	197-236	237+
5’ 5”	115-202	203-242	243+
5’ 6”	118-207	208-249	250+
5’ 7”	122-213	214-255	256+
5’ 8”	126-220	221-264	265+
5’ 9”	130-227	228-274	275+
5’ 10”	134-230	231-276	277+

5’ 11”	138-236	237-284	285+
6’ 0”	142-240	241-288	289+
6’ 1”	147-248	249-298	299+
6’ 2”	153-253	254-303	304+
6’ 3”	158-261	262-313	314+
6’ 4”	163-269	270-333	334+
6’ 5”	169-275	276-340	341+
6’ 6”	174-282	283-348	349+
6’ 7”	178-290	291-359	360+
6’ 8”	182-296	297-367	368+
6’ 9”	186-303	304-375	376+
6’ 10”	190-308	309-382	383+
6’ 11”	194-316	317-392	393+
7’ 0”	198-322	323-400	401+

FEMALE Height and Weight Table – *South Dakota Only*

Ages 15 and Over

Height	Normal Weight	Ratable Weight	Decline
4’ 10”	90-155	156-182	183+
4’ 11”	90-160	161-187	188+
5’ 0”	94-165	166-192	193+
5’ 1”	96-170	171-198	199+
5’ 2”	97-175	176-203	204+
5’ 3”	99-180	181-208	209+
5’ 4”	102-185	186-214	215+
5’ 5”	105-190	191-219	220+
5’ 6”	108-195	196-224	225+
5’ 7”	111-200	201-230	231+
5’ 8”	115-205	206-235	236+
5’ 9”	118-212	213-242	243+
5’ 10”	122-219	200-249	250+
5’ 11”	125-225	226-258	259+
6’ 0”	129-230	231-267	268+
6’ 1”	132-238	239-275	276+
6’ 2”	135-245	246-280	281+
6’ 3”	138-250	251-285	286+
6’ 4”	142-255	256-295	296+
6’ 5”	146-260	261-300	301+
6’ 6”	150-265	266-305	306+

Juvenile Height and Weight Table

Ages 14 and under

Ages 0 - 2			Ages 3 - 9			Ages 10 - 14		
Height (In.)	Min.	Max.	Height (In.)	Min.	Max.	Height (In.)	Min.	Max.
24	8	23	30	18	40	48	44	92
25	9	24	31	19	41	49	46	96
26	10	26	32	20	42	50	49	100
27	11	28	33	21	43	51	52	104
28	13	31	34	22	44	52	54	108
29	14	33	35	23	46	53	56	113
30	15	36	36	24	49	54	58	118
31	17	38	37	25	51	55	60	122
32	18	40	38	26	54	56	63	126
33	20	41	39	27	56	57	65	131
34	21	42	40	28	59	58	68	135
35	22	44	41	30	61	59	71	140
36	23	45	42	32	64	60	74	144

37	25	47	43	33	68	61	77	149
38	26	48	44	34	72	62	80	154
39	28	50	45	36	75	63	83	160
40	29	52	46	38	78	64	87	166
			47	40	82	65	90	171
			48	42	86	66	93	176
			49	44	91	67	97	180
			50	46	94	68	100	186
			51	48	98	69	103	190
			52	50	102	70	107	195
			53	53	107	71	110	200
			54	56	111	72	113	206
			55	58	115	73	116	210
			56	60	119	74	120	216
			57	63	124	75	123	221
			58	66	128	76	126	228

Additional Height and Weight information

- Recent weight loss: If there has been weight loss within one year, divide the loss by two and add it to current weight before checking the table.
- Underweight applicants: Many underweight applicants will be declined due to the serious health concerns related to low body weight. However, in certain people of small physical stature, an underweight condition is normal and healthy. Medical records may be requested on underweight applicants.
- Removing or reducing a rating due to build: A reduction in rating due to build may be considered once an insured loses enough weight to qualify for the lower rating, and maintains the reduced weight for at least 12 months. Ratings will only be considered for removal at the insured's written request and expense, and will only be allowed on the anniversary of the effective date.

Preferred Rating

A lower, preferred rating may be available for the primary and/or spouse based on age and health history. The following criteria must be met in order to qualify for a preferred rate. The applicant and/or spouse must:

- Be age 18 through 49;
- Not have a condition that would result in a health exclusion rider or health rate-up at any level of benefit for the plan;
- Not have been treated for high blood pressure or have blood pressure readings in excess of 130/85;
- Not have a total cholesterol reading above 200 or treated for elevated cholesterol or triglycerides;
- Not have had a DUI, DWI or more than two moving violations in the past two years;
- Not be outside the weight range on the Preferred build chart below;
- Not be taking any prescription medication other than those used for acute medical conditions such as antibiotics or those for non-medical conditions such as birth control;
- Have had major medical insurance inforce within the past 90 days; and
- If age 40-49, have had a physical exam by a doctor that included evaluation of build, blood pressure and cholesterol within the past three years (a paramed exam does not fulfill this requirement).

If applying for a preferred rating, the Application for Preferred Underwriting Classifications must be completed and submitted **with the application**. A preferred rate cannot be applied if requested after the underwriting decision has been made. If empowered underwriting guidelines are used for any condition resulting in approval without an exclusionary rider, the preferred rates will still be removed on the applicant. Please note: Any application for a preferred rating will be required to complete a prescription medication inquiry and a telephone interview.

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

IHC Health Solutions considers applicants with more than one coronary risk factor to present a greater risk than the total medical load each condition could address. As a result, underwriting will assess an additional premium load of 25 percent to applicants with two coronary risk factors and an additional premium load of 40 percent to applicants who have three coronary risk factors. Applicants with more than three coronary risk factors will be declined. When medications are being used to control conditions that contribute to a co-morbidity load, a prescription load may be applied as well.

Underwriting considers the following conditions to constitute a coronary risk factor for underwriting purposes: hypertension (high blood pressure), elevated 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.

In addition to those listed above, the presence of respiratory conditions in an applicant who uses tobacco presents a high co-morbidity risk. Applicants who use tobacco and have a current or chronic respiratory disorder will be assessed a co-morbidity rating of 40 percent, in addition to any loads required for tobacco use or the respiratory condition under consideration.

The quoting software will automatically determine the appropriate load for co-morbidity factors including build (height/weight), tobacco use, hypertension (high blood pressure) and elevated or treated cholesterol.

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 ten 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
- Behcet’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
- Gastrinoma
- 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
- Meniere's 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
- Porphyria
- Pregnancy/Infertility
- Primary Pulmonary Hypertension
- Prosthetic Heart Valve
- Psychotic Disorders
- Pulmonary Embolism
- Pulmonic Stenosis
- Renal Disease (ESRD)
- Scleroderma
- Sickle Cell Anemia
- Simmond's Disease
- Stroke
- Suicide Attempt
- Syphilis
- Ventricular Fibrillation
- Whipple's Disease

Submitting an Application

Checklist for a New Applicant

When submitting a paper application, the following must be sent to apply for coverage:

1. **The Application**
   The application can be faxed or mailed to IHC Health Solutions. The original application does not need to be sent unless requested by the underwriting department.

2. **Payment of the Enrollment Fee**
   If electing monthly credit card or bank withdrawal, the Monthly Automatic Payment Plan form must be completed and submitted with the application. The enrollment fee will be charged to this credit card or bank account when the application is submitted and **the full monthly premium will be charged if/when the application is issued even if the coverage is issued or placed inforce prior to the effective date**. 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 completed and signed form is required with every application.

4. **Copy of the Premium Quote**
   A copy of the computer quote calculated for the applicant is required with the initial submission. Premium rates are based on numerous factors including resident state and mode of payment. The effective date also determines the premium since rates change monthly based on a trend factor.

5. **Application for Preferred Underwriting Classification** *(optional)*
   This form must be completed and signed by those applicants (primary and/or spouse) applying for a lower, preferred rating and submitted with the initial application.

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 day of the month the case is effective.

7. **HSA Application** (optional)
   Complete the HSA application and custodial agreement if selecting the Freedom HSA to accompany a mPowerMed high-deductible health plan.

8. **Confirmation of Sole Employee Entity** (optional)
   A business check will be accepted in the states of Florida, Georgia, Kansas, Michigan, North Carolina, Oklahoma, Tennessee, Virginia and Wisconsin only if the Confirmation of Sole Employee Entity form is sent with the application. The client must read and sign that he/she agrees to all of 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 that his/her health insurance premium be included on a list bill. See the List Bill Guidelines section below for additional list bill information.

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 billing requires paper applications. Be sure to include the enrollment fee, list billing forms and premium at time of application. List billing is not currently available in the states of California, Colorado, Florida,* Maryland, Michigan, North Carolina, South Dakota, Tennessee, Virginia and Wisconsin.

*List billing is available in Florida only when the employer has not had a group health benefit plan in place within the prior six months, merely collects the premium, and does not contribute toward the premium. If the Florida employer currently has a group health benefit plan in place, **only** part-time, temporary or substitute employees who are **not** eligible under the employer's group plan can apply for this insurance and request list bill. In Florida, the coverage can only be marketed directly to the individual employee; not through the employer and with no employer involvement. If you are submitting list bill business through our online quoting and enrollment tool, please submit a paper List Bill Election Form to IHC Health Solutions to ensure your cases are accurately established and administered.

List Bill Guidelines

- List billing mode must be monthly. The billing statement will be sent directly to the third party who will be required to remit the amount due as billed.
- Individual certificates/policies are issued to those approved applicants participating in the list bill.
- There must be a minimum of three participants to establish a list bill.
- As noted above, the third party payer must complete the Payroll Deduction/List Bill Setup Form and agree to all provisions therein.
- Each applicant is required to complete and submit the separate List Billing Election Agreement Form.

Paper vs. Online Applications

Do not re-key paper applications into the online enrollment system. Applications must be submitted to New Business/Underwriting the way they were taken with the customer.

Paper

If you personally visit a customer and take a paper application – we need the paper, handwritten application with all appropriate signatures. You are required to leave with the customer applicable marketing brochures of product(s) applied for, as well as any state-required forms.

Please refer to your sales representative for complete guidelines on submission process.

Online Application Process

The online process allows you to obtain a quote and then complete and submit the application all electronically. A verification call must be completed following submission of an online application. IHC Health Solutions utilizes Voicelog for this verification call; it is not completed by RDM. The Voicelog telephone number is 877-851-3182. There are many advantages to the online process and we encourage use of online enrollment for the following reasons:

- Applications are submitted immediately and are automatically entered into the new business system which saves processing time and mailing expenses.

- Applications can only be submitted when fully complete so there is no delay obtaining missing information. This may lead to fewer amendments, so business can be issued without the need for the applicant to sign additional documents before issue.

Pre-existing Conditions – 12/24 *(may vary by state)*

The policy defines a pre-existing condition as: Any 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-month period ending on the effective date of the covered person's insurance coverage.

Health conditions that are fully disclosed in writing on the application will not be subject to the pre-existing condition limitation and will be covered from the effective date of insurance coverage, provided the condition is not specifically excluded by endorsement or exclusionary rider attached to the certificate. When not disclosed, a pre-existing condition will be considered a covered charge at the end of a continuous 24-month period following the covered person's effective date of coverage unless specifically excluded by the certificate.

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 coverage with altered benefits (higher deductible or out-of-pocket)
- Decline the application

The actual certificate/policy can be issued and delivered only if the primary applicant accepts the modified coverage within the allotted time frame by signing, dating and returning any required acceptance forms to IHC Health Solutions.

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 close out. The rider will be mailed to the applicant and posted to the website for you, the producer. Consideration to remove the rider may be given after coverage has been inforce for at least 12 months. The insured 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
- Arthritis, osteoarthritis
- Asthma
- Back or neck disorder
- Bell's Palsy
- Carpal Tunnel Syndrome
- Cataracts
- Disc surgery, within five years
- Ear infections and disorders, recurrent
- Endometriosis
- Gall stones, un-operated
- Glaucoma
- Hernia, present
- Joint replacement/knee disorder
- Menstrual disorders
- Migraine headaches
- Phlebitis
- Ulcer
- Ulcerative colitis
- Varicose veins

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 be issued with a rodeo exclusion rider and medical expenses resulting from the activity would not be covered.

Issued with a Rating

An application can be approved with a rating which increases the premium of the certificate/policy. The minimum rating issued on an adult application is five percent and the maximum is 100 percent, increasing in five percent increments. The

maximum rating on a child is 500 percent which may apply to the entire case. Common medical impairments that usually warrant a rating include elevated blood pressure or a build that falls outside of the height/weight guidelines.

Offer Coverage with Altered Benefits
In order to lower the Company's risk on a certain individual, underwriting 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.

Empowered Underwriting Matrix

The conditions listed in the charts below will be accepted "standard" (without a rider or rating) if the selected plan deductible is at least the amount in the column heading. For example, under the $5,000 deductible section, "Benign Prostatic Hypertrophy – minimum symptoms, controlled with medications" will be issued standard with a $5,000 deductible or higher.

Condition	Underwriting Action	Minimum Deductible for Standard Decision
Acne – No treatment in last three months. No past or future treatment with Accutane.	Rider	$1,500 deductible
Acne – Currently being treated. No Accutane use in the past or anticipated in the future.	Rider	$2,500 deductible
Allergies –No other respiratory conditions, w/ or w/o allergy shots	Rider	$1,500 deductible
Allergies and Asthma combined - allergies - with or without allergy shots; Asthma - Mild, controlled with one inhaler. Not available to smokers or children under age 3	Rider	$2,500 deductible
Anemia – Iron Deficiency, present, mild, cause known	Rating	$1,500 deductible
Anxiety– Situational, no counseling in last six months. Rate for medication as needed	Rider	$1,500 deductible
Anxiety – Moderate. Over 21 years old	Rider	$5,000 deductible
Arteriosclerosis, Atherosclerosis – Mild, incidental finding on x-ray only. Ages 55 and over, no co-morbidity factors apply	DEC	$2,500 deductible
Asthma – Mild, controlled with one inhaler Note: Not available to smokers and/or children under 3	Rider	$1,500 deductible
Attention Deficit Disorder (ADD); Attention Deficit Hyperactivity Disorder (ADHD) - Controlled with medication. No counseling required or evidence of aggressive behavior. No anti-psychotic medication.	Rider	$2,500 deductible
Baker's Cyst – Present	Rider	$1,500 deductible
Basal Cell Carcinoma – Single incident, recovered	Rider	$2,500 deductible
Basal Cell Carcinoma – Up to 3 episodes in last two years	Rider	$5,000 deductible
Bell's Palsy – Stable, not progressive	Rider - DEC	$5,000 deductible
Benign Prostatic Hypertrophy – Minimal symptoms. Controlled w/medications.	Rider	$5,000 deductible
Blepharospasm – treated with Botox injections or surgery indicated	25% rating	$5,000 deductible
Bone Spur – Asymptomatic, no surgery required	Rider	$2,500 deductible
Breast Implants – Not associated w/ cancer or breast disorder	Rider	$2,500 deductible
Bunions or Hammer Toes – Single foot only	Rider	$5,000 deductible
Bursitis or Tendonitis	Rider	$1,500 deductible
C-Section Delivery – Due to Breech, large baby or non-progressing labor only	Rider	$5,000 deductible
C-Section – For all reasons other than Breech, large baby or non-progressing labor only	Rider	$10,000 deductible
Carpal Tunnel Syndrome – Mild, or resolved, no future surgery required	Rider	$2,500 deductible

Cataract – Unoperated, no impending surgery	Rider	$10,000 deductible
Cerebral Palsy – Ages 21 and over only. High functioning individuals only.	25% rating-DEC	$5,000 deductible
Cervicitis – No erosion of the cervix noted	Rider	$5,000 deductible
Chalazion	Rider	$5,000 deductible
Cholecystitis – One attack, recovered	Rider	$5,000 deductible
Chronic Fatigue Syndrome – Stable, non-disabling only	25% rating-DEC	$5,000 deductible
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema – Mild, incidental finding only. No symptoms of airway disease, shortness of breath, or tobacco use in last 12 months	DEC	$10,000 deductible
Chronic Otitis Media – with or without ear tubes	Rider	$2,500 deductible
Condyloma Acuminatum – (Genital warts), With recovery of at least one year. No other sexually transmitted diseases.	50% rating	$1,500 deductible
Conjunctivitis	PP until recovered	$1,500 deductible
Corneal Implant – Stable, with no problems for a minimum of two years.	Rider	$10,000 deductible
Cystitis - Chronic	Rider	$5,000 deductible
Deafness – From birth or due to traumatic cause only.	Rider	$5,000 deductible
Depression – Mild, 1 prescription only, no history of counseling	Rider	$2,500 deductible
Depression – Moderate, over the age of 21 years old.	Rider	$5,000 deductible
Deviated Septum – Congenital, after surgery	Rider	$1,500 deductible
Diverticulitis – Single episode, no surgery required	Rider	$5,000 deductible
Diverticulosis – No inflammation. Asymptomatic. Incidental Finding.	Rider	$2,500 deductible
Dysfunctional Uterine Bleeding – Current. Controlled with birth control pills.	Rider	$2,500 deductible
Dysmenorrhea – W/normal pap smear	Rider	$2,500 deductible
Eczema (mild), Dermatitis, Keratosis or Other Mild Skin Conditions	Rider	$1,500 deductible
Erectile Dysfunction – No known coronary issues.	Rider	$5,000 deductible
Fibrocystic Breast Disease – No malignancy suspected	Rider	$5,000 deductible
Fibromyalgia – Stable, non-disabling only	50-DEC	$5,000 deductible
Fracture with internal fixation – fracture healed, joint stable, more than one year since internal fixation placed with no symptoms	Rider	$5,000 deductible
GERD (Reflux Disease) – Infrequent and stable, over age 15. Rate for medication as needed.	25-50% rating	$1,500 deductible
Glaucoma – Stable. Controlled w/drops. No surgery anticipated.	Rider	$10,000 deductible
Gout – No history of kidney stones or other related impairments	Rider and possible 50% rating	$2,500 deductible
Gouty Arthritis – Stable, non-progressive.	Rider	$10,000 deductible
Grand Mal Epilepsy – Evaluated to rule out brain lesion or other known cause. Stable w/o seizures for minimum of two years. Compliant w/medications.	Rider - DEC	$10,000 deductible
Headaches (including Migraines) – Once evaluation and initial work-up has been completed	Rider	$1,500 deductible
Heart Murmurs – Described as functional. Systolic grades I or II only.	25% rating	$1,500 deductible

Hemorrhoids – Asymptomatic	Rider	$1,500 deductible
Hepatitis A and E – Current normal liver function test	PP for 2 years	$1,500 deductible
Hernia – Asymptomatic, incidental findings only, Not inguinal.	Rider	$2,500 deductible
Herpes Simplex II – Genital, no current medication	Rider	$1,500 deductible
Hypertension (HTN) – Well controlled w/ maximum of three medications (one is a potassium supplement). No co-morbidity factors	25-50% rating	$10,000 deductible
Hyperthyroidism – One year post treatment w/radioactive iodine. No goiter, no other thyroid conditions	Rider	$1,500 deductible
Hypothyroidism – Controlled w/thyroid replacement medications	Possible Decline	$1,500 deductible and $500 daily deductible
Indigestion, Gastroenteritis – Occasional attacks, evaluation of symptoms fail to reveal cause	25-50% rating	$1,500 deductible
Irregular Menstruation – Birth control pills to regulate only, no indication of other conditions	Rider	$2,500 deductible
Irritable Bowel Syndrome – Mild, infrequent attacks. No evidence of colitis	25- 50% rating	$1,500 deductible
Kidney Stones – One attack, passed spontaneously	Rider	$2,500 deductible
Labrynthitis – Stable, non-disabling. No evidence of neurological disease w/work-up.	Rider	$2,500 deductible
Lipoma – (Benign growth) Small, asymptomatic, no surgery indicated	Rider	$1,500 deductible
Lupus Erythematosus – Discoid, not systemic. Stable or in remission for minimum of two years. Work up performed to rule out tumors or lesions. Best cases only	DEC	$10,000 deductible
Meniere's Disease – Stable. No serious underlying cause identified	25% rating-DEC	$2,500 deductible
Mental Retardation – No physical impairment, no Down's Syndrome, IQ of 60 or greater	25% rating-DEC	$5,000 deductible
Menopausal Syndrome –Non-disabling, one Rx	25% rating	$1,500 deductible
Mitral Valve Prolapse – Asymptomatic, incidental finding.	25% rating	$1,500 deductible
Neuritis – Three or fewer episodes in the past two years	50% rating -DEC	$5,000 deductible
Orchitis – Recurrent, complete recovery	Rider	$5,000 deductible
Osteoarthritis – To age 50 at DX, confined to specific joint, no history of opoids, corticosteroid injections or hyaluronic acid injections	Rider	$2,500 deductible
Osteomyelitis – Complete recovery for minimum of six months.	Rider and 25-50% rating	$5,000 deductible
Osteoporosis – No symptoms, no other conditions	25% rating	$2,500 deductible
Osteopenia – No symptoms, no other conditions	25% rating	$2,500 deductible
Ovarian Cyst – Under age 45, single cyst, asymptomatic, adequate investigation to rule out malignancy	Rider	$2,500 deductible
Overactive Urinary Bladder - Complete workup to rule out other causes, treated with medication only	Rider	$5,000 deductible
Paroxysmal Atrial Tachycardia – Two to three attacks annually with no evidence of other heart disorders	50% rating	$5,000 deductible
Passive Aggressive Personality Disorder – Over 21 years old. Mild outbreaks of disorder only. Controlled and compliant w/medication.	Rider	$10,000 deductible
Peptic Ulcer Disease – No malignancy or H-pylori. Complete recovery.	Rider or 25% rating-DEC	$5,000 deductible
Petit Mal Epilepsy – No underlying cause found after work up. Well controlled with infrequent episodes (one to two a year) and compliant with medications.	Rider -DEC	$5,000 deductible
Phlebitis – Superficial, no current edema	Rider and 25-75% rating	$5,000 deductible
Pilonidal Cyst – Asymptomatic or drained only with complete recovery	Rider	$2,500 deductible

Plantar Fasciitis – Current treatment, no surgery indicated	Rider	$5,000 deductible
Polycystic Ovaries – No anticipated surgery	Rider	$5,000 deductible
Pregnancy Complications – Multiple miscarriages, eclampsia, preeclampsia.	Rider	$10,000 deductible
Pre-Menstrual Syndrome – Mild, non-disabling, controlled with one medication only.	Possible DEC	$1,500 deductible
Prostatitis - Single occurrence, recovered	Rider	$1,500 deductible
Prostatitis – Recurrent, mild to moderate. Present or current.	Rider	$5,000 deductible
Pterygium	Rider	$1,500 deductible
Pyelonephritis, Pyelitis – Complete recovery.	25-50% rating	$2,500 deductible
Radiculitis – Single episode, complete recovery	Rider	$1,500 deductible
Raynaud's Disease or Phenomenon – Stable, mild to moderate	Rider or 50% rating	$2,500 deductible
Reactive Airway Disease – Mild to moderate, non-disabling. Controlled w/inhaler.	Rider and possible 50% rating	$2,500 deductible
Rectocele, Cystocele, Urethrocele – Present, no surgery indicated.	Rider	$10,000 deductible
Renal Cyst – Only one kidney affected, no impaired function of either kidney. Incidental finding only.	Rider	$10,000 deductible
Restless Leg Syndrome – Other neurological problems rules out.	25% rating	$2,500 deductible
Retinitis Pigmentosa	Rider	$10,000 deductible
Ruptured Ear Drum – Mild to moderate hearing loss.	Rider	$5,000 deductible
Sciatica – No herniation or bulging disc	Rider	$5,000 deductible
Sebaceous Cyst – Small asymptomatic. No surgery indicated	Rider	$1,500 deductible
Sexually Transmitted Diseases (Other than AIDS or ARC) – Single episode, complete recovery	Rider, 50% rating, or DEC depending on the condition.	$2,500 deductible
Sinusitis – Chronic or acute. Not current	Rider	$1,500 deductible
Sinus Tachycardia – Pulse rate to 100. No known coronary disease.	50% rating	$1,500 deductible
Sleep Apnea – After successful surgery only. No coronary disease.	Rider	$2,500 deductible
Spinal sprain or strain – Single episode, complete recovery. No disc bulge or herniation	Rider	$1,500 deductible
Spinal Strain or Sprain – Chronic, no herniation or bulging discs. Non-disabling	Rider	$5,000 deductible
Tourette Syndrome – Mild	25-50% rating	$5,000 deductible
Tremor – Benign, non-progressive. Not attributed to Parkinson's Disease or other diagnosed neurological disorder. Thorough neurological work up performed.	Rider	$5,000 deductible
Tuberculosis – Positive serology w/o disease manifestation. Serology positive a minimum of one year	25% rating	$2,500 deductible
Tuberculosis – W/disease manifestations, current to minimum of two years.	50% rating	$5,000 deductible
Tumor – Class 3, 4, or 5, complete recovery for a minimum of two years.	50% rating-DEC	$10,000 deductible
Urethritis – Acute, recovered	Rider	$1,500 deductible
Vaginitis – Complete recovery	25% rating	$1,500 deductible

Varicose Veins - mild, asymptomatic, surface veins only. No surgery indicated	Rider	$1,500 deductible
Vertigo – Occasional, mild with work up to rule out underlying neurological disease	Rider -DEC	$2,500 deductible

Empowered Underwriting with a Family High-Deductible Plan

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 two if the application contains between two and four applicants to obtain the allowable deductible for each individual family member.
- Divide the family deductible by three if the application contains five 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 two applies for a plan with a $2,500 family deductible. The deductible is divided by two, 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 seven applies for a $10,000 family deductible plan. The family deductible is divided by three, 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.

Decline

In the event that the underwriter feels that more than three exclusionary riders or more than a 100 percent 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.

Application Withdrawals

In order to withdraw an application during the underwriting process, a verbal or written request is required.

Requirements to Place

Pending Requirements

Correspondence for pending requirements is published on www.myihcgroup.com and an email 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 IHC Health Solutions or must be verbally accepted through the telephone interview unit within 30 days of notification before the case can be placed inforce. An electronic/faxed copy of the rider is acceptable.

Premium Rating

If a case is rated, the agent or applicant must accept the premium rating verbally or in writing. Coverage can be placed inforce once acceptance is given and the required premium has been paid.

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 the 1st or 15th of the month. IHC Health Solutions must receive the application for insurance on or before the requested effective date. IHC Health Solutions will honor the effective date requested provided the application is not over 60 days old.

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 inforce until notice of approval is received.

If replacing an existing IHC major medical plan, the effective date must be the same day of the month as the previous plan. Coverage will not be pro-rated and can only be cancelled on the billing date of the case. We do not automatically cancel an existing hospital indemnity plan when a fully insured medical plan is issued. They can have both plans at one time.

Please note: **A requested effective date cannot be changed once the certificate/policy is 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 the application has been approved by IHC and accepted by the client.****

Billing Modes and Options
The major medical plans allow for automatic bank draft or credit card charge on a monthly basis or direct billing quarterly or semi-annually. Applications submitted online only allow automatic bank draft or credit card charge on a monthly basis. If a quarterly or semi-annual direct billing option is desired, a paper application must be submitted.

After the Sale

Inforce Health Insurance Changes

Submit all inforce changes to the Policy Services department. If the requested change requires a new application, a paper application must be used. Do not use the online quote and enrollment system for an inforce plan change. Most changes are processed for the billing date following receipt of the request or approval, if underwriting review is needed. PPO network changes require additional processing time.

Type of Change	Requirements	UW Required?	IHC 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 Completed application if after 31 days	No Yes	Letter confirming the addition, new certificate face page and ID cards will be sent to the insured
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
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
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

Medical Claim Review
Claims received at IHC Health Solutions that are inconsistent with information provided on the application or may be subject to a pre-existing condition limitation are sent for medical review. When a claim is reviewed, the analyst will look at the original application, telephone interview, prior coverage and determination of HIPAA eligibility. The analyst's investigation 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
If the insured person performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact on the application, coverage may be rescinded or reformed. 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 by the chosen effective date (1st or 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
If coverage under the Policy terminates as the result of the death of the Insured Person, or the severance of the family relationship because of annulment or valid decree of divorce, a Dependent may continue coverage without providing evidence of insurability by making the required premium payments for issuance of his or her own Certificate. The eligible Dependent must submit a written request for this continuation of coverage within 31 days of the date on which coverage would otherwise terminate.

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.