PIVOT HEALTH

THE BRIDGE TO MEDICARE PLAN

Marketing Guide for Producers

For Agent Use Only. Not For Distribution.

This is not qualifying health coverage ("Minimum Essential Coverage") that satisfies the health coverage requirement of the Affordable Care Act. Plans include pre-existing limitation provisions that may prevent coverage from applying to medical conditions that existed prior to the plan effective date. This is not Medicare or Medicare supplement coverage.

Table of Contents

Select from the links below to move from chapter to chapter.

Contact Information

Billing, claims and customer service is provided by Pivot Health's third party administrator, Insurance Benefit Administrators (IBA). Representatives at IBA can be reached Monday – Friday, 8:30 a.m. to 4:30 p.m. Central Standard Time

Telephone: 844-630-7500 **Email**: clientservices@insurancebenefitadministrators.com

Web support or technical issues with PivotHealth.com should be directed to:

Email: agentsupport@pivothealth.com

Precertification is required for inpatient admissions or outpatient surgeries over $5000. Contact IBA.

Telephone: 866-317-5273

Provider verification of benefits call should always be directed to the "Provider" number on the insured's medical plan ID card.

Telephone: 844-223-2985

All other questions regarding the administration of the plans, including questions regarding claim status, should be referred to the client information number on the medical plan ID card.

Telephone: 844-630-7500

Welcome to Pivot Health!

Launched in 2016, Pivot Health is an insurance product development, management and marketing company led by an experienced team of health insurance professionals that has managed more than $7 billion of insurance premium. The company has proprietary products and dedicated relationships with many national carriers. The leadership of Pivot Health have led previous firms that were acquired by NYSE companies or that rank in the Top 100 for fastest growing private companies in the U.S. To date, our rapidly growing company serves thousands of contracted insurance offering plans through agent-assisted web pages.

We are backed by Axis Capital (NYSE:AXS) an international financial services company with more than $21 billion in assets.

Pivot Health understands that changes happen in life.

- Major medical insurance for pre-Medicare individuals is extremely costly.
- Unemployment strikes.
- Couples decide to retire before they are eligible for Medicare.
- Marriage or divorce force change in coverage.

And through it all we know that consumers want to be in control of their choices, doing what they think is best for them, often working with a trusted, licensed advisor.

That's why Pivot Health is a leading alternative in the marketplace, helping consumers move in any direction they need to go. And helping brokers and advisors serve them with technology-enabled tools, resources and solutions that are tailor made.

Pivot Health is also affiliated with Communicating for America , a national non-profit advocacy organization that supports affordable health care for all Americans and provides useful non-insurance benefits to each Pivot Health member. More than 100,000 consumers trust CA to help them find health insurance while advocating on their behalf for affordable choices.

Take a moment to review informational details and business rules for Pivot Health's Bridge to Medicare Plan. If you have any questions, contact agentsupport@pivothealth.com .

Regards,

Jeff Smedsrud

About Pivot Health

Pivot Health is an insurance product development, management and marketing company led by an experienced team of health insurance professionals. The company has grown from $36,000 in monthly premium in Jan. 2017 to $2.4 million in monthly premium by Jan. 2018 across all products. Pivot Health has proprietary products and dedicated relationships with several national carriers and continues to bring the market new and innovative products to fit the health care needs of individuals, which include short term medical plans, limited benefit insurance and supplemental insurance for individuals and families through consumer websites, insurance brokers and web-based entities.

Our insurance partners include:

About Companion Life Insurance Company

Companion Life Insurance Company is headquartered in Columbia, S.C., and is rated A+ (Excellent) by A.M. Best Company, Inc.

About Insurance Benefit Administrators

Plans sold through Pivot Health are administered by Insurance Benefit Administrators(IBA) (formerly Allied National), headquartered in Overland Park, Kan.

About Communicating for America

Non-insurance benefits are provided by Communicating for America, Inc. (CA) a non-profit, 501(c)(5)association.

Agent Appointment Checklist

Here are the steps to get appointed with Pivot Health:

- Complete and sign requisition for agent appointment form
- Provide copies of current individual licenses for each state you plan to write business
- Provide copy of agency license if commissions are paid to agency
- Sign Pivot Health producer's agreement
- Agree to Commission Schedule(s)
- Complete W-9

All the above forms need to be scanned and emailed to PHcontracting@pivothealth.com to get started!

The Bridge to Medicare Plan Attributes

- The Bridge to Medicare Plan combines two coverages: short term medical and limited benefit health insurance, both underwritten by Companion Life Insurance Company.
- Coverage is three 364-day short term medical plans. The limited benefit insurance is renewed annually.
- Payment can only be made by credit card at this time.
- Payment is entered by the applicant one time. The credit card will be applied in two transactions (one for short term medical and one for the limited benefit health insurance plan).
- The total one-time application fee is $35 ($15 for short term and $20 for limited benefit insurance).
- To enroll, the primary insured must be between the ages of 62 years and 64 years and 11 months.
- Coverage can include a spouse (no limitations on age) and/or child(ren).
- The free-look period is 10 days.
- Coverage is by Plan Year, not Calendar Year.
- Effective date can be next day or up to 60 days in the future.
- The short term medical plan is referred to as Coverage A and the limited benefit insurance is referred to as Coverage B for ease of explaining to clients.
- There are three options, referred to as Plan 1, Plan 2, Plan 3.
- The short term medical plan used for this plan is Pivot Health's Economy Plan with an integrated Rx prescription benefit.
- The Bridge to Medicare Plan Rx prescription coverage for Plan 1 and Plan 2 have a $500 deductible. Plan 3 has no deductible for $10 generics, and then a $500 deductible for brand name drugs.
- The Bridge to Medicare Plan has set benefits for each plan. There are no variables for the deductible, coinsurance out-of-pocket or coverage period max.
- Enrollment is completed on the Pivot Health website. The applicant answers one set of enrollment questions.
- The member will receive one combined welcome email that explains that there are two coverages (Coverage A and Coverage B). Coverage A (short term) is fulfilled on the Pivot Health site. Coverage B (limited benefit insurance) is fulfilled by IBA.

The Pivot Health agent portal will allow you to see your client sales and expiration dates by year.

Order #180870 (12/03/2018) **Companion Bridge to Medicare (CLIC-STM-ECO-10000-250000-30)** Agent: None

App ID	Name	Effective Date	Expiration Date	Termination Date	Cost	
180870	Mia Test	12/04/2018	12/02/2019		$309.33 /mo	
180871	Mia Test	12/03/2019	11/30/2020		$309.33 /mo	
180872	Mia Test	12/01/2020	11/29/2021		$309.33 /mo	

The Bridge to Medicare Plan Underwriting Requirements

Here is a list of underwriting requirements for the Bridge to Medicare Plan's short term medical and limited benefit insurance coverages:

- The primary insured must be between the ages of 62 years and 64 years and 11 months.
- Weight: male applicants are not eligible for coverage if over 300 pounds. Female applicants are not eligible for coverage if over 250 pounds.
- Applicants must not have other insurance coverage in force.
- Applicants must not be eligible for Medicaid.
- Applicants must not be eligible for Medicare.
- Applicants must not have been denied health insurance in the past due to any health reasons for a condition that is still present. (Does not apply to residents of Missouri.)
- Applicants must not be pregnant, an expectant parent, or in process of adoption or undergoing infertility treatment.
- If any applicant has been advised by a medical professional to have diagnostic testing, treatment, surgery that has not yet been completed, they do not qualify.
- If any person to be insured is not a United States citizen, they cannot have resided outside the United States at any time during the prior 12 months.

Within the last 5 years, if any applicant has been diagnosed, had symptoms, an abnormal test result or received treatment, medication or consultation for any of the following ailments, they do not qualify for coverage:

- cancer or malignant melanoma;
- atrial fibrillation or abnormal heart rhythm, heart disorders, angina, heart attack or heart failure;
- stroke, uncontrolled hypertension;
- diabetes except gestational (does not apply to residents of DC);
- hepatitis C or liver or kidney disorders;
- organ transplant;
- chronic obstructive pulmonary disease (COPD) or emphysema;
- rheumatoid arthritis or degenerative disk disease;
- hemophilia, leukemia or blood disorders;
- multiple dystrophy or sclerosis;
- alcohol or drug abuse or misuse;
- bipolar, schizophrenia;
- or an eating disorder(s)
- If an applicant been diagnosed or treated by a medical practitioner for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV), they do not qualify for coverage. (Residents of WI do not need to disclose HIV test results.)

The Bridge to Medicare Plan Coverage Duration

Beginning at age 62, eligible individuals can purchase three back-to-back separate and distinct 364 day short term plans that will provide coverage until Medicare eligibility. Each plan year new coverage periods would go into effect, starting with new deductibles, coinsurance and out of pocket maximums. The limited benefit plan portion of coverage remains inforce throughout the period of coverage. Coverage for the Bridge to Medicare Plan can be terminated by the insured during any billing cycle.

Medicare Eligibility Rules

If your client applies for Medicare in a timely manner according to Medicare guidelines, their coverage starts the first day of the month they turn 65 years of age unless their birthday is on the 1st of the month. If their birthday is on the 1st of the month, they become eligible on the 1st of the prior month. Coverage under Bridge to Medicare will terminate the 1st of the month the consumer turns age 65.

10-Day Free Look

If a consumer is not satisfied for any reason and no claims have been filed, they may cancel their plan within 10 calendar days from the effective date and receive a full refund. The refund will include the first payment and application fee.

Coverage Effective Date

Consumers can select a coverage effective date up to 60 days in advance of their purchase. The first month of coverage plus fees is charged at time of sale, and then payment resumes the month following the first effective date.

SHORT TERM MEDICAL BENEFITS

Temporary health insurance that covers traditional medical services for up to three 364-day policies until individuals are eligible for a Medicare plan.
Benefits based on each 364-day coverage duration, for covered expenses.

	PLAN 1	PLAN 2	PLAN 3
Deductible †	$10,000	$7,500	$5,000
Coinsurance (Plan Pays)	70%	70%	80%
Out-of-Pocket Coinsurance Maximum	$10,000	$10,000	$10,000
Coverage Period Maximum	$250,000	$500,000	$500,000
Prescription Deductible	$500	$500	$0
Prescription Benefit	After $500 Rx deductible, generic copay $10, preferred $50, non-preferred brand $75. No specialty drugs.	After $500 Rx deductible, generic copay $10, preferred $50, non-preferred brand $75. No specialty drugs.	Generic copay $10. After $500 Rx deductible (does not apply to generics), preferred $50, non-preferred brand $75. No specialty drugs.
Outpatient Surgical Facility Deductible*	$500	$500	$500
Inpatient Deductible	$750	$750	$750
Ground Ambulance	Up to $1,000		
Air Ambulance	Up to $2500		
Home Health Care	Up to 40 days		
Hospice	Up to $2000		
Skilled Nursing Facility	Up to $150 per day for a maximum of 60 days		
Mental Illness	Outpatient: $50 per visit; 10 visit max; inpatient: $100 per day, 31 day max		
Physical Therapy	$50 per visit; 20 visit max		

+ Family out-of-pocket deductible limit is three deductibles per family, per coverage period.Emergency Room Deductible: An additional deductible of $250 per visit is payable if not admitted to the hospital, in addition to the standard deductible and coinsurance.

**Outpatient Surgical Facility Deductible: an additional deductible applied to the facility bill.*

Policy Form# STMC5100

This is not Medicare or Medicare supplement coverage.

LIMITED BENEFIT HEALTH INSURANCE

Fixed, first-dollar benefits that pay cash for everyday medical expenses. **Benefits are per day, per plan year**

OFFICE VISITS	PLAN 1	PLAN 2	PLAN 3
Doctor Office Visits	$50 for 5 days	$75 for 5 days	$85 for 6 days
Preventive Care	$100 for 1 day	$100 for 1 day	$150 for 1 day
Physical Therapy	NA	$75 for 5 days	$85 for 6 days
Chiropractor	NA	$75 for 5 days	$85 for 6 days
DIAGNOSTIC			
Outpatient Diagnostics	$50 for 3 days	$75 for 3 days	$85 for 3 days
Advanced Diagnostics (MRI, CT, etc.)	$250 for 1 day	$250 for 1 day	$500 for 1 day
SURGICAL BENEFITS			
Inpatient Surgery	N/A	$250 for 1 day	$250 for 1 day
Inpatient Anesthesia	N/A	$62.50 for 1 day	$62.50 for 1 day
Outpatient Surgery	N/A	$250 for 1 day	$250 for 1 day
Outpatient Anesthesia	N/A	$62.50 for 1 day	$62.50 for 1 day
Outpatient Surgery Facility	N/A	$250 for 1 day	$250 for 1 day
Outpatient Minor Surgery	$75 for 1 day	$75 for 1 day	$75 for 1 day
EMERGENCY ROOM & AMBULANCE			
Emergency Room	$150 for 1 day	$150 for 1 day	$200 for 1 day
Ground-Air-Water Ambulance	NA	$300 for 1 day	$300 for 1 day
INPATIENT HOSPITAL BENEFITS			
First Night Hospital Stay	$250 for 1 day	$250 for 1 day	$250 for 1 day
Hospital Stay, Days 2-30*	$100 for 30 days	$250 for 30 days	$500 for 30 days
ICU*	$200 for 30 days	$500 for 30 days	$1000 for 30 days

** Hospital confinement and Intensive Care Unit confinement are not paid concurrently.*
Mental or nervous disorders confinement, substance abuse confinement, maternity and skilled nursing facility confinement are not eligible. Complications from pregnancy are covered. Benefits and exclusions vary by state. Policy form #LBHP 3250 DE.

Communicating for America Association Benefits

In addition to short term medical insurance, Pivot Health offers added value non-insurance benefits with every plan that include:

Telemedicine
Telemedicine through Doctor on Demand provides fast, easy and affordable access to Board Certified medical doctors (for adults and children), through a video visit on your smartphone or computer from the comfort of home 24/7.* And, consultations are FREE! (Up to five visits per plan year.) Download the Doctor on Demand app on iTunes or Google Play or visit doctorondemand.com to get started for a discounted rate of $49. (Enter "CFA" as the employer name to receive the discount.) When visiting with the doctor, ask for a "superbill" when you visit with the doctor and they will send you the correct form to submit to the claims administrator for reimbursement of your expenses. Once you receive the superbill from Doctor on Demand, email it with the reimbursement request to clientservices@insurancebenefitadministrators.com.

Discount Vision
Consumers save up to 15% on eye exams and 20%–40% on frames, lenses, and contacts.

Plus audiology, hearing aid discounts, emergency helicopter transportation and much more!

Value-Added Benefit

Discount Prescription Drug

In addition to Rx drug coverage, every medical ID card includes prescription drug discount information, which helps consumers save on medications from 58,000 pharmacies nationwide or through home delivery service while waiting to meet the prescription drug deductible.

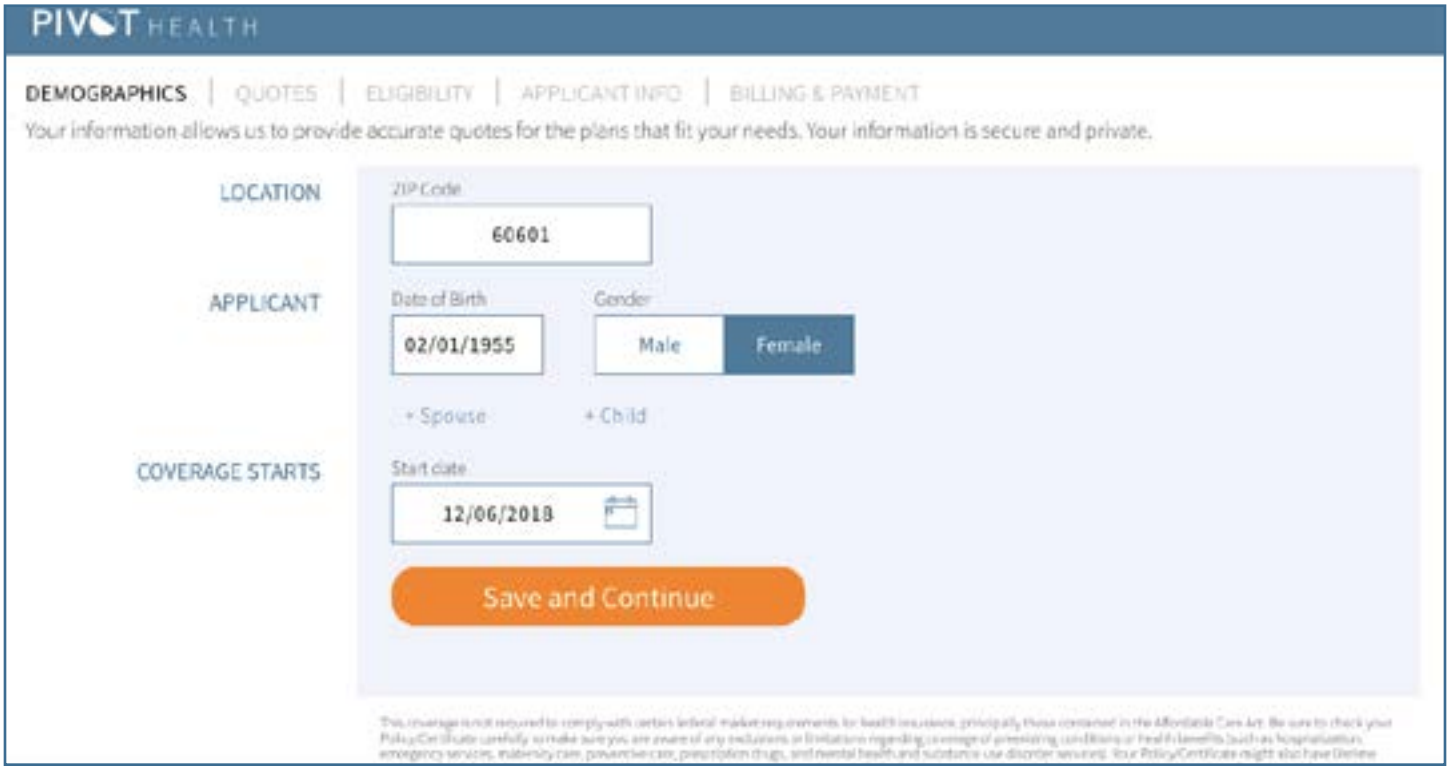
Quoting Process

Below are screenshots of the quote and enrollment process. There are in total five steps to the process which takes an average of about three minutes to complete.

Start The Bridge to Medicare Plan application

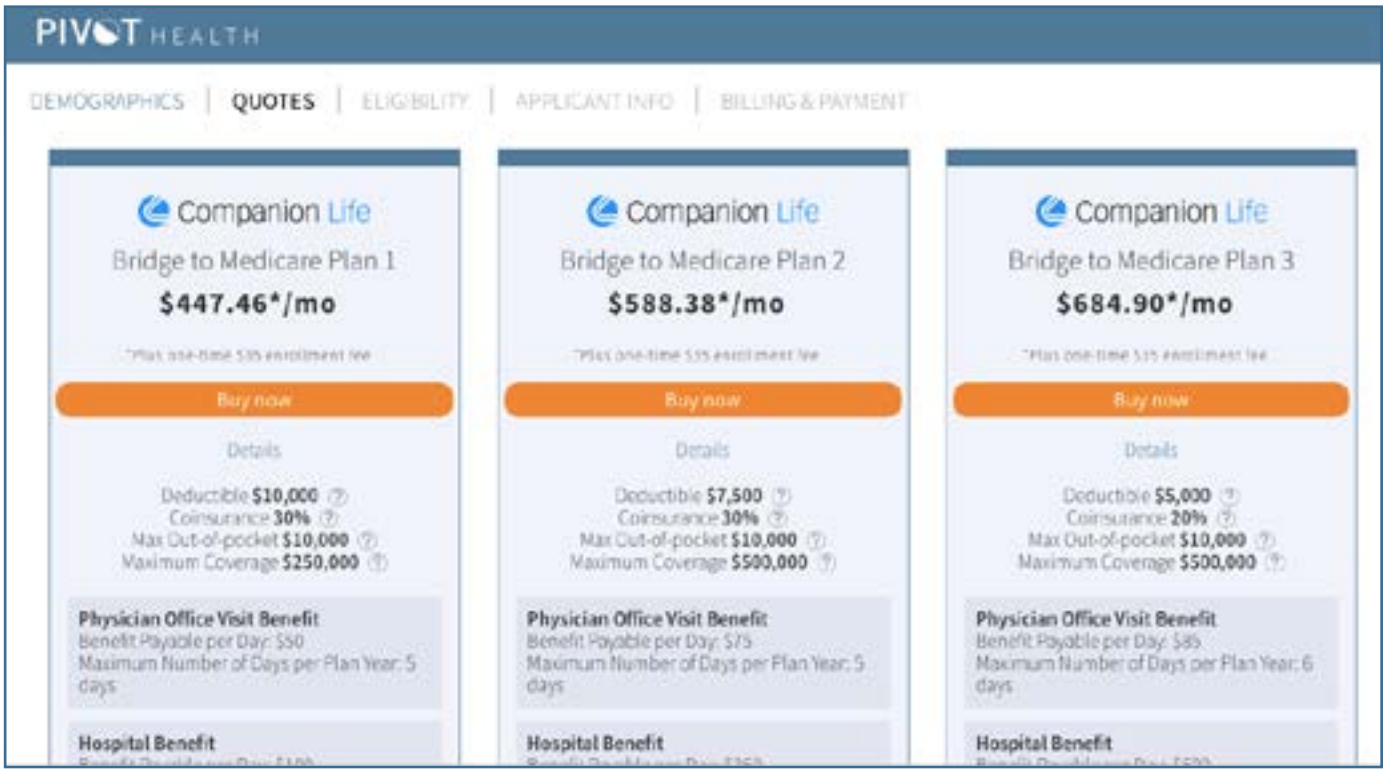
Demographic Information, Coverage Duration and Effective Date Desired

Start The Bridge to Medicare Plan application by answering census questions.



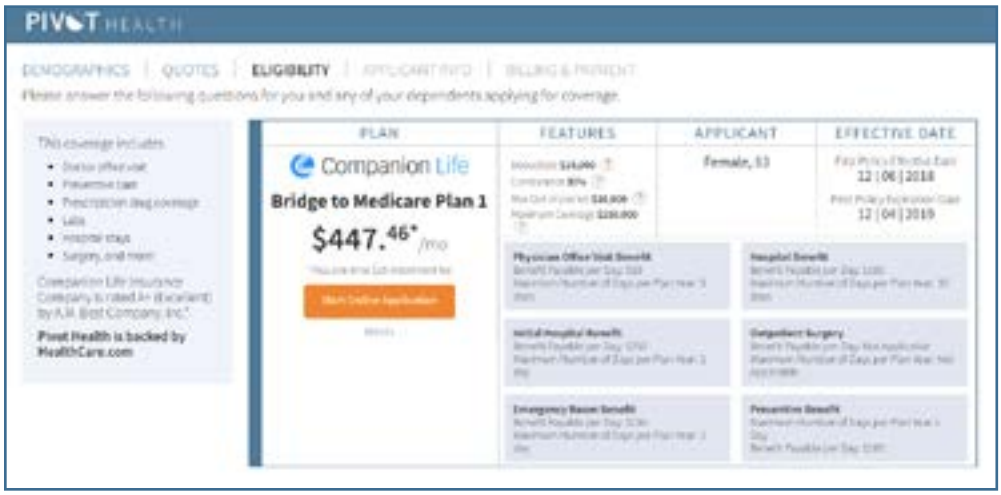
Quote Page

Quote page includes short term medical benefits and highlights of limited benefit health insurance benefits.



Eligibility Page (Medical Questions)

The eligibility page includes plan benefits, monthly premium plan details link and the medical underwriting questions.



Plan Details

Plan details list short term medical benefits first, limited benefit insurance second, with exclusions and limitations by coverage in similar order. Note that you can print a copy of the plan details from the link in the upper right corner.

Bridge to Medicare Plan 1

Print friendly version

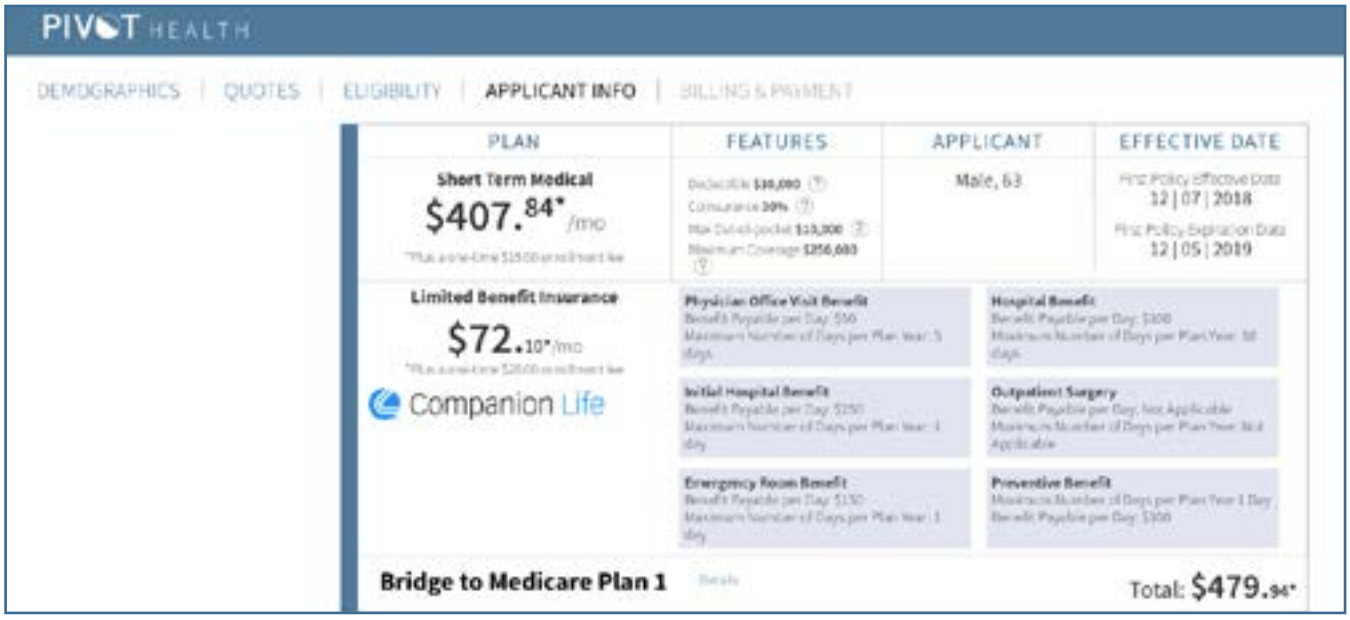
The following benefits are details about your insurance coverage, and coverage for any dependents you wish to include on your Bridge to Medicare policy.

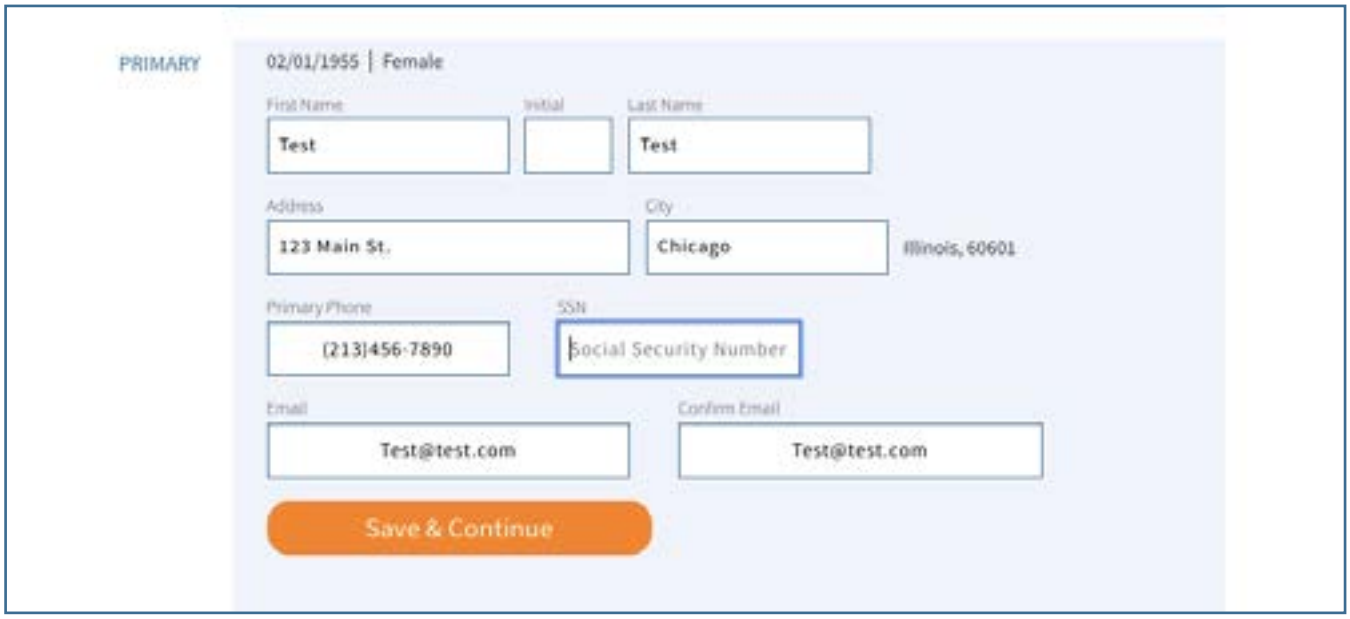
SHORT TERM MEDICAL BENEFITS

Temporary health insurance that covers traditional medical services for up to three years until individuals are eligible for a Medicare plan. Benefits based on each 364-day coverage duration, for covered expenses.	
Underwritten by	Companion Life Insurance Company
Deductible †	$10,000
Coinsurance (Plan Pays)	70%
Out-of-Pocket Coinsurance Maximum	$10,000
Coverage Period Maximum	$250,000
Prescription Deductible	$500
Prescription Benefit	After $500 Rx deductible, generic copay $10, preferred $50, nonpreferred brand $75. No specialty drugs.
Outpatient Surgical Facility Deductible	$500

Application Page

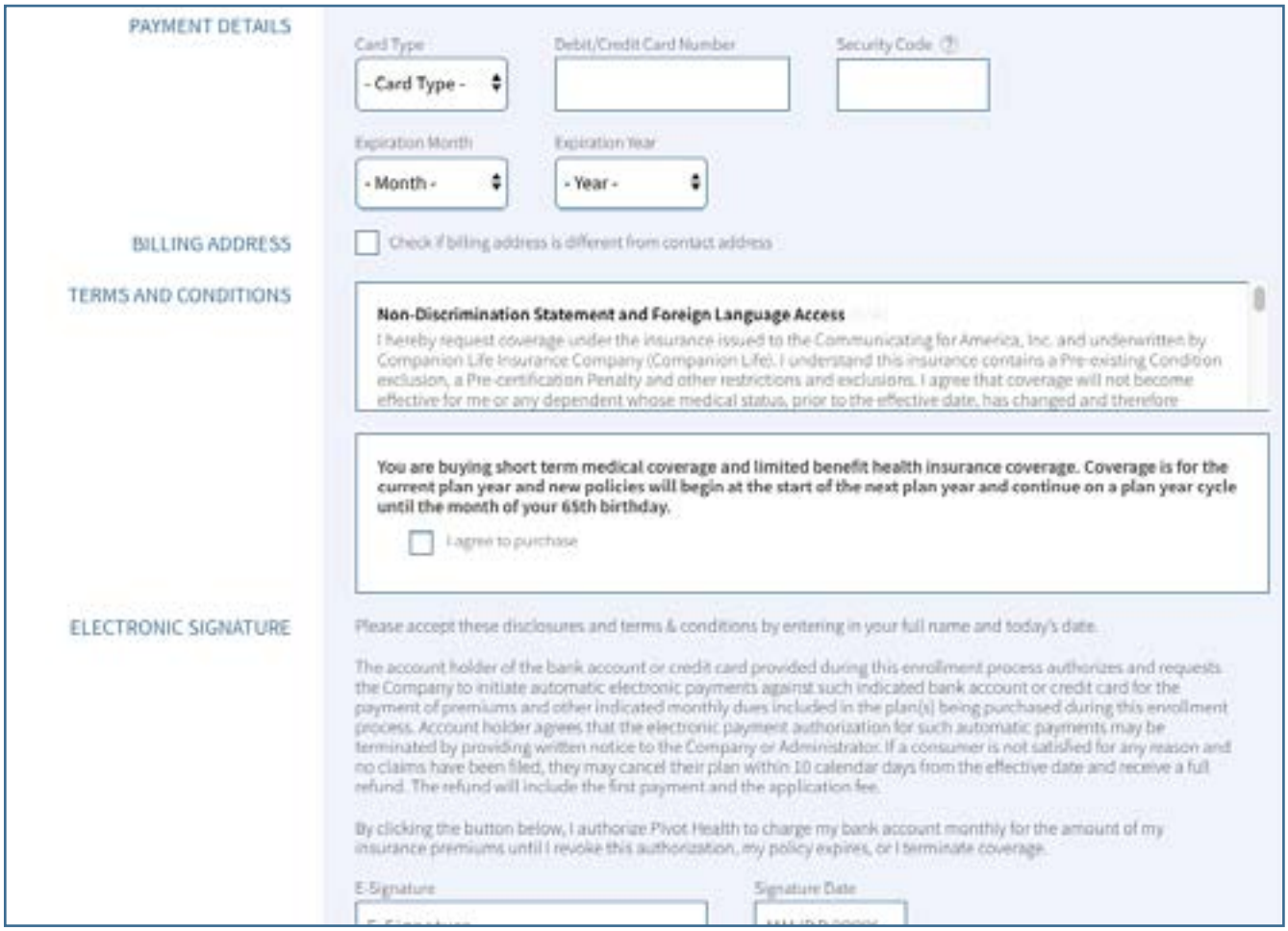
The application page includes plan highlights and premium pricing broken out by certificate - short term medical and limited benefit health insurance. Note that a social security number is required on the application.





Payment Page and Checkout

The payment page includes fields for credit card information and disclosures.
Credit cards are the only method of payment accepted.



How Certificates and Documents are Delivered

Once a consumer completes their application, verifies their length of coverage and pays their premium, they are immediately sent two emails: 1) the Bridge to Medicare Plan welcome email, and 2) an email with a temporary password and encouragement to login to their account to retrieve their policy documents. Producers are copied on their client's welcome email which includes the name of the applicant, type of coverage purchased and premium amount.

Copy of the Pivot Health Plan Order Confirmation:

RE: {first_name}{last_name}
Policy Effective Date: {effective_date}

Welcome to Pivot Health and Bridge to Medicare

Thank you for trusting Pivot Health for your pre-Medicare health insurance needs. This letter confirms your application for Bridge to Medicare medical coverages has been approved.

Bridge to Medicare coverage is a unique package with two types of plans - short term medical insurance (coverage A) and limited benefit health insurance (coverage B).

Coverage A can help you pay for catastrophic type medical expenses beyond your deductible and coinsurance limits. Accident benefits covered under Coverage A start right away, however, to keep your costs down, and to allow all data to be received by service providers, there is a five-day waiting period before coverage begins for sickness or prescription Rx services (30 days waiting period for cancer claims). Benefits for accidents and your non-insurance benefits begin on your policy effective date.

Coverage B provides additional benefits to cover routine specific medical expenses. You will be reimbursed directly for a predetermined dollar amount with is outlined in your schedule of benefits with no deductible or coinsurance limits. It will be important you be familiar with both coverages and review each coverage schedule of benefits.

As a part of your Bridge to Medicare coverage, you receive prescription drugs benefits through Cerpass Rx. Be sure to share your medical ID card with your pharmacy the next time you pick up a prescription to see if you qualify for discounts.

You will soon receive an email with instructions for logging into your personal Pivot Health account. From this account you can retrieve your Bridge to Medicare health insurance medical ID card, Coverage A certificate, and a copy of your completed application. Download your ID card as soon as possible so you have your insurance coverage with you at all times.

In addition, you can immediately access and print your Coverage B insurance certificate and a schedule of benefits by registering online with Insurance Benefits Administrators, the third-party administrator of the plan. Select "Register as a first-time user" and identify yourself as a "Member" to get your account established. From this account you will also be able to monitor any claims activity and payments.

You also receive non-insurance benefits as part of your membership in Communicating for America, a partner of Pivot Health. Some of the most popular benefits include:

- Telemedicine reimbursement that includes low-cost doctor consultations
- Eyewear and hearing aid discounts
- Emergency helicopter evacuation

To download the entire list of your non-insurance benefits, log in to your Pivot Health account and download "About Communicating for America". Due to waiting periods on some of the benefits, please call 800-432-3276 to confirm your waiting period has passed before using the services.

If you have any questions about your insurance benefits, claims or billing please call the administrator of the plan, Insurance Benefits Administrators, at 844-630-7500.

Copy of Pivot Health Temporary Password email:

Welcome Jane Doe,

Your temporary password has been created.
Log in to https://www.pivothealth.com/member/login using the email and password credentials listed below. You will be prompted to change your password before
entering the website.
Email: Jane.Doe@email.com
Password: dv8l-i7nh-ji5x
HAVING PROBLEMS LOGGING IN?
Your new password is case-sensitive and needs to be entered exactly as it appears above.

To login to their account, clients need to visit Pivot Health and select “My Account.”

Consumers should refer to the *Pivot Health Temporary Password* email. They will be prompted to change their password before entering the website with the email and password credentials provided in the email.

Once logged into their account a consumer can download their:

1. Application
2. Medical ID card
3. Schedule of Benefits
4. Association information
5. Policy certificate and amendments

Since fulfillment delivery is completely electronic, brokers do not receive copies of the fulfillment and are not responsible for delivering policy documents to their clients.

Example medical ID card:

Insured by: Companion Life
Provided by Pivot Health

ALL PROVIDERS ACCEPTED

Member Name:

Insured Spouse:
Dependent(s):

Member ID:
Effective Date:
Primary Care Office Visit Copay:
Specialty Doctor Office Visit Copay:
Short term medical insurance — limitations and exclusions apply.
Physician services reimbursement: up to 125% of Medicare allowable. Medical facilities reimbursement: up to 150% of Medicare allowable.

Send Claims To:
Insurance Benefit Administrators c/o Zelis
Box 247 Alpharetta, GA 30009-0247
EDI Payor ID: 07689

BIN: 018729
PCN: GBX
GRP: HCHRX

For Claim & Benefit Questions:
Client Services: 844.630.7500
Benefit Verification: 866.323.2985
Pre-certification: 866.317.5273
Pre-certify to ensure that full benefits will be received.

CERPASSRX Prescription Drug Help Desk: 844.636.7506

Possession of this card does not guarantee eligibility or payment of benefits.
***CerpassRx discount is not insured by Companion Life Ins. Co.*

Email Notice

Consumers who purchase policies for multiple years receive an email approximately five days before their next coverage begins, reminding them to download their new ID card for the upcoming plan year.

Email Notice of Credit Card Rejection

If a credit card is rejected, IBA sends an email to the insured notifying them that their credit card has been rejected for premium payment.

- This notification typically occurs within 24-48 hours of the initial transaction.
- The associated agent is copied on the outbound email to the insured.

Once the grace period is exceeded and no payment has been made, the member is terminated and a termination notification and sent via mail to both insured and their agent.

Short Term Medical Exclusions and Limitations

1. Pre-existing Conditions
   a. Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice within the sixty-month period immediately preceding such person's Effective Date are excluded for the first 12 months of coverage hereunder.

   b. Pre-existing conditions includes conditions that produced any symptoms which would have caused a reasonable person to seek diagnosis, care or treatment within the sixty-month period immediately prior to the coverage effective date.

This exclusion does not apply to a newborn or newly adopted child who is added to coverage under this certificate in accordance with PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE.

2. Waiting Periods
   a. Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, at least 5 days following the Covered Person's Effective Date of coverage under the policy.

   b. Covered Persons will only be entitled to receive benefits for Cancer that begins, by occurrence of symptoms or receipt of treatment at least 30 days following the Covered Person's Effective Date of coverage under the policy.

3. Outpatient Prescription Drugs, medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the- counter medicines, whether or not ordered by a Doctor, unless specifically covered under the Policy.

4. Routine pre-natal care, Pregnancy, child birth, and post natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)

5. Alcoholism.

6. Substance Abuse.

7. Charges which are not incurred by a Covered Person during his/her Coverage Period.

8. Treatment, services or supplies which are not administered by or under the supervision of a Doctor.

9. Treatment, services or supplies which are not Medically Necessary as defined.

10. Treatment, services or supplies provided at no cost to the Covered Person.

11. Charges which exceed Usual and Customary charge as defined.

12. Telephone consultations or failure to keep a scheduled appointment.

13. Consultations and/or treatment provided over the Internet.

14. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.

15. All charges Incurred while confined primarily to receive Custodial or Convalescent Care, unless specifically covered under the Hospice Benefit under the Policy.

16. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.

17. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.

18. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery which is expressly covered under this certificate.

19. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.

20. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction.

21. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.

22. Dental treatment, except for dental treatment that is expressly covered under this certificate.

23. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, and all vision and hearing tests and examinations.

24. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.

25. Treatment for cataracts.

26. Treatment of the temporomandibular joint.

27. Injuries resulting from participation in any form of skydiving, scuba diving, auto racing, bungee jumping, hang or ultralight gliding, parasailing, sail planing, flying in an aircraft (other than as a passenger on a commercial airline), rodeo contests or as a result of participating in any professional, semi-professional or other non-recreational sports including boating, motorcycling, skiing, riding all-terrain vehicles or dirt-bikes, snowmobiling or go-carting.

28. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.

29. Willfully self-inflicted Injury or Sickness.

30. Venereal disease, including all sexually transmitted diseases and conditions.

31. Immunizations and Routine Physical Exams.

32. Services received for any condition caused by a Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.

33. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.

34. Any services performed or supplies provided by a member of the Insured's Immediate Family.

35. Orthoptics and visual eye training.

36. Services or supplies which are not included as eligible Expenses as described herein.

37. Care, treatment or supplies for the feet: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.

38. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.

39. Treatment of sleep disorders.

40. Hypnotherapy when used to treat conditions that are not recognized as Mental or Nervous Disorders by the American Psychiatric Association, and biofeedback, and non-medical self-care or self-help programs.

41. Any services or supplies in connection with cigarette smoking cessation.

42. Exercise programs, whether or not prescribed or recommended by a Doctor.

43. Treatment required as a result of complications or consequences of a treatment or condition not covered under this certificate.

44. Charges for travel or accommodations, except as expressly provided for local ambulance.

45. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
46. Organ or Tissue Transplants or related services.

47. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus.

48. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.

49. Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to the certificate.

50. Spinal manipulation or adjustment.

51. Sclerotherapy for veins of the extremities.

52. Charges during the first 6 months after the Effective Date of coverage for a Covered Person for the following (subject to all other coverage provisions, including but not limited to the Pre-existing Condition exclusion):

a. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma;
b. Tonsillectomy;
c. Adenoidectomy;
d. Repair of deviated nasal septum or any type of surgery involving the sinus;
e. Myringotomy;
f. Tympanotomy;
g. Herniorraphy; or
h. Cholecystectomy

53. Chronic fatigue or pain disorders; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or related immunodeficiency disorders.

54. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.

55. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.

56. Kidney or end stage renal disease.

57. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.

58. Charges resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.

59. Charges incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to the Covered Person on a pro-rated basis.

60. Injury or Sickness arising out of and in the course of any occupation for compensation, wage or profit, including expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits have been made.

Limited Benefit Insurance Exclusions & Limitations

No benefits will be payable for expenses incurred as a result of a Pre-Existing Condition until the earlier of: (a) the end of a continuous period of 12 months commencing on or after the Covered Person's effective date of coverage under the Policy during all of which the Covered Person has received no medical advice or treatment in connection with such Pre-Existing Condition; or (b) coverage has been in effect under the Policy for 12 consecutive months.

Other Limitations and Exclusions

(a) suicide or any attempted thereat, while sane;

(b) any intentionally self-inflicted injury or Sickness;

(c) rest care or rehabilitative care and treatment;

(d) cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery resulting from a covered Accident if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;

(e) immunization shots and routine examinations such as: health exams; periodic checkups; pre-marital exams; and routine physicals;

(f) routine newborn care, including routine nursery charges;

(g) voluntary abortion, except with respect to the Insured or covered Dependent spouse: (1) where such person's life would be endangered if the fetus were carried to term; or (2) where medical complications have arisen from an abortion;

(h) normal pregnancy, except for Complications of Pregnancy;

(i) the treatment of: (1) mental illness; (2) functional or organic nervous disorder, regardless of cause; (3) alcohol abuse; (4) drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed for more than 10 days in any Benefit Year, with respect to payment of the Daily In-Hospital Indemnity Benefit;

(j) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;

(k) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;

(l) participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee-jumping, or hang gliding;

(m) air travel, except: (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or (2) as a passenger for transportation only and not as a pilot or crew member;

(n) any Accident occurring as a result of the Covered Person being intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Accident took place);

(o) sex changes;

(p) experimental treatments or surgery;

(q) the reversal of tubal ligation and vasectomies;

(r) artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or Physician's services, unless required by law;

(s) treatment of exogenous obesity or weight control;

(t) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war.

(u) accident or sickness arising out of and in the course of any occupation for compensation, wage or profit. Expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits have been made;

(w) air or ground ambulance service on Plan 1 only;

(x) for loss incurred, care of treatment received, or hospital confinement occurring outside of the United States or its possessions (except in the case of an emergency)

(y) Dentistry or oral surgery except: (1) Excision of impacted third molars; or (2) Closed or open reduction of fractures or dislocation of the jaw.

In addition to the Exclusions and Limitations for all coverages, the following are not covered under the Out-Patient Physician Office Visit Indemnity Benefit and the Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit: (a) visits made, examinations given, or x-rays or laboratory tests performed as an in-patient while Confined to a Hospital; (b) routine eye examinations or fitting of glasses; (c) fitting of hearing aids; (d) dental examinations or dental care other than expenses resulting from accidental injury; and (e) benefits which are provided under any other part of this Policy.

State-Specific Variations
Claims Processing and Resolution

Claims are processed and paid by IBA National, and insureds should contact IBA for all questions regarding claims. They can be reached Monday – Friday, 8:30 a.m. to 4:30 p.m. CST. Missing or incorrect information may result in a delay in processing the claim. Providers or insureds must submit medical expense claims which can be addressed to: IBA c/o Global Care, Box 247, Alpharetta, GA 30009-0247. Reference EDI Payor ID: 07689.

Telephone: 844-630-7500
Email: clientservices@insurancebenefitadministrators.com

Pre-certification is required for inpatient admissions or outpatient surgeries over $5000.
Telephone: 866-317-5273

If a consumer believes a claim has been wrongfully denied, email clientservices@insurancebenefitadministrators.com.

Agent Website and Marketing Materials

- All advertising and training material must be pre-approved by Pivot Health before distributing, including website presentations and training material where Pivot Health, Companion Life or Insurance Benefit Administrators are mentioned.

Free Look Period and Cancellations

- The 10-day free look period is available, and if no claims are made during that time, the initial payment will be fully refunded, including the application fee.
- Credit and debit cards are the required method of payment – Visa, Mastercard and Discover only. Cancellation of coverage when billing is monthly requires notice from the insured in writing or a call to IBA's client services. Coverage will terminate as of the next due date.
- Cancellation of a Bridge to Medicare Plan results in the cancellation of both the short term medical and limited benefit insurance plans.

Domestic Partner Relationships

- Domestic partnerships and same-sex marriages may apply as "primary" and "spouse" on the application.

Voice Verification

- Call centers who market Pivot Health products telephonically have special requirements that must be followed, including voice verification of sales and random audits. Please contact Pivot Health before marketing this product telephonically through a call center environment at agentsupport@pivothealth.com.

Commissions

Insurance Benefit Administrators (IBA) is the administrator of broker commissions and monthly reporting statements. If IBA is paying the broker directly, commissions are paid based on the effective date of the coverage and paid approximately the 15th of the month for the previous month's business. If you have assigned commissions to a general agent, check with that organization regarding the timing of commissions. Note: since the Bridge to Medicare Plan is two certificates, commissions are paid in two separate payments.

Insurance Benefit Administrators Agent Portal

IBA provides agents an online portal to view current cases that have been submitted. To create an account, visit IBA's Agent Self-Service website and select "Register as first time user."
Also note:

- You must be appointed and have an IBA agent number before gaining access to the site.
- You must have business already placed.
- If you have previously signed up with IBA for other products, use your existing login information.

If you have questions about your commission statement, please contact IBA. Representatives at IBA can be reached Monday – Friday, 8:30 a.m. to 4:30 p.m. CST.

Telephone: 844-630-7500
Email: clientservices@insurancebenefitadministrators.com

Note: Business is reflected in the portal 3-4 business days following enrollment.

Co-Branded Upline Agency Landing Page

Co-branded agent landing pages are available with customized links, giving brokers the opportunity to email a link to Pivot Health's short term medical plans to clients showing the agency's logo, producer's name, email and telephone number. To submit your agency logo email the image to PHcontracting@pivothealth.com. Preferred standards are: 1) a vector logo (Illustrator file); or 2) a 200 pixel tall .png or .jpg logo.

Pivot Health Website Functionality

The Pivot Health website is designed to work from a computer desktop and respond to mobile devices. Here are a few tips to make your experience with the website as user-friendly and functional as possible.

1. The website on a desktop looks like this. Notice that your clients can log in to their Pivot Health accounts in the upper right corner. They are able to access all of their policy documents, application and medical ID card from their account. If you do not see the My Account please set your screen font to a smaller size or maximize your screen to a full size view.

If a client is on a mobile device, they will see this:

2. If you are running multiple quotes for clients, you may need to clear your cache to avoid a prior client's ZIP code from populating the ZIP field.

To clear cache, clear browser history. This will not clear any saved passwords. From menu bar:

– Safari: Safari -> Clear History

– Chrome: Chrome -> Clear Browsing Data

– Firefox: Firefox -> History -> Clear Recent History

– Internet Explorer 11: Tools -> Browsing History -> Delete

– Microsoft Edge: Select three dots in upper left of browser -> Settings -> Clear Browsing Data

Non-Discrimination Statement

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If someone you're assisting needs interpretation assistance, free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed in this non-discrimination policy.

Frequently Asked Questions

Does The Bridge to Medicare Plan qualify as a major medical insurance plan and include "essential benefits" that are required by current law?

No, The Bridge to Medicare Plan is not comprehensive, major medical health insurance.

When is each monthly payment deducted from my account?

There are two charges each month - one for the short term medical certificate and one charge for the limited benefit health insurance certificate. The first payments are taken at the time of sale and applied to the first monthly premium statement and charged immediately for the first 30 days of coverage. The second monthly premium statement will be charged on or around the 10th of the month if the coverage effective date is between the 1st and 19th of the month. For coverages effective between the 20th and 30th/31st the credit card will be charged on or around the 22nd. All premiums are drafted on normal business days.

What is the network?

There is no network. Consumers can see any doctor or hospital facility. Billing is repriced based on the usual and customary fee schedule which is stated on the medical plan ID card.

The deductible and coinsurance do not add up to the maximum out-of-pocket. Why?

The deductible does not go towards maximum out-of-pocket. Out-of-pocket expenses are strictly tied to coinsurance. For example, if an individual has a $5,000 deductible, 30% coinsurance and a $10,000 maximum out-of-pocket, they first have to meet their $5,000 deductible, then have more than $30,000 in claims, of which they pay 30%, in order to meet their maximum out-of-pocket amount of $10,000.

Explain the Usual and Customary Billing Process.

The Pivot Health claims reimbursement system is set up to guarantee that no member will be responsible for a balance bill due to the discount taken for charges above the Medicare Reference Pricing amount, subject to the terms outlined in the certificate of insurance. This insurance plan reimburses medical providers based on a percentage above Medicare allowable amounts, paying:

- 150% of Medicare allowable amount for medical facilities
- 125% of Medicare allowable amount for physician claims

When bills are received, they are repriced according to these percentages of the Medicare allowed amounts, based on the Medicare fee schedule. Payment is made to the provider based on this amount and the reduction shown as a discount by the provider.

If a provider wishes to review and discuss the allowed amount or initially objects to the reimbursement amount, the provider is connected with the repricing vendor. The repricing vendor is authorized to negotiate a settlement.

In addition, providers are contacted proactively, to confirm that they are accepting the reimbursements and not shifting costs to members.

If the provider bills the member for any portion of the discount, the member may refer that bill to IBA who will initiate the negotiation process.

- The member needs to send a copy of the bill to IBA to validate the provider is billing for the discount.
- The member is responsible for their out of pocket amounts (deductible and coinsurance). However, some members may not be clear on exactly what is being billed by the provider.IBA National will research and advise the insured if the discount has been applied or initiate contact with the provider by the repricing vendor.

When insured members have questions or concerns, they should submit the bill to IBA by email to clientservices@insurancebenefitadministrators.com

May spouses and dependent children be enrolled in The Bridge to Medicare Plan?

Yes. Spouses and dependent children under the age of 26 may be added to the primary applicant's application. The primary applicant must be between the ages of 62 years and 64 years and 11 months.

If an insured resides in a state where the plan is available and moves to a state where the The Bridge to Medicare Plan is not available, can the Insured keep their coverage?

Yes, however, benefits are based on the state the plan was issued in.

If the Insured moves from one state to another state where the plan is offered, do we change their rates to the state where they move to?

No, however, benefits are based on the state the plan was issued in. There is no guarantee both insurance certificates will be available in a new state of residence.

If a primary insured wishes to terminate coverage for themselves alone, can the remaining dependents keep their coverage? How are rates impacted?

If a primary member cancels their coverage, the spouse or oldest dependent can become the primary member of the policy if they wish to keep the coverage. New rates will apply.

If a dependent child reaches age 26, do they automatically get transferred to their own plan OR do they need to apply for a new plan?

Any dependent children who reach the age of 26 must apply for separate coverage. They are not eligible for The Bridge to Medicare Plan.

If the primary insured reaches age 65, what happens to the other covered dependents?

If a primary insured reaches age 65 during the term of their coverage, the plan runs out at the end of the term. Any covered dependents can re-apply at PivotHealth.com or contact their agent for help re-enrolling. New rates apply, and a new certificate will be issued at time of sale.

How does a client cancel their Bridge to Medicare Plan?

Brokers have the ability to cancel clients in the agent portal of the IBA National Self-Service login. Or, you can send an email to clientservices@alliednational.com requesting the cancellation on behalf of your client. However, you must have the consent of your client in order to cancel the certificate.

Can you pre-pay all three 364-day plans at once?

No. Pivot Health's pre-pay option is not available on The Bridge to Medicare Plan.

Can a policyholder delete a dependent from their plan or add a new dependent?

Dependents can be deleted from a plan by contacting IBA at 844-630-7500. Additional new dependents cannot be added to existing policies without a new application and enrollment.

Is the Pivot Health website secure?

Yes, the Pivot Health website has an SSL certificate, which makes the site secure. The site also contains security icons throughout the application process so clients can feel confident their information is secure as they enroll in a Pivot Health product.

How does the prescription drug benefit work?

If your client has a Plan 1 or Plan 2, they have to meet a $500 drug deductible before their copay pricing kicks in. Tell your client they need to instruct the pharmacy technician to use the "Rx Group #" located on the back of the card to receive a discount up to their $500 deductible. Once they hit their deductible you are then only responsible for the copay amount.

If your client has a Plan 3, generics are $10 with no deductible. For name brand and non-preferred drugs, there is a $500 deductible, and then copays apply (name brand - $50 and non-preferred drugs - $75) once the deductible is met. Specialty drugs are not covered.