

## **Health Option One Frequently Asked Questions as of February 2011**

### **PLAN QUESTIONS:**

- Q: How is major medical different from a limited medical plan?

A: The limited medical indemnity benefit plans do not provide comprehensive medical coverage. It is a limited benefits policy and is not intended to cover all medical expenses. This plan is not designed to cover the costs of serious or chronic illness. It contains specific dollar limits that will be paid for medical services which may not be exceeded. If the cost of service exceeds those limits, the member and not the insurance company is responsible for payment of the excess amounts.

- Q: Is the member purchasing a limited medical plan?

A: No, they are purchasing a membership in the UCAA, the United Consumer Awareness Association. As a member in a benefits class of membership, the membership includes limited medical benefits as well as other non insurance related membership benefits.

- Q: What are the rules around Medicare and Medicaid?

A: If the member currently has Medicare or Medicaid the plan will not benefit them as the benefits the member has with Medicare or Medicaid are more comprehensive. For Medicare recipients who are 65 or older they are not eligible for these plans. If they live in CA the law prohibits selling the plans to those on MediCal or Medicare. These plans are primary to either Medicaid or Medicare if they were to have both.

- Q: What about Domestic Partners, Common Law Marriages and Same Sex Marriage?

A: Couples who are not within the “traditional” structure of marriage may or may not be permitted to claim their partner on the same plan as a spouse. These circumstances are to be presented to the plan administrator. This will be submitted to the carrier for the most up to date laws of the resident state that will determine the outcome.

- Q: What are the age parameters for the plans?

A: The primary member must be at least 18 years old. The plan terminates upon the attained age of 65. Plans should not be sold to those who are 64. This applies to both the primary and spouse.

Eligible dependents are;

- (1) A lawful spouse; and
- (2) An unmarried child or children who:

- (a) Reside in the primary member's home for more than 6-months a year;
- (b) Chiefly relies on primary member for support and maintenance; and
- (c) Who is under 26 years of age (the limiting age)

“Child” includes stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

- Q: Can a person have or be part of more than one plan?

A: No, a person may only enroll in one plan. There are no duplicate or multiple memberships permitted by the carrier.

- Q: Are the plans available nationwide?

A: No, the available states can be found on the plan brochure. The plans cannot be sold in AK, CT, KS, MD, ME, MT, ND, NJ, NY, OR, VT, WA, NH, RI

- Q: Are the Limited Medical Plans HIPPA compliant?

A: No, these plans are not considered credible coverage thus do not qualify for HIPPA.

#### **COMPLIANCE QUESTIONS:**

- Q: What are the requirements to be able to sell the Health Option One plans?

A: All agents soliciting sales and enrolling consumers must hold a valid health and life insurance license in the state in which they sit and the state in which the consumer resides.

- Q: Can an agent create their own marketing materials.

A: No, marketing materials are provided for the agent by Health Option One and preapproved by the carrier. If the agent wishes to develop their own marketing such as a website, blog or mailing, it must be pre-approved by the plan administrator prior to its release.

- Q: What can not be said to a potential member?

A: Pressure sales are not permitted such as; “there is a limited time only to enroll” or “you must enroll now or you may miss your chance.”

The plans can not be referred to as Health Insurance plans or Medical Insurance. The member is purchasing a membership in the UCAA which affords them the opportunity to

access a Limited Medical Indemnity plan that includes other types of insured benefits as well as Discount Medical Plans and consumer savings benefits.

There can be no misrepresentation of the plan. The agent must follow the provided script and only discuss the benefits the plan includes.

### **BENEFIT QUESTIONS:**

- Q: Is Pregnancy covered?

A: No, the insurance portion of the plans does not cover normal pregnancy or childbirth. The only exception is that complications of pregnancy are covered. Members may receive discounted rates if services are provided by an in network provider.

- Q: Is mental illness covered?

A: Treatment of mental or nervous disorders is not covered under the insurance portion of the plan. Members may receive discounted rates if services are provided by an in network provider.

- Q: Must a member go to an in network provider to receive benefits on a limited benefit medical plan?

A: No. However, if they visit an in network provider they will benefit from the deeply negotiated discounts.

- Q: Will in network claims be re-priced even when there is no insurance amount to be paid?

A: Yes, all applicable claims will be re-priced. The claims administrator who pays the claims will do the re-pricing and send the Explanation of Benefits (EOB) to both the member and the provider. At that time the provider will bill the member the remaining balance.

- When does the Accident Medical Benefit coverage become applicable?

A. The Accident Medical Benefit coverage is an excess benefit meaning this benefit will only become applicable after any valid and collectible insurance has been exhausted. The member must submit a claim form to the carrier and include their bills for the benefit to be paid.

- Q: If a member is having outpatient surgery does the pre-ex still apply?

A: Yes, it applies to Inpatient and Outpatient surgery.

- Q: Is there a 30-day waiting period for diagnostic testing?

A: The 30 day waiting period applies to illness so if the testing is due to an illness then the 30 day wait does apply if the testing is due to an accident then the 30 day wait does not apply.

- Q: If a member does not have wellness benefits, is he/she covered for vaccinations?

A: No. The only option they have is to use an in-network provider which will provide them with an up to 50% discount.

### **CANCELLATION QUESTIONS:**

- Q: When does the 30 day free look start?

A: The 30 day free look begins the day the member enrolls in the plan, their start date not the effective date.

- Q: How does a member cancel their plan if it does not fit their needs?

A: The cancellation must be in writing and sent by fax or email. Cancellations can be faxed to 516-495-7195 or emailed to [cancellations@unitedconsumer.org](mailto:cancellations@unitedconsumer.org). It is the member's responsibility to make sure the email or fax was received.

Members canceling within the first 30 days of signing up for the plan will be refunded their first month's payment. The one time enrollment fee is non-refundable, except in FL, NE, SC, SD, TN, and VT. Refunds take 2 - 4 weeks for processing.

Members canceling after the 30 day refund period are not entitled to a refund and their membership will terminate at the end of the billing cycle for which they have paid.

- Q: If a member cancels the plan when can they rejoin the plan?

A: The member can rejoin 6 months from the cancellation date not the effective date.

- Q: If a member is inactive when will they be able to reactivate their coverage?

A: A member must wait 6 months from the termination date before being able to rejoin.

### **BILLING QUESTIONS:**

- Q: What are the acceptable payment methods?

A: Credit Card (American Express, MasterCard, Visa, Discover) or ACH. There are no paper bills.

- Q: Is there any way to stop a charge once it is paid for through ACH?

A: No, once it is charged there is no way of stopping it. A refund can be issued 8 days after the initial charge date as long as the payment clears.

- Q: What effective dates are available to an individual when signing up for the plan?

A: Members signing up with the payment method of Credit Card may have an effective date of next day or any day within the next 30 days. Members signing up with the payment method of ACH may have an effective date of 8 days after enrollment or any day, after the 8 day period, within 22 days.

- Q: What name will show on my credit card or bank statement?

A: Charges are done by Patriot Health and that is the name that will appear on statements. The member will be charged the day they enroll into the plan, and automatically every month thereafter on their effective date.

- Q: What happens if a payment declines?

A: Members have a 30 day grace period to make a good payment. Members receive notification of the declined payment by email, phone, and post-mail.

- Q: Is the agent notified when the member's payment declines?

A: Yes, once a member's payment is declined the member will be sent an email notification and the agent will be copied on that email.

The agent can also log into back office and see the notes in the members' record.

- Q: Can the member change their billing method?

A: Yes, a member's payment method can be changed at any time by just calling customer service.

- Q: The agent made a mistake and was not supposed to charge the member yet and the member received overdraft fees. What can be done?

A: The customer service rep will apologize to the member letting them know that we will contact their agent and if this is a mistake on the agent's part the agent will be responsible for the member's overdraft fees.

- Q: Why did the member not receive reimbursement of his enrollment fee when he cancelled within the 30-day allowance period?

A: The one time enrollment fee is non-refundable except in the following states; Florida, Nebraska, South Carolina, South Dakota, Tennessee and Vermont.

## **FULFILLMENT QUESTIONS:**

- Q: When will an e-mail fulfillment be sent?

A: An e-mail fulfillment is sent as soon as the application is processed into the system as long as we have a valid e-mail address. The agent is copied on the email that is sent as well.

- Q: If a member didn't receive an e-mail fulfillment, what should they do?

A: If an e-mail fulfillment is not in their inbox, please be sure to have them check their "Spam or Junk mail" box. If it's not in either place, please call Customer Service at 888-633-5080 and a representative will send them another e-mail.

- Q: If a member is having problems registering online for their e-mail fulfillment, what can they do?

A: They should call Customer Service at 888-633-5080 and a representative will walk the member through the registration process.

- Q: When will the paper fulfillment be sent?

A: A paper fulfillment is sent as soon as the payment is cleared. So, if a membership paid using a credit card, a fulfillment will be sent the following business day. If the member paid using an ACH, the package will be sent the next business day after payment has cleared (this normally takes 8 business days for an ACH to clear).

- Q: Where will the fulfillment package be sent?

A: The membership materials will be sent to the address given to us at the time of enrollment.

- Q: What happens if a member misplaced their cards?

A: They should call Customer Service at 888-633-5080 to request a second set of cards sent to them or login to their email fulfillment area and print another card.

- Q: What happens if the member has not received their membership fulfillment package?

A: If their payment has been cleared and they have allowed 5 business days for regular mail delivery, the member should call Customer Service at 888-633-5080 to make sure that the correct address is in our database. Once the address has been verified another package will be sent on the following business day.

- Q: If the member's name is misspelled, who should the member call?

A: They should call Customer Service at 888-633-5080 and a representative will make the proper corrections and request another set of cards sent to them, which will be sent the following business day.

- Q: If the member's missing dependents on their membership cards, what should they do?

A: They should call Customer Service at 888-633-5080 where they will verify the type of membership purchased. Once the membership has been verified a representative will add any missing dependents. At that time another set of cards will be requested and sent to the member on the following business day.

### **UPGRADE/DOWNGRADE QUESTIONS:**

- Q: Can a member upgrade/downgrade their plan after it is already in effective?

A: Once the plan has begun, the member can upgrade/downgrade the plan only if there is a life changing event. That includes; marriage, divorce, death, or loss of income.

- Q: If a plan has not become effective yet, what is the time frame in which a member can change the plan type?

A: The member has until 5 days before their effective date to do this. This must be done in writing by the member only and must include the current plan, the desired new plan and new price, and the reason for the change.

- Q: What is the time frame in which a member can make changes to the level of coverage of the plan (i.e. changing to a family or couple plan)?

A: A member can change the coverage type by adding or dropping eligible dependents at any time to an existing plan. They must make the request in writing and it will be processed on their next bill date, monthly amount will be changed and new membership cards will be sent.

### **STATUS DEFINITIONS:**

- Q: What is the definition of each status?

A: Here is a definition of what each means:

- **Active:** Case is active and payment has been received and approved.
- **Hold:** Case is currently processing a payment, an ACH payment that has not yet cleared.
- **Pending Term:** Two options, first is payment has declined. Payment was not received and member will be sent an email, called and sent a letter to get a good form

of payment. Option two, a member cancelled and their plan is active for a few more weeks since they made a successful payment. During that time the status will be Pending Term.

- **Inactive:** Case has been cancelled either for non payment (30 days are given from the date it declined for member to call in with a new form of payment) or written request by the member.

#### **CLAIMS QUESTIONS:**

- **Where do claims get processed?**

For Services provided in 2010 claims are sent to Administrative Concept Inc. (ACI) at 994 Old Eagle School Road, Ste. 1005 Wayne, PA 19087. Claims status & questions: can be directed to 800-964-7096. For Services provided in 2011 the claims will be sent to Co-ordinated Benefit Plans (CBP) at P.O. Box 21517, Eagan, MN, 55121. Claims status and questions can be directed to 877-693-8529. ACI & CBP do all re-pricing and claims payment as well as sending out the explanation of benefits to both the provider and patient.