Health ProtectorGuard Producer Guide

Hospital & Doctor Fixed Indemnity Insurance

For insurance plans: Choice Value, Choice Plus, Select Value, Primary Preferred, Select Preferred Select Plus, and Premier Plus

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THIS PRODUCT PROVIDES LIMITED BENEFITS.

HEALTH PROTECTORGUARD IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR CLIENT'S TAXES.

This product provides benefits in a stated amount regardless of the actual expenses incurred.

Golden Rule Insurance Company is the underwriter of these plans.

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UnitedHealthcare®

Golden Rule Insurance Company

Feb 26 2018 02:20:35 pm

Health ProtectorGuard offers coverage with simple, straight-forward benefits and application process. Designed to provide predictable fixed benefits for eligible services received, Health ProtectorGuard can help in situations where your clients may have gaps in coverage.

Key features of Health ProtectorGuard insurance plans:

- Choose any licensed doctor or hospital in the country.
- There is no lifetime maximum benefit.
- No coordination with other forms of insurance, which means your client is paid a fixed amount for a covered service regardless of when or how other health insurance your client may have pays the claim.

SUMMARY OF BENEFITS

HOSPITAL SERVICES

For each year your client renews the plan, the client's hospital confinement benefit specifically related to injuries will increase through Year 5. See pages 9 and 11 for details.

SURGICAL SERVICES

The surgeon benefit is paid per surgery and is based on the Surgical Schedule Tiers. See pages 9 and 11 for details. If multiple surgeries are performed on the same day, the highest tiered amount will be paid.

DOCTOR VISITS

A doctor office or urgent care visit for illness is eligible after a **5-day waiting period.** Rollover a maximum of 5 unused doctor office (illness or injury) or urgent care visits remaining at the end of a calendar year to the next calendar year. See page 11 for details.

WELLNESS/PREVENTIVE CARE

A Wellness/Preventive Care visit is eligible after a **6-month waiting period**. Services eligible for benefits may include the following: annual physicals, immunizations (other than a flu shot), mammograms, and blood screenings.

PHARMACY SERVICES

A National Prescription Savings Network (NPSN) non-insurance discount card is automatically included with every plan and is free to use. Most U.S. pharmacies honor this card. Discounts can range up to 75% off the retail price, but the average discount is nearly 50% (*www.npsncard.com/faqs*, "What type of discounts can I expect?").

OUTPATIENT SERVICES

Outpatient Lab/X-ray pays a set amount when your client undergoes an X-ray or lab test to diagnose an eligible injury or illness. Other Outpatient Diagnostic Imaging services include: angiogram, arteriogram, thallium stress test, EEG, PET, CT or an MRI scan. See the limits on page 10.

Eligibility & Renewability

Eligibility of Applicants

Those eligible for a Health ProtectorGuard insurance plan must meet the following criteria at the time of application:

- Primary insured and spouse must be between 18-64 years of age (drop off on 65th birthday)
- Have a primary address and be a legal resident in a state where Health ProtectorGuard is available for sale
- Dependent children may be included on the application so long as they are a defined dependent of the primary insured or the spouse of the primary insured and are 0-25 years of age (drop off on 26th birthday).
  A dependent child is defined as a:
  - Natural child
  - Legally adopted child
  - Child placed for adoption
  - Child for whom legal guardianship has been awarded
  - A Child of the Eligible Person for whom the Eligible Person is obligated to provide medical Child support pursuant to a Qualified Medical Support Order.
- Health ProtectorGuard does not allow for “Child Only” plans.

Misstatement of Age, Gender, or Tobacco Use

If the covered person’s age, gender, or use of tobacco has been misstated on the covered person’s application for coverage under the policy, any future premiums will be adjusted and past premiums will be refunded or owed to us based on the correct gender or tobacco status.

If a covered person’s age has been misstated and we would not have issued coverage for that covered person, we will refund the premium paid minus any benefit amounts paid by us, and coverage would be void from the effective date.

Renewability and Termination

The policy is renewable until the earliest of the following:

- The primary insured’s 65th birthday or death. If the policy includes dependents, it may be continued after the primary insured’s death or 65th birthday:
  - By the spouse, if a covered person
  - Otherwise, by an eligible child who is a covered person;
- Nonpayment of premiums when due.
- The date your client requests to terminate the policy; or
- The date there is fraud or a material misrepresentation made by or with the knowledge of a covered person in filing a claim for policy benefits.

This guide references general terms and conditions of the Health ProtectorGuard product. State variations may apply in some instances. Refer to the product brochure.

Underwriting

Health ProtectorGuard insurance plans are subject to health underwriting. If your client provides incorrect or incomplete information on the application for insurance, coverage may be voided or claims denied.

Height and Weight Chart

- The chart applies to all applicants age 18 and over.
- If an applicant exceeds the weight maximum for their height, coverage will be declined.

Height		Weight Maximum
Feet	Inches	Pounds
4	8	179
4	9	185
4	10	191
4	11	198
5	0	205
5	1	211
5	2	218
5	3	226
5	4	233
5	5	240
5	6	248
5	7	255
5	8	263
5	9	271
5	10	279

Height		Weight Maximum
Feet	Inches	Pounds
5	11	287
6	0	295
6	1	303
6	2	311
6	3	320
6	4	329
6	5	337
6	6	346
6	7	355
6	8	364
6	9	373
6	10	382
6	11	391
7	0	400

Unacceptable Medical Conditions

Please note that some medical conditions present an increased risk we are unwilling to accept.

An automatic decline will likely result if an individual has one or more of these conditions. If surgery is pending or serious ailments exist without a diagnosis, a decline will also occur. Everyone has the right to apply for coverage, and clients who appear unacceptable may apply if they choose.

If, in the last 5 years, your client has been diagnosed with or received medical or surgical care from a member of the medical profession for any of the following, an automatic decline will likely result:

- Acquired AIDS, ARC, HIV infection, or any AIDS related condition
- Alzheimer's or senile dementia
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease)
- Any cancer (excluding basal cell or squamous cell skin cancer)
- Atrial fibrillation
- Bone marrow transplant
- Bypass/stents/angioplasty
- Carcinoma in Situ
- Cardiomyopathy
- Chronic kidney disease or disorder (not including stones)
- Chronic liver disease including Cirrhosis, Hepatitis B or Hepatitis C
- Chronic obstructive pulmonary disease (COPD) or chronic lung disease
- Congestive heart failure
- Crohn's Disease or Ulcerative Colitis
- Cystic Fibrosis
- Diabetes (except gestational diabetes)
- Disease or disorder of the heart or circulatory system
- Emphysema
- Heart attack
- Heart surgery (including valve replacement or correction)
- Hodgkin's or Non-Hodgkin's Lymphoma
- Implant of pacemaker/defibrillator
- Leukemia
- Multiple Sclerosis
- Muscular Dystrophy
- Organ Transplant (or awaiting an organ transplant)
- Paralysis
- Parkinson's
- Pulmonary fibrosis
- Renal hypertension
- Schizophrenia, bipolar disorder, mood (affective) disorder, or currently taking medication for depression/anxiety that were prescribed by a psychiatrist
- Stroke/Transient ischemic attack
- Systemic lupus erythematous (SLE)
- Thrombosis, embolism or hemophilia

Preexisting Conditions & Waiting Periods

Unacceptable Medical Conditions, continued

If, in the past 12 months, your client has been diagnosed with or received medical care from a member of the medical profession for, or experienced symptoms of any of the following, an automatic decline will likely result:

- Abnormal Pap smear without normal follow-up pap smear
- Chest pains
- A condition that has yet to be diagnosed
- Recurrent breast tumors or unexplained tumors/growths
- Irregular heartbeat
- Pulmonary hypertension
- Tachycardia
- Uncontrolled hypertension/high blood pressure
- Unexplained dizziness
- Unexplained fatigue
- Unexplained seizures
- Unexplained weight loss
- Vascular insufficiency (circulatory problems)

Preexisting Conditions

The certificate/policy defines preexisting conditions as a disease, accidental bodily injury, illness or condition for which within the 12 months immediately preceding the applicable effective date a covered person received:

- Medical advice,
- Diagnosis,
- Care,
- Treatment or was recommended to or received treatment.

Preexisting conditions also include manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the policy.

No benefits will be payable for services received in connection with preexisting conditions as defined above until coverage has been in effect for a 12-month period.

The definition of a preexisting condition may vary by state.

Waiting Periods

- There is a 5-day waiting period before benefits will be payable due to an illness.
- There is a 6-month waiting period before benefits are payable for the Wellness/Preventive Care benefit.

Network & Claims

Your clients do not have to use network doctors, hospitals or pharmacies; they may see any licensed doctor or care provider or visit any pharmacy they wish. They may be able to reduce out-of-pocket costs by using providers that have contracted with the MultiPlan Limited Benefit Plan Network or pharmacies that have contracted for prescriptions with the National Prescription Savings Network (NPSN). These doctors, hospitals, and pharmacies have agreed to offer discounts.

- Health ProtectorGuard benefits are paid the same regardless of which licensed providers your client chooses to use.
- There is no deductible to meet before the insurance plans will pay.
- There is no lifetime maximum benefit.
- **There is no coordination of benefits with other forms of insurance, which means your client is paid a fixed amount for a covered service regardless of when or how other health insurance your client may have pays the claim.**
- If your client has a major medical plan, they may need to stay with certain networks and providers to get the most coverage out of that insurance plan.

MultiPlan Limited Benefit Plan Nationwide Network

Network providers have agreed to offer discounts on covered services which are reflected in your client's final bill. (Discounts for non-covered services are at the provider's discretion.) Discounted costs for services mean your client may be able to reduce their out-of-pocket costs for medical services. The MultiPlan Limited Benefit Plan Network is not insurance. It is a discount program only.

Note: A flat MultiPlan network fee of $3.25 per policy is charged per month. It is collected each month that the policy is in force and there is no pro-rating for a partial month. This fee is in addition to the premium your client pays for the insurance plan.

How Your Client Receives Benefits:

Any time your client receives a covered medical service:

Your client should present the Member ID card (that has the MultiPlan Limited Benefit Plan logo in the bottom right corner) to the doctor or other healthcare provider. Claims for covered services are submitted by the doctor who is then paid by the client's insurance plan:

- **In order for the MultiPlan network discount to apply, benefits must be paid to the provider. Your client should ask the provider for the assignment of benefits form.**
- If the payment is less than the claim amount, your client will pay the difference to the provider.
- If the payment is more than the claim amount, after the provider is paid, the remaining benefit is paid to your client by check.

Alternatively, your client may choose to complete a claim form and send it with copies of the doctor's bill to us. A check will be sent directly to your client.

Whether receiving services from a doctor or filling a prescription, your client should refer to the policy for what the plan will pay and use the claim form included in the welcome packet.

National Prescription Savings Nationwide Network

A National Prescription Savings Network (NPSN) discount card is automatically included with every plan. Most U.S. pharmacies honor this card. Discounts vary based on the type of prescription. Discounts can range up to 75% off the retail price, but the average discount is nearly 50% (*www.npsncard.com/faqs*, "What type of discounts can I expect?"). The card is valid at more than 62,000 pharmacies nationwide (some exclusions apply) with discounts available on most FDA-approved prescription medication. The card is completely free to your clients and their dependents. It is pre-activated and ready to use upon receipt and may be used even if the plan selected does not offer prescription benefits. The NPSN card is not insurance. It is a discount program only.

Network & Rx Discount Resources

DOCTOR VISITS

2 Ways to Find a MultiPlan Provider:

- **Visit multiplan.com/HealthProtectorGuard**
- **Call 1-800-457-1403**

PHARMACY SERVICES

3 Ways to Find a Listing of Covered Medications:

- **Visit searchrx.com/UHO**
- **Call 1-877-890-8077**
- **App download: searchrx.com/UHOapp**

Any Time Your Client Fills a Prescription:

- Your client should present the National Prescription Savings Network (NPSN) discount card to the pharmacist and ask for discounts on the prescription drugs.
- Your client pays the pharmacy directly, and if the insurance plan provides prescription benefits, your client can submit a claim form for reimbursement.

HEALTH PROTECTORGUARD PLANS PAY BENEFITS FOR THESE ELIGIBLE COMPREHENSIVE MEDICAL SERVICES:

HOSPITAL SERVICES

SURGICAL SERVICES

			Choice Value	Choice Plus	Select Value	*New* Primary Preferred	*New* Select Preferred	Select Plus	Premier Plus
HOSPITAL SERVICES									
Inpatient Hospital Confinement (unlimited)		We pay:	$1,000 per day	$2,000 per day	$3,000 per day	$4,000 per day	$5,000 per day	$4,000 per day	$5,000 per day
Increasing Injury Reimbursement (unlimited) Inpatient Hospitalization Benefits increase 25% each year, years 2-5, for injury-related hospital stays.	**Year 2**	We pay:	$1,250 per day	$2,500 per day	$3,750 per day	$5,000 per day	$6,250 per day	$5,000 per day	$6,250 per day
	Year 3		$1,500 per day	$3,000 per day	$4,500 per day	$6,000 per day	$7,500 per day	$6,000 per day	$7,500 per day
	Year 4		$1,750 per day	$3,500 per day	$5,250 per day	$7,000 per day	$8,750 per day	$7,000 per day	$8,750 per day
	Year 5		$2,000 per day	$4,000 per day	$6,000 per day	$8,000 per day	$10,000 per day	$8,000 per day	$10,000 per day
Inpatient Hospital Intensive Care Unit (ICU) or Critical Care Unit (CCU) (maximum per confinement)		We pay:	$2,000 per day (31 days)	$4,000 per day (31 days)	$6,000 per day (31 days)	$2,000 per day (60 days)	$2,000 per day (60 days)	$8,000 per day (31 days)	$10,000 per day (31 days)
			ICU/CCU benefit amounts are in addition to Inpatient Hospital Confinement benefits.						
Inpatient Physician Visits (maximum during Inpatient Hospital Confinement)		We pay:	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (2 visits per day)	$100 per visit (2 visits per day)
Emergency Room (maximum per calendar-year)		We pay:	$200 per day (2 days)	$200 per day (2 days)	$300 per day (2 days)	$300 per day (3 days)	$300 per day (3 days)	$400 per day (2 days)	$500 per day (2 days)
Ambulance-Ground or Water (maximum per calendar-year)		We pay:	$500 per trip (1 trip)	$500 per trip (1 trip)	$500 per trip (1 trip)	$500 per trip (1 trip)	$500 per trip (1 trip)	$1,000 per trip (1 trip)	$1,000 per trip (1 trip)
Ambulance-Air (maximum per calendar-year)		We pay:	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)
SURGICAL SERVICES									
Outpatient Facility Fee (maximum per calendar-year)		We pay:	$500 per day (2 days)	$500 per day (2 days)	$1,000 per day (2 days)	$500 per day (3 days)	$500 per day (3 days)	$1,000 per day (3 days)	$1,000 per day (3 days)
Surgeon: 4-Tier Surgical Schedule (unlimited days per calendar-year)*	**Tier 1**	We pay:	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000
	Tier 2		$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000
	Tier 3		$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
	Tier 4		$500	$500	$500	$500	$500	$500	$500
Assistant Surgeon - Surgical Schedule Tiers 1 & 2 only (per day)		We pay:	20% of surgeon benefit schedule above						
Anesthesiologist (per day)		We pay:	30% of surgeon benefit schedule above						

* If more than one surgery in any given day, the largest benefit amount is paid.

HEALTH PROTECTORGUARD PLANS PAY BENEFITS FOR THESE ELIGIBLE DAY-TO-DAY MEDICAL SERVICES:

DOCTOR VISITS | WELLNESS/ PREVENTIVE | PHARMACY SERVICES | OUTPATIENT SERVICES

		Choice Value	Choice Plus	Select Value	*New* Primary Preferred	*New* Select Preferred	Select Plus	Premier Plus
DOCTOR VISITS								
Office Visits/Urgent Care Visits for Injury or Illness: Benefit per visit (maximum per calendar-year) Note: Benefits for illness have an initial 5-day waiting period.*	We pay:	$100 (2 visits)	$100 (2 visits)	$100 (5 visits)	$100 (10 visits)	$100 (10 visits)	$100 (5 visits)	$100 (5 visits)
		↑ See rollover benefit details on page 5. ↑						
Second Surgical Opinion (maximum per calendar-year)	We pay:	$250 (1 day)	$250 (1 day)	$500 (1 day)	$500 (1 day)	$500 (1 day)	$500 (1 day)	$500 (1 day)
WELLNESS/PREVENTIVE								
Wellness/Preventive Care Visit (maximum per calendar-year after initial 6-month waiting period)	We pay:	$100 (1 day)	$100 (1 day)	$200 (1 day)	$250 (1 day)	$250 (1 day)	$200 (1 day)	$250 (1 day)
PHARMACY SERVICES								
Prescription Drugs (Per Rx fill)	We pay:	Discount Card only	Generic: $20 Brand: $40	Discount Card only	Generic: $10 Brand: $40	Generic: $10 Brand: $40	Generic: $20 Brand: $40	Generic: $20 Brand: $40
Maximum Rx Fills Per calendar-year (Combined Brand and Generic)		N/A	12	N/A	12	12	12	12
OUTPATIENT SERVICES								
Outpatient Lab/X-ray - Non-preventive/Non-routine: Benefit per test (maximum per calendar-year)	We pay:	$200 (1 test)	$200 (1 test)	$300 (1 test)	$100 (3 tests)	$100 (3 tests)	$300 (1 test)	$300 (1 test)
Outpatient Diagnostic Imaging Services: Benefit per test (maximum per calendar-year)	We pay:	$500 (1 test)	$500 (1 test)	$500 (1 test)	$500 (1 test)	$500 (1 test)	$800 (1 test)	$1,000 (1 test)
Oral Chemotherapy: Benefit per month (maximum per calendar-year)	We pay:	$1,000 (3 months)	$1,000 (3 months)	$1,000 (3 months)	$1,000 (3 months)	$1,000 (3 months)	$2,000 (6 months)	$2,000 (6 months)
Outpatient Chemotherapy and Radiation - Non-Oral: Benefit per day (maximum per calendar-year)	We pay:	$1,000 (40 days)	$1,000 (40 days)	$1,000 (40 days)	$500 (20 days)	$500 (20 days)	$2,000 (60 days)	$2,000 (60 days)

* Services received for injuries are eligible for coverage as of your client's plan effective date; services received for illnesses are eligible for coverage beginning on the 6th day following the effective date. Preexisting conditions apply. See page 12 for details.

Special Features

Inpatient Hospital Increasing Injury Reimbursement

For each year your client renews the insurance plan, the hospital confinement benefit specifically related to injuries will increase. This means if anyone covered by the policy has a hospital stay related to an injury the hospital confinement benefit is replaced with the "Increasing Injury Reimbursement" benefit earned starting year 2 of your plan. The benefit does not compound from policy year to year. (This increase does not apply to Inpatient Reimbursement related to sickness.)

If the effective date of coverage is prior to July 1, then the Second Year of coverage will begin on the following January 1. If the effective date is on or after July 1, the Second Year will begin January 1 following 12 consecutive months of coverage. Subsequent years after the Second Year will begin the following January 1.

Doctor Visit Rollover Benefit

If your client can rollover unused data, why not doctor visits too? This unique benefit allows your client to rollover any unused doctor office (illness or injury) or urgent care visits remaining at the end of a calendar year to the next calendar year. A maximum of 5 visits are allowed to rollover.

If the effective date of coverage is prior to July 1, then any eligible unused visits may rollover on the following January 1. If the effective date is on or after July 1, then unused visits cannot begin accruing until January 1 following 12 consecutive months of coverage.

4-Tier Surgical Schedule (based on surgery type)

Surgeries may be performed in a hospital, an outpatient surgical facility, or a doctor's office/clinic.

Tier 1 Extreme Listed Conditions: Significant, non-diagnostic, invasive surgical procedures requiring general anesthesia and open incision. Procedures include open heart surgery (including bypass), major organ transplant, and brain surgery.

Tier 2 Major Listed Conditions: Non-diagnostic, open incision, surgical procedures requiring general anesthesia. Procedures may include knee replacement, hip replacement, rotator cuff repair, removal of tonsils or adenoids, and major organ removal or repair performed on organ within chest, abdomen or pelvic cavity that is not included in Tier 1.

Tier 3 Non-Major Listed Conditions: Surgical procedures requiring general anesthesia or conscious sedation such as colonoscopy, stent placement, insertion of pacemaker, balloon angioplasty, heart catherization and laparoscopic hernia repair.

Tier 4 Local/Minor Listed Conditions: Surgical procedures requiring local or regional anesthesia such as emergency C-sections and closed treatment of a fracture or dislocation.

Benefit Examples

Below are some examples of how Health ProtectorGuard can help your clients pay for medical costs resulting from an illness or injury. Note that claims for services for any preexisting conditions will be denied.

Hospital Confinement - 3 days total with 1 day in ICU — **Plan Selected: Choice Plus**

Benefit Category	Benefit Payment
Hospital Confinement (3 days)	$6,000 ($2,000 per day x 3)
ICU Confinement (1 day)	$4,000 ($4,000 per day x 1)
Inpatient Physician Visits (3 visits)	$300 ($100 per visit per day x 3)
Total Benefit Payment:	**$10,300**

Emergency Room — **Plan Selected: Premier Plus**

Benefit Category	Benefit Payment
Emergency Room Visit (1 day)	$500 ($500 per day x 1)
Outpatient Diagnostic Testing (1 test)	$1,000 ($1,000 per test x 1)
Brand Prescription Drug (1 prescription)	$40 ($40 per brand prescription x 1)
Total Benefit Payment:	**$1,540**

Outpatient Surgery — **Plan Selected: Select Value**

Benefit Category	Benefit Payment
Outpatient Facility Fee (1 day)	$1,000 ($1,000 per day x 1)
Surgeon (Tier 2 Surgery)	$5,000 ($5,000 Tier 2 Surgery Benefit per day x 1)
Assistant Surgeon (Tier 2 Surgery)	$1,000 ($5,000 Tier 2 Surgery Benefit x 20%)
Anesthesiologist (Tier 2 Surgery)	$1,500 ($5,000 Tier 2 Surgery Benefit x 30%)
Total Benefit Payment:	**$8,500**

Effective Dates, Payment & Premium

Effective Dates

No insurance will become effective unless your client's application is approved and the appropriate premium is actually received by Golden Rule Insurance Company (GRIC) with the application.

The following rules apply for plan effective dates:

- The earliest effective date is the later of the requested effective date or the day after the received date of the application. If received more than 90 days from the signing date, a new application is required.
- The latest possible requested effective date of coverage is 90 days from the received date of the application.
- The original application is still acceptable 90 days from the sign date for reopens/reconsideration files. If more than 90 days from the sign date, a new application is required.

Proof of Loss

Your client or your client's covered dependent must give us written proof of loss within 90 days of the date of loss or as soon as reasonably possible. Proof of loss furnished more than one year after the date written proof of loss is required to be submitted will not be accepted, unless your client or the client's covered dependent had no legal capacity that year.

Payment

Initial Payment

- Initial Payment must be included with the application, including the monthly MultiPlan network fee of $3.25.
- Initial Payment may be in the form of EFT or Credit Card.

Ongoing Payment

Ongoing monthly payments must be in the form of EFT or Credit Card.

Premium

Premium rates are guaranteed for 12 months then subject to change. The age, gender, and tobacco class of a covered person and type and level of coverage are some factors that could be used to determine your premium rate. Your client will be given at least a 31-day notice (or longer if required by their state) of any change in premium. We will make no change in the premium solely because of claims made by a covered person under the policy or a change in a covered person's health.

Upon Issue

Once your client's insurance plan is issued, he or she will receive a welcome packet in the mail that includes the policy and application. Your client should review the following:

- The Policy - It provides details about the benefits payable, as well as the limitations and exclusions.
- The Data Page - It is a summary of your client's specific benefits.
- The Application - To verify that the answers are correct and complete. Incorrect or incomplete information may result in voidance of coverage or claim denial.

Your client will receive two separate IDs in two separate mailings as follows:

- The Member ID Card with the MultiPlan Limited Benefit Plan logo in the bottom right corner.
- The National Prescription Savings Network (NPSN) discount card.

Plan Changes After Issue

Once the policy is issued, the following will apply to your clients:

- Increasing benefits on an existing Health ProtectorGuard plan is not permitted.
- Purchasing an additional Health ProtectorGuard plan (of any generation) is not permitted.
- They may not have both a Health ProtectorGuard and a Hospital SafeGuard or Hospital SafeGuard Premier plan.

If your client wants to switch between insurance plans, they must terminate the existing policy and apply for the other insurance plan as a new applicant. Waiting periods and preexisting conditions on the new insurance plan will start over.

Service Contact Information

2 Ways to Find a MultiPlan Provider:

- **Visit multiplan.com/HealthProtectorGuard**
- **Call 1-800-457-1403**

FOR YOUR CLIENTS

Customer Service and Hours of Operation

1-800-657-8205

8:00 am – 6:00 pm ET (Monday - Friday)

Customer Fax

1-801-478-5461

(Name/address/bank changes, add/delete dependents and cancellation requests can be faxed to this number)

Submit a Claim

Claims Department
PO Box 31374
Salt Lake City, UT 84131-0374
EDI #37602

Claims-Only Fax

1-801-478-7581

FOR PRODUCERS

Broker Service Center and Hours of Operation

1-800-474-4467

8:00 am – 6:00 pm ET (Monday - Thursday)
9:00 am – 5:00 pm ET (Friday)

E-Store

www.UHOne.com/Broker

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