PIVOT HEALTH

SHORT TERM MEDICAL

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. These plans are subject to a tax penalty. Plans include pre-existing limitation provisions that may prevent coverage from applying to medical conditions that existed prior to the plan effective date.

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 founders 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 becomes too costly.
- Unemployment strikes.
- Children age off their parent's plan.
- 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.
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!

Short Term Medical Coverage Duration

90-Days or Four 90-Days Plans Pivot Health offers clients the opportunity to apply for one 90-day policy which gives them nearly 3-months of coverage. We also allow your clients to apply for four (4) back-to-back 90-day policies at one time. They do not have to qualify again for the three additional policies, there are no additional waiting periods, and you can cancel at any time. New ID card must be downloaded every 90-days to ensure coverage is current. Pre-payment option is available for a discounted rate on shorter 90-day-only plans. For the first policy, pre-existing conditions diagnosed within the 60-month period immediately preceding the covered person's effective date are excluded for the first 12 months of coverage.

180-Days of Coverage Get one policy for up to 180 days (approximately 6 months).

364-Days of Coverage If your clients need health insurance coverage for nearly a year while they wait for additional coverage, 364-days of short term health insurance can take them the distance.

State Specific Coverage Duration Rules

Arizona	Coverage may consist of four consecutive non-renewable policies or less in any 12-month period, then individual must wait 63 days from the termination date of the last short term policy by Companion Life Insurance Company beforeenrolling again.
Idaho	After 90 days of coverage, individual must wait 64 days from the termination of the last short term policy before re-enrolling.
Michigan	Limited to 185 days of coverage in a 365 day period with one carrier.
Nevada	After 180 days of coverage, individual must wait 180 days from the termination of the last short term policy before re-enrolling.
North Dakota	After 180 days of coverage, individual must wait 30 days from the termination of the last short term policy before re-enrolling.
Oregon	After 90 days of coverage, individual must wait 60 days from the termination of the last short term policy before re-enrolling.
Wisconsin	After 18 months of coverage, individual must wait 63 days from termination of last short term policy from Companion Life Insurance Company before enrolling again.

Pre-Existing Expense Allowance

Pivot Health's short term medical (STM) plans have a pre-existing condition expense allowance. Essentially, it allows for pre-existing conditions which have a very limited expense (half the deductible) to be adjudicated without a pre-existing investigation of the claims to be initiated.

This provision means the claims administrator will minimize its need to determine if submitted claims are on medical conditions that fall within the pre-existing limitation provision until total claims exceed half of the plan deductible. This helps reduce claims processing time when medical expense claims are just being applied to the plan deductible.

10-Day Free Look

If you are not 100% satisfied with your Companion Life insurance plan, provide a written request for cancellation to Companion Life within 10 days of receipt. Certificate of coverage will be canceled as of the effective date and your premium will be returned.

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 Underwriting Requirements

Here is a list of underwriting requirements for Pivot Health short term medical coverage:

- Primary applicant must be 6-months to 64 years and 11 months of age.
- Newborns can be added to the policy up to 30 days
- 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.)

Classic Short Term Medical Plans
Benefits Chart

Companion Life	ECONOMY	CHOICE	STANDARD	DELUXE
Deductible	$3,000, $5,000, $7,500 or $10,000	$1,000, $2,000, $5,000, or $10,000	$2,000, $3,000 or $5,000	$1,000, $2,500 or $5,000
Coinsurance	20% or 30%	20% or 30%	20%	20%
Coinsurance Maximum Out-of-Pocket †	$10,000	$10,000	$5,000	$3,000
Coverage Period Max Benefit	$100,000 or $500,000	$100,000, $250,000 or $1,000,000	$250,000 or $500,000	$500,000 or $1,000,000
Prescription Drugs	Discount only	Discount only	After $500 Rx deductible, generic copay $10, preferred $50, non-preferred brand $75. No specialty drugs.	Generics copay $10. After $500 Rx deductible (does not apply to generics), preferred $50, non-preferred brand $75. No specialty drugs.
Primary Doctor Office Visit*	Subject to deductible and coinsurance	$30 primary doctor copay	Subject to deductible and coinsurance	$30 primary doctor copay
Specialty Doctor Office Visit*	Subject to deductible and coinsurance	$60 Urgent Care and specialty physician copay	Subject to deductible and coinsurance	$60 Urgent Care and specialty physician copay
Additional Emergency Room Deductible**	$450 plus medical deductible & coinsurance	$250 plus medical deductible & coinsurance	$350 plus medical deductible & coinsurance	$250 plus medical deductible & coinsurance
Inpatient Hospital Benefits	Subject to deducitble and coinsurance	Subject to deducitble and coinsurance	Subject to deducitble and coinsurance	Subject to deducitble and coinsurance
Additional Outpatient Surgical Facility Deductible***	$500 plus medical deductible and coinsurance	Medical deductible and coinsurance	Medical deductible and coinsurance	Medical deductible and coinsurance
Additional Inpatient Admission Deductible	$750 plus deductible & coinsurance	$0 plus deductible & coinsurance	$500 plus deductible & coinsurance	$0 plus deductible & coinsurance
Ground Ambulance	Up to $1,000 per coverage period			
Air Ambulance	Up to $2,500 per coverage period			
Home Health Care	Maximum of 40 days			
Athletic Injury ‡	Same as any other illness/accident			
Physical Therapy	$50 per visit; 20 visit max			
Mental Illness	Outpatient: $50 per visit; 10 visit max; inpatient: $100 per day, 31 day max			
Network	No network -all access			
Out-of-Network Coverage	Yes			
Benefit Rules & Limitations	*Primary Physician, Specialist & Urgent Care Office Visit Copay: Limited to 3 visits per coverage period. Additional services and tests subject to deductible and coinsurance. **Emergency Room Deductible: An additional deductible is payable if not admitted to the hospital, in addition to the standard deductible and coinsurance apply. ***Outpatient Surgical Facility Deductible: an additional deductible applied to the facility bill. ‡ Semi professional, professional, non-recreation and hazardous sports are excluded.† Family out-of-pocket limit is three times the individual maximum. See Plan Details for additional limitations and exclusions.			

Core Short Term Medical Plans Benefits Chart

	CORE 1000	CORE 2000
Deductible	*$1,000*	*$2,000*
Coinsurance	*20%*	
Coinsurance Maximum Out-of-Pocket †	*$1,000*	
Coverage Period Max Benefit	*$750,000*	
Prescription Drugs	*Discount only*	*Generics copay $10. After $500 Rx deductible (does not apply to generics), preferred $50, non-preferred brand $75. No specialty drugs.*
Network	*PPO*	
Primary Doctor Office Visit*	*$30 copay*	
Urgent Care and Specialty Doctor Office Visit*	*$60 copay*	
Outpatient Emergency Room	*Up to $500 maximum per day*	
Outpatient Surgical Facility	*Up to $1,000 maximum per day*	
Semi-Private Hospital Room & Board	*Up to $1,000 maximum per day*	
Intensive Care Unit	*Up to $1,250 maximum per day*	
Surgeon Services	*Up to $2,500 per surgery, up to $5,000 maximum per coverage period*	
Local Ambulance	*Up to $250 maximum per trip if related to a covered injury, $250 maximum per trip for a covered sickness if hospitalized*	
Home Health Care	*1 visit per day up to 40 days per coverage period*	
Extended Care Facility	*$150 maximum per day up to 60 days*	
Athletic Injury **	*Same as any other illness/accident*	
Physical Therapy	*$50 per visit per day*	
Out-of-Network Coverage	*Yes*	

Benefit Rules & Limitations:

† Family out-of-pocket limit is three times the individual maximum. See Plan Details for additional limitations and exclusions.

** Primary Physician, Specialist & Urgent Care Office Visit Copay: Limited to 3 visits per coverage period. Additional services and tests subject to deductible and coinsurance.*

*** Semi professional, professional, non-recreation and hazardous sports are excluded.*

Copays, deductibles and penalties do not accumulate toward the out-of-pocket maximums.

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
Doctor on Demand is a video consultation service with board certified doctors who can diagnose and write prescriptions for most medical problems. Visits are $49 (an average of $100 in savings). Clients receive information about accessing Doctor on Demand in their welcome/ confirmation email.

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

Value-Added Benefit

Discount Prescription Drug

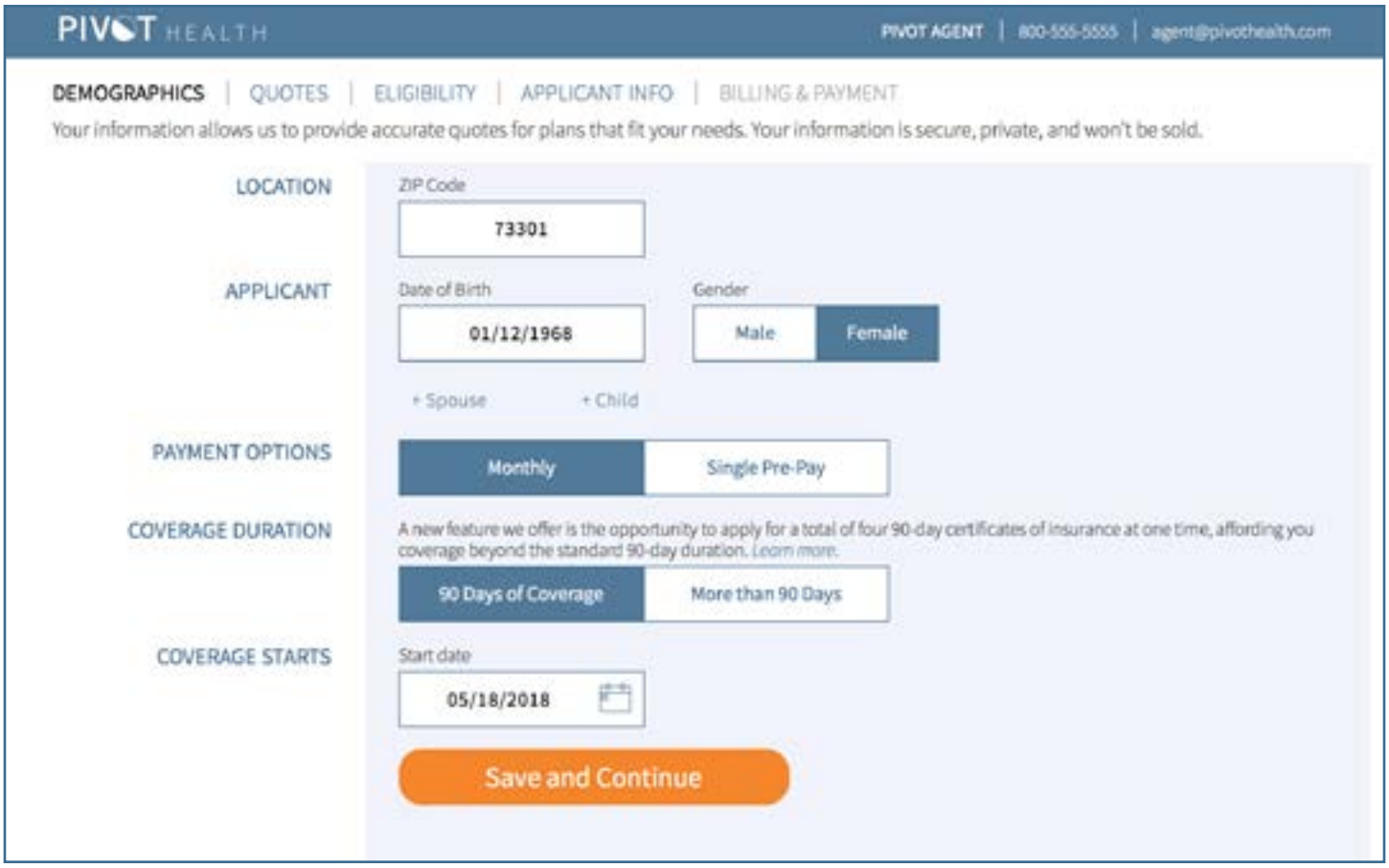
In addition to Rx drug coverage, every medical ID card includes prescription drug discount information, which helps consumers save on medications from 66,000 pharmacies nationwide or through home delivery service while waiting to meet the prescription drug deductible.

Quoting Process

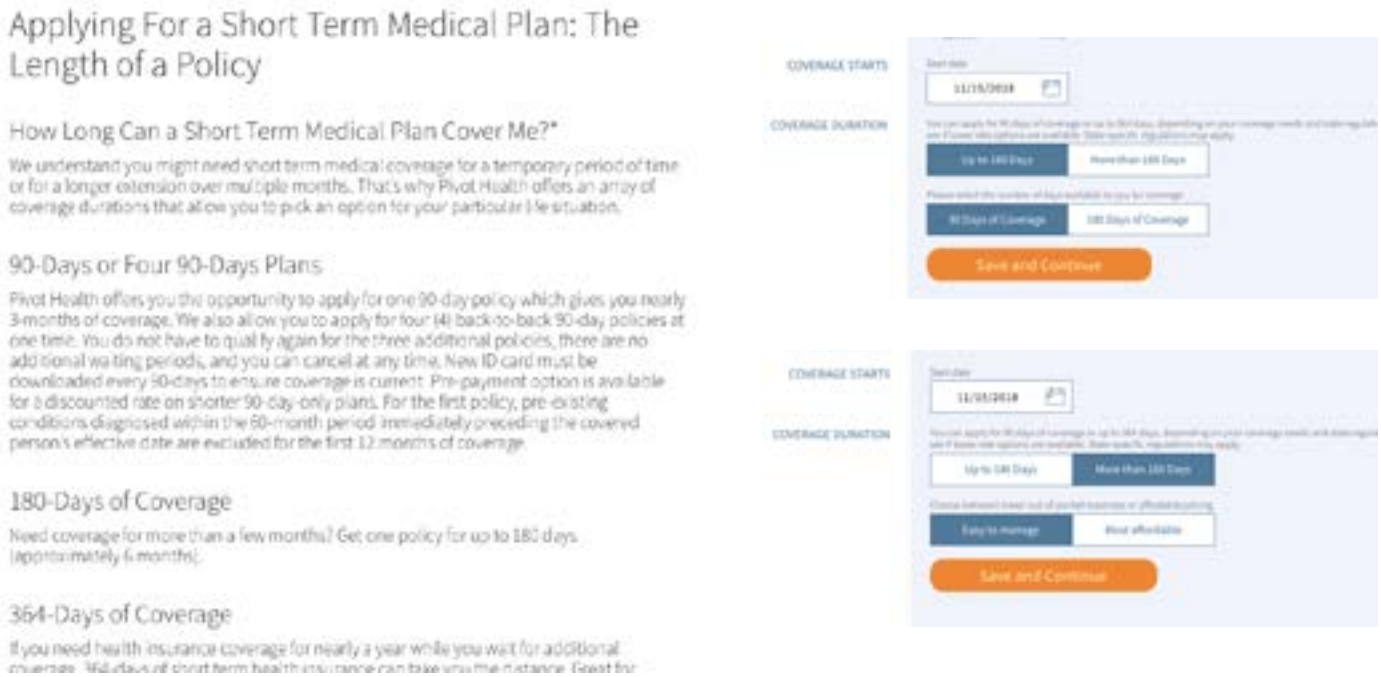
Below are screenshots of the quote and enrollment process. There are in total five steps to the process which takes an average of about three minutes to complete.

Co-Branded Landing Page

Demographic Census Information, Coverage Duration and Effective Date Desired



Coverage Duration Options



Applying For a Short Term Medical Plan: The Length of a Policy

How Long Can a Short Term Medical Plan Cover Me?*

We understand you might need short term medical coverage for a temporary period of time or for a longer extension over multiple months. That's why Pivot Health offers an array of coverage durations that allow you to pick an option for your particular life situation.

90-Days or Four 90-Days Plans

Pivot Health offers you the opportunity to apply for one 90-day policy which gives you nearly 3-months of coverage. We also allow you to apply for four (4) back-to-back 90-day policies at one time. You do not have to qual fy again for the three additional policies, there are no additional wa ting periods, and you can cancel at any time. New ID card must be downloaded every 90-days to ens..re coverage is current. Pre-payment option is ava lable for a discounted rate on shorter 90-day-only plans. For the first policy, pre-existing conditions diagnosed within the 60-month period immediately preceding the covered person's effective date are excluded for the first 12 months of coverage.

180-Days of Coverage

Need coverage for more than a few months? Get one policy for up to 180 days (approximately 6 months).

364-Days of Coverage

If you need health insurance coverage for nearly a year while you wait for additional

COVERAGE STARTS

COVERAGE DURATION

Save and Continue

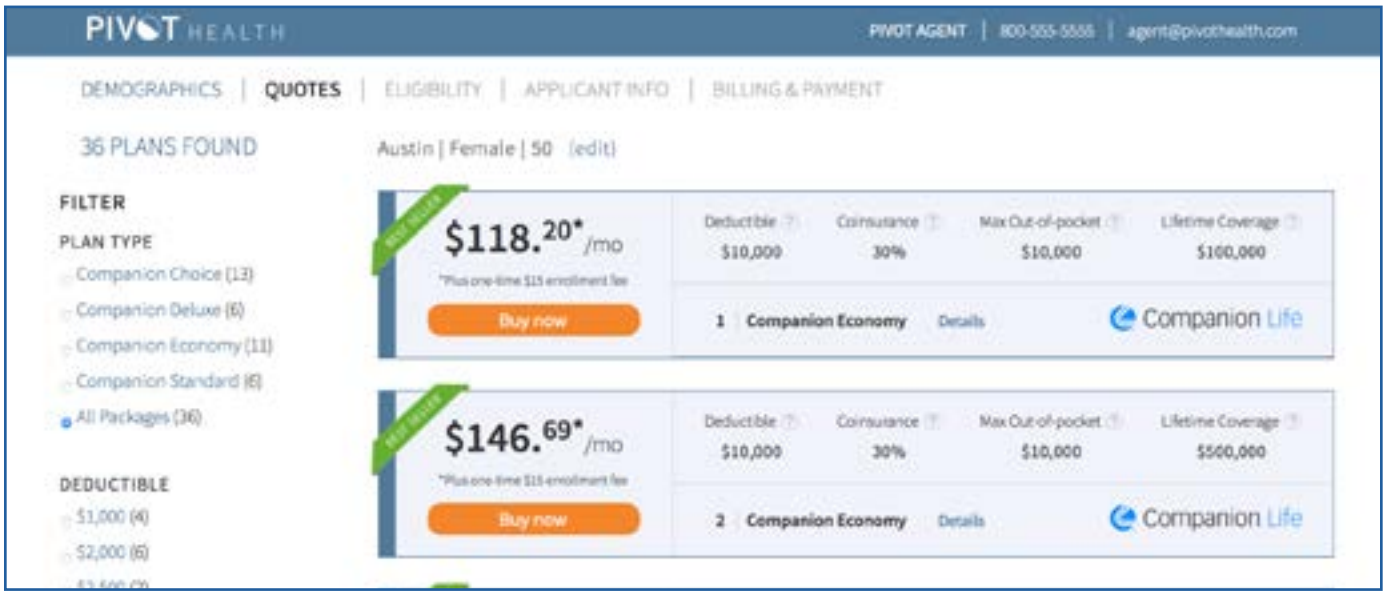
COVERAGE STARTS

COVERAGE DURATION

Save and Continue

Quote Page

(Note: There are pop-ups next to each insurance term to help consumers better understand what their out-of-pocket responsibilities are.)



PIVOT HEALTH

PIVOT AGENT | 800-555-5555 | agent@pivothealth.com

DEMOGRAPHICS | QUOTES | ELIGIBILITY | APPLICANT INFO | BILLING & PAYMENT

36 PLANS FOUND

Austin | Female | 50 (edit)

FILTER

PLAN TYPE

- Companion Choice (12)
- Companion Deluxe (6)
- Companion Economy (11)
- Companion Standard (6)
- All Packages (36)

DEDUCTIBLE

- $1,000 (4)
- $2,000 (6)

$118.20* /mo

*Plus one-time $15 enrollment fee

Buy now

Deductible	Coinsurance	Max Out-of-pocket	Lifetime Coverage
$10,000	30%	$10,000	$100,000

1 Companion Economy Details Companion Life

$146.69* /mo

*Plus one-time $15 enrollment fee

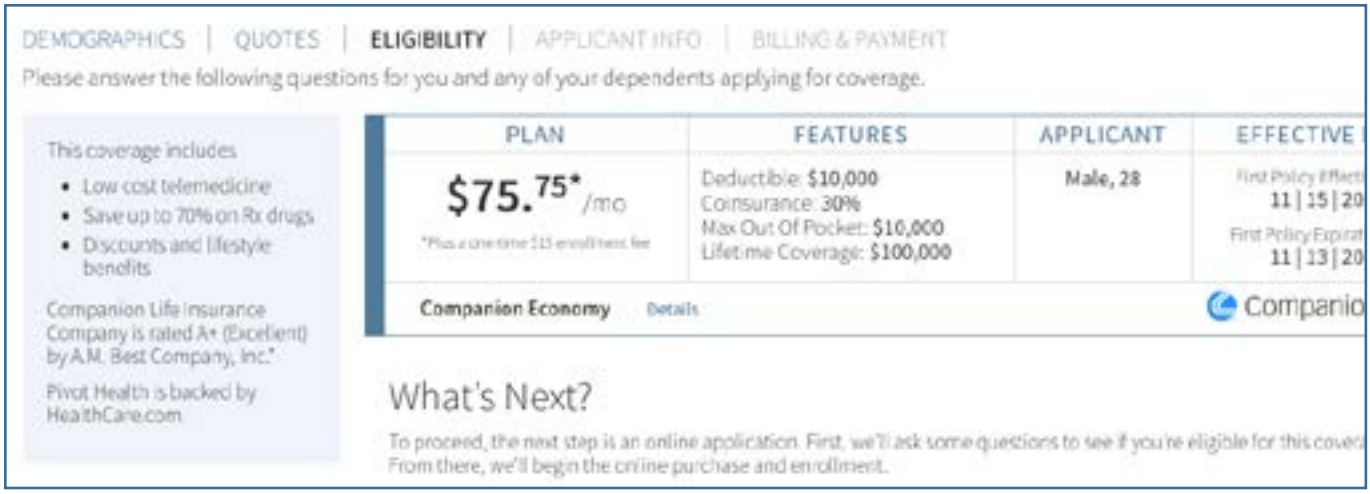
Buy now

Deductible	Coinsurance	Max Out-of-pocket	Lifetime Coverage
$10,000	30%	$10,000	$500,000

2 Companion Economy Details Companion Life

Plan Filter Options

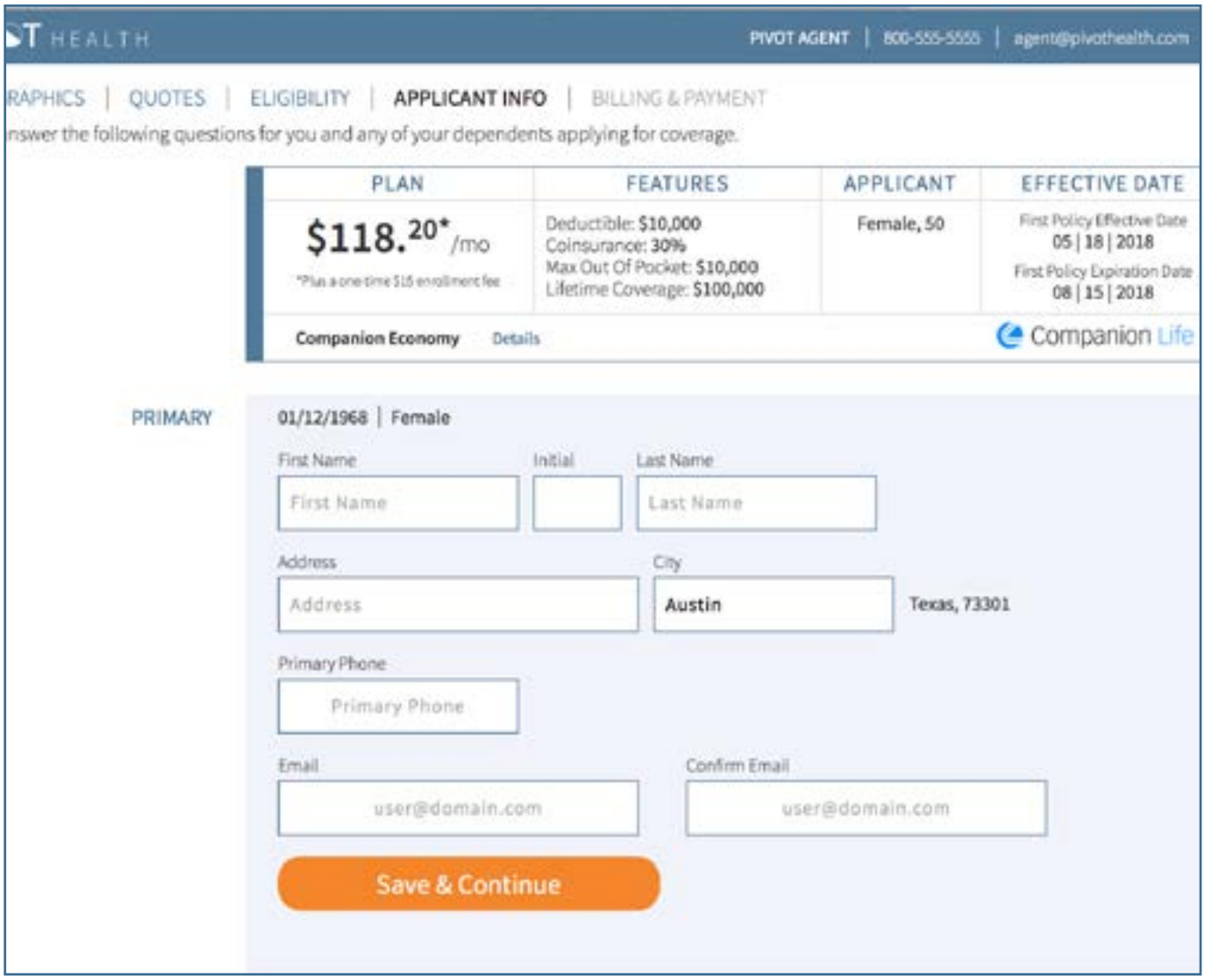
Eligibility Page (Medical Questions)



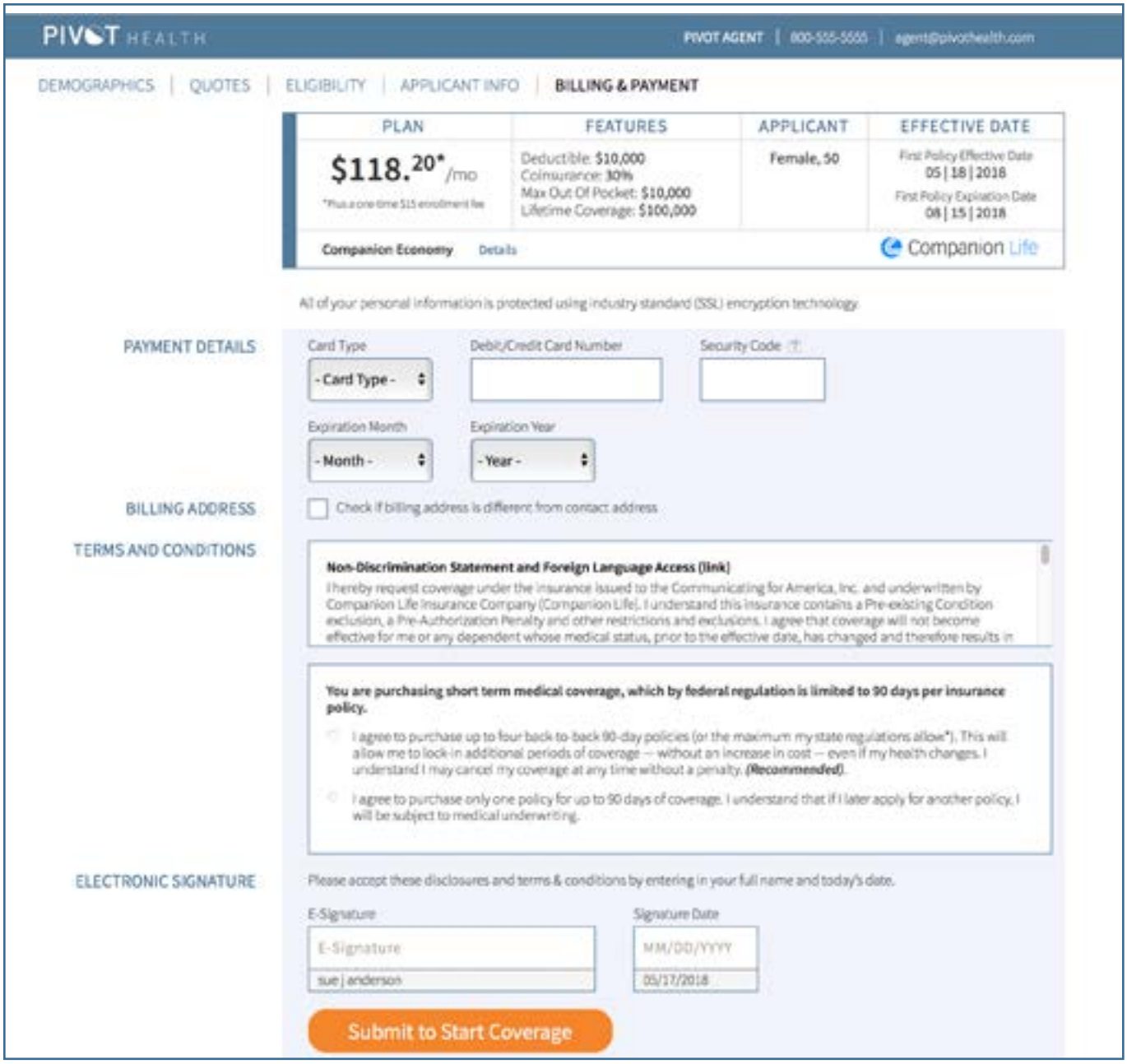
Plan Details

(Example: Economy plan can have 20% or 30% coinsurance and $100,000 or $500,000 coverage maximum with a range of deductibles. Each plan details page outlines coverage specifics.)

Application Page



Payment Page and Checkout



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) a 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 Pivot Health Order Confirmation:

RE: {first_name}{last_name}
Policy Effective Date: {effective_date}
Coverage Type: {package_name}
Total Premium: (Add payment_frequency_amount} and {application_fee} together)

Welcome to Pivot Health and Your New Medical Benefits

Thank you for trusting Pivot Health for your short term health insurance needs. This letter confirms your application for insurance has been received by Pivot Health.

You will soon receive an email with instructions for logging into your new Pivot Health account. From this account you can retrieve your health insurance certificate, application and medical ID card. Download your ID card as soon as possible so you have your insurance coverage with you at all times.

In addition to your Pivot Health insurance coverage, you receive non-insurance benefits and a free discount prescription drug program 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.

Your accident benefits start right away, however, to keep your costs down, and to allow all data to be received by health providers, there is a five day waiting period before coverage is available on any claims for sickness or Rx discounts/reimbursement (30 days for cancer claims). Benefits for accidents and your non-insurance benefits begin on your policy effective date.

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

We value each and every one of our customers, and look forward to serving you.

Sincerely,
Pivot Health

CC: (Writing Agent Name from agent_ID number)

Non-Discrimination Statement and Foreign Language Access

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, they 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:

Email Notice for Back-to-Back Coverage

Consumers who purchase four 90-day back-to-back policies receive an email approximately five days before their next coverage begins, reminding them to download their new ID card for the upcoming policy term.

RE: {first_name}{last_name}
Policy Effective Date: {effective_date}
Coverage Type: {package_name}
Total Premium: {payment_frequency_amount}

Your New Short Term Health Insurance Documents Are Ready

Thank you for choosing Pivot Health for your health insurance needs.

In 2017, federal regulations limited short term health insurance plans to 90-days of coverage. However, Pivot Health allows consumers to enroll in consecutive 90-day plans so you can have continuous health coverage beyond the 90-day limit.

You selected to enroll in consecutive 90-day plans. Please login to Pivot Health and retrieve your new application, forms and coverage ID card. **NOTE:** You will need to present your new ID card to any medical provider you visit. Destroy your existing ID card after your new coverage begins.

New deductibles and out-of-pocket limits will apply under your new coverage period, but any medical conditions that arose under your prior policy will be covered under the new policies if medical expenses are incurred for that medical condition, subject to all plan limitations. State rules may also apply.

If you have any questions about the coverage of your four 90-day plans, please call 866-566-2707.

Regards,
The Pivot Health Team

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.

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.

State-Specific Variations
Claims Processing and Resolution

Claims are processed and paid by IBA, and insureds should contact Allied 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

General Business Rules

- There is a one-time application fee. The fee is waived on the second, third and fourth applications for back-to-back plans.

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 IBA are mentioned.

Free Look Period and Cancellations

- The 10-day free look period is available from time of receipt, 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.

Domestic Partner Relationships

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

Child-Only Applications

- Children under the age of 18 may apply for child-only primary coverage once they reach the age of six months. Children should be listed on the application as primary insured and dependents, from youngest to eldest child. An adult who can attest to the children's health must sign the application and attestations. Children cannot legally enter into a contract of insurance.
- Newborn or adopted children can be added by making application within 30 days of birth or adoption.

Pre-Paid Applications

- If the applicant selects a pre-pay option (only available for 90 day plans), the applicant can obtain up to a 25% discount in premium. However, no refunds are available if coverage is no longer needed. Benefits will be coordinated with the additional health plan until coverage under the short-term plan expire.

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

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.

Insurance Benefit Administrators (IBA) Agent Portal

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

If you have questions about your commission statement, please contact IBA. Representatives at Allied 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:

By clicking on "Menu" they will be able to see Pivot Health's toll-free number and "My Account."

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

3. Coverage Duration is asked twice on the site: on the census and payment pages. If someone selects “90 Days” on the census page and then decides they really want coverage for a longer duration, they can make the change on the payment page. It does not interfere with their purchase.

4. Be mindful of using a different email address on each application. For example, if a mother enrolls herself on one application, and her son on a second application, she should NOT use the same email address for her son. This overrides her policy documents with the most recent version (her son’s). If this occurs, contact Pivot Health at support@pivothealth.com.

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 short term insurance qualify as a major medical insurance plan and include “essential benefits” that are required by current law?

No, short term health insurance is a temporary insurance product and is not comprehensive, major medical health insurance.

When is each monthly payment deducted from my account?

The first payment is taken at the time of sale and applied to the first monthly premium statement and charged immediately for the first 30 days of coverage. Your second monthly premium statement will be charged on or around the 10th of the month if your coverage effective date is between the 1st and 19th of the month. For coverages effective between the 20th and 30th/31st your credit card will be charged on or around the 22nd. Your 3rd month premium notice will be for fewer days than the prior two months which will be the balance of the maximum 90-day coverage period allowed by federal regulation. All premiums are drafted on normal business days.

What is the network for Pivot Health plans?

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 short term medical 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 Allied who will initiate the negotiation process.

- The member needs to send a copy of the bill to Allied 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 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 Allied by email to balancebilling@alliednational.com.

Can children apply for short term medical coverage?

Children may apply for a short term policy when they reach six-months of age. Subsequent siblings can be added to the application as dependents. See General Business rules for more details.

What do doctor office visit copays on the Choice, Deluxe and Core Pivot Health plans pay for?

Not all procedures and treatments are covered with an office visit copayment. Periodic health exams, well baby care and additional tests and services do not qualify for copayment and are subject to the medical deductible.

If an insured resides in a state where the plan is available and moves to a state where the short term medical 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.

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.

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 short term medical plan?

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

Is pregnancy covered if it is not a pre-existing condition?

Maternity, pre-and post-natal office visits are not covered. Only complications of pregnancy as defined by the insurance certificate are covered as any other illness. Deductible, coinsurance and other policy limitations would apply.

Can you pre-pay all four coverage certificates at once?

No. Pivot Health's pre-pay option is only available for a coverage duration of 90-days or less. Any coverage that is longer than 90-days must be paid monthly.

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. However, newborns and adopted children can be added to existing policy certificates by calling IBA.

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 enrolls in an Economy, Choice or Core plan, they only receive a drug discount benefit. They need to instruct the pharmacy technician to use the "Rx Group Number" located on the back of the card to receive the discount.

If your client has a Standard plan, 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 Deluxe or Core plan, 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.

What happens if my client's short term coverage terminates while they are hospitalized?

If your client's coverage ends while they are in the hospital, they are considered "totally disabled" based on the "total disability" provision in the insurance certificate. The total disability provision is located under "Extension of Benefits"

The provision reads: "Total Disability" (or "Totally Disabled") means the Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, "Totally Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

The Extension of Benefits continues:
"Extension of Benefits - If a covered Bodily Injury or Sickness commences while the Policy is in force as to a Covered Person, benefits otherwise payable under the Policy for the Injury or Sickness causing the Total Disability will also be paid for any Eligible Expenses incurred after the termination of insurance for a Covered Person if, from the date of such termination to the date such expenses are incurred, the Covered Person is Totally Disabled by reason of such Injury or Sickness. Such benefits shall be payable only during the continuance of such disability until the earlier of:

1. the date the Total Disability ends;
2. the date when treatment for the Total Disability is no longer required;
3. the date following a time period equal to the Covered Person's Coverage Period, with a minimum of thirty (30) days not to exceed a maximum of ninety (90) days;
4. the date the Covered Person becomes eligible for any other group insurance plan providing coverage for the same conditions causing the Total Disability; or
5. the date the Coverage Period Maximum Benefit amount has been reached.

Since hospitalization forbids an insured to work, they are considered "totally disabled" and coverage will follow the Extension of Benefits rules.