



ASSURANT
Health

Medical Coverage Offered To Individuals and Families

Michigan Underwriting & Administrative Guidelines

These guidelines are in place in order to comply with health insurance legislation in Michigan and include the underwriting practices and procedures of Time Insurance Company. For state specific product information, refer to your product brochures and State Variations.

Enrollment: For those agents not using EASE, and applying for any of the Standard Portfolio Plans, the following forms are required:

Distribution Channel	Paper Enrollment Form Number	Revision Date	Tele-App Part 1 Form Number included in Tele-App Packet	Revision Date	Tele-App Packet Form Number	Revision Date
RSD, MGA, RBG, NA & DSC	29300	(Rev.1/2009)	29400	(Rev.1/2009)	39400-PKT	(Rev. 2/2010)
State Farm	29300	(Rev.1/2009)	29400	(Rev.1/2009)	29304	(Rev.2/2010)

Enrollment for Assurant Affordable Health Access Plans: These plans may be quoted and submitted using EASE or manually quoted using rate sheets. For those agents not using EASE and applying for any of the Assurant Affordable Health Access Plans, the following forms are required:

Distribution Channel	Health Access Plan A Enrollment Form	Revision Date	Rate Sheet Packet for Health Access Plan A/Revision Date	Health Access Plan B or C Enrollment Form	Revision Date	Rate Sheet Packet for Health Access Plan B or C/Revision Date
RSD, MGA, RBG, NA & DSC	29700	(Rev. 1/2010)	29701-PKT (Rev. 2/2010)	29800-MI	(Rev. 1/2010)	29801-MI-PKT (Rev. 2/2010)

For the most current versions of the application forms listed above as well as product brochures, Health Access Plan Rate Sheet Packets and State Variations, please refer to Find A Form on the Assurant Health Agent Information website at www.assuranthealthsales.com. State Farm agents; please refer to the Assurant Health Sales Site.

Limited Benefit Plan Internal Replacement Form: If an applicant is replacing an existing Assurant Health medical plan with any Assurant Affordable Health Access Plan, Notice to Applicant Regarding Replacement of Comprehensive Medical Plan, Form 29956 must be completed.

Eligibility: In order to be eligible for coverage, an individual must be a resident of Michigan, must be a member of the Health Advocates Alliance Association and must not have the coverage sponsored by a small employer. If a small employer is sponsoring coverage for any eligible employees as defined below, they are ineligible for this plan and should apply for a small group health plan. With the exception of Health Access Plan A, all individuals enrolling for coverage will be medically underwritten.

Employer Sponsorship: Michigan defines employer sponsorship as meeting any one of the following criteria:

- Any portion of the premium or benefits is paid by or on behalf of the small employer.
- An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of a small employer for any portion of the premium.
- The health benefit plan is treated by the employer or any of the eligible employees as part of a plan or program for the purposes of Internal Revenue Code sections 106, 125, or 162.

If an employer's only role is collecting premium through payroll deduction on behalf of an employee, the health benefit plan is not considered employer sponsored.

The capability exists to debit multiple individual policies on one Check-O-Matic (COM) account, up to a maximum of 18 policies per COM account. The employer should have one common draft date for all policies, even though the effective dates may be different. The multiple COM group must also qualify per the state employer sponsorship requirements as outlined in this guideline.

A List Bill payment option is available to small employers and their eligible employee as defined later in this guideline. When establishing a new List Bill Account, the List Bill Account Agreement Form 29237 is required as well as the List Bill Transmittal Form, Form 29236, for each application. Please refer to the Agent Administration Guide for List Bill, Form 29240, for additional details.

Small Employer: A small employer is defined as an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

Eligible Employee: An eligible employee is an employee who works on a full-time basis with a normal work week of 17.5 to 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary, or substitute employee.

Employer Sponsored Business Questionnaire Form 29174 for Standard Portfolio Plans: In order to verify the coverage is not employer sponsored, Form 29174 must be completed with paper Enrollment Form 29300 in the following situations:

- If you are adding an enrollee to an existing Check-O-Matic (COM) or List Bill account.
- If you are submitting 2 or more Enrollment Forms with a common billing mode of multiple COM or List Bill.
- If you are submitting 2 or more Enrollment Forms with an employer or business check, or with an employer or business billing address.

Employer Sponsored Business Questionnaire Form 29953 for Health Access Plan A: is incorporated into the Plan A enrollment form 29700. It is available as a stand alone employer sponsorship verification tool in the rare event that a separate form is needed.

Employer Sponsored Business Questionnaire Form 29954 for Health Access Plan B or C: is incorporated into the Plan B or C enrollment form 29800-MI. It is available as a stand alone employer sponsorship verification tool in the rare event that a separate form is needed.

None of the Employer Sponsored Business Questionnaire Forms are required with the EASE or Tele-App process. Verification that coverage is not employer sponsored will be completed during the Personal Health History Interview.

Underwriting Actions Standard Portfolio Plans: Underwriting actions for our Standard Portfolio Plans may include the following and coverage may be issued with:

- preferred non-tobacco or preferred tobacco rates
- standard non-tobacco or standard tobacco rates.
- a special class premium.
- a condition specific deductible endorsement.
- a special exception rider. The maximum duration a special exception rider can remain on a policy is 12 months. In order for a condition to be excluded, an individual must have had medical advice, diagnosis, care or treatment received or recommended within 6 months of applying for coverage. The maximum duration of 12 months does not apply to hazardous activities.

Coverage may be declined due to medical history.

Underwriting Actions Assurant Affordable Health Access Plans: Underwriting actions vary by plan.

- Health Access Plan A - Coverage may be declined based on eligibility criteria
- Health Access Plan B or C – Coverage may be declined based on medical history and/or eligibility criteria.

Pre-existing Condition Limitation: For most plans pre-existing conditions may be excluded up to 12 months following the effective date of coverage. A pre-existing condition is a sickness or injury and related complications for which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider, or prescription drugs were prescribed during the 6-month period immediately prior to the covered person's effective date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or a sickness, injury and related complications that produced signs or symptoms during the 6-month period immediately prior to the covered person's effective date; or a pregnancy existing on the day before the policy effective date.

Benefits are not paid for charges incurred due to a pre-existing condition until you have been continuously insured under the plan for up to 12 months, unless the condition was fully disclosed on the application. After the up to 12-month period, benefits are paid for a pre-existing condition, unless the condition is specifically excluded from coverage. Refer to product brochures and state variations for details. **Note:** Health Access Plan A is not subject to a pre-existing condition limitation.

Continuity of Coverage: The pre-existing condition limitation period will not be applied if there is no gap in coverage between the termination date of the prior plan and the effective date of the Assurant plan and the prior qualifying coverage was in effect for a minimum of 6 months.

In order to provide continuity, we require that proof of prior qualifying coverage be submitted. Proof of prior qualifying coverage includes on or more of the following:

- A copy of the declarations,
- A summary of benefits or schedule page,
- A letter from the prior carrier indicating dates of coverage, type of coverage and names of those insured.

If proof of prior qualifying coverage is provided at a later date, we will provide continuity of coverage.

Qualifying Coverage: Qualifying coverage is defined as coverage under a group health plan with a minimum duration of at least 6 months.

Preferred Rating Questionnaire Form 26566: If submitting paper Enrollment Form 29300, and applying for preferred rates, then the Preferred Rating Questionnaire Form 26566 must be completed and submitted. **Note:** Preferred Rating is not available with Assurant Affordable Health Access Plans.

Form 26566 will not be required with the EASE or Tele-App process. Preferred Rating class eligibility will be verified during the Personal Health History Interview.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA eligible individuals who wish to obtain coverage on a guaranteed issue basis with no pre-existing limitations, should apply for coverage through **Michigan Blue Cross/ Blue Shield at telephone 1-877-4my-blue (1-877-469-2583)**

HIPAA Eligible Individual: An eligible individual is a person who meets ALL of the following requirements:

- Has an aggregate period of creditable coverage of 18 months or more, with the most recent coverage being under a group health plan, government plan, or church plan.
- No gap in coverage or a gap of 63 days or less.
- Most recent coverage was not terminated due to nonpayment of premiums or fraud.
- Not eligible for coverage under a group health plan, Medicare, Medicaid, and does not have other health insurance coverage.
- Accepted and exhausted any available COBRA coverage or state continuation coverage.
- Not eligible for coverage under a group health plan, Medicare, Medicaid, and does not have other health insurance coverage.