



ASSURANT  
Health

# Agent's Guide

Small Group Underwriting  
and Administration



## Time Insurance Company Small Group Products

Time Insurance Company's Small Group plans are designed to meet the varied needs of the business market, specifically groups with up to 50 full-time employees including corporations, partnerships, and sole proprietorships.

Our Small Group plans are fee-for-service products offering numerous options including different deductible and rate of payment combinations. You can design a wide range of coverage – from the very richest protection to basic, catastrophic coverage – depending on the needs of your client.

We specialize in high deductible plans specifically designed for combining with Health Reimbursement Arrangements and Health Savings Accounts. The high deductible plan may provide small business owners with premium savings. HRAs and HSAs are a means to pay for some of the employees' medical expenses, and in doing so, make the high deductible plan more attractive to employees.

We offer the following small group insurance coverage:

- Medical
- Life
- Dental
- Short Term Disability

**NOTE:** Contact Assurant Employee Benefits for any Long Term Disability coverage needs at 800-733-7879.

## Assurant Health

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

## The Agent's Guide

This Agent's Guide contains general information you need to sell and service Time Insurance Company's plans.

*Our procedures are subject to change without notice. Current business procedures and applicable law will take precedence over this Guide. This material is for agent use only and is not intended for distribution to the general public.*

## State Variation Form

The State Variation Form briefly covers the underwriting guidelines, mandates and product variations for your state. The State Variation Form overrides the guidelines set forth in this Agent's Guide. State Variations can be downloaded from the Web site ([www.assuranthealthsales.com](http://www.assuranthealthsales.com)).

**It is important to note, no coverage is in effect until written approval is received from us. Be sure your client does not cancel existing coverage until approval of the Time Insurance plan is confirmed.**

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# How To Submit A Case

1. Complete the Employer Participation Agreement/ Application in full. The employer must sign and date the form. You need to sign and date the Agent's Statement on the reverse side of the form. Certain states require the use of a state-specific Employer Participation Agreement/ Application.
2. Each full-time employee including the employer/owner needs to fully complete an Employee Enrollment Form. Employees are eligible for coverage on the original effective date if they are employed at the time of application. Certain states require the use of state-specific Employee Enrollment Forms.

Because of the confidential medical information which may be included on the enrollment form, you, the agent, rather than the employer, should assist the employee in completion of the form.

3. If an employee or dependent is waiving the medical or dental coverage, the Waiver of Coverage section of the Employee Enrollment Forms must be completed. Since life and AD&D coverages are often mandatory, an Employee Enrollment Form is required even if the employee waives medical coverage. To expedite the verification process, please include a copy of the employee's current carrier's identification card.
4. Premiums are calculated by using our proposal software. Please contact your distribution partner for a proposal.
5. The following items may be required on all new business cases:
  - Employer Participation Agreement/ Application
  - Employee Enrollment Forms
  - Computer-generated proposal signed and dated including census and benefit pages based on actual enrollment
  - State-specific forms, where applicable
  - State Quarterly Wage and Tax Statement (if required)
  - Census Form (Form 24311) listing full and part-time employees and (if required) copy of last year's federal tax return and all schedules if a State Quarterly Wage and Tax Statement is not filed.

- The full first month's premium payable to Time Insurance Company.
- If contract takeover applies, submit a copy of the last billing notice from the previous carrier.

6. Indicate on the Employer Participation Agreement/ Application where you would like individual certificates, identification cards, and an Employer's Administration Guide sent when a case is issued.
7. Request additional forms by contacting the Supply Department at 800-800-1212, Ext. 8325.

## Common Omissions

Below is a list of the most common omissions when submitting group applications. Omitting any of these items causes a delay in approval and issuance:

1. **The first month's premium payable to Time Insurance Company**  
*NOTE: Checks are not cashed until group coverage is ready to be issued.*
2. **A copy of the most recent billing statement from the prior carrier** for the period up to the requested effective date.
3. **State Quarterly Wage and Tax Statement, if required by us.**
4. **Missing information on Employee Enrollment Form such as:**
  - Signature
  - Date
  - Medical questions left blank
  - Details to medical questions answered "Yes"
  - Waiver of Coverage section not completed
  - Dependents' names and birth dates
  - Prior coverage information
5. **Missing information on Employer Participation Agreement/Application such as:**
  - Signatures
  - Dates
  - City and State
  - Workers' Compensation Carrier
6. **A copy of the group proposal including the census and benefit pages.**  
*(This form must be signed and dated.)*

# Underwriting Guidelines – New Groups

Underwriting requirements may vary based on state law.

## Group Eligibility

Our Small Group plans are designed for groups of up to 50 employees. A business must be a viable business at the time of application and continue to meet this requirement for the life of the contract.

- **Seasonal businesses** are not eligible.
- **“Scattered groups”** (where some employees live in a state different from where the business is located) are eligible.

Use the principal business location as the contract state regardless of where the employees live. If the principal business location is in a state in which Time Insurance does not currently offer insurance products, coverage is not available. If an employee resides in a state we do not currently write business, contact your underwriter. Use the proposal software by including the zip codes for each state.

- **Businesses operating in the home** are not eligible for disability coverage.

## Underwriting Follow-up

A telephone call may be conducted directly to the group at the underwriter’s discretion. These calls entail a short interview with the employer or employee. The focus of this interview is to clarify information reported in the enrollment materials or to obtain missing information.

## Occupational Eligibility

Although all types of businesses are eligible for coverage, certain occupations may not be eligible for short term disability, or require additional underwriting information, or a premium surcharge of up to 50%. Final decisions on occupational eligibility or Standard Industrial Classifications are determined by the Home Office. Contact the Small Group Underwriting Department if you need clarification.

Some businesses are considered “high risk” or have high turnover and therefore are subject to coverage limitations (i.e. not eligible for disability) and/or surcharges.

Due to their nature, other businesses have no coverage limitations but may be either discounted or surcharged.

High risk industries are generally determined by their standardized occupational class rating for disability coverage. There may be additional charges for certain conditions. Contact the Small Group Underwriting Department for final determination.

Discounts and surcharges may vary by state and are subject to change. Our software will have the current discounts, surcharges and disability limitations. Below is a list of current businesses that are discounted.

### Preferred Groups for Disability Coverage

*(Numbers indicate SIC codes)*

Accounting, Auditing & Bookkeeping Services (872)

Advertising (731)

Business Credit Institutions (615)

Computer & Data Processing Services

(programmers, software publishers, computer renting & leasing, computer maintenance & repair) (737)

Depository Institutes (finance companies, credit agencies, mortgage bankers)

(601-603, 606, 608, 609)

Engineering Services (871)

Management & Public Relations Services (874)

Mortgage Bankers & Brokers (616)

Personal Credit Institutions (614)

Printing & Publishing (271-279)

Research, Development & Testing Services (873)

## Prescreen Process

The Small Group Underwriting Department’s prescreen process allows you to provide your customers with an estimated cost of obtaining Small Group medical coverage prior to actual enrollment. Please be advised that the medical rating indicated could be subject to change based on the full medical underwriting at time of enrollment.

For groups of 10 or fewer employees, you may save your customers time by reviewing the Serious Conditions List. Due to the potential risk of these conditions, the rating is likely the maximum allowed by your state if an individual in the group has one of these conditions. Please work with your distribution partner to determine the best options for your client.

## Plan Effective Date

Enrollment forms should be received in our office at least 15 days prior to the requested effective date. This allows Underwriting sufficient time to make a decision regarding the acceptance of the proposed group. Enrollment forms must be postmarked prior to the requested effective date in order to receive consideration for that date. Proper and complete submissions will expedite the process.

Groups may choose from two available effective dates:

- The 1st of the month
- The 15th of the month (subsequent billing occurs on the 1st of the month)

*NOTE: For HSA plans, an employee must be covered for the entire month in order to make an HSA contribution for that month.*

## Contribution Requirements

The employer must pay at least 50% of the employee's portion of the premium on all coverages selected.

The employees may pay all or part of their dependents' portion of the medical and dental premiums at the option of the employer.

We offer direct monthly billing. The employer is responsible for remitting all premiums when due. The first monthly premium must be submitted to Time Insurance Company with the application for insurance. All subsequent premium payments must be submitted directly to Time Insurance Company. Agents are not authorized to collect renewal premium.

## Participation Requirements

### Medical

- Groups with 2 or 3 employees:  
100% of all employees – no waivers
- Groups with 4 employees:  
75% of all employees – no waivers
- Groups of 5-50 employees:  
50% of all employees – no waivers; and  
75% of all employees – after waivers\*

\* Valid waivers

The following are considered valid waivers: Medicare/Medicaid; coverage under spouse's employer group health plan; TRICARE; coverage under an Indian health services program; state health benefits risk pool.

For an eligible employee or dependent to have a valid waiver, he/she must submit satisfactory proof of the other coverage. To provide this proof, the Waiver of Coverage Section on the Employee Enrollment Form must be fully completed, and the following information must be provided:

- Reason for waiving our coverage.
- The name and telephone number of the carrier providing the other coverage.
- A copy of the medical ID card of the other carrier to expedite processing.

If the above information is not provided, the waiver will be considered invalid.

### Medical Participation Calculation Formula

**A** = Number of employees applying for medical coverage

**B** = Number of employees not applying for medical coverage who do not have a valid waiver

**C** = Number of employees not applying for medical coverage who have a valid waiver

$A \div (A+B+C)$  = the no waivers percentage

$A \div (A+B)$  = the after valid waivers percentage

### Life and AD&D

- 75% participation is required for all full-time employees.
- The first \$15,000 is guaranteed issue.
- Additional amounts are available up to \$250,000 in \$1,000 increments.
- A group is limited to three different employee classes.
- There is a limit of two and one-half times the benefit between two employee classes.

### Short Term Disability

100% participation is required for all full-time employees. (Cannot be sold as a standalone plan)

### Dental

- Groups of 4 or fewer employees:  
100% of all employees – after waivers<sup>††</sup>
- Groups of 5 or more employees:  
75% of all employees – after waivers<sup>††</sup>

<sup>††</sup> Waivers allowed for other dental coverage

*NOTE: If the employer contributes 100% of the premium, all employees and dependents that do not have other dental coverage must participate.*

For dental plans with an active PPO, orthodontia is available for groups with at least ten medical certificates.

For dental plans with no PPO, orthodontia is available for groups with at least ten medical certificates on plans with a minimum major rate of payment of 50% and a minimum annual maximum of \$1,500.

The dental plan is available to all size groups when packaged with Major Medical Coverage. The dental plan may also be written as a standalone product with a minimum of three covered certificates.

## Participation and Eligibility Review Process

Participation requirements must be maintained throughout the life of the contract. Renewal questionnaires may be sent or a telephone call may be made to in-force groups to verify participation and eligibility information. Payroll records and/or other documentation may be requested at any time during the life of the contract. **Groups who fail to maintain participation requirements or supply the requested information to verify participation may be terminated.**

## Employee Choice Program

The employer may create four medical plans and allow each employee to choose which plan best meets his/her needs. The employer contribution can be based on the lowest cost plan chosen and the employees can “buy-up” to the other medical plan(s).

The Employee Choice Program allows the employer to vary the following benefits:

- Annual deductible
- Out-of-pocket limit
- PPO plan type
- Network Choice\*
- Health Savings Accounts (HSAs)
- Health Reimbursement Arrangement (HRA)
- Accident Medical Expense (AME)
- Medical Plan – Clear Choice/Healthy Edge

*\* Network Choice allows groups to select different PPO vendors in the same service area as long as the chosen PPO vendors do not have exclusivity agreements.*

## Employee Choice Rules

- The number of medical plans is limited to four.
- A group must have a minimum of six medical certificates to vary plan types or payment structures. At least two medical certificates must be included in each plan.
- The drug deductible and copays must be the same on all plans.
- If the maternity or HSA wellness options are offered, they must be included on all plans.
- If the first-dollar optional x-ray and lab benefit is offered, then all PPO copay plans must include the x-ray and lab buy-up benefit.
- The only time an indemnity plan can be matched with a PPO plan is to accommodate scattered employees.
- A minimum of three medical certificates is required if offering more than one plan which includes an HSA/non-HSA plan or HRA/non-HRA plan combination.
- If offering plans that include an HSA and HRA, only two medical certificates are required.

*NOTE: There are different Employee Choice Rules for states selling the Portfolio Product. Please contact the Small Group Underwriting Department.*

## Adding Employee Choice Options to a Group Plan

The addition of the Employee Choice Option is limited to January 1st or the group’s renewal date.

## Employees Switching Between Medical Plans

- Changes between medical plans can be made one time per any 12-month period.
- The request must be submitted in writing using the Employee Enrollment Form. The request must include the medical plan number (listed on the billing statement) for the plan the employee is switching to.
- The switch to the other medical plan may only be requested with an effective date of January 1st or the group’s renewal date.

## Employee Eligibility

An eligible employee is any person who performs services on a full-time basis (defined as at least 30 hours per week) and is considered an employee for federal income tax purposes, at any of the employer's business establishments within the United States.

A partner, proprietor or corporate officer of the employer is eligible if he/she performs services for the employer on a full-time basis (defined as at least 30 hours per week), at any of the employer's business establishments within the United States.

The term "Employee" does not include: a) retirees or persons who are not expected to perform any duties, responsibilities or services for the employer; b) "part-time" employees; or c) any "seasonal" or "temporary" employees who work only part of the calendar year on the basis of natural or suitable times or circumstances.

Straight commissioned employees under exclusive contract may be eligible but must be pre-approved by our Underwriting Department. We may request verification of the employee status at any time.

Employees are eligible for coverage on the original effective date if they are employed at the time of group application.

## Medicare Age

For groups of 19 or fewer full-time and part-time employees, we pay eligible benefits secondary to Medicare.

Groups with 20 or more full-time and part-time employees fall under the federal legislation referred to as TEFRA. TEFRA determines premium and reimbursement guidelines. Under TEFRA rules, we are the primary insurer and Medicare is secondary.

## Dependent Eligibility

Dependents are eligible for all medical options selected by the employer in addition to dental coverage if provided.

Eligible dependents include the lawful spouse and unmarried children of the employee who are legally listed as dependents for income tax purposes, or for whom a court order requires the employee to provide health insurance. Children must be age 18 or less, or age 23 or less if a full-time student.

*NOTE: We also offer coverage that is designed for college students. If an employee's dependent children are no longer eligible for coverage under the group plan, our Student Select plan may be the best option. Review your clients' group plans to determine which employees can benefit from Student Select.*

## Adopted Dependents

An adopted child is eligible as a dependent when the certificate holder has agreed to assume total or partial responsibility of support for a child in anticipation of adoption or legal physical placement of the child in the home. Please provide legal documentation.

## Husband and Wife Employment

On groups of three or more medical certificates, the employer can choose how to cover a husband and wife. A husband and wife can either be covered under one medical certificate or under separate medical certificates. The choice will often depend on tax considerations. If a client is establishing an HSA or HRA, he/she may want to consult with a qualified tax or legal professional regarding plan design. Regardless of the choice, the husband and wife will maintain separate life and disability coverages.

## Waiting/Affiliation Periods

Waiting or affiliation periods for future employees of 30, 60, 90, 120, 150 and 180 days are available in most states. Only one waiting/affiliation period is available for all classes of employees.

Certain states may have restrictions as to the waiting/affiliation periods available.

The employer may waive the waiting/affiliation period for all current employees enrolling for the group's original effective date.

For underwriting purposes, an enrollment form is required on all employees employed at the time of group application regardless of the waiting/affiliation period chosen for current employees.

## Evidence of Eligibility

Evidence of eligibility is required for all applicants. Also, the Small Group Underwriting Department reserves the right to investigate medical conditions as it considers necessary, including but not limited to requiring a blood or urine profile and/or an attending physician's statement. In addition to answering health questions, parameds may be required on all applicants applying for life insurance amounts of \$100,000 or more. Please use either of these authorized parameds, APPS (800-727-2101) or EMSI (800-530-0560). These companies have Assurant Health's required forms and will forward them to LabOne. If the whole group cannot be issued as applied for, you are contacted before any coverage is issued. This offer may include a special class premium. If questions arise during underwriting, a telephone call is made to you or the employee.

It is important that all medical history and pertinent information regarding the employee, spouse and dependents be fully disclosed on the Employee Enrollment Form. Failure to do so may result in a premium surcharge back to the effective date of the group due to material misrepresentation, subject to the time limit on certain defense provisions of the Certificate of Insurance.

Health questionnaires have been developed to help expedite the underwriting process by reducing the number of medical details post submission and also reducing the need to request medical records for conditions such as high blood pressure, diabetes, cancer, etc.

If an applicant indicates any of these medical conditions on the enrollment form, have the applicant complete the appropriate health questionnaire along with the enrollment form. You can obtain these questionnaires from the Assurant Health Sales Web site ([www.assuranthealthsales.com](http://www.assuranthealthsales.com)).

Dependent Life coverage is included for all dependents as follows:

- \$2,500 for spouse
- \$1,000 for dependent children ages 6 months and older
- \$100 for dependent children ages 15 days to 6 months

## Pre-existing Conditions

Pre-existing conditions are not covered for one year unless the takeover provision or continuity of coverage applies. Late enrollees are subject to a pre-existing limitation of up to eighteen (18) months depending on state requirements.

## Contract Takeover Provision

This provision pertains to the types of coverage that would amend the standard pre-existing condition provision. The takeover provision applies to our group medical, dental and disability plans.

Takeover provisions for group coverages are:

### Medical

Benefits are provided for pre-existing conditions for each individual who has coverage under a group plan for at least one year.

Credit is given for any portion of a calendar year deductible satisfied under the prior plan during the same calendar year. The takeover/ deductible credit does not apply to the family maximum limit.

If the prior plan had a prescription drug card, credit is provided for any portion of the deductible satisfied under the prior prescription drug card. These drug charges are applied to the medical calendar year deductible. Since the credit is not applied toward the drug deductible under this plan, the full drug card deductible (if selected by the business) needs to be satisfied. The takeover/ deductible credit does not apply to the family maximum limit.

### Dental

These provisions apply to the *Dental Ease* product. If the business is replacing an existing group dental plan that has been in force for at least one year at the time of enrollment, contract takeover benefits are provided according to the guidelines in this section for those employees who were covered under the prior group's dental plan.

The **waiting/affiliation period** for Major Dental Services is waived as long as the prior carrier also provided coverage for Major Services.

Any **deductible** amount incurred under the prior plan during the current calendar year is used toward satisfying the new *Dental Ease* deductible.

In order for proper deductible credit to be given, written documentation must be submitted at time of enrollment.

A **paid benefit** applied to the maximum benefit amounts under the prior plan is also applied to the maximum benefit amounts under *Dental Ease*.

**Orthodontic treatment** that began under the prior plan and continues under *Dental Ease* is considered for takeover if both plans include orthodontic coverage. If the bands or appliances were inserted while covered under the prior plan, then Assurant Health pays the lesser of the *Dental Ease* plan's or the prior plan's maximum benefit. Any benefits payable under *Dental Ease* are reduced by the amount payable under the prior plan.

Although there are no specific dollar provisions for takeover benefits on the dental plan, there are limitations in coverage when not replacing a current group dental plan. Please refer to the certificate for these limitations.

### **Disability**

If the business had another group disability plan in force for at least one year, and that plan is being replaced, pre-existing conditions are covered according to the lesser plan's provisions.

Please note that the benefits payable under our small group products may be different than those of the prior carrier, and the takeover provision only pre-empts the pre-existing provision restriction. It does not alter the contract provisions and benefits.

## **Takeover Requirements**

The takeover provisions apply to the medical, dental and disability lines of coverage.

For takeover benefits to be considered, a copy of the last billing from the previous carrier must be submitted with the original application.

Absence of this information could result in a delay of plan approval or benefit payments. Coverage for a pre-existing illness or injury is only provided if specifically approved by us.

Takeover benefits are limited to employees and their dependents covered on the effective date of this plan who were also covered under the previous plan. Any new employees do not have coverage for pre-existing conditions until they have been insured under the Time Insurance Company group plan for one year, unless continuity of coverage applies.

## **Continuity of Coverage**

The pre-existing conditions limitation is credited for any time a person was covered under creditable coverage, if coverage was continuous and if there is no more than a 63-day gap between coverages, exclusive of any waiting/affiliation period.

The continuity of coverage provision applies to the medical line of coverage. For continuity of coverage benefits to be considered, the following information must be submitted with the original application:

- Completed Prior Insurance Coverage Information section on the Enrollment Form; or
- The Certificate of Creditable Coverage letter from the prior carrier; or
- A Continuity of Coverage Form (Form 28168).

## **Creditable Coverage**

Creditable coverage includes:

- A group health plan
- Health insurance coverage
- Medicare
- Medicaid
- TRICARE
- A medical care program of the Indian Health Service or of a tribal organization
- A state health benefits risk pool
- A health plan offered under the Federal Employees Health Benefits Program
- A public health plan, or
- A health benefit plan under the Peace Corps Act

## **Workers' Compensation**

For the Clear Choice and Healthy Edge Products, 24-hour coverage is provided for a work-related illness or injury for an owner, officer or partner of a business provided the state allows an owner, officer or partner to waive Workers' Compensation coverage.

In states offering the Group Portfolio product and where employers are not required to carry Workers' Compensation Insurance, groups receive a surcharge that is calculated into the entire group's monthly medical premium. The surcharge does not alter or waive any provisions that result from a business not carrying Workers' Compensation coverage.

Groups located in a state where Workers' Compensation is required on all size groups are not subject to the surcharge. However, no benefits are provided for work-related injuries.

## Health Saving Accounts (HSAs)

An HSA is a tax-favored account set up to pay for qualified employee health care expenses. We offer plans specifically designed for use with HSAs.

### Plan Types

An HSA plan can be combined with Hospital-only PPO plans, PPO plans without a copay or with Traditional Indemnity plans.

### Deductible

Our HSA plan for small groups is available with qualified HSA deductibles and out-of-pocket maximums.

The specially designed plans are all high deductible plans. For family coverage there is a choice of accumulation methods. With the Common Family Deductible, the entire family deductible must be satisfied before benefits are paid for any family member.

The other accumulation method is one used by most medical insurance plans, referred to as Individual Deductible with a Family Maximum. When a covered individual satisfies his or her individual deductible, the plan pays all additional covered expenses for that individual. Expenses for other covered family members are combined to satisfy the remainder of the family deductible.

Every January the Department of Labor reviews the qualified HSA deductibles and out-of-pocket maximums based on the Consumer Price Index (CPI) and may make cost of living adjustments (COLA) to the qualified HSA deductibles and out-of-pocket maximums. As a result, all insurance companies selling HSAs are required to re-evaluate their HSA deductibles and out-of-pocket maximums to make sure they are within the new range of qualified HSA deductibles and out-of-pocket maximums. If an adjustment is required, all groups with the HSA deductible and out-of-pocket maximums that are no longer qualified will be automatically changed to a new deductible and out-of-pocket maximum that are within the new range of qualified HSA deductibles and out-of-pocket maximums. The change will be made effective January 1st and the group will be notified once the change has been made.

## Prescription Drugs

A preferred pricing card is issued for use with our HSA Plans. Expenses are applied to the deductible. Once the deductible is satisfied, the insured is reimbursed for the prescription at the rate of payment amount.

### HSA Administration

Your client can select any HSA administrator. For your convenience, we offer HSA Tools, a comprehensive HSA administration program. Your clients get an integrated program for both their HSA plan and HSA account. There are no setup or separate monthly fees to pay when combined with a qualified Time HSA Plan. HSA Tools also includes a debit card and checkbook as well as online access to manage funds.

## Health Reimbursement Arrangements (HRAs)

An HRA is a tax-favored program that allows an employer to reimburse employees for a portion of their medical expenses. We have designed plans specifically for use with HRAs so that employers can maximize their premium savings.

### Plan Types

The specially-designed plans for HRAs include:

- PPO Plans (without a copay),
- Hospital-Only PPO Plans and
- Traditional Indemnity Plans.

### Deductible

The specially designed plans are all high deductible plans. For family coverage there is a choice of accumulation methods. With the Common Family Deductible, the entire family deductible must be satisfied before benefits are paid for any family member.

The other accumulation method is one used by most medical insurance plans, referred to as Individual Deductible with a Family Maximum. When a covered individual satisfies his or her individual deductible, the plan pays all additional covered expenses for that individual. Expenses for other covered family members are combined to satisfy the remainder of the family deductible.

## Prescription Drugs

Employers get a preferred pricing card with Clear Choice HRA plans. Expenses are applied to the deductible. Once the deductible is satisfied, the insured is reimbursed for the prescription at the rate of payment amount. An employer can add the Prescription Drug Program option if he/she wants to offer an enhanced drug benefit featuring a drug copay.

## HRA Administration

Your client can select any administrator to provide reimbursement services. For your convenience, a special arrangement exists between Time Insurance Company and Employee Benefits Corporation (EBC). There are no setup fees or separate monthly service fees when the employer:

- 1) Selects a qualified Clear Choice HRA plan and EBC as the HRA administrator.
- 2) Designs an HRA so that employees are responsible to pay for at least 50% of the deductible.

## Rates

Small Group rates for quoting new business are available on our easy-to-use proposal software through your distribution partner.

New business rates are “trended” monthly to account for medical inflation. It is important to remember this when deciding upon an effective date of coverage for the business. Changing the effective date to a later date may result in a change in premium rates. The monthly trend factor is built into the proposal software program. The rates on new groups are guaranteed for twelve months. During the twelve-month period when new business rates are guaranteed, the total monthly premium can still change if:

- A new employee or dependent is added to the group
- A member is terminated
- The business moves to a new address
- An employee or spouse moves into a new age bracket
- An employee makes a change in the type of coverage selected; i.e. family to single
- Changes are made to the plan’s benefits

Rating procedures have been designed to treat all groups fairly and consistently.

The premium rate charged to a group depends primarily on the specific benefit plans the group has selected, the case characteristics of the group and applicable state insurance regulations.

These include, but may vary by state:

- Age and gender of employees and spouses
- The number of children
- Geographic location of the business
- Eligibility of employees for Medicare coverage
- Medical history of members
- Group size
- Type of industry in which the group is involved
- Mandated state benefits

## Step-Rated Groups

(9 or fewer medical certificates)

Rates are based on the attained age of the employee on the effective date of coverage. Rates are generally in five-year age brackets, but may vary by state. In most states, the premium changes on the first of the month following entry into a new age bracket.

## Average-Rated Groups

(10-50 medical certificates)

All groups with 10 or more medical certificates are automatically average-rated.

Rates are based on the attained age of the employee and then averaged based on the employees and dependents that make up the group. Rates are generally in five-year age brackets, but may vary by state. Adjustments to a new age bracket are made when the group’s premium is re-averaged.

A group’s rates are re-averaged at renewal or when the employer requests a group level plan change.

For more information, please refer to the Employer Administration Guide.

# Serious Conditions List

To properly evaluate the risks associated with the conditions listed below, medical records must be submitted for applicants with any of the listed conditions, along with the group application<sup>1</sup>. We are not responsible for any costs associated with obtaining these records.

Conditions followed by an asterisk (\*) require a paramed examination. The paramed will be ordered once the group application is submitted.

<sup>1</sup> Medical records or parameds may be requested for any condition, in addition to those below, if the application or a questionnaire does not provide adequate information for underwriting.

AIDS or HIV Infection	Congenital Heart Conditions – With symptoms or taking medications (ASD, VSD, coarctation of the aorta, tetralogy of fallot, transposition of vessels)	Marfan’s Syndrome
Alpha 1 Antitrypsin Deficiency*	Congestive Heart Failure*	Mitral Valve Stenosis or Mitral Regurgitation/ Insufficiency
Alzheimer’s Disease	Craniosynostosis	Mixed Connective Tissue Disease (MCTD)*
Amyloidosis	CREST Syndrome (related disorder of scleroderma)*	Multiple Myeloma
Amyotrophic Lateral Sclerosis (ALS)	Crohn’s Disease Severe (multiple surgical procedures, complications, immunotherapy)	Multiple Sclerosis
Angioplasty or Bypass/CABG (>10 yrs ago or multiple procedures)*	Cystic Fibrosis	Myeloproliferative Disorders (including polycythemia vera and thrombocytosis)
Aortic Valve Stenosis	Diabetes w/ Kidney Disease* (nephropathy or proteinuria)	Myocardial Infarction (multiple episodes)*
Aplastic Anemia*	Diabetes w/ History of Heart Disease*	Non-Hodgkin’s Lymphoma
Atrial Fibrillation (current symptoms, not controlled on medication)	Down’s Syndrome with Cardiac Abnormalities	Paget’s Disease
Autoimmune Disorders (SCID, DiGeorge Syndrome, Wiskott-Aldrich Syndrome, CVID)	Esophageal Varices*	Pancreatitis*
Build – Weight in excess of Build Chart (BMI of 55 or greater)*	Gaucher’s Disease	Paralysis (within last year)
Cancer - <5 yrs ago (solid tumors)*	Hemochromatosis*	Peripheral Vascular Disease/ Arteriosclerosis Obliterans or Intermittent Claudication*
Cancer (any site with metastasis to other organs)*	Hemophilia	Pregnancy (current) with multiples (twins or greater)
Cardiac Arrhythmia (current symptoms not controlled on medication)	Hepatitis (B, C and Autoimmune)*	Premature Infant (<1 yr old with complications)
Cardiomyopathy or Heart Enlargement	Hodgkin’s Disease (<10 yrs ago)	Pulmonary Hypertension
Cardiovascular Disease with Current Chest Pain*	Hydrocephalus w/ Shunt	Rheumatoid Arthritis with Disability
Cerebral Palsy (or spastic hemiparesis)	Kidney Disease (polycystic kidneys, chronic glomerulonephritis, chronic nephritis, nephrosclerosis)*	Scleroderma*
Chronic Inflammatory Demyelinating Polyneuropathy	Kidney Failure or End Stage Renal Disease (ESRD)*	Sickle Cell Anemia*
Cirrhosis of the Liver*	Leukemia (<10 yrs ago)	Stroke*
	Malignant Melanoma - < 5 years ago or if there has been lymph node involvement of if there has been metastasis to other organs	Systemic Lupus Erythematosus (SLE)*
		Thalassemia Major (Cooley’s Anemia)*
		Transplants (bone marrow, heart, kidney, liver, lung, pancreas)*

# Guidelines – Existing Groups

## Adding Employees

New employees should enroll one month prior to the expiration of the waiting/affiliation period to allow for sufficient time for underwriting evaluation and issuance of certificate(s). A new employee (add-on) must fully complete an Employee Enrollment Form. The Enrollment Form must be signed, dated and submitted within 30 days after the expiration of the employee's waiting/affiliation period or the applicant is considered a Late Enrollee. Employees are added on the date their waiting/affiliation period, if any, ends.

*NOTE: If the group has Employee Choice, the Employee Enrollment Form must list the medical plan number (listed on the billing statement) for the plan the employee is being added to. Enrollment forms dated more than 60 days prior to the eligible effective date are not accepted.*

Under no circumstances may the effective date of coverage be prior to the employee's date of employment. If the employee had previous health coverage, the other carrier's effective date, termination date and type of coverage must be provided. Submit a copy of the previous carrier's identification card.

All add-on employees are subject to the pre-existing condition provision, unless otherwise indicated. All add-on employees must complete the medical questions on the Employee Enrollment Form.

Timely eligible enrollees requesting medical coverage are guaranteed issue where HIPAA regulations require. The first \$15,000 of life coverage is guaranteed issue. Any amount above \$15,000 is medically underwritten. Disability coverage is also medically underwritten. Parameds may be required on all applicants applying for life volumes of greater than \$100,000. Completion of the medical questions on the Employee Enrollment Form is required.

Dependents who are currently covered under their parent's policy and become full-time employees of the same business as their parent must follow the guidelines for adding employees. If the dependents are currently covered under their parent's policy the waiting/affiliation period is waived. Payroll records must be submitted with the Employee Enrollment Form.

*(See Continuity of Coverage section on page 7.)*

## Adding Dependents

- We insure new spouses and dependent children, without requiring evidence of insurability, provided that an enrollment form with the dependent's name and date of birth (or date of marriage) is received in our office within 31 days of birth/marriage.
- If coverage for an eligible spouse or dependent children was previously waived with no creditable coverage in force, the dependent(s) may be considered a late enrollee. See Late Enrollee guidelines below.
- Submit changes in coverage to Assurant Health in writing. For dependents being added, include the date of birth, or date of legal documentation stating intent of adoption or physical placement of a child in a home. An Employee Enrollment Form must be completed.

## Late Enrollees

A late enrollee is 1) anyone who "waived" medical or dental coverage originally and is now requesting coverage; 2) one who requests an effective date other than that which he/she is eligible; 3) a new employee requesting coverage more than 30 days after the waiting/affiliation period has expired; or 4) a spouse or newborn or adopted child added more than 31 days after the date of marriage/birth or date of original eligibility for an adopted child. **All late enrollees are subject to a pre-existing period of up to 18 months depending on state requirements. The coverage will be effective the first of the month following the date we approve the application for insurance.**

*NOTE: Special enrollment periods may apply.*

## Effective Dates of Coverage

- The effective date for a new employee who applies for coverage on time is the date the selected waiting/affiliation period expires and upon our approval of the application.
- The effective date for a new spouse when coverage was applied for within 31 days of the date of marriage is the date of marriage unless otherwise requested.

- The effective date for a newborn or acquired children when coverage was applied for within 31 days of the birth or legal dependence is the date of birth or legal dependence.

*Legal dependence, as used here, means the legal responsibility to provide support.*

- The effective date of a late enrollee (employees or dependents) is the first of the month following the date we receive and approve the application for insurance.

## Changing an Effective Date

If requesting an effective date other than that for which an employee is eligible, note the following impacts:

- Insured will be considered a late enrollee
- Continuity of coverage may be impacted
- Pre-existing period may be lengthened from 12 to 18 months depending on state requirements
- Proof of eligible employment date may be required
- Effective date would be first of the month following receipt of request

## Special Enrollment Period

A special enrollment period is a period of time during which eligible employees may apply for coverage under the policy for themselves and their eligible dependents without being considered a late entrant. A special enrollment period is granted and commences with:

- The day following termination of coverage under another group health plan or other health insurance coverage if all of the following criteria are met:
  - a. The employee and/or dependent were covered by the creditable coverage when they were first eligible to apply
  - b. The employee previously waived coverage under the policy because of being covered by the group health plan or other health insurance coverage, and
  - c. The coverage described in “a” above:
    1. Was under a COBRA or State Continuation (where applicable by state law) provision and the period for which coverage could be continued has been exhausted, or

2. Has terminated as a result of loss of eligibility for coverage due to: legal separation, divorce, death, termination of employment, reduction in the number of qualifying hours of employment, or termination of employer contributions toward the coverage

- The date of the employee’s marriage
- The date the employee acquires a dependent child through birth or adoption, or
- In the case of a dependent spouse or child, the date a court orders coverage to be provided under the policy

## Plan Coverage Changes

### Medical Plan Changes – Group Level

- All change requests must be submitted in writing, signed and dated by the employer or group administrator. (If a group obtains a quote to change its deductible, the signed quote may be submitted to serve as a written request.)
- The effective date is the group’s annual renewal date or January 1st. Network changes are allowed at any time of the year – effective the first of the month. Signed proposals must be received by the end of the month in which the quote is effective.

*NOTE: Any adjustments appear on future billing notices.*

### Health Savings Accounts (HSA) or Health Reimbursement Arrangements (HRAs)

- The addition of an HSA or an HRA to a group's health insurance plan may only be requested with an effective date of January 1st or the group’s renewal date. This request will be subject to underwriting approval.

### Maternity Coverage

Maternity coverage may be an optional benefit depending on your state and contract.

If optional:

- Deletion of maternity coverage is effective the first of the month following the date the request is **received** in our office..

- If maternity coverage was not elected at time of issue, the benefit may be added when the business grows to 15 employees (full or part-time). The group has 30 days from the date the 15th employee is hired to add maternity coverage. We reserve the right to request proof of group size at the time the request is made.

#### PPO Networks

- The PPO network may be changed at any time during the year.
- The effective date is the first of the month following the date the request is received.

#### All Other Medical Plan Changes

- Change may only be requested with an effective date of January 1st or the group's annual renewal date.
- Changes to a specific benefit may only be requested one time during any 12-month period (i.e. if the medical deductible is changed on a group's September renewal, another change to the medical deductible may not be requested on January 1st).
- Changes are subject to underwriting approval.

#### Dental Plan Changes – Group Level

- All change requests must be submitted in writing, signed and dated by the employer or group administrator.
- Submit the request 30 days prior to the effective date to ensure benefits are paid correctly. The request must be **received** prior to the requested effective date in order to honor that date.
- Changes to the dental plan may only be requested one time during any 12-month period.
- Dental plan changes may only be requested with an effective date of January 1st or the group's annual renewal date.
- **The orthodontic benefit may not be reinstated once it is deleted.**

*NOTE: Any adjustments appear on future billing notices.*

#### Short Term Disability/Life Insurance

- To add or increase disability or life insurance coverage, all employees must complete an Employee Enrollment form, including answers to all health questions.
- Issuance or increasing of disability or life insurance requires underwriting approval. If approved, it is effective on the first of the month following our approval.
- Disability coverage ends on the employee's 65th birthday.

#### Waiting/Affiliation Periods

- All employees must abide by the waiting/affiliation period chosen. You cannot waive the waiting /affiliation period for any employee.
- Waiting/affiliation periods may be changed one time per any 12-month period.
- Employees must satisfy the waiting/affiliation period in effect as of their hire date.

#### State/Federal Continuation (COBRA)

When applicable, our Small Group products comply with the Federal COBRA continuation mandate. COBRA applies to groups with 20 or more employees. Notification of COBRA continuation must be received in writing. Employees on continuation are only eligible for medical and dental coverages. Our Small Group products also comply with state continuation mandates for medical coverage. Continuation of coverage provided under COBRA runs concurrent with state mandated continuation coverage. Additional information is contained in the Employee's Certificate of Insurance and the Employer Administration Guide.

Employees on State Continuation or COBRA coverage that are rehired are considered new employees and must re-enroll for coverage.

*NOTE: Short Term Medical (STM) Insurance is available to fill the temporary gap in coverage during your employees' waiting period and may also be an alternative to COBRA.*

*Our STM Insurance is not guaranteed issue so review your clients' group plans carefully to determine which is the right coverage for temporary needs of the employees.*

#### Termination

We do not terminate a participating group's coverage because of the group's claim experience or the health status of a covered member. A group may be terminated for the following reasons:

- Premium payment is not received by us on the date it is due or by the end of the grace period.
- The number of employees insured in a group is fewer than two persons, except in states that require coverage to groups of one.
- There is evidence of fraud or misrepresentation.
- There is non-compliance with plan provisions.
- The group fails to meet participation requirements.
- All plans in the state in which the group is located are terminated.
- The business moves to a state where we no longer write business.
- The group submits a voluntary written request for termination.

# Premium Payment and Billing

When a new group plan is approved, the first premium notice is sent to the employer. The employer should review this bill carefully to ensure all of the information is accurate. Subsequent monthly premium notices are mailed approximately 20 days prior to the bill due date. Each covered employee is listed with his/her coverages in force and premium amounts.

The employer may terminate coverage for a person no longer employed by entering the employee's name and termination date on the back of the billing statement. To expedite the processing of employee coverage terminations, the employer can contact our Customer Service Center at 800-743-8463. Coverage ends at 12:01 a.m. on the day following the last day of employment. Backdated terminations are not accepted. For additional billing information, refer to the Employer Administration Guide.

## Grace Period

There is a 31-day grace period for payment of premiums. If we do not receive payment within 31 days of the due date, all coverage for all employees terminates as of the due date. No claims are paid during the grace period. A lapse notice is sent to the employer and notification is sent to the agent.

# Claims Submission and Service

We do not require insureds to submit claim forms in order to make a claim for medical benefits. Fully itemized bills from providers are accepted as an indication of loss. If the insured assigns benefits to the provider, we pay benefits directly to that provider. The itemized bills should always include the policy number. If family members have the same first name, the date of birth and social security numbers should be indicated for the claimant.

All medical bills should be sent as soon as reasonably possible after an expense has been incurred.

If an inpatient hospital stay or surgery is planned, the insured needs to follow the instructions for authorization which are included in his/her certificate booklet. Penalties may be incurred if an authorization is not obtained.

Disability claims can be submitted by having the Disability Benefits Form (Form 15345) fully completed and submitted as soon as the disability occurs.

Dental claims may be submitted on the dentist's own claim form.

In order to provide quality service, we do need to know about changes to your client's name, address and dependent status. Certificate holders should notify the Customer Service Center at 800-743-8463 of any such change.

**This material is for agent use only and is not intended for distribution to the general public.**



# ASSURANT Health

**Assurant Health**  
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## *About Assurant Health*

Assurant Health has been in business since 1892 and is the brand name for products underwritten and issued by Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company.

Together, these three underwriting companies provide health insurance coverage for almost one million people nationwide. Each underwriting company is financially responsible for its own insurance products. Primary products include individual medical, small group, short term and student health insurance products, as well as non-insurance products and consumer-choice products such as Health Savings Accounts and Health Reimbursement Arrangements. With almost 3,000 employees, Assurant Health is headquartered in Milwaukee, Wis., and has operations offices in Minnesota, Idaho and Florida, as well as sales offices across the country. The Assurant Health Web site is [www.assuranthealth.com](http://www.assuranthealth.com).

Assurant Health is part of Assurant, a premier provider of specialized insurance products and related services in North America and selected international markets. Its four key businesses – Assurant Employee Benefits, Assurant Health, Assurant Solutions and Assurant Specialty Property – have partnered with clients who are leaders in their industries and have built leadership positions in a number of specialty insurance market segments worldwide.

Assurant, a Fortune 500 company, is traded on the New York Stock Exchange under the symbol AIZ. Assurant has more than \$20 billion in assets and \$7 billion in annual revenue. The Assurant Web site is [www.assurant.com](http://www.assurant.com).