Client Tip Sheet

PENNSYLVANIA

Short Term Medical
Thank you for your interest in Short Term Medical from Assurant Health. Please review the product brochure so you understand the benefits and limitations of this plan, and talk to your agent to make sure the plan you're applying for suits your needs.

Follow these steps to enroll now!

1. Review the plan information in the brochure with your agent to determine if this is the right plan for you.
2. Decide whom you want to cover — just you, just another individual or your whole family.
3. Select the length of coverage, and deductible and coinsurance amounts that meet your needs.
4. Determine the appropriate rate for the coverage you select. Ask your agent to run an online quote or calculate the rate using the enclosed rate sheet.
5. Determine if you wish to pre-pay for your coverage and save 20%, or if you wish to pay month-to-month.
6. Submit your enrollment form, rating sheet *or* agent quote, and payment.

   Please check that you have:
   - Answered all questions on the enrollment form
   - Included necessary signatures
   - Enclosed your payment

For more information, or for help applying for coverage, contact your insurance agent.
If you would like to submit your enrollment form directly to Assurant Health, you can mail it to:

Assurant Health
P.O. BOX 3175
Milwaukee WI 53201-3175

Or fax your enrollment form to: 414.299.1137

ATTENTION AGENT: When an email address is provided for purpose of e-policy, your customer should be made aware that upon request:

- They may receive paper versions of their policy and other correspondence relating to the issuance of coverage for which they are applying.
- They may withdraw their consent to receive their policy and/or other correspondence electronically.

Requests should be submitted via email to epolicymgr@assurant.com.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.
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Pennsylvania

Chart 1 - Primary Insured/Spouse Daily Rate

AGE	Deductible			
	$1,000	$2,500	$3,500	$5,000
0-14	1.25	0.95	0.80	0.68
15-19	1.55	1.25	1.10	1.03
20-24	1.50	1.10	0.95	0.88
25-29	1.38	0.97	0.95	0.78
30-34	1.41	1.10	1.05	0.81
35-39	1.78	1.26	1.15	1.08
40-44	2.11	1.52	1.31	1.18
45-49	2.51	1.75	1.50	1.43
50-54	3.36	2.51	2.16	1.98
55-59	4.42	3.26	2.81	2.59
60-64	7.08	5.07	4.37	4.10

Chart 2 - Dependent Child Daily Rate

AGE	Deductible			
	$1,000	$2,500	$3,500	$5,000
Per Child	0.96	0.60	0.60	0.54

Chart 3 - ZIP Code Factor

ZIP code	
162-181	3.02
190, 191	3.96
All other PA	3.36

Chart 4 - Deductible and Coinsurance Factor Table

	Deductible			
	$1,000	$2,500	$3,500	$5,000
50%	.80	.80	.80	.80
80%	1.00	1.00	1.00	1.00
100%	N/A	1.25	1.25	1.25

A FEW THINGS TO REMEMBER:

- The $1,000, $2,500, $3,500 and $5,000 deductible options are available with the 6-month plan (30-180 days).
- The $2,500 and $5,000 deductible options and 50% and 80% coinsurance options are only available with the 12-month plan (181-360 days).

Premium Calculation Instructions

Refer to charts on the left when figuring the premium

	Single Payment	Monthly Payment
Step 1. Choose a payment option - single or monthly		
Step 2. List each applicant's daily rate. Rate chart is set up by age and deductible.* a) Primary insured rate	_____	_____
b) Spouse rate ..... (see Chart 1)	+_____	+_____
SUBTOTAL =	_____	_____
Step 3. List the per child rate (Chart 2). Enter the number of dependent child(ren). Multiply the rate by the number of children.	_____ x_____	_____ x_____
SUBTOTAL =	_____	_____
Step 4. Add the subtotal from Step 2 & 3. =	_____	_____
Step 5. Monthly factor Multiply by the subtotal in Step 4.	x 1.00	x 1.28
SUBTOTAL =	_____	_____
Step 6. Enter ZIP code factor (Chart 3). Multiply by subtotal in Step 5.	x_____	x_____
SUBTOTAL =	_____	_____
Step 7. Plan type - 6-month plan (30-180 days) enter 1.00. - 12-month plan (181-360 days) enter 1.40. Multiply by the subtotal in Step 6.	x_____	x_____
SUBTOTAL =	_____	_____
Step 8. Enter the number of days of coverage. Multiply the number of days by the subtotal in Step 7.	x_____ Minimum 30 Maximum 360	x 30
SUBTOTAL =	_____	_____
Step 9. Coinsurance Enter the Coinsurance Factor (Chart 4). Multiply by the subtotal in step 8.	x_____	x_____
SUBTOTAL =	_____	_____
Step 10. Application fee** Add fee to subtotal in Step 9.	+ $25.00	+ $25.00
TOTAL =	_____	_____

*Choose one deductible amount per policy
** Application fee is added to first month's premium only

Enter this amount on the enrollment form in the box marked TOTAL

Pennsylvania

Applying for another STM plan

When your plan expires, you may be eligible for another plan depending on how long you have been covered by Short Term Medical plans. Short Term Medical is temporary coverage, so plans cannot be renewed like permanent insurance. If you are issued a new Short Term Medical plan, the new plan will not provide benefits for any conditions or symptoms that existed during the previous plan.

Keep in mind that short term plans are not meant to be a substitute for permanent health insurance coverage. An Assurant Health individual medical plan may be a better option.

Eligibility

To be considered for coverage, each person must be between the age of 30 days and 64 years, 11 months. To be considered dependents your child(ren) must be age 18 or younger, or 24 or younger if full-time student.

Extended protection

If you become injured or ill while your plan is in force

- your benefits may be extended at no additional cost for up to 12* months if you are hospitalized
- you can receive up to $1,000 in benefits at no additional cost for up to 60 days if you have a nondisabling condition

* With the 12 month plan (181-360 days), coverage continues beyond the policy period for up to 90 days if you are totally hospitalized — at no additional cost.

Health Advocates Alliance details

When you purchase Short Term Medical insurance, you are enrolled in Health Advocates Alliance, an association dedicated to the health and well-being of its members. Benefits include a 24-hour nurse helpline and discounts on vitamins and LensCrafters purchases.

Pre-existing conditions

Short Term Medical plans provide coverage for unexpected illnesses and injuries, meaning they do not cover pre-existing conditions. A pre-existing condition is a medical condition due to sickness or injury for which you received medical treatment or advice during the 5-year period immediately prior to your Short Term Medical effective date, regardless of whether the condition was diagnosed or not.

If you have a pre-existing condition, treatment for that condition will be excluded from your Short Term Medical plan.

Premium refunds

If you aren't completely satisfied with your Short Term Medical plan, simply call and cancel coverage within 10 days of delivery and receive a premium refund, no questions asked. The one-time application fee is not refundable. Keep in mind that premium is not refundable *after* the 10 day period for any unused premium. For example, if you select coverage for 60 days and end up requiring only 45 days of coverage, there is no premium refund on the remainder.

Exclusions

- Charges for sickness or injury caused or aggravated by suicide, attempted suicide or self-inflicted sickness or injury, even if you did not intend to cause the harm which resulted from the action which led to the self-inflicted sickness or injury. This exclusion applies whether you were sane or insane at the time of the suicide, attempted suicide or self-inflicted sickness or injury.
- Sickness or injury to the extent that benefits are paid by Medicare or any other government law or program, except Medicaid (medi-cal in california); or medical coverage under any automobile or no fault insurance.
- Sickness or injury eligible for benefits under worker's compensation, employers' liability or similar laws even when you do not file a claim for benefits.
- Treatment of sickness or injury caused by or contributed to by:
  - War or any act of war; or
  - Participation in the military service of any country. Any premium paid for a time not covered will be returned pro-rata
- Charges for dental care, including dental braces and dental appliances, unless a hospital stay is required due to injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient hospital care must be the least expensive setting needed to produce a professionally adequate result and the hospital charges only are covered expense. The treatment must be received while the certificate is in force.
- Charges for the following:
  - Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.
  - Preventive treatment including, but not limited to, routine physical exams and immunizations, unless otherwise noted as a covered expense in this certificate or a rider to this certificate.
  - Treatment, services or supplies to address smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.
  - Weight reduction or weight control programs or treatment; surgery for weight control, obesity or morbid obesity; or any type of gastric bypass surgery.
  - Therapy or treatment for learning disorders or disabilities or developmental delays.
  - Custodial care; respite care; rest care; or supportive care.
  - Private duty nursing services rendered during hospital confinement; or standby health care practitioners.
  - Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations and case management fees.

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- Cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure, including medical or surgical complications arising therefrom, except as provided in the benefits section.
- Treatment of mental illness or substance abuse, whether organic or non-organic, chemical or non-chemical, biological or non-biological in origin and irrespective of cause, basis or inducement, unless otherwise noted as a covered expense in this certificate or a rider to this certificate.
- Treatment or services rendered by, or supplies purchased from, a member of your immediate family or an employer.
- Treatment or services required due to accidental injury sustained in operating a motor vehicle while the insured's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the injury occurred. This exclusion applies whether or not the injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not the insured is charged with any violation in connection with the accident.
- Treatment or services required due to injury received while engaging in any hazardous occupation or other activity including, but not limited to participating, instructing, demonstrating, guiding or accompanying others in parachute jumping, hang-gliding, bungee jumping, flight in an aircraft other than a regularly scheduled flight by an airline, racing any motorized or non-motorized vehicle, rock or mountain climbing, parkour and extreme sports. Also excluded are treatment and services required due to injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.
- Treatment or services required due to injury received while engaging in any hazardous occupation or other activity for which compensation is received in any form, including but not limited to participating, instructing, demonstrating, guiding or accompanying others in skiing, horse riding, rodeo activities, professional or semi-professional sports, adult sporting competition at a national or international level and extreme sports. Also excluded are treatment and services required due to injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.
- Treatment or services required due to injury sustained while participating in any inter-collegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.
- Expense incurred due to sickness or injury of which a contributing cause was the insured's voluntary attempt to commit, participation in or commission of a felony, whether or not charged, or as a consequence of the insured's being under the influence of illegal narcotics or non-prescribed controlled substances.
- Expenses incurred outside of the United States or its possessions or Canada.
- Transplants, except as covered in the benefits section.
- Charges for foot conditions including, but not limited to care of corns; bunions, except capsular or bone surgery; calluses; toenails; and foot supportive devices, including orthotics and corrective shoes.
- Prophylactic treatment or services. Prophylactic means any surgery or other procedure performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
- Drugs and medicines, except as covered in the benefits section.
- Charges for reproductive or sexual treatment including, but not limited to normal pregnancy or childbirth; routine well baby care, except for including hospital nursery charges at birth or as otherwise covered under the immunizations for covered dependent children provision in the benefits section; abortion, except as otherwise covered in the complications of pregnancy provision in the benefits section; infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization; sterilization and drugs or devices used directly or indirectly to promote or prevent conception; genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing; and treatment of sexual dysfunction or inadequacy.

Short Term Medical and Health Care Reform

Short-term, limited duration plans are not subject to certain provisions of federal health care reform, including the provisions related to lifetime limits, dependent coverage, preventive care, and pre-existing conditions. The pre-existing condition exclusion for Short Term Medical plans will apply for all insureds, including those under the age of 19.

Know your plan- Short Term Medical plans offer affordable major medical coverage, but are underwritten and do not provide Minimum Essential Coverage. What does this mean for you?

- You may need to pay a tax penalty depending upon your income level and the cost of plans available.
- This plan is an affordable option because it is underwritten. Examples of the benefits STM plans do not cover are preventive care, maternity, mental health and benefits for ongoing medical conditions diagnosed prior to your plan.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.
Contract number 135/136/137
30217-PA (Rev. 12/2013) For effective dates of 1/1/2014 and later.

Short Term Medical Enrollment Form | Time Insurance Company | **PENNSYLVANIA**

Requested Effective Date			**Note:** Effective date is assigned by Time Insurance Company. The effective date is the later of: 1. The day after: a) the date this form is signed; b) the date this form is postmarked for mailing to Time Insurance Company; or c) the date we receive your enrollment request by electronic transmission in our home office, OR 2. If dates cannot be determined, the day we receive this form by mail. **The agent cannot assign an effective date different than this.**	**Certificate/Policy Number**
Month	Day	Year		

Applicant's Name (print last, first, middle)	Gender	Birth Date	Social Security Number

Street Address	City, State, ZIP Code

Spouse's Name (if to be insured)	Gender	Birth Date	Social Security Number

Children (Name) (if to be insured) 1.	Birth Date	Name 2.	Birth Date	Name 3.	Birth Date

Note: The plan cannot be issued if YES is answered to questions 1-3.
Under no circumstances can coverage become effective prior to the date this application is signed.

Answer the following questions completely and accurately. **YES** **NO**

1. Have/Are you, your spouse, or any person to be insured:..... ☐ ☐
   - ◆ over 300 pounds if male, or over 250 pounds if female?
   - ◆ now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?
2. For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for: ..... ☐ ☐
   - ◆ heart disorder?
   - ◆ emphysema, Chronic Obstructive Pulmonary Disease (COPD)?
   - ◆ Crohn's disease, ulcerative colitis or hepatitis B or C?
   - ◆ stroke?
   - ◆ diabetes, except Gestational Diabetes?
   - ◆ cancer or tumor except Basal Cell Skin Cancer which has been removed?
   - ◆ alcoholism, chemical dependency, drug or alcohol abuse?
   - ◆ AIDS or tested positive for HIV?
3. Do you or any person to be insured have any current physical symptoms or health concerns for which you intend to seek medical advice? ..... ☐ ☐
4. Will this proposed coverage replace any existing health insurance?..... ☐ ☐
   (if yes, replacement notice 28949 must be included with the application)

Deductible Amount	**Payment Option and Length of Coverage**	**Coinsurance**	**Total**
☐ $1,000* ☐ $2,500 ☐ $3,500** ☐ $5,000*** **Available only with the 6 month plan for policies of 30-180 days with 50% and 80% Coinsurance.* ***Available only with the 6 month plan for policies of 30-180 days.* ****Available only with the 12 month plan for policies of 181-360 days.*	☐ Single Payment — Total number of days needed _____ ☐ Monthly Payment — ☐ Coverage is needed for up to 6 months (30-180 days) ☐ Coverage is needed for up to 12 months (181-360 days)	☐ 50% ☐ 80% ☐ 100%* **Available only with the 6 month plan for policies of 30-180 days with the $2,500 and $3,500 deductibles.*	

The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. The undersigned also understands that this is not a continuation of any previous medical plan, including any prior Short Term Medical plan.

If I am self employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (Internal Revenue Code sections 106,125,162 or 213).

Primary Physician's Name (if any)	Primary Physician's Telephone Number
Applicant's Signature	**Today's Date**
Day Telephone Number	Evening Telephone Number

Form 28786.PA (Rev. 10/2008)

Electronic Policy Option

I would like to receive my policy and the company's "Notice of Privacy Practice" via the Internet . . . . . ☐ **Yes** ☐ **No** **To receive policy delivery via the Internet, you must provide your email address in the space to the right. ➡**	Email Address

Payment Information

Step 1: Select a Method of Payment:

☐ MasterCard ☐ Visa ☐ Check Automatic charge: ☐ Checking ☐ Savings account
(Only available with the Monthly Payment Option)

When submitting via paper application, please submit first month premium via check along with a separate voided check

Bank Routing Number:_____ Account Number:_____

▼ Enter your Credit Card information here ▼

Card # ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ Exp. Date: _____ /_____

Authorized Amount $ _____ (Insert Initial Premium Payment Amount)

Important Reminders: The application fee is non-refundable. There will be no refund of premium after the 10-day free look period in the contract.

Step 2: Authorization

- **When selecting the single payment option with MasterCard/Visa:** I authorize Assurant Health to charge my account for the Short Term Medical policy listed above.
- **When selecting the monthly payment option with MasterCard/Visa or Automatic Charge to a checking or savings account:** I authorize Assurant Health to charge my account each month for the Short Term Medical policy listed above, until the end of the policy or until I request cancellation in writing. I understand I can request the charge be stopped if I notify Assurant Health seven days in advance of the charge occurring.

Account Holder's Signature	**Date**	App Source

Health Advocates Alliance Membership Application: Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the right to participate in all programs offered by the Association. Information regarding the benefits provided by the Association will be sent under separate cover. The premium includes your membership in Health Advocates Alliance.

I hereby request enrollment in the Health Advocates Alliance.

Member Name (please print)	Member's Signature	Date
Agent Name	Agent ID#	Confirmation Code (home office use only)