Agent guide

HOSPITAL assure℠

HOSPITAL INDEMNITY INSURANCE

Focus on your care, not on the costs.

Washington National®

H3-BOOK-AGT

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SECTION 1: PRODUCT INTRODUCTION

Washington National Hospital Assure offers a simple yet flexible solution to help cover expenses associated with a hospital stay. Even with major medical insurance or Medicare, our customers can be faced with high deductibles, co-payments and out-of-pocket expenses.

Hospital Assure complements major medical insurance by providing fixed-dollar coverage for out-of-pocket expenses. For your individual and worksite customers ages 18-69, this product provides meaningful coverage and offers long-term value for your clients and their families.

The base policy features core benefits designed to help cover basic hospital-related expenses due to a covered accident or sickness. Coverage may be tailored with additional riders to fit the specific needs of your clients depending on the base plan purchased.

PRODUCT HIGHLIGHTS

- **Guaranteed renewable for life** – if your clients continue to timely pay their premiums, the policy is guaranteed renewable
- **Guarantee issue underwriting** available for worksite and unions/associations, subject to participation requirements
- **Normal pregnancy coverage** – normal pregnancy or childbirth that occurs after a 10-month waiting period is covered as any other sickness
- Coverage for **ICU, rehabilitation facility, observation room and ambulatory surgical center**
- **Cash Value/Return of Premium Rider** allows customers to get back 100% of premiums paid, minus any claims incurred, at the end of the ROP/CV period
- **Optional Wellness & Diagnostic Rider** provides coverage for physician office visits (including telemedicine), lab tests, x-rays, as well as imaging and diagnostic exams
- **Optional Supplemental Benefits Rider** provides coverage for surgery, ambulance trips and increases/enhances base policy coverage

MARKET OPPORTUNITIES

Hospital Assure can be used to serve the following customers:

- Employees who have major medical insurance, but are faced with copays, deductibles and out-of-pocket costs
- Large employers and small businesses that want to offer additional medical coverage solutions as part of their benefits package
- Retirees with Medicare, Medicare Advantage or Medicare Supplement plans that are exposed to copays, deductibles and out-of-pocket costs
- Self-employed individuals
- Spouses
- Families

The information in this agent guide is based on standard policy language. For state variations, refer to the state-specific brochure and sample policy book for your state, available to order or download at WNbizlink.com.

Note: The policy language takes precedence over all other references and sales materials.

SECTION 2: HEALTH SAVINGS ACCOUNTS (HSA)

Based upon our understanding of IRS guidelines, if a person has a Health Savings Account (HSA), generally that person cannot have any health insurance coverage other than a High Deductible Health Plan, with certain exceptions. Two exceptions, referred to as "permitted insurance," are:

- Insurance for a specified disease or illness; and
- Insurance that provides benefits of a fixed amount per day (or other period) of hospitalization.

Accident and disability insurance are also permissible.

It is our interpretation that the Hospital Assure base plans (1H) and (2H) are permitted and are compatible with HSA's, and as a result may be sold to individuals with HSAs. It is also our belief that, under current IRS rules and regulations, Hospital Assure base plans (3) and (4) and all the available riders for those plans, may not be compatible with HSA's, and as a result should not be sold to individuals with HSA's.

When selling Hospital Assure, you should discuss with all potential customers whether the individuals applying for coverage have an HSA to determine their plan eligibility.

Owning and maintaining hospital indemnity plans that offer benefits beyond fixed amounts for hospitalization may negatively impact HSA eligibility.

It is important to keep IRS HSA guidelines in mind when selling hospital indemnity insurance. Washington National Hospital Assure has 2 base plans that can be offered to clients that have HSA's. This gives you an opportunity to service customers (and their spouses) that have HSA's without negatively impacting their HSA eligibility.

- For any persons proposed for coverage with HSA's, only plans **1H** and **2H** are permitted
- If no persons proposed for coverage have HSA's, **all plans** are permitted (**1H, 2H, 3, 4**)

Note: Optional riders are not permitted to be offered with base plans 1H and 2H, as benefits included in the riders may extend beyond the coverage allowed for HSA compatible hospital indemnity products or other permitted insurance under IRS HSA guidelines.

Additional information regarding the IRS HSA guidelines can be obtained from the Internal Revenue Service web site at www.irs.gov.

As a reminder, Washington National and its agents do not provide legal or tax advice. Any specific legal and tax questions that your clients may have on High Deductible Health Plans, Health Savings Accounts or HSA compatibility should be directed to their own personal tax advisors.

DEFINITIONS

Health Savings Account (HSA) – A type of savings account that lets individuals set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses, individuals can lower their overall health care costs.

High Deductible Health Plan (HDHP) – A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but individuals pay more health care costs before the insurance company starts to pay its share. A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing individuals to pay for certain medical expenses with money free from federal taxes.

HSA Eligibility – To be an eligible individual and qualify for an HSA, individuals must meet the following requirements:

- Be covered under a high deductible health plan (HDHP), on the first day of the month.
- Have no other health coverage except what is permitted under Other health coverage.
- Not be enrolled in Medicare.
- Cannot be claimed as a dependent on someone else's tax return.

Other Health Coverage – Individuals (and their spouse, if they have family coverage) generally can't have any health coverage, other than an HDHP. However, they can still be an eligible individual even if their spouse has non-HDHP coverage provided they aren't covered by that plan.

Individuals can have additional insurance that provides benefits only for the following items:

- Liabilities incurred under workers' compensation laws, tort liabilities, or liabilities related to ownership or use of property.
- A specific disease or illness.
- A fixed amount per day (or other period) of hospitalization.

They also can have coverage (whether provided through insurance or otherwise) for the following items:

- Accidents
- Disability
- Dental care
- Vision care
- Long-term care

Sources: HealthCare.gov, 2018. IRS.gov, 2018

SECTION 3: COVERAGE DESCRIPTION AND OPTIONS

POLICY STRUCTURE

Hospital Assure allows your clients to customize their coverage to fit their individual needs yet remains simple to understand.

The base plan provides the client with basic coverage for hospital-related expenses. Additional riders (available with plans 3 and 4 only) allow the client to add benefits to ***expand*** their coverage to cover other expenses, as well as to ***increase*** the coverage provided by the base plan.

Base plans–availability may vary by state

BASE PLAN	UNDERWRITING TYPE	CAN BE SOLD TO A PERSON WITH AN HSA (HSA COMPATIBLE)?	OPTIONAL RIDERS AVAILABLE?
1H	Guarantee Issue	Yes	No
2H	Simplified Issue	Yes	No
3	Guarantee Issue	No	Yes
4	Simplified Issue	No	Yes

Optional riders–availability may vary by state. Only available with plans 3 and 4.

OPTIONAL RIDERS	UNDERWRITING TYPE
Wellness and Diagnostic Benefits Rider	Guarantee Issue
Supplemental Benefits Rider	Simplified Issue
Return of Premium/Cash Value Rider	Guarantee Issue

There are 4 base plans and 3 optional riders available with Hospital Assure. However, the base plan(s) and riders available to your client are determined by the following factors:

Is this an individual or worksite sale?

- If this is an individual sale, only the simplified issue (SI) plans would available (2H or 4). Guarantee issue underwriting is not available on an individual (direct) basis.
- If this is a worksite sale, all plans are available, subject to meeting the participation requirement for guarantee issue (GI) underwriting and the below factors.

If this is a worksite sale, has the group met the participation requirement for guarantee issue underwriting?

- If the group has met the participation requirement, then the GI plans may be offered (1H or 3).
- If the group has not met the participation requirement, then only the simplified issue plans may be offered (2H or 4).

Does any person proposed for coverage have a Health Savings Account (HSA)?

- If either the applicant or their spouse has an HSA (for Ind/SP and Family coverage), only the HSA-compatible plans may be offered (1H or 2H), subject to the level of underwriting for worksite sales. **Optional riders cannot be sold with the HSA-compatible plans.**
- If neither the applicant nor spouse have an HSA (for Ind/SP and Family coverage), all plans may be offered (1H, 2H, 3 or 4), subject to the level of underwriting for worksite sales. **Optional riders cannot be sold with the HSA-compatible plans.**

The base plan(s) available would be limited depending on the responses to these questions. For example, a worksite customer in a group that has met the GI participation requirement and has an HSA can only purchase plan 1H – as this is the HSA-compatible plan with guarantee-issue underwriting. On the other hand, if your customer is not in a worksite and does not have an HSA, they may purchase plans 2H or 4 – as these are both simplified issue plans and they have the option to purchase either the HSA compatible or non-HSA compatible plan.

MARKETING HOSPITAL ASSURE

There are two Hospital Assure brochure versions available for you to use after determining the plan(s) and riders (if any) that your customer is eligible for:

- HSA-Compatible Brochure [**H3-BR-HSA-1118**] – This brochure is for marketing base plans **1H or 2H**. No rider descriptions are included in this brochure. This brochure may be used for presentations to customers ***with or without*** HSA's.

- Non-HSA-Compatible Brochure [**H3-BR-ROP-1118 or H3-BR-CV-1118**] – This brochure is for marketing base plans **3 and 4**, as well as the Optional Wellness and Diagnostic Benefits Rider, Optional Supplemental Benefits Rider, and Optional Return of Premium/Cash Value Rider. This brochure may ***only*** be used for presentations to customers ***without*** HSA's.

Note: If any of your customers are planning to open an HSA, it is important to disclose the potential impact of a Non-HSA-Compatible hospital indemnity plan to their future HSA eligibility. Customers that are planning to open an HSA should consider purchasing the HSA-Compatible plan.

BASE PLAN COVERAGE – See benefit descriptions for additional limitations

BENEFITS	PLAN 1H	PLAN 2H	PLAN 3	PLAN 4
Hospital Confinement Lump Sum[1]	Choice of $1,000 / $2,000 / $3,000 limited to one day per calendar year	Choice of $1,000 / $2,000 / $3,000 / $4,000 / $5,000 limited to one day per calendar year	Choice of $1,000 / $2,000 / $3,000 limited to one day per calendar year	Choice of $1,000 / $2,000 / $3,000 / $4,000 / $5,000 limited to one day per calendar year
Daily hospital confinement	$100/day	$100/day	N/A	N/A
ICU confinement	$50/day, up to 30 days per period of confinement	$50/day, up to 30 days per period of confinement	N/A	N/A
Hospital outpatient	N/A	N/A	$100/day, up to 2 days per calendar year[2]	$100/day, up to 2 days per calendar year[2]
Hospital emergency room	N/A	N/A	$100/day, up to 2 days per calendar year[3]	$100/day, up to 2 days per calendar year[3]
Rehabilitation facility	N/A	N/A	$100/day, up to 15 days per period of hospital confinement, limited to 30 days per calendar year	$100/day, up to 15 days per period of hospital confinement, limited to 30 days per calendar year
Waiver of Premium	Included	Included	Included	Included

[1] The hospital confinement lump sum amount is selected at the point of application.

[2] Payable when the covered person receives care in a hospital, including an observation room or ambulatory surgical facility for less than 23 hours.

[3] Payable for a hospital ER or hospital urgent care visit only. Not payable on the same day the Hospital outpatient benefit is paid.

BASE PLAN BENEFIT DESCRIPTIONS

See benefit descriptions for additional limitations

BENEFITS	BENEFIT DETAILS
Hospital confinement lump sum	Choice of $1,000 / $2,000 / $3,000 / $4,000* / $5,000* Payable on the first day a covered person is hospital confined for 23 hours or more. The lump sum amount is selected at the time of application. This benefit is reset each January 1st. If a hospital confinement continues uninterrupted without discharge from one calendar year to the next, no hospital confinement lump sum benefit shall be payable for any day of that hospital confinement in the later calendar year. Upon discharge, for a benefit to be payable in the later calendar year, a hospital confinement for any covered sickness or any covered accident must begin more than thirty days after the discharge. Limited to 1 day per calendar year per covered person. There must be 30 days between confinements from one calendar year to the next. ***The $4,000 and $5,000 lump sum options are not available with plans 1H and 3.***
Daily hospital confinement	Payable per day, per covered person, for up to 365 days per period of confinement when hospital confined for 23 or more hours. A readmission within 30 days of a prior hospital confinement, for the same medical condition, is considered part of the previous period of confinement. ***Not available with plans 3 and 4.***
ICU confinement	Payable per day, per covered person, for up to 30 days when confined to an intensive care unit. This pays in addition to the daily hospital confinement benefit. A readmission within 30 days of a prior hospital confinement, for the same medical condition, is considered part of the previous confinement. ***Not available with plans 3 and 4.***
Hospital outpatient	Payable per day, per covered person, for hospital, observation unit, or ambulatory facility stays of less than 23 hours. Limited to 2 days per covered person, per calendar year. This benefit is not payable for the same day as the emergency room benefit is payable. ***Not available with plans 1H and 2H.***
Hospital emergency room	Payable per day, per covered person, for any day a covered person is admitted to an emergency room or visits an urgent care facility. Admission to the emergency room or a visit to an Urgent Care Facility for a covered accident must occur within seventy-two (72) hours of covered accident. Limited to 2 days per covered person, per calendar year. This benefit is not payable for the same day as the hospital outpatient benefit is payable. ***Not available with plans 1H and 2H.***
Rehabilitation facility	Payable per day when a covered person receives rehabilitation services in a rehab facility due to a covered sickness or covered accident. If a covered person is hospital confined within thirty (30) days for the same covered sickness or covered accident, then that later confinement will be considered a continuation and part of the prior period of confinement. This benefit does not include outpatient rehabilitation services. Limited to 15 days per period of confinement. Limited to 30 days per calendar year per covered person. The covered person must be hospital confined and the covered person is transferred to a rehabilitation facility by physician's order as the direct result of the covered sickness or covered accident. The transfer must be within 24 hours after the discharge from the hospital confinement. ***Not available with plans 1H and 2H***
Waiver of Premium	If the policyowner is hospital confined for a period of more than 30 consecutive days, this benefit will begin on the 31st day for any period of uninterrupted continuation of that inpatient hospital confinement and end on the earlier of (1) discharge from the hospital or U.S. government hospital, or (2) twelve (12) months of uninterrupted continuous inpatient hospital confinement. This period, if any, is referred to as the waiver period. We will waive the premium payments for this policy and any attached rider(s) that fall due during the wavier period. Any premium payments that fall during this period will be waived on a maximum of a month by month basis regardless of the current mode of payment of premium. Upon discharge or at the end of 12 months of uninterrupted continuous hospital confinement, premium payments must be resumed.

OPTIONAL WELLNESS AND DIAGNOSTIC BENEFITS RIDER

Available only to non-HSA compatible plans

The Optional Wellness and Diagnostic rider gives your client's opportunities to take preventive measures for their wellbeing by covering physician office visits, additional benefits such as X-rays and imaging and diagnostic exams for a covered sickness or a covered accident are also available. This is an effective way to expand your clients' coverage while increasing the overall value of the product. The optional Wellness and Diagnostic Benefits rider is available on a GI basis if applied for at the time of policy issue. SI underwriting is required if added after the policy is issued.

BENEFITS	AMOUNT	BENEFIT DETAILS
Physician office visit	$25/day	Payable for any day a covered person goes to a Physician's office appointment, including a tele-medicine visit. This benefit covers appointments for a covered accident, a covered sickness or routine wellness exams. This benefit only pays once per day regardless of the number of appointments on that day. Individual coverage: Limited to 3 days per calendar year. Individual/Spouse, Individual/Child, & Family Coverage: Limited to 3 days per covered person, up to 6 days if more than 1 covered person, per calendar year.
Lab test and X-ray	$50/day	Payable for any day a covered person has laboratory testing or x-ray, ordered by a physician, for a covered sickness or a covered accident. The laboratory testing or x-ray must be performed at a hospital, U.S. government hospital, a medical diagnostic imaging center, a physician's office, an urgent care facility or an ambulatory surgical facility. Individual coverage: Limited to 3 days per calendar year. Individual/Spouse, Individual/Child, & Family Coverage: Limited to 3 days per covered person, up to 6 days if more than 1 covered person, per calendar year. This benefit pays only once per day regardless of the number of exams performed on that day. This benefit is not payable for the exams as listed under the Imaging Benefit or the Diagnostic Benefit.
Imaging exams	$100/day	Payable for any day a covered person has 1 of the following exams, ordered by a physician, for a covered sickness or covered accident: computed tomography (CT scan, CAT scan), magnetic resonance imaging (MRI), electroencephalogram (EEG), thallium stress test, myelogram, angiogram, or arteriogram. The exam must be performed at a hospital, U.S. government hospital, a medical diagnostic imaging center, a physician's office, an urgent care facility or an ambulatory surgical facility. Individual coverage: Limited to 3 days per calendar year. Individual/Spouse, Individual/Child, & Family Coverage: Limited to 3 days per covered person, up to 6 days, per calendar year. This benefit pays only once per day regardless of the number of exams performed on that day. This benefit is not payable for a Laboratory Test or X-Ray which are only payable under the Laboratory Test and X-Ray Benefit or the exams as listed under the Diagnostic Benefit.
Diagnostic exams	$100/day	Payable for any day a covered person has 1 of the following exams, ordered by a physician, for a covered sickness or covered accident: arthroscopy, bronchoscopy, colonoscopy, cystoscopy, endoscopy, esophagoscopy, gastroscopy, laparoscopy, laryngoscopy, or sigmoidoscopy. The exam must be performed at a hospital, U.S. government hospital, a medical diagnostic imaging center, a physician's office, an urgent care facility or an ambulatory surgical facility. Individual coverage: Limited to 3 days per calendar year, per policy. Individual/Spouse, Individual/Child, & Family Coverage: Limited to 3 days per covered person, up to 6 days, per calendar year. This benefit pays only once per day regardless of the number of exams performed on that day. This benefit is not payable for a Laboratory Test or X-Ray which are only payable under the Laboratory Test and X-Ray Benefit or the exams as listed under the Imaging Benefit.

OPTIONAL SUPPLEMENTAL BENEFITS RIDER

Available only to non-HSA compatible plans

The Optional Supplemental Benefits rider allows your customers to tailor their policy to fit their specific needs. This rider enhances the base plan by expanding coverage to include ambulance and surgery, as well as increasing some of the benefits covered by the base plan.

There are 3 levels to choose from with the Optional Supplemental Benefits rider, so your clients can select the level that best fits their needs.

BENEFITS	LEVEL 1 AMOUNT	LEVEL 2 AMOUNT	LEVEL 3 AMOUNT	BENEFIT DETAILS
Additional Hospital Confinement Lump Sum	$100, up to 3 per calendar year	$200, up to 3 per calendar year	$300, up to 3 per calendar year	After the hospital confinement lump sum benefit included in the base policy pays, this benefit is payable for the first day of a new period of hospital confinement within the same calendar year. Periods of confinement separated by 30 days or less are considered the same period of confinement. This benefit is reset each January 1st. If a Hospital Confinement continues uninterrupted without discharge from one calendar year to the next, no Hospital Confinement Lump Sum Benefit shall be payable for any day of that Hospital Confinement in the later calendar year. Upon discharge, for a benefit to be payable in the later calendar year, a Hospital Confinement for any covered sickness or any covered accident must begin more than thirty (30) days after the discharge. **Limited to 3 days per calendar year per covered person.**
Daily Hospital Confinement	$50 per day	$100 per day	$150 per day	This benefit adds to the daily hospital confinement benefit provided by the base plan. Payable per day, per covered person, for up to 365 days per period of confinement when hospital confined for 23 or more hours. A readmission within 30 days of a prior hospital confinement, for the same medical condition, is considered part of the previous confinement. **Limited to 365 days per period of confinement.**
ICU Confinement	$50 per day	$100 per day	$150 per day	This benefit adds to the ICU confinement benefit provided by the base plan. Payable per day, per covered person, for up to 30 days when confined to an intensive care unit. This pays in addition to the daily hospital confinement benefit. A readmission within 30 days of a prior hospital confinement, for the same medical condition, is considered part of the previous confinement. **Limited to 30 days per period of confinement.**
Additional Hospital Outpatient	+$50 per day	+$100 per day	+$150 per day	This benefit adds to the hospital outpatient benefit provided by the base plan. Payable per day when a covered person is in a hospital or U.S. government hospital for less than 23 hours, including observation units and ambulatory surgical facilities. **Limited to 2 days per calendar year. This benefit is not payable for the same day as the emergency room benefit is payable.**

BENEFITS	LEVEL 1 AMOUNT	LEVEL 2 AMOUNT	LEVEL 3 AMOUNT	BENEFIT DETAILS
Additional Rehabilitation Facility	+$50 per day	+$100 per day	+$150 per day	This benefit adds to the rehabilitation facility benefit provided by the base plan. Payable per day when a covered person receives rehabilitation services due to a covered sickness or covered accident. If a covered person is confined within thirty (30) days for the same covered sickness or covered accident, then that later confinement will be considered a continuation and part of the prior period of confinement. This benefit does not include outpatient rehabilitation services. **Limited to 15 days per period of confinement, limited to 30 days per calendar year. The covered person must be hospital confined and the covered person is transferred to a rehabilitation facility by physician's order as the direct result of the covered sickness or covered accident. The transfer must be within 24 hours after the discharge from the hospital confinement.**
Surgical procedure	$100-$1,000 per surgery			Payable for a covered surgery performed in a hospital, U.S. Government hospital, or an ambulatory surgical facility. This benefit is limited to one surgical procedure in a 24-hour period per covered person. For this benefit the relative value information should be added. We will use the Relative Values for physician's publication and the procedural terminology code (CPT) to determine the surgical value assigned to each procedure as of the date of the procedure. If a covered person has more than one surgical procedure performed at the same time through the same incision. We will pay only for the one surgical procedure performed for which the largest benefit amount is payable.
Ambulance	$200 Ground, $2,000 Air			Payable if a licensed surface or air ambulance service transports a covered person to or from a hospital. **Individual coverage: Limited to 3 one-way trips per calendar year, per policy.** **Individual/Spouse, Individual/Child, & Family Coverage: Limited to 3 one-way trips per covered person, up to 6 one-way trips, per calendar year.**

RETURN OF PREMIUM/CASH VALUE RIDERS

Available only to non-HSA compatible plans

Hospital Assure has two premium-return riders available, depending on the state. Most states offer the Return of Premium rider, whereas the Cash Value rider is offered in states that do not allow the Return of Premium rider.

Note: If a premium-return rider is dropped from a policy, another cannot be added.

RETURN OF PREMIUM (ROP) RIDER (R2076)

The Return of Premium (ROP) rider provides a benefit by which a policyowner can receive a check for all premiums paid—minus claims incurred—so long as the ROP rider is kept in force, up until each "maturity date" under the Rider.

The maturity date is the date on which each "return of premium period" (ROP period) ends.
Each ROP period is broken down by issue age, as follows:

- **Age 54 or under:** 20 years.
- **Age 55-64:** The number of years from the beginning of the ROP period to the first anniversary date after a policyowner reaches age 75.
- **Age 65 or over:** 10 years.

At the maturity date, a new ROP period begins, and the policyowner becomes eligible for a new ROP benefit at the end of the renewed ROP period. If the policy is canceled or surrendered before the maturity date, no premiums are returned.

If the policyowner terminates the rider and later reinstates, all maturity dates will be deferred by the period of time the rider is inactive. If a maturity date occurs after the policyowner reaches the age of 75, the maturity date will not be deferred.

CASH VALUE (CV) RIDER (R2077)

The Cash Value rider for Hospital Assure allows the policyowner to receive a check for premiums paid—minus claims incurred—every 25 years. To collect, the policyowner is required only to keep the policy and rider in force until the maturity date. When any premiums are returned, the policyowner can continue coverage and collect again.

Beginning with the sixth year, the policyowner will receive a percentage of premiums paid—minus claims incurred—if the policy is surrendered, canceled, terminated or policyowner dies. This percentage increases over time to 100%.

If a policyowner surrenders their policy and receives the CV, the policy has ended and cannot be reinstated.

TABLE OF CASH VALUE PERCENTAGES*	
COMPLETED YEAR(S)	CASH VALUE PERCENTAGE
1-5	0%
6	5%
7	9%
8	12%
9	15%
10	18%
11	21%
12	24%
13	27%
14	30%
15	34%
16	38%
17	42%
18	47%
19	52%
20	58%
21	64%
22	72%
23	80%
24	90%
25	100%

**This may vary by state, see state-specific policy language.*

It is the responsibility of the agent that ROP or CV benefits are accurately explained to every policyowner. ROP and CV explanatory aids are available for order on WNbizlink.com.

Note: ROP/CV riders cannot be purchased with HSA-compatible plans 1H and 2H.
The waiver of premium benefit is included in all base plans and applies to the policy and rider premiums.
Premiums waived are considered premium paid and claims incurred for the ROP/CV benefit calculation.

LIMITATIONS AND EXCLUSIONS

Limitations and exclusions vary by state; please refer to the state-specific sample policy language.

In addition to the limitations and exclusions contained in the benefit section and other parts of the policy and riders, the policy contains a section specifically listing limitations and exclusions. Under this section, we will not pay benefits for any loss contributed to, caused by, or resulting from any of the following:

Cosmetic or Plastic Surgery: Surgery that is not for the diagnosis or treatment of a Covered Sickness or a Covered Accident, or considered medically necessary, or resulting from, directly or indirectly, any complications of cosmetic or plastic surgery, including but not limited to, the following: Abdominoplasty (tummy tuck); Mammaplasty (breast modification); Rhinoplasty (nose job); or Suction Assisted Lipectomy (liposuction).

Dental Procedures: Treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident and is considered medically necessary.

Elective Surgery: Surgery that is not for the diagnosis or treatment of a Covered Sickness or a Covered Accident, or considered medically necessary, or resulting from, directly or indirectly, any complications of elective surgery, including but not limited to, the following: gastric bypass surgeries; voluntary abortion (except where the Covered Person would be endangered if the fetus were carried to term or where medical complications have arisen from abortion); or sex change.

Flying: Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft including those which are not motor-driven.

Hazardous Activities: Including but not limited to: Hang gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting, rock climbing, scuba diving, mountaineering, or similar activities.

Illegal Acts: Participating or attempting to participate in an illegal act or working at an illegal job.

Intoxication: Being legally intoxicated, or so intoxicated that mental or physical abilities are seriously impaired, being under the influence of any illegal drugs, or being under the influence of any narcotic, unless such narcotic is taken under the direction of and as directed by a Physician.

Mental Disorder: Having a behavioral or psychological disorder, disease or syndrome, without demonstrable organic origin.

Newborn Care: We will not pay for a separate charge made for the newborn's stay in a nursery as a result of a normal delivery.

Pregnancy: Normal pregnancy or childbirth that occurs within the first ten (10) months after the Effective Date of coverage; or, a Cesarean delivery that is not the result of complications of pregnancy. Loss due to complications of pregnancy will be paid the same as for any other covered benefit.

Pregnancy of a Dependent Child: A pregnancy of a dependent child will not be covered. Loss due to complications of pregnancy will be paid the same as for any other covered benefit.

Racing: Riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or while testing any vehicle on any race course or speedway.

Self-Inflicted Injuries: Injuring or attempting to injure yourself intentionally, regardless of mental capacity.

Substance Abuse: Alcoholism, drug abuse, or chemical dependency.

Suicide: Committing or attempting to commit suicide, regardless of mental capacity.

Sports: Participating in any sporting event for pay or prize money.

Travel/Location: Being more than forty (40) miles outside the territorial limits of the United States, Canada, and Puerto Rico.

Vision Procedures: Routine vision exams or vision procedures, unless treatment is the result of a Covered Accident and is considered medically necessary.

War/Military Service: Being exposed to war or any act of war, declared or not, or participating in or contracting with the Armed Forces (including Coast Guard) of any country or international authority.

Pre-Existing Condition Limitation: No benefits are payable for a Covered Person with a Pre-Existing Condition during the first twelve (12) months after the Effective Date of coverage for that Covered Person. See the definition for Pre-Existing Condition in the definition section.

Waiting Period Limitation: No benefits are payable for any Covered Sickness that is diagnosed, treated or produces a clear or obvious symptom during the Waiting Period for the first twelve (12) months after the Effective Date of coverage for that Covered Person. See the Waiting Period limitation on the first page of the Policy and the definition in the definition section.

IMPORTANT DEFINITIONS

Pre-Existing Condition: means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a twelve (12) month period preceding the effective date of coverage for that covered person or a condition for which medical advice or treatment was recommended by a physician or received from a physician or for which prescription drugs were prescribed within a twelve (12) month period preceding the effective date of coverage for that covered person. A pre-existing condition can exist even though a diagnosis has not yet been made.

Waiting Period: This Policy contains a thirty (30) day waiting period for any covered sickness. We will not pay benefits for the first twelve (12) months of coverage for any sickness for a covered person that is diagnosed, treated or produces a clear or obvious symptom during the first thirty (30) days of coverage for that covered person. Benefits for that sickness, if a covered sickness, will only be provided for care or treatment that begins more than twelve (12) months after the effective date of coverage for that covered person. If a sickness is diagnosed, treated or produces a clear or obvious symptom during the waiting period that would otherwise be covered under this policy during the first twelve (12) months of coverage, you may elect to void this policy from its effective date and receive a full refund of any premiums paid. Covered accidents do not have a waiting period.

Period of Confinement: means (1) for a covered sickness, a period which begins at least thirty (30) days after a covered person's effective date of coverage, beginning on the first day of hospital confinement for a covered sickness and ending on the last day of hospital confinement for that covered sickness; and (2) for a covered accident, a period which begins on or after a covered person's effective date of coverage, beginning on the first day of hospital confinement for a covered accident and ending on the last day of hospital confinement for that covered accident. If a covered person is re-confined within thirty (30) days for the same covered sickness or covered accident, then the later period will be considered a continuation of the prior period of confinement. If the beginning of a re-confinement for the same covered sickness or covered accident occurs more than thirty (30) days later, we will treat the later hospital confinement as a new period of confinement.

SECTION 4: ELIGIBILITY AND UNDERWRITING GUIDELINES

WHO IS COVERED?

There are four coverage options offered in this policy:

- Individual
- Individual + children—covers one adult and all dependent children (all children must be listed on the application to be covered.)
- Individual + spouse—covers main policyowner and spouse as defined under policy
- Family—covers main policyowner, spouse and all dependent children (all children must be listed on the application to be covered.)

"Spouse" means the insurable person named as spouse on the application and legally married to the policyowner on the effective date of the policy.

"Child(ren)" means the policyowner's and spouse's natural child, stepchild, legally adopted child, child placed with the policyowner for adoption, foster child or the court-appointed guardianship, order or administrative order of a child (including a grandchild), who is:

- Insurable and named on the application;
- Unmarried;
- Chiefly dependent on the policyowner or spouse for support; and
- Younger than the limiting age of 26

Covered children who become mentally or physically handicapped prior to the limiting age and cannot support themselves because of their handicap may continue to be covered. We must be provided with proof of the child's incapacity and dependency no more than thirty-one (31) day after the child attains the limiting age. Thereafter, such proof must be provided at our request, but not more frequently than annually after the second policy year following the attainment of the limiting age.

Newborn children are covered from the moment of birth. Benefits for newborns will be paid for the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity due to a covered sickness or a covered accident. Benefits are not payable for normal, newborn childcare.

A child(ren) placed for adoption, a foster child(ren), or court appointed guardianship of a child(ren) after the effective date of this policy will be covered from the date of placement; pre-existing condition limitations and exclusions will not apply. Coverage on a child for whom adoption proceedings have been filed will terminate on the date such proceedings are terminated and the child is removed from placement.

Newborn, adopted, foster or court-appointed children guardianship must be added to the policy within 31 days of their date of birth or date of placement without having to answer the health questions. To add a child, written notice including name, date of birth or date of placement as well as any additional premium is required.

A covered person must be eligible for benefits before any benefits are payable due to a covered sickness or covered accident. Please refer to the Eligibility section of the policy for additional information on Eligibility.

ISSUE AGES FOR THE PRIMARY POLICYOWNER AND SPOUSE

- 18–69

Issue-age limits apply to the primary policyowner and the spouse. For example, if the primary policyowner is 69 or younger and the spouse is older than 69, the spouse cannot be covered and the primary policyowner must purchase an individual or individual + children policy.

ISSUE LIMITS

Remember these guidelines when selling Hospital Assure:

- A person can only own one Hospital Assure policy.
- An individual may own more than one WNIC hospital indemnity policy subject to the below limits.
    - An individual cannot own more than $1,000 in daily hospital benefits from any sources. In determining this total, benefits from major medical and specified disease products may be excluded. The optional Supplemental Benefits rider is to be included in determining this total.
    - An individual cannot own in excess of $110,000 lump sum benefits from all WNIC sources.
- All policyowners within an individual + spouse, individual + child(ren), and family policies must select the same coverage, riders and benefit levels. If differing levels are wanted, separate policies would be needed.
- If individuals want to change their benefits or add benefits, they need to upgrade or downgrade their policy.

The issue limits:

- Hospital confinement for one diagnosis type—$1,000 per day
- ICU confinement—$1,500 per day
- Lump-sum payment for one diagnosis type—$110,000

GUARANTEE ISSUE UNDERWRITING

Hospital Assure can be offered on a GI basis for worksite, unions and association sales when a group meets certain levels of participation based on the number of eligible employees in the group who enroll in the product.

Worksite Eligibility

- The employer must not be in an ineligible industry
- **Minimum participation requirement: the greater of 3 submitted employee applications or 10% eligible employees**
- Employees must be actively at work and work a minimum of 20 hours per week
- New employees are eligible for GI if they apply within 31 days of their eligibility date or at the next enrollment opportunity if monthly enrollment is not available
- Late entrants to a GI plan are subject to SI underwriting unless they are newly employed since the last enrollment period
- If the employee/member is eligible for GI, so are the employee's spouse and eligible children

The group chooses whether they want to try to become eligible for GI.
Individuals within the group can choose between an HSA-compatible plan or non-HSA compatible plan, depending on whether they have an HSA. Within the base plan selected, they can choose the hospital confinement lump sum amount.
They can also choose to add any optional riders if they are selecting a non-HSA compatible base plan. The SI base plans (Plans 2H and 4) are not available for purchase if the group chooses to be eligible for GI.

ENROLLMENT GI OPTIONS

Options 1: Enroll new employees within the 31-day eligibility window

If the employer chooses this option, you can service your groups more than once a year and enroll new employees during the 31-day window after their eligibility waiting period. The employer can specify the length of the eligibility waiting period, or it can be mandated by Washington National based on the group's industry classification.

Option 2: Enroll all new employees one time per year

If the employer selects this option, you can visit groups just once a year, such as during the benefit enrollment period. For this option, you'll enroll all new employees who have completed the eligibility period at the same time, once per year.

When setting up a new group, the new hire enrollment option must be indicated in the special instructions box on the case profile. You can choose only one option per group. If you do not indicate one of the two options, the group will default to the first enrollment option, "enroll new employees within the 31-day eligibility window." Groups are monitored to make sure new employees are enrolled according to the enrollment option selected. If you choose a different enrollment option, medical underwriting will be required.

Unions/Associations Eligibility

- Must have been organized for at least 60 months.
- Must have at least 100 dues paying members in good standing for the last 12 months.
- Cannot be associated with an ineligible industry - all unions and associations need to be approved by Underwriting.
- **Minimum participation requirement: 20% of the eligible members.**

Note: Section II (EMPLOYER INFORMATION) of the application must be completed for both worksite and unions/associations business, regardless of the type of underwriting.

Ineligible Industries

Some industries allow for a certain degree of exposure that could increase the possibility or attribute to the illness associated with this coverage. Therefore, there are a few industries that are ineligible for Hospital Assure.

Below is a list of industries that are ineligible and their SIC Codes for GI. SIC codes listed as Major Group means all SIC's within that group are being considered.

- Ammunition, explosives and chemicals - SIC codes 287X -2899, 3482-3484, and 3489
- Manufacturing of stone, clay, glass concrete, abrasive and asbestos products - SIC Major Group 32XX
- Mining - SIC Codes Major Groups 10XX, 12XX, 13XX and 14XX
- Manufacturing of industrial inorganic chemicals and radioactive substances - SIC Codes 2819, 2835
- Sanitary services (refuse) – SIC code 4953

Note: The optional Wellness and Diagnostic Benefits rider is available on a GI basis if applied for at the time of policy issue. SI underwriting is required if added after the policy is issued.
The optional Supplemental Benefits rider is always subject to SI underwriting, regardless of the group's GI eligibility.

SIMPLIFIED ISSUE UNDERWRITING

Hospital Assure is subject to SI underwriting when offered on a direct/individual basis, when a group is not eligible for GI underwriting, or when an employee in a GI group chooses to select a hospital confinement lump sum amount that is above the GI hospital confinement lump sum amounts allowed for the group. SI underwriting is also required when applying for the Supplemental Benefits rider. The application features 8 simple YES/NO knockout health questions.

HEIGHT AND WEIGHT REQUIREMENTS

The proposed primary policyowner and spouse must fall within the following height and weight guidelines when subject to SI underwriting.

UNISEX HEIGHT AND WEIGHT REQUIREMENTS		
HEIGHT	MIN	MAX
4' 6"	N/A	N/A
4 ' 7"	N/A	N/A
4' 8"	N/A	N/A
4" 9"	N/A	N/A
4' 10"	77	181
4' 11"	79	187
5' 0"	82	194
5' 1"	85	200
5' 2"	88	207
5' 3"	91	214
5' 4"	93	221
5' 5"	96	228
5' 6"	99	235
5' 7"	102	242
5' 8"	105	249
5' 9"	109	257
5' 10"	112	264
5' 11"	115	272
6' 0"	118	279
6' 1"	121	287
6' 2"	125	295
6' 3"	128	303
6' 4"	132	311
6' 5"	135	320
6' 6"	139	328
6' 7"	142	336
6' 8"	146	345
6' 9"	N/A	N/A
6' 10"	N/A	N/A
6' 11"	N/A	N/A

INSURED ELIGIBILITY

Individual/Direct: Must not be currently hospitalized or recently been recommended for hospitalization.

Employees:

- Full and/or regular part-time employees.
- Must work a minimum of 20 hours per week for GI.
- Must be actively at work at time of enrollment.
- Must be actively at work on the date of the first payment deduction.
- Must not be currently hospitalized or recently been recommended for hospitalization.
- Temporary, Transient or Seasonal workers are excluded.
- Active military employees are excluded.
- Must be living in the United States.
- Issue ages are 18 through 69.

Unions/Association Members:

- Must be a full-time member.
- Must be dues paying and in good standing.
- Must be actively employed for a minimum of 20 hours per week. This will be validated by requiring the member to fill in the employer information on the enrollment form(s).
- Must not be currently hospitalized or recently been recommended for hospitalization.
- Temporary, Transient or Seasonal workers are excluded.
- Active military employees are excluded.
- Must be living in the United States.
- Issue ages are 18 through 69.

Dependent Children:

- Must be 25 years old or younger.
- Must be unmarried.
- Must be living in the United States.
- Must be a dependent of the primary policyowner for support and maintenance.

CONTINUITY OF COVERAGE

Hospital Assure does not offer continuity of coverage. If replacing an existing policy, Hospital Assure will be treated as a new policy.

Contact the underwriting department at IndividualUnderwriting@WashingtonNational.com or (800) 525-7662 ext. 77733 should you have any additional questions.

MAIN INSURED AND SPOUSAL EXCLUSIONS

There are no main policyowner or spousal exclusions on this product.

SALES TO PERSONS ELIGIBLE FOR MEDICARE OR MEDICAID[1]

Federal statute makes it illegal to issue a health insurance policy that duplicates Medicare benefits to anyone who is eligible for Medicare, unless the policy pays without regard to other insurance and the applicant at the time of application is shown a disclosure statement prescribed in the regulation for that type of insurance. Persons may qualify for Medicare if they are 65 or older, have permanent kidney failure or are disabled regardless of age. Because our policies pay without regard to other insurance, Washington National may sell them to people who qualify for Medicare, as long as the applicant signs the appropriate disclosure statement and submits it with the application. The application will not be processed if the statement is not signed or not attached.

The disclosure form number is N2082. This guideline applies only if the policyowner is eligible for Medicare; therefore, Washington National does not need a disclosure statement if only a spouse or dependent child is eligible for Medicare. The disclosure statements and the pamphlet "Guide to Health Insurance for People with Medicare" (form MEDICARE-GUIDE) are available to order from WNbizlink.com. These guidelines apply to new business, but not reinstatements.

Persons eligible for Medicaid MUST understand that participating in Medicaid will likely reduce or eliminate their Washington National benefits. Even though each state's Medicaid regulations vary, the use of taxpayer dollars to pay these medical expenses mandates that Washington National reimburse the public program first, based on those regulations.

PRIVACY OVERVIEW

Washington National Insurance Company ("the company") must adhere to various legal and regulatory requirements. The company, and its agents, each have a responsibility to be in compliance with state insurance laws and regulations. It is the obligation of each licensed insurance agent to be aware of all laws, regulations and requirements for their state so that they conduct all sales activities in a manner that complies with these laws and regulations.

Additionally, we have set high standards in connection with the sale and servicing of our insurance products. Agents are expected to conduct business with honesty and integrity, as outlined in the Washington National sales representative agreement.

This agreement provides an overview of ethical and compliance expectations as they relate to advertising, field conduct, disclosure, suitability, replacement and unfair trade practices. This agreement is not intended to be a complete listing of all compliance requirements.

[1] The comments regarding Medicare and Medicaid simply reflect our current interpretation of the programs. It is not our intent to give advice on Medicare or Medicaid. Please consult a qualified adviser.

SUITABILITY GUIDELINES

To determine whether the sale or solicitation of Washington National Insurance Company products is reasonable, prudent or in the prospective policyowner's best interest, you should take into account their personal circumstances.

- You should examine the totality of the prospective policyowner's circumstances, including the following: Financial condition, i.e. is the person on a fixed income, premium cost;
- Need for insurance at the time of sale, i.e., existing policies, policyowner's finances; and
- The values, benefits, and costs of the prospective policyowner's existing insurance program, if any, when compared to the values, benefits, and costs recommended policy or policies.

Personally Identifiable Information (PII) is information that clearly identifies a distinct individual (a consumer, customer, associate or agent). Examples of PII are name, address, Social Security number, information about health and finances and other information that is not generally available to the public.

A copy of the consumer privacy notice is available at WNbizlink.com under the "Materials" link. Agents should review this form to familiarize themselves with how we handle PII and what consumers can do to change or access it.

Agents are required by law to take an active role in preventing PII from being disclosed to unauthorized parties. If you suspect PII is lost, stolen or disclosed to an unauthorized party, it is critical that you immediately report the situation to the home office by submitting a DATA ALERT form. This form and instructions for submitting it are located on WNbizlink.com. It may be completed online and submitted by email to privacy@cnoinc.com.

Since independent agents are legally responsible for consumers' personal information while under an agents' control, completing and submitting a DATA ALERT should be approached with a sense of urgency and priority.

Questions about privacy regulations should be directed to privacy@cnoinc.com.

ETHICS HOTLINE

At Washington National, we value ethics, fairness and personal responsibility. It's up to each of us to report actions that are illegal, unethical or inconsistent with the CNO Code of Business Conduct and Ethics.

Our door is always open to raise concerns when you don't feel comfortable reaching out resources within your organization, which is why we have the Ethics Hotline (previously referred to as In Touch).

- The Ethics Hotline is confidential, secure and anonymous.
- The Ethics Hotline is available 24/7 365 days a year.
- You can report an issue by calling (855) TELL-CNO or by emailing TellCNO@GetInTouch.com.

The Ethics Hotline phone number and email address are operated by In Touch, an independent third party. Your identity and contact information will not be disclosed to CNO—unless you clearly state in your report that you wish to be identified.

SECTION 5: EFFECTIVE DATES

INDIVIDUAL BUSINESS

The effective date is the date the application is received in the home office, unless otherwise requested. It cannot be earlier than the date the application is received in the home office.

WORKSITE BUSINESS

The effective date of worksite payroll deduction business can be no earlier than the date the application is received in the home office.

- All payroll business is given an effective date of the **1st of the month**.
- If the application is received **on or before the 15th of the month**, the effective date will be the 1st of the month following the date the application is received in the home office.
- If the application is received **after the 15th of the month**, the effective date will be the 1st of the next month following the date the application is received in the home office.
- Payroll check deductions should begin on the policy effective date so that funds are available to remit when the first bill is due.

CREDIT UNIONS

If applications are received on the **1st through the 15th day of the month**, the effective date is 60 days from the first day of the month the application is received.

For applications received on the **16th through the 31st of the month**, the effective date is 90 days from the first day of the month that the application is dated.

The new business department must approve any exceptions to the guidelines stated above.

WAITING PERIOD

In most states, Hospital Assure has a 30-day waiting period. The waiting period does not begin until the effective date of coverage, which is assigned according to the guidelines stated above.

COMMON ERRORS

The following errors require investigation by the underwriting department. The incorrect or incomplete application will be returned to the agent for correction or completion. Additionally, the policy will not be issued until the application is received back in the home office and processed. An application may be returned for correction or completion for any of the following reasons:

- Incorrect application
- Incorrect premium shown on application
- No date shown on application
- Missing/incorrect signature on application
- Missing applicant's age and/or birth date or Social Security number
- Health questions not answered
- Replacement question not answered when required
- Representative not licensed in the state where application is written
- Appropriate boxes not checked on the application
- Missing spouse's age and/or birth date or Social Security number missing (if electing spouse coverage)
- Application altered but not initialed by client
- Information missing on electronic funds transfer form (CI-747)
- Any other required information or forms not provided

SECTION 6: PREMIUM PAYMENT

MINIMUM PREMIUM

There is a minimum premium payment of $15 per month on this policy. Any applications received at a lower premium amount will be rejected. State variations may apply. Please check the state-required forms grid.

INDIVIDUAL AND WORKSITE

Hospital Assure may be sold to applicants who are ages 18-69, based on their last birthday.

These age guidelines apply to the primary policyowner and spouse. Individual and worksite sales use the same rates.

On all new worksite groups, a worksite case profile form (WIS-GRPPRO) must be completed and signed by an officer of the group. This form is required for all worksite sales.

Note: A worksite group must have at least three applicants to qualify for coverage.

BANK DRAFT (PAC/ACH)

When submitting automatic check business, the following items should be attached:

- Electronic funds transfer form (CI-747) for initial and future deductions
- Applicant's check, payable to Washington National Insurance Company, for one month's premium
- A voided check with bank routing transit numbers and account number printed on the slip for the account from which deductions will be made. (Experience shows that far fewer bank processing errors occur when a voided check is provided.) Deductions can be made from checking or savings accounts. Please indicate the type of account on the authorization form.

The automatic check deduction day is the day each month that a policyowner's premium is automatically deducted from his or her checking or savings account. Policyowners should select their preferred day of the month (between the 1st and the 28th) on the electronic funds transfer form (CI-747). If no day is specified, the default deduction day is the date the application is received in the home office. (Applications received on the 29th, 30th or 31st are assigned deduction days of the 1st, 2nd and 3rd, respectively.)

TAXABILITY OF BENEFITS

To avoid the policy being a tax-reportable product, the employee must pay 100% of premiums. The standard policy can be sold under a Section 125 (cafeteria) plan, but the cash return riders are not available under a Section 125 plan. If sold under Section 125, a tax form 1099 will be generated when benefits are paid to employees per Internal Revenue code guidelines. If an employer pays or is treated as paying all or part of the premium, the benefit may be considered taxable income unless excluded under one or more provisions of the Internal Revenue Code. Generally, if benefits paid are less than actual costs incurred, then benefits will be received income tax-free. Policyowners should contact a tax adviser for specific information.

SECTION 7: CHANGES TO POLICIES

It is important that you do not confuse a conversion with an upgrade or downgrade.

- An **upgrade** is defined as increasing the benefits within the current coverage or adding a rider.
- A **downgrade** reduces benefits.
- A **replacement** is when a new policy is taken out and the current policy is canceled.
- A **conversion** is defined as changing of coverage from one product to another.

On upgrades and downgrades, the current policy number is retained.

Note: Conversions are not allowed on this policy.

ADMINISTRATIVE REQUIREMENTS

- For an upgrade, a new application (AP-2078 or state variation) must be completed and will be underwritten. If approved, the increased benefits become effective on the next monthly anniversary date of the existing policy. The original policy number is retained.
- All applications for upgrades must include the policy number on the application.
- The total premium for the policy that will be effective after the upgrade should be listed in the column labeled "premium total."
- Enter the amount of money being submitted with the upgrade application in the blank labeled "amount collected."
- Downgrades may be requested in writing from the policyowner or on an application. Either must include his or her signature to be processed.
- If a multiple-policyowner policy (individual + child, individual + spouse or family) is being upgraded or downgraded, all members must upgrade or downgrade to the same coverage type and the same option amount.

UPGRADES

The following upgrades are allowed:

- Increasing the lump-sum benefit amount
- Adding additional coverages/riders
- Adding a ROP or CV rider
- Adding a spouse and/or child(ren)
    - A new application (AP-2078 or state variation) is required. Please check the appropriate box on the application in Section 1. Newborn, adopted, foster or court-appointed children must be added to the policy within 31 days of their date of birth or date of placement without having to answer the health questions. To add a child, written notice including name, date of birth or date of placement as well as any additional premium is required. They will not be covered if not added to the policy.

The effective date of coverage will be the next monthly anniversary date upon receipt of the application by the home office. Rates are based on the effective date of coverage and use the policyowner's attained age.

Note: Policyowners cannot apply for upgrades until at least 30 days after the policy effective date.

DOWNGRADES

The following downgrades are allowed:

- Decreasing the lump-sum benefit amount
- Removing a family member
- Removing coverages or riders
- Removing the ROP or CV rider

Downgrades can be requested by the policyowner in a letter containing his or her signature or by completion of an application.

Please note that the applicant or spouse cannot improve his or her tobacco class at upgrade or downgrade.

INTERNAL REPLACEMENTS

An internal replacement occurs when a policyowner cancels or lapses their current Washington National policy in order to purchase a Hospital Assure policy.

If a new Hospital Assure policy is written and a hospital indemnity policy is subsequently canceled or allowed to lapse, commissions will not be paid for the new policy. Any advances and earned commission already paid will be recouped by the company.

Hospital Assure does not offer continuity of coverage. The client will be subject to the policy's 30-day wait and underwriting of the new policy.

Note: If selling Hospital Assure in an existing group and the group is eligible for GI, then any customers that would like to replace their old hospital indemnity policy with Hospital Assure are also eligible for GI.

REINSTATEMENTS

When the coverage lapse or termination is 90 days or less, the policy can be reinstated, subject to new underwriting with the following guideline: The original writing agent will continue to receive commissions due on the reinstated policy. When a policy lapses or has been terminated between 90 and 180 days, the policy will be reinstated, subject to new underwriting. In addition:

- The original writing agent will not continue to receive commissions on the reinstated policy; rather, the reinstating agent will receive commissions based on the original effective date.
- If the policy is upgraded at the time of reinstatement, first-year commissions will be paid on the incremental increase in premium.

GENERAL RULES FOR REINSTATEMENTS

- Once approved, the policy will be reinstated with the same policy number, the lapse in coverage will be shown and the new effective date will indicate when coverage resumed.
- Resumption of a canceled policy (if not canceled at issue) is considered a reinstatement.
- All reinstatements must be done by signed application.
- Premiums will not be accepted for the inactive coverage period.
- Claims incurred during the inactive coverage period will not be paid.
- The ROP maturity date will be extended by the number of days the coverage lapsed.
- For any upgrades executed upon reinstatement, first-year commissions are credited to the reinstating agent based on the incremental premium increase.
- There is a 10-day waiting period after reinstatement.

Note: If a policy lapses or has terminated for more than 180 days, it cannot be reinstated.

REPLACEMENT OF A NON-HSA COMPATIBLE POLICY WITH AN HSA-COMPATIBLE POLICY

In some cases, customers that have purchased Non-HSA compatible plans 3 or 4 (who did not have a Health Savings Account at the time of purchase), may be inclined to open an HSA account. If you receive an inquiry regarding this, you may inform these policyowners that keeping their current Hospital Assure plan **may negatively impact HSA eligibility**. Any additional questions regarding HSA eligibility should be directed to their own personal tax advisors.

If a policyowner wants to keep their hospital indemnity coverage, HSA-compatible plans (**1H** or **2H**) are available to exchange for their current plan. The current non-HSA compatible plan and any attached rider(s) attached will be cancelled, and a new HSA-compatible plan would be issued.

Note that any Return of Premium (ROP) benefit that has not reached maturity will not be paid if the plan and ROP rider are cancelled. For Cash Value (CV) states, the CV benefit paid will be based upon the CV percentage available according to the CV schedule at the time the plan and CV rider are cancelled.

Instructions:

- A paper application must be submitted for the new HSA-compatible plan (1H or 2H)
- The reinstatement question should be marked "Yes" under Section 1 (GENERAL INFORMATION) of the application
- Medical underwriting will not be required. Health questions should be left blank.
- Any covered person(s) would be subject to new pre-existing condition and waiting period limitations

First-year and renewal commissions are paid on the new base policy from the date the application is signed, at a rate of 50% of the percentages shown on the schedule of commissions in effect with your marketing agreement.

SECTION 8: SUBMITTING BUSINESS

APPLICATION REQUIREMENTS AND DETAILS

These items must be left with the policyowner at the time of application in all states:

- Outline of coverage (OC2073 or state variation)
- Signed medical record auth form–point of sale form (MEDAUTH-FORM-PRE)

In the state of South Dakota, it is required that a copy of the appropriate outline of coverage for any product sold is left with every customer at point of sale. All outlines of coverage are available on WNbizlink.com.

The following forms are required to be sent with the application in certain situations:

- New business transmittal form (C-NBT), for all business
- Electronic funds transfer form (CI-747), if an applicant chooses to pay premium by bank draft
- Payroll deduction authorization form (WS-PREM-AUTH), if the applicant is having premium payroll deducted
- Replacement insurance form (REPLACESPECDIS), if the applicant intends to terminate or allow existing coverage to lapse and be replaced
- Conditional receipt (CONDITIONALRECPT), if the applicant pays the initial premium by check
- Medicare disclosure notice (N2082), if the applicant is eligible for Medicare

For any additional state-required forms, please visit WNbizlink.com.

NEW AND UPGRADE APPLICATIONS

New and upgrade applications should be mailed to:

INDIVIDUAL SALES	WORKSITE SALES
Attn: New Business Department Washington National Insurance Company 11825 N. Pennsylvania Street Carmel, IN 46032 **OR** P.O. Box 1908 Carmel, IN 46082-1908 **OR** Fax: (800) 906-3926	Attn: Worksite New Business Washington National Insurance Company 11825 N. Pennsylvania Street Carmel, IN 46032 **OR** P.O. Box 2036 Carmel, IN 46082-2036 **OR** Fax: (800) 981-8413 **OR** Email: WIS@WashingtonNational.com

No paper check is required when you fax business to us. To help avoid confusion and delays when faxing business, do not send the original copy of the application to the home office. The application can also be submitted electronically using Washington National One Source®. Please check WNbizlink.com for state availability.

REINSTATEMENT APPLICATIONS

Reinstatement applications and downgrade requests should be mailed to:

INDIVDUAL SALES	WORKSITE SALES
Attn: Policy Change Department Washington National Insurance Company 11825 N. Pennsylvania Street Carmel, IN 46032 **OR** P.O. Box 2022 Carmel, IN 46082-2022 **OR** Fax: (800) 906-3926	Attn: Worksite New Business Washington National Insurance Company 11825 N. Pennsylvania Street Carmel, IN 46032 **OR** P.O. Box 2036 Carmel, IN 46082-2036 **OR** Fax: (800) 981-8413 **OR** Email: WIS@WashingtonNational.com

DELIVERY RECEIPT

Agents may hand-deliver a Hospital Assure policy packet to a policyowner.

- For the agent to receive the policy packet, the "mail to agent" box on the application must be marked. Otherwise, the policy will be mailed directly to the policyowner.
- If the "mail to agent" option is selected on the application, the agent must have the policyowner sign the delivery receipt included in the policy packet. If this form is not returned to the above address when this option is selected, the policyowner will receive a follow-up letter from us requesting the delivery receipt be returned.

If the policy is mailed directly to the policyowner, the delivery receipt will be included in the policy packet. A follow-up letter will be mailed to the policyowner asking for the policy receipt, if it is not returned. No adverse action will be taken if the receipt is not returned.

WNEZQUOTE®

Washington National has a quote-generating tool available for you to use on WNbizlink.com. WNezQuote is quick and easy to use to create custom quotes.

On WNezQuote, you can select the table, individual or census tabs to run a quote. Each tab has two sections: general options and optional riders. Under general options, you can enter basic group information, including premium modes and base coverage selections. In the optional riders section, you can choose which riders to build into the coverage or make available as optional.

For table and individual quotes, you can enter information to generate rate sheets for your group.
The census quote option has an additional category, called "census," where you can upload the group census to generate rates. Worksite case management offers a standard census template you may use.

WASHINGTON NATIONAL ONE SOURCE®

One Source is our state-of-the-art enrollment platform that lets you complete both worksite and individual applications with one convenient tool. You can use the online version of One Source or the offline One Source software on most Windows devices.

For individual sales:

- Reduce pending applications.
- Shorten application processing times.
- Take applications with or without an internet connection.

For worksite sales:

- Enroll core and voluntary benefits on one convenient platform.
- Ensure efficient, accurate enrollments.
- Reduce enrollment time to mere minutes.
- Eliminate manual data entry.

Run a product quote on the spot with WNezQuote® and let the One Source enrollment platform guide you through the application from beginning to end. It doesn't just make submitting new business easier, One Source makes it easy to see any missing or incorrect information, virtually eliminating common errors that lead to pending applications. Business is processed more quickly, and you get paid faster.

Visit the One Source support page on WNbizlink.com to learn more, or to download the software.

SECTION 9: COMPENSATION

NEW SALES

First-year and renewal commissions are paid on the base policy and riders from the date the application is signed, according to the percentages shown on the schedule of commissions in effect with your marketing agreement.

UPGRADES

When upgrading coverage within the Hospital Assure product, new commissions are calculated on the incremental increase in premium between the original coverage and the new coverage. Commissions on the incremental increase in premium are calculated according to the same schedule in effect for new sales.

DOWNGRADES

When downgrading coverage within the Hospital Assure (e.g., decreasing lump-sum amount), the original writing agent will continue to receive commission on any premium not exceeding the original premium amount.

REINSTATEMENTS

When the coverage lapse or termination is 90 days or less, the policy can be reinstated, subject to new underwriting with the following guideline: The original writing agent will continue to receive commissions due on the reinstated policy.

When a policy lapses or has been terminated between 90 and 180 days, the policy will be reinstated, subject to new underwriting. In addition:

- The original writing agent will not continue to receive commissions on the reinstated policy; rather, the reinstating agent will receive commissions based on the original effective date.
- If the policy is upgraded at the time of reinstatement, first-year commissions will be paid on the incremental increase in premium.

If a policy lapses or has terminated for more than 180 days, it cannot be reinstated.

South Dakota mandate SDCL 58-17-11 requires that "every individual health insurance policy or contract, except single premium nonrenewable policies or contracts, issued for delivery in South Dakota on or after December 31, 1966, by an insurance company, nonprofit hospital service plan, or medical service corporation, shall have printed thereon or attached thereto a notice stating in substance that the person to whom the policy or contract is issued shall be permitted to return the policy or contract within ten days of its delivery to said purchaser and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason. If a policyowner or purchaser pursuant to such notice, returns the policy or contract to the company or association at its home or branch office or to the insurance producer through whom it was purchased, it is void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

INTERNAL REPLACEMENTS

If an internal replacement does occur, no commissions will be paid.

ADVANCES/CHARGEBACKS

Advances are the prepayment of commission based on annualized premium. Advances are calculated by agent setup on all newly issued business, including upgrades. (Not all agents are on advances.)

Annual premium x commission rate x advance rate = advance amount

Example: $420 x 35% x 60% = $88.20

Advance balances are recovered as premium is received on a policy-by-policy basis. The advance balance of any policy that is terminated before the advance is fully recovered will be recouped (charged back) immediately and transferred to the secondary balance. The agent's 1099 earnings include advances paid and are reduced by advances recouped.

COMMISSION EARNINGS

The following formula is used to calculate commission earnings:

Commissionable premium collected x commission rate = commission earned

Earned commissions and advance activity are applied first to pay off any outstanding primary account debt. Earned commission and advance activity in excess of debt in primary and minus secondary paybacks are paid to the agent via electronic funds transfer.

ELECTRONIC FUNDS TRANSFER (EFT)

Advances and commissions are paid via EFT, which helps expedite the payment of advances and commissions and eliminates the wait for a check.

COMMISSION PAYMENTS

The minimum payment is $25. Primary balances that do not meet the minimum payout accumulate until the minimum is met. At that time, an EFT is issued for the accumulated net balance. The file transmission is sent to our bank on Monday of each week, excluding holidays.

COMMISSION STATEMENTS

A statement with detail by policy of premium processed and commission activity is generated weekly for all activity during that week's pay period for every active agent and manager.

All business processed Monday through Friday is reflected on the weekly commission statements.

Commission statements are available at WNbizlink.com, posted by 8 A.M. ET each Monday.

SECTION 10: MARKETING MATERIALS

MARKETING MATERIALS AND FORMS USAGE

The insurance industry is state-regulated. For that reason, Washington National product availability and forms required to sell policies vary by state.

If you have questions regarding product availability or form requirements, please consult the home office. Please don't assume that policies available in one state are available in another state, or that the required forms are the same.

WNBIZLINK.COM

Our online portal, WNbizlink.com, provides easy-to-find product information, news and field updates. You can access forms and marketing materials on WNbizlink.com or by contacting agent care. Registration is required for first-time users. You can view materials on your screen, send them to your printer or download them for later use.

On-hand supplies are normally mailed within 48 hours after an order is received. All supplies are sent by FedEx® ground delivery. There is no charge for most materials and no charge for ground delivery. Expedited shipping can be requested for an additional charge. If you need help, please call agent care at (888) 754-3406. A representative can help you place an order or determine the status of your order.

Need help accessing WNbizlink.com? Contact the help desk, (800) 888-4918, ext. 72269.

CREATING ADVERTISING AND MARKETING MATERIALS

Advertising is anything intended to generate interest in a specific insurance product, company or agent. This includes, but is not limited to, website information and other online services; product brochures; newsletters; agent recruiting materials; prospecting letters; print, radio, television and all other forms of media advertising; illustration and presentation materials; and business cards and stationery.

You may not publish, advertise, use or promote any material concerning our policies/certificates without written approval from the home office. For example, you're authorized to use a comparison statement between a competitor's product and a Washington National product only if that statement is approved in writing by the home office prior to use. Failure to submit advertising may result in termination of the agent contract. Please allow sufficient time for the review and approval process.

Please email all requests for approval to: WNmaterialsreview@WashingtonNational.com.

SECTION 11: CLAIM INFORMATION

Hospital Assure uses multiple claim forms. The claim forms will correspond with the type of diagnosis being claimed. All applicable forms can be ordered at WNbizlink.com or downloaded from WashingtonNational.com.

The policyowner and the attending physician must complete all required sections of the claim form. All necessary documentation—such as hospital bills, doctor bills, etc.—should be attached to the completed form. Claim forms should be mailed to:

Washington National Insurance Company
Attn: Claims Office
Specified Disease Products
P.O. Box 2024
Carmel, IN 46082-2024

Policyholders: (866) 481-9266
Agents: (888) 754-3406

Information concerning a policyholder who has been paid benefits on his or her Washington National policy may be used only if written permission is first obtained from the policyholder and has not reached its expiration date.

CONTESTABLE REVIEW

Knowing the ins and outs of contestable review will help you support a client who files a claim during the contestable period of his or her policy.

What is contestable review?

Insurance companies have a limited amount of time to challenge or contest the validity of a policy based on the policyholder's answers to application questions. In most circumstances, the "contestable period" is the first two years of a new policy, conversion, reinstatement or upgrade. Claims incurred during this time frame trigger a contestable investigation where the claims department collects information to verify the accuracy of the information provided by the policyholder.

Which policies are subject to a contestable review?

All Washington National policies are subject to a contestable review except guarantee-issue (GI) policies. The extent of the review depends on the type of policy. For example, the base plan of an accident policy wouldn't be reviewed. However, the optional disability coverage on an accident policy, which requires health questions on the application, is reviewed for contestability.

Note: Coverage amounts over the GI limit are also subject to a contestable review.

How many claims undergo a contestable review?

Approximately 3% of Washington National's claims in a year undergo a contestable review.

How long does the contestable review process take?

Length of the contestable review depends on how quickly the policyowner and their medical provider(s) return the required information. Some reviews take 90 days or longer to complete, while others are completed more quickly.

Washington National will expedite the processing time once the claim has been approved to be processed following the contestable review.

What are common reasons for delays during the contestable review?

The following circumstances can delay the contestable review investigation:

- Incomplete sections within the claim packet, such as, authorization dates and primary care physician information
- Policyowner failure to complete forms sent by our claims department when a provider requires a different authorization to receive medical records
- Delays in receiving a doctor's response, a valid medical record authorization form, medical records and the employer response if required

What documentation is needed to complete a contestable review?

To complete a review, our claims department requires the following information from the policyowner:

- A fully completed claim form for the appropriate benefits being claimed. All sections should be completed, including the following:
    - A list of primary care physicians, with complete contact information, visited during the look-back years (The look-back period varies by product and is specified on the application.)
    - A signed authorization to obtain medical information
    - A physician's statement, and
    - An employer's statement

Once all necessary information referenced above is received, our claims department may request the following additional information from outside agencies or resources:

- Prescription history
- Physician questionnaire and applicable medical records
- Employer questionnaire

What happens if the contestable review shows misstatements?

If, during the contestable investigation, potential misstatements are identified, our claims department will request an agent statement from the original writing agent. The statement will ask questions related to the medical questions answered by the policyowner within the application and relied upon to issue coverage.

Note: If it's decided that any portion of the policy shouldn't have been issued due to misstatements on the application, correspondence will be sent to the policyowner explaining the results of the investigation.

IF…	THEN…
A misstatement is found in the base policy	A letter will be mailed to the policyowner, the policy will be canceled, and all premiums will be refunded.
A misstatement is found about a secondary policyowner	An option letter will be mailed to the policyowner giving him or her 30 days to either cancel and receive refund of all premiums or remove the secondary insured and return any prorated premiums.
A misstatement is found in secondary coverage, but the base coverage isn't affected	An option letter will be mailed to the policyowner giving him or her 30 days to cancel and receive refund of all premiums or keep the base policy in place and remove optional coverages and return any prorated premiums

How can you help your client expedite the contestable review process?

If your client contacts you for assistance, you can help him or her prepare for the review by:

- Helping your client understand the contestable review process and requirements.
- Reminding him or her to fully complete the claim form, including all sections, authorization dates and physician information.
- Helping your client understand what can create processing delays, including:
    - Incomplete forms.
    - Provider delays in responding to Washington National's requests for information.
    - Provider requests for payment of records.

- Helping your client understand **what not** to do:
    - They should not pay for anything Washington National has requested. Washington National will pay the provider for records requested on the policyowner's behalf.
    - They **should not** collect any medical information on behalf of Washington National.

SECTION 12: FORMS

State-specific forms and marketing materials are available at WNbizlink.com.

FORM NAME	FORM NUMBER	DESCRIPTION
New business application	AP2078 or state variation	The application should be used to apply for a new, reinstating, upgrading, or adding a family member to a Hospital Assure policy.
Outline of coverage	OC2073 or state variation	The Outline of coverage form should be left with every applicant.
Privacy notice	WNPRIV-FORM-APP	A privacy notice must be left with each application at the time of sale. This form does not require any signatures.
Medical authorization form	MEDAUTH-FORM-PRE	A medical authorization form must be completed with every application. One copy must be submitted with the new business application and one must be left with applicant.
New business transmittal form	C-NBT	This form must accompany applications being sent to the home office for new business, conversions and upgrades. One form is required for every 10 applications submitted.
Worksite new group case profile form	WIS-GRPPRO	A group profile must be completed and submitted with applications for each new group.
Payroll deduction authorization form	WS-PREM-AUTH	This form authorizes the employer to deduct premiums from the employee's payroll check. It should be completed for payroll sales and left with the group's payroll administrator.
Conditional receipt form	CIC-DELIVERY RECEIPT	This form must be completed and left with the customer whenever premium is collected at the point of sale.
Electronic funds transfer form	CI-747	This form is required whenever an applicant wishes to have either his or her first or subsequent monthly premiums deducted from a checking or savings account. For details, refer to page 25 of this agent guide.
Replacement notice	CIC-REPLACESPECDIS	The replacement notice must be given to and signed by the applicant (and spouse, if applicable) whenever the application intends to terminate or allow existing coverage to lapse and be replaced by a Hospital Assure policy. The application book includes two copies of this form. The applicant copy must be left with the applicant and the home office copy must be submitted to the home office with the application.
Medicare notice	N2082	This form must be submitted for any applicant who is eligible for Medicare.

Insurers and their representatives are not permitted by law to offer tax or legal advice. The general and educational information here supports the sales, marketing and service of insurance policies. Based upon individuals' particular circumstances and objectives, they should seek specific advice from their own qualified and duly-licensed independent tax or legal advisers.

Washington National Insurance Company
Home Office
11825 N. Pennsylvania Street
Carmel, IN 46032

WashingtonNational.com

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