

HMA[®] Broker Client Sales Instructional Guide

**Your Comprehensive Summary
And Resource For Educating
Your Clients On The
HMA[®] Program**

**BROKER USE ONLY
NOT FOR CLIENT USE**



The HMA[®] is not health insurance.

Table Of Contents

PAGE 3

- Important HMA[®] Program Rules And Member Contract Update Policy
- HMA[®] Customer Service Policies
- How Your Clients Should Use This Program

PAGE 4

- HMA[®] Covered Services

PAGE 5

- Non-Covered Services
- Limitations On HMA[®] Covered Services

PAGE 6

- Reimbursement Rules
- Scaling Up And Scaling Down To Different Monthly Contribution Plans
- HMA[®] Plan Termination
- Rules For Brokers Rules When Marketing And Enrolling Clients

PAGE 7

- HMA[®] Beneficiary Rules
- Verifying Eligibility Of Client HMA[®] Transactions

PAGE 8

- HMA[®] Contact Information

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It is very important that you know and can educate your clients on all of the important aspects and details of the HMA[®] program to maintain your business and keep them happy, which will help you to also secure future business from these clients as well. Once you have read through and understand all of the information in this guide you will easily be able to explain essential HMA[®] program features during enrollment and answer and address any question from your client regarding the HMA[®].

Important HMA[®] Program Rules And Member Contract Update Policy

1. There are no spend down benefits. If your clients leave the HMA[®] program then they will forfeit all of their HMA[®] medical benefits.
2. The HMA[®] is not insurance and is a patented and trademarked product so nobody else can duplicate it.
3. An updated HMA[®] contract with any change in program policies will be sent to your clients at least once per year.
4. HMA[®] primary plan owners must be 18 years or older; children can stay on the plan as dependents until they reach the age of 26. Both spouses are permitted to purchase their own individual HMA[®] plans, but by doing so they are increasing their overall costs by paying for two separate maintenance fees.
5. HMA[®] medical services must be performed within the 50 United States or the District of Columbia (Washington D.C.).
6. There is no cash value associated with the HMA[®] plan. The HMA[®] must be exclusively used for the payment or reimbursement of HMA[®] eligible medical expenses.
7. The HMA[®] cannot be used for the payment or reimbursement of medical services for dependents not listed as secondary account holders on the plan.
8. Dependents can only be included on one HMA[®] plan per household. Family members over the age of 18 can have a separate individual HMA[®] plan or be listed as a dependent on one plan per household.
9. When dependents on a HMA[®] plan reach the age of 26, they are no longer eligible to be a dependent but can purchase their own individual plan.

HMA[®] Customer Service Policies

1. We make every effort to contact the member when his/her payment is declined by leaving automated voice messages to call us back to avoid terminating their account. Our procedure is to block the plan from being used for a 60-day grace period. If we do not hear back from the client and get the plan brought current within the 60-day grace period their plan is terminated and any remaining medical benefits are relinquished.
2. The HMA[®] Medical Reimbursement Card will be mailed in an unmarked, non-descript, white envelope for security reasons. The first card is complimentary at no cost to receive and activate the card. If the card is not received within 15 days of the start date, the member needs to contact the HMAS[®] office. If it is not reported that the card was not received within 15 days of the contract start date the cost is \$5 for a replacement card. Additional HMA[®] Medical Reimbursement Cards for eligible family members can be issued for \$5 each card.

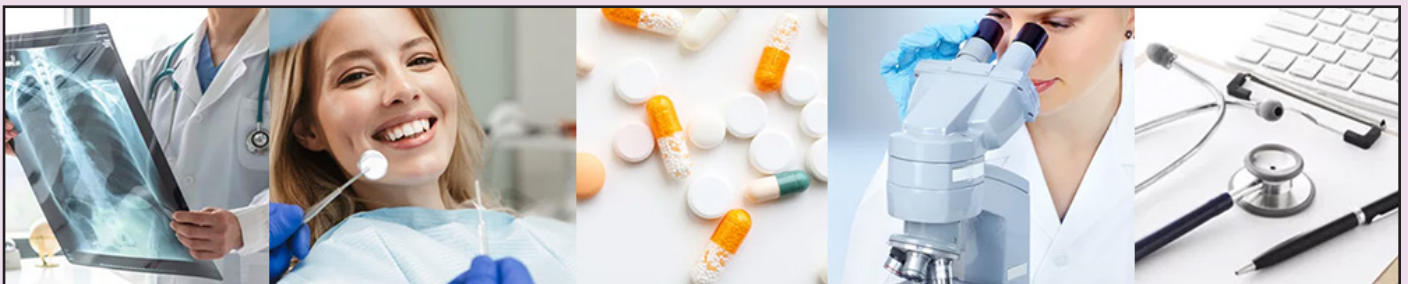
How Your HMA[®] Clients Should Use The Program

1. Please remember to stress to the prospective member that the goal is to make contributions without use for as long as possible to allow the excess medical benefit to work for the member's advantage so they eventually reach the HMA[®] target medical benefit cap selected by the member.
2. The member must maintain a minimum medical benefit of one month's contribution at all times. Claims that are submitted that could exceed this will be reduced automatically to ensure the one month's contribution is maintained in the member's plan.

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HMA[®] List Of Covered Services

- **Elective Procedures**
(Lasik, Plastic Surgery, etc. with MD surgeons only)
- **Ambulance Services**
- **Chiroprodists, Podiatrists**
- **Chiropractors**
(2 routine adjustments per month, \$150 max)
- **Counseling Service: performed by PsyD or PhD**
- **Dentists, Orthodontists**
- **Drug Stores, Pharmacies (no sundries / reimbursement only on grocery store pharmacy purchases)**
- **Hearing Aid: Sales, Service, Supply Stores**
- **Hospitals**
- **Hospital Equipment**
- **Laboratory / Medical / Dental / Ophthalmic**
- **Medical and Dental Laboratories**
- **Opticians, Optical Goods and Eyeglasses**
- **Optometrists, Ophthalmologists**
- **Prosthetic Devices**
- **Osteopathic Physicians**



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Non-Covered Services

If a primary plan holder or dependent uses their HMA® in an unauthorized manner for non-covered services, the primary will be required to reimburse HMA® services in full for all funds paid out for such unauthorized use.

1. **Drugs, alcohol or any rehabilitation facilities**
2. **Over the counter medicine including non-Rx prescriptions**
3. **Non-prescription purchases at pharmacies**
4. **Payments to medical collection agencies and any provider asking for payments past 30 days of the date of service or 90 days for a hospital service**
5. **Health care financial consultants**
6. **Massage therapy**
7. **Acupuncture**
8. **Naturopathic medicine**
9. **Supplements and non prescription vitamins**
10. **Elective procedures not performed by an MD**
11. **The HMA® only covers medical expenses that are incurred directly or through prescriptions from Medical Doctors (MD), Doctors of Osteopathy (DO), Dentists (DDS or DMD), Optometrists (OD), Podiatrists (DPM) or hospitals and clinics**
12. **Annual, semi-annual or quarterly membership fee payments for Direct Primary Care or Concierge Medical Services**
13. **Covid tests whether prescribed or not prescribed by an MD**
14. **Cosmetic or other elective procedures not performed by Medical Doctors (MD), Doctor of Osteopathy (DO), Doctors of Psychology, Dentist (DDS or DMD), Optometrists (OD), Podiatrists (DPM)**
15. **Payment plans set up for outstanding past, present or future medical bills**

Limitations On HMA® Covered Services

1. **Chiropractors (DC) are only paid directly two visits per month per account, so if both spouses in a household have their own HMA® plan they can each have two covered chiropractor services.**
2. **The member can only use the HMA® Medical Reimbursement Card for the services paid directly to the doctor or a stand-alone pharmacy for prescribed drugs or paid directly to a testing facility for blood work, X-rays, MRI, CT scans, etc. with a prescription from a doctor.**
3. **Because many stand-alone pharmacies sell much more than prescription drugs, use of the HMA® Medical Reimbursement Card for anything other than prescription drugs is a violation of the member's contract and will require reimbursement from the member for such unauthorized use as well as potentially blocking their card for up to 12 months in the discretion of HMAS®. This will require the member to submit paid receipts to receive reimbursements from us. This holds true for Sam's Club, Costco and any other establishment that accepts the HMA® Medical Reimbursement Card even though it is not for prescriptions. Just because the HMA® Medical Reimbursement Card is successfully swiped and payment is accepted doesn't mean it is a qualified eligible medical expense. Our products seek to empower our customers by providing them with a whole new level of health care solutions and service, including telemedicine. You should emphasize that to your prospects. Tell them that the HMA® Medical Reimbursement Card is a convenience for the member, but abuse of the card will have consequences which will require reimbursement of any inappropriate use and the card can be blocked for up to 12 months. They will still have access to their medical benefits, but they will be relegated to pay upfront at the provider and submitting for reimbursements for 12 months.**
4. **The HMA® will not cover and reimburse any payment plans set up for outstanding past, present or future medical bills.**

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Claim Reimbursement Rules

Medical expense reimbursements will not be paid after 30 days from the date of service unless the claim is related to surgery or a hospital stay in which case reimbursement requests must be made within 90 days. Medical expense payments that are paid after 30 days from the date of service (or 90 days after a hospital stay or surgery) will require reimbursement to HMAS® from the member.

Claim Automation

Health Matching Account Services, Inc. is always striving for ways to improve our program and make all aspects of it more convenient and user friendly for our members. Not every medical provider has the correct merchant category code (MCC) in place that pertains to the service they provide, so therefore there are times when the HMA® Visa® card will not process for that payment. Therefore, we are providing our clients with a fast and convenient claim reimbursement process through the HMA® member portal in order to submit eligible medical expenses that could not be paid with your HMA® Visa® card.

Tell your clients to please refer to their HMA® Member Contract for eligible claim reimbursements under Section 1.1 "Eligible Medical Expense" on page 3 and Section 1.11 "Eligible Medical Provider" on page 5. All claim reimbursement requests must be paid in full showing a \$0 balance when uploading an itemized paid receipt to the member portal. The paid itemized receipt must match the dollar amount requested on the reimbursement claim form. Prescriptions must have a Rx number to be covered, and no over the counter products are covered. Each claim reimbursement must be submitted separately. When submitting their first claim reimbursement through their HMA® member portal, your clients will be prompted to add a bank account as a payment method so that HMAS® can automatically submit reimbursements to your clients by ACH within 30 days of the claim being submitted once it is reviewed and approved.

Scaling Up And Scaling Down To Different Monthly Contribution Plans

A member cannot move down his/her plan during the first 24 months of becoming a member, so make sure the prospect understands that their plan choice cannot be moved down during the first 24 months. However, HMA® primary plan holders are permitted to scale up to a higher HMA® contribution level at any time.

HMA® Plan Termination

1. Your clients HMA® plans will be terminated and their medical benefits will be cancelled and relinquished if:
 - A. The primary plan holder fails to bring their plan current on all outstanding payments after 60 days
 - B. Fraud, misrepresentation of a material fact or not complying with the terms of the agreement (Ex: using the HMA® to purchase gift cards)
2. Your clients can terminate their plans at the end of any month by completing the HMA® Addition/Termination/Change Form located in the Resources section of their member portals and submitting it to HMAS®

Rules For Brokers When Marketing And Enrolling Clients

1. You as the broker cannot register the member yourself on the portal, it must be completed by the member who must have an email address of their own. The reason for this is that the member must accept the terms and conditions on our website, which constitutes an acceptance of terms and conditions. You cannot agree on their behalf due to privacy and contract law. If you are meeting with the prospect in person and using your laptop computer, you need to give control to the prospective member to check the "accept" box on the terms and conditions section so there can be no dispute who signed up. Once they accept the terms and conditions, it leaves your laptop. If you are selling to a prospective member over the phone, you must send a link to the prospect which has your writing number embedded in the link. You then walk the prospect through the enrollment and they sign up through the link you have sent them.
2. If a prospect does not have an email address they cannot enroll. You cannot use your email address.
3. Brokers are not allowed to develop their own HMA® marketing materials or put any HMA® references on any website or social media platform. Brokers are only permitted to use approved HMA® marketing materials such as client brochures and the HMA® website (www.healthmatchingaccounts.com).

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HMA® Beneficiary Rules

1. In the event of the primary plan holder's death, HMA® Services will pay the hospital directly for end-of-life medical bills with proof provided to HMA® Services of a final bill of Eligible Medical Expenses not covered by insurance or other non-insurance health plans within 90 days of the primary plan holder's death.
2. When the primary plan holder dies, the remaining HMA® medical benefits will be transferred in full to the surviving legally married spouse if they are listed and covered under the existing plan and if they continue to make the required monthly payments. Only a legally married spouse can be transferred the full HMA® medical benefit. If legally married spouses have separate individual plans, they cannot list each other as beneficiaries, and they cannot list the same beneficiary.

If both spouses are deceased, 1/3 of the remaining medical benefits can be transferred to one (1) designated beneficiary over the age of 18 by the primary plan holder if they complete and submit to HMA® the "HMA® Beneficiary Transfer Form" located in the Resources section of the member portal and appoint a designated beneficiary before they die who must also continue to make the required monthly payments. If the primary plan holder is single and does not have a legally married spouse, 1/3 of the remaining medical benefits can be transferred to one designated beneficiary over the age of 18 by the primary plan holder if they complete and submit to HMA® Services the "HMA® Beneficiary Transfer Form" located in the Resources section of the member portal and appoint a designated beneficiary before they die. If the current beneficiary dies while the primary plan holder is living, the primary plan holder will be permitted to appoint and switch to a new beneficiary as long as the primary plan holder does so before they die.

The designated beneficiary is not required to assume the plan but must notify HMA® of their intention to assume ownership of the plan within 60 days of the death of the primary plan holder and must continue to make the required HMA® monthly contribution payments in order to keep their plan in force. If the beneficiary does choose to assume ownership of the plan, they are not permitted to scale down to a lower monthly contribution plan than what the deceased primary account holder was on for the first two years after they inherit it and begin to make monthly contributions (Ex: If your client was on the HMA® 20000 plan with a current medical benefit of \$18,000 at the time of death, the designated beneficiary would assume \$6,000 in medical benefits and must continue to pay the required monthly contribution into their HMA® 20000 plan for at least 24 months before they would be permitted to scale down to a lower HMA® plan level). However, the designated beneficiary is permitted to scale up to a higher monthly contribution plan at any time. You as the broker will not be paid additional commission when your clients' beneficiaries assume ownership of their HMA® plans.

Verifying Eligibility Of Client HMA® Transactions

1. If the HMA® primary plan holder or other eligible person covered under the plan uses the HMA® Medical Reimbursement Card in a suspected, unauthorized manner for non-eligible expenses, their cards will be blocked while an audit and review of the expense is conducted. The primary plan holder will be required to submit an itemized receipt to verify the eligibility of the transaction. If the eligibility of the service cannot be verified, the primary plan holder will be required to reimburse HMA® for such unauthorized charges and will also be required to submit on a claim reimbursement basis all future reimbursements for up to 12 months of completing the claim reimbursement process in their HMA® member portal.
2. **Whitelisting:** The whitelist card swiping program is yet another enhanced, customer service feature for your clients that we have put in place to make it simple and easy for them to make sure that their HMA® cards work at all of their approved and recurring medical providers. Our whitelist card swiping program allows us to approve eligible medical expenses that are initially declined when the provider does not have the correct merchant category code (MCC) that pertains to the service they provide when the HMA® Visa® card should seemingly be able to be used for payment.

When your clients have a declined transaction on their HMA® Visa® card at the point of sale (and not an online or virtual payment), tell them to not leave their provider and immediately call our whitelist hotline at 713-357-4733 to find out if their medical provider is eligible to be whitelisted. If their eligible medical provider is whitelisted, they will be immediately put in our system, and they will be able to use their HMA® Visa® card there both that day and in the future.

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The medical and Medicare costs covered are subject to specification.

*The HMA® Medical Reimbursement Visa®
Prepaid Commercial Credit Cards are issued by Celtic Bank.

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