Simplified Funding Concepts

for groups of 10 to 50 employees

The IHC Group provides a program to establish and maintain a self-funded health plan coordinated with stop-loss insurance protection for employers with 10 to 50 enrolled eligible employees. Stop-loss insurance is underwritten by Independence American Insurance Company, a member of The IHC Group. The IHC Group has been providing life, health and stop-loss insurance solutions for more than 30 years.

Administrative services for the self-funded health plan are provided by licensed Third Party Administrators (TPA). The TPAs are not members of The IHC Group.

Simplified Funding Concepts

THE IHC GROUP

IHC's Simplified Funding Concepts offers a different way for businesses to provide health insurance benefits.

The complexity of new healthcare laws, and their potential to raise insurance rates, may leave some employers looking for an alternative to fully insured plans. The Affordable Care Act (ACA), also known as Obamacare, requires fully insured employer group plans to cover Essential Health Benefits (EHB) as defined by the legislation. The law also puts certain rating restrictions on employer group insurance which, along with the requirements for EHB, could increase the total cost of providing health insurance to employees.

The IHC Group brings you a program to cover your employees under a self-funded health benefit plan coordinated with stop-loss insurance protection. The self-funded plan provides the required coverage to meet the ACA's individual mandate. Governed by federal law under the Employee Retirement Income Security Act (ERISA), self-funded plans allow employers greater latitude in designing coverage. From the options available, you can select the plan that best meets your employees' needs.

Your single monthly payment is applied to the claims account, Plan administrative expenses and stop-loss insurance premium.

- ### Claims account
  Funds are deposited into an account set up specifically for the group's covered medical claims. The amount deposited is based on the anticipated medical claims for the group.
- ### Administration
  Administrative Plan expenses, such as billing, customer service and claims payment, are also included as part of the monthly payment.
- ### Stop-loss insurance
  The IHC Group program includes the protection of stop-loss insurance underwritten by Independence American Insurance Company.

Simple process

1. Your single monthly payment applies to the claims account, Plan expenses and stop-loss insurance premium.

2. All covered employee and dependent medical expenses are paid from funds deposited into the claims account.

3. Stop-loss insurance provides protection if covered claims exceed the employer's monthly funding limit (monthly Aggregate Attachment Point).

4. If claims do not exceed the employer's annual funding limit (annual Aggregate Attachment Point) at the end of the claims run-out period, the employer may apply the unused claims funds to future program costs or request the remaining fund balance.

Self-funding with stop-loss insurance provides protection.

Specific stop-loss insurance

Specific insurance is designed to prevent the claims of **one covered individual** from exhausting the group's entire claim fund. If a member's covered medical claims exceed the pre-determined threshold (the Specific Deductible per covered person), the specific stop-loss insurance reimburses the plan for the excess amount.

Aggregate Stop-Loss Insurance

Aggregate stop-loss insurance is designed to provide a limit on the employer's total liability to a specified dollar amount, also called the Aggregate Attachment Point. When covered claims for **all covered employees** and their dependents exceed the Attachment Point, at the end of the contract year the stop-loss carrier reimburses the claims account for the excess amounts. The Monthly Aggregate Accommodation will provide a monthly reimbursement, helping to limit your maximum claim liability.

The claims account is used to pay your group's covered medical claims. The amount of funds deposited each month is based on numerous factors, including your group's enrollment, location and medical history. **Your risk is always limited to the single monthly payment.** If at any time during the policy year there are not enough funds in the claims account to cover the employees' claims, the stop-loss carrier will **provide an advance against the monthly aggregate accommodation benefit** to pay the outstanding claims.[1]

For example, a group purchases an IHC Simplified Funding Concepts program that deposits $3,000 per month into the claims account. In a 12-month period, the account would have $36,000 available to pay claims.

Consider these three scenarios:

- If covered claims total $7,000 in month two and only $6,000 has been deposited to the claims account, the stop-loss carrier would advance $1,000 to the account to ensure sufficient funds are available.
- If covered claims total $40,000 for the year, exceeding the required annual contribution to the claims account, the stop-loss insurance would reimburse the plan $4,000 - the difference between the account total and the claims total.
- If covered claims total $25,000 at the end of the claims run-out period, the claims account will have a positive balance of $11,000, which belongs to the Plan and can be returned to the Plan, or the employer can apply it to the following year's program expenses.[2]

Even if your group has higher than expected claims, the monthly bill does not change during your initial rate guarantee period, unless your group's enrollment or benefits change.

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[1]At the end of each policy month, any accumulated funds advanced to the employer's claims account must be repaid to the stop-loss carrier, unless the Plan has met the annual Aggregate Attachment Point, in which case all previous accommodations will apply towards that aggregate claim. If the policy is terminated prior to the end of the policy year, all amounts advanced must be returned to the carrier and no coverage is in effect. For complete details, see the Monthly Cumulative Accommodation for Aggregate Stop-Loss Rider.

[2]These funds may be used in a limited manner. Please contact your broker or tax consultant for additional information.

Plan Options

Design your group's health plan using the following options. Not all benefit combinations are available.

Physician Office Visit If selected, the copay applies to the physician consultation charge per in-network covered visit with a primary care physician, with a specialist or at an urgent care facility. After the copay, the Plan pays 100 percent of the balance of the office visit consultation charge. Other covered services performed during the visit are subject to the deductible and coinsurance percentage.	Primary Care Physician/Specialist/Urgent Care copay ○ $20/$40/$50[NQ] ○ $30/$50/$50[NQ] ○ $40/$60/$50[NQ] ○ No copay; covered charges apply to deductible and coinsurance Out-of-network provider visit: Deductible and coinsurance
Deductible The in-network deductible options listed apply per plan member to covered charges within the Plan year. Covered charges for all covered family members accumulate to satisfy the family deductible within the Plan year. In-network and out-of-network deductibles accumulate separately. For employees with dependents enrolled on the Plan, covered expenses for all family members accumulate together and are applied to the family deductible; however, the amount contributed on behalf of any one family member will not exceed the individual deductible. *The Plan will give credit for any deductibles satisfied, in whole or in part, under the employer's previous plan of benefits within the calendar year, provided the member submits sufficient evidence of having satisfied them.*	**Individual** / **Family** ○ $1,300 / ○ $2,600 ○ $1,500 / ○ $3,000 ○ $2,000 / ○ $4,000 ○ $2,500 / ○ $5,000 ○ $3,000 / ○ $6,000 ○ $3,500 / ○ $7,000 ○ $5,000 / ○ $10,000 ○ $6,550* / ○ $13,100* Out-of-network deductible: Two times the in-network deductible amount **Amount subject to change based on Health and Human Services Department guidelines*
Coinsurance Percentage After the deductible has been satisfied, the plan will pay the selected percentage of in-network covered charges.	○ 100% ○ 90% ○ 80% ○ 70% ○ 50%[1] Out-of-network coinsurance percentage: 70% for the 100% and 90% in-network options, 60% for the 80% in-network option, and 50% for the 70% and 50% in-network options
Out-of-Pocket Maximum[2] After the deductible has been satisfied, the plan member is responsible for the selected individual out-of-pocket maximum amount for in-network covered charges per Plan year. Covered charges applied to the out-of-pocket maximum for all covered family members accumulate to satisfy the family maximum within the Plan year. The in-network out-of-pocket maximum and the out-of-network out-of-pocket maximum shall accumulate independently and shall not be used to satisfy each other. For employees with dependents enrolled on the Plan, covered expenses for all family members accumulate together and are applied to the family out-of-pocket maximum. However, the amount contributed on behalf of any one family member will not exceed the individual out-of-pocket maximum.	Individual / Family ○ $0 / ○ $0 ○ $1,500 / ○ $3,000 ○ $2,000 / ○ $4,000 ○ $2,500 / ○ $5,000 ○ $3,000 / ○ $6,000 ○ $4,000 / ○ $8,000 ○ $5,000 / ○ $10,000 Out-of-network out-of-pocket maximum: Three times the in-network out-of-pocket maximum. When $0 is selected, the out-of-network out-of-pocket maximum is $4,500 for an individual and $9,000 for a family.

[1]50 percent coinsurance is not available when certain preferred provider networks are selected.

[2]The election of the out-of-pocket maximum is made at the Plan level. Expenses applied toward the deductible or incurred for inpatient notification penalties and charges excluded under the self-funded Plan Document do not accumulate toward the out-of-pocket maximum.

Features

Mental, Nervous and Substance Abuse Disorders[3]	Covered charges for all mental, nervous and substance abuse disorders are subject to the deductible and then a 50% coinsurance percentage. Inpatient mental, nervous and substance abuse care: Maximum benefit of 28 inpatient days per Plan year Outpatient mental, nervous or substance abuse care: Maximum benefit of $50 per outpatient visit
Organ Transplant Covered human organ and tissue transplants include those for bone marrow, cornea, heart, heart-lung, lung, pancreas, pancreas-kidney, kidney, liver and small intestine.	Subject to deductible and coinsurance A transportation expense benefit of up to $5,000 is available per transplant when performed at a Center of Excellence.
Chiropractic Care	If a physician office visit copay benefit is elected, chiropractic care visits are subject to the specialist copay amount up to a maximum benefit of 20 visits per Plan year. If a copay benefit is not elected, chiropractic care is subject to deductible and coinsurance up to a maximum benefit of 20 visits per Plan year.
Oral Surgery	Subject to deductible and coinsurance
Skilled Nursing Care	Subject to deductible and coinsurance up to a maximum benefit of 60 days per Plan year
Home Healthcare	Subject to deductible and coinsurance up to a maximum benefit of 60 visits per Plan year
Hospice Care[4]	100% after the deductible
Preventive Services Covered preventive services are those rated with an “A” or “B” by the United States Preventive Services Task Force (USPSTF), along with immunizations and screenings as outlined in the self-funded Plan Document.	In-network providers: 100%; covered charges are not subject to the Plan copay, deductible or coinsurance Out-of-network providers: Not a covered benefit
Outpatient Diagnostic Tests, Lab and X-ray	If a copay is selected - In-network providers: 100% up to $500 per visit, then subject to deductible and coinsurance If no copay is selected - In-network providers: Subject to deductible and coinsurance Out-of-network providers: Subject to deductible and coinsurance
Ambulance (Air and ground services only)	Subject to deductible and coinsurance
Emergency Services	Subject to deductible and coinsurance In an emergency, as defined by the Plan, out-of-network charges will be paid at the in-network benefit level.
Inpatient Facilities and Surgical Services	Subject to deductible and coinsurance
Maternity Services	Subject to deductible and coinsurance
Physical, Speech or Occupational Therapy	Maximum benefit per Plan year of 60 treatments for any combination of therapies. Benefits are subject to deductible and coinsurance.

Benefits

Prescription Drug Coverage

Copay and percentage amounts below indicate the plan member's responsibility.

Option 1[NQ]	Generic: $10 copay; Brand: Subject to the plan deductible and coinsurance; Specialty drugs: $150 copay
Option 2	All drugs apply to the plan deductible and coinsurance.
Option 3[NQ]	Generic: $10 copay; Brand Formulary: $50 copay; Brand Non-formulary: $100 copay; Specialty drugs: $150 copay
Option 4[NQ]	Generic: $10 copay; Brand Formulary: $50 copay and 30% of the remaining charge; Brand Non-formulary: $100 copay then 50% of the remaining charge; Specialty drugs: $150 copay
Option 5[NQ]	Generic: $10 copay; Brand Formulary: $25 copay; Brand Non-formulary: $40 copay; Specialty drugs: $150 copay

[NQ]Benefit selections do not meet federal guidelines for use with a Health Savings Account (HSA). Based on the total Plan year out-of-pocket amount (deductible plus selected out-of-pocket maximum listed above) certain benefit combinations will not qualify for use with an HSA. The Plan year deductible and out-of-pocket maximum amounts on HSA-qualified plans are subject to annual cost-of-living adjustments as may be required by federal guidelines to maintain the Plan's eligibility. For tax-related questions and/or advice regarding an HSA, please consult your accountant or attorney.

[3]Covered charges for all mental, nervous and substance abuse disorders are subject to the deductible and then a 70 percent coinsurance percentage for in-network providers and 50 percent coinsurance percentage for out-of-network providers when selecting the GWH CIGNA or Aetna networks.

[4]Hospice care is covered at 100 percent after the deductible for in-network and 80 percent for out-of-network when selecting the GWH CIGNA or Aetna networks.

Important Information

The information included in this brochure is a summary outline of the features, Plan provisions, benefits, exclusions, limitations and other information about the medical coverage provided under IHC employer self-funded health plans and a brief introduction to the employer stop-loss insurance policy. This brochure is not a contract and it is not intended to serve as legal interpretation of the self-funded Plan Document. Any provisions of the self-funded Plan Document or stop-loss policy or policies that are in conflict with federal laws, or any applicable state law, are amended to meet the minimum requirements of the law. More details are provided in the self-funded Plan Document, which is the prevailing document and the basis for payment under the Plan. Plan designs are subject to change to comply with federal law, as necessary. The program is not available in all states. The exact provisions governing the stop-loss insurance are contained in Policy Form series SL2014-IAIC and SL2004-IAIC underwritten by Independence American Insurance Company.

Self-funded health plans are not right for every group. In some instances, a fully insured plan may be a better option. Stop-loss underwriting is a key to determining which groups may save using IHC's Simplified Funding Concepts. Medical history is obtained from all plan participants (employees and their dependents). This is used expressly for the purpose of enabling the stop-loss insurance carrier to assess and rate its risk for the employer's stop-loss insurance policy. **Should a plan participant fail to disclose a serious medical condition, the stop loss carrier may retroactively re-rate the employer's stop-loss insurance policy, increase the stop-loss Specific Deductible for the covered employee or dependent in question, or exclude them from the stop-loss coverage. If that occurs, and the plan participant is excluded from the stop-loss coverage, the employer's self-funded Plan will remain liable for all claim expenses incurred by the excluded participant.** A stop-loss carrier cannot advise a policyholder with respect to the policyholder's rights to rescind or cancel a participant's coverage for fraud or misrepresentation. The policyholder should consult with the TPA or its attorney concerning this issue.

Self-funded Plan Exclusions Summary

The following is a partial listing of the IHC Simplified Funding Concepts Plan Document's exclusions. Please consult the self-funded Plan Document for a complete description of the charges, services and supplies excluded from coverage. Except as specifically provided for in the self-funded Plan Document, the Plan does not provide any benefits for the following charges, treatment, services, or supplies for or related to:

- Expenses not medically necessary for the treatment of a sickness or injury
- Experimental or investigational treatment
- War or an act of war
- Service in the armed forces of any country
- Medications and vitamins purchased without a Physician's written prescription (over-the-counter medications)
- Any injury or sickness that arises out of or in the course of any employment for wage or profit; an injury or sickness for which the employee or dependent has or had a right to recovery under any workers' compensation or occupational disease law
- The teeth; the gums other than tumors, or any other associated structures
- Temporomandibular joint (TMJ) dysfunction and/or myofascial pain dysfunction (MPD)
- Eyeglasses or contact lenses, their fitting or examination
- Routine hearing exams to assess the need for or change to hearing aids; the purchase, fittings or adjustments of hearing aids
- Any service or supply in connection with the implant of an artificial organ
- Services performed by a person who is a member of the plan member's immediate family or who resides in the plan member's home
- Room-and-board charges incurred for hospital confinement which begins on Friday, Saturday or Sunday except for emergency admissions, pregnancy or scheduled surgery within the 24-hour period immediately following hospital admission
- Charges incurred by the plan member related to an injury or sickness that is intentionally self-inflicted while sane
- Any loss sustained or incurred due to a plan member being intoxicated or being under the influence of any illegal narcotic, barbiturate, hallucinatory or other drug, unless administered by a physician and taken in accordance with the prescribed dosage
- Government-operated facilities; services furnished to the plan member in any veteran's hospital, military hospital, institution or facility operated by the United States Government, by any state government, by any agency or instrumentality of such government, or any foreign government agency, for which the plan member has no legal obligation to pay for services rendered or expenses incurred, except for care or service: a) furnished by a tax-supported state hospital for treatment of mental/nervous disorders; or b) that the Plan is required to provide reimbursement for by federal law
- Elective abortions; charges related to fertility testing and studies, sterility testing and studies, consultations, examinations, medications and procedures to restore or enhance fertility
- Weight reduction by diet control or surgery, or complications of such weight reduction surgery
- Foot orthotics; treatment, services or supplies related to the feet by means of posting or strapping
- Private-duty nursing; custodial care
- Charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services, drugs or supplies.
- Expenses for completion of claim forms or for preparation of medical reports; for missed appointments or for computer, Internet and telephone consultations

In addition to all of the exclusions listed above for the health Plan, the following exclusions apply to outpatient prescription drug coverage:

- Immunization agents, biological sera, blood or blood plasma
- Homeopathic medications
- Medications purchased outside the United States

General Information

The following provides a brief overview of the IHC program's self-funded plan guidelines, definitions, limitations and exclusions. This brochure is not the self-funded Plan Document. Please refer to the self-funded Plan Document for detailed definitions along with a full explanation of Plan guidelines, benefits, exclusions and limitations.

Timely notification of inpatient hospitalization

Notification of advanced outpatient imaging (CT, MRI and PET) and inpatient hospitalization within 48 hours after admission is required. If a Plan member does not comply with the notification of advanced imaging and inpatient hospitalization when required, covered expenses will be reduced by 50 percent up to a maximum penalty of $500 per confinement. This reduction is in addition to the deductible and will not be applied to the out-of-pocket maximum. Notification is not pre-approval of coverage and does not guarantee payment of benefits.

Total monthly cost

With respect to the self-funded Plan, the administrative costs and amounts necessary to fund the claims account may vary if: 1) the employer adds or deletes covered employees or dependents; 2) the business moves to another geographic area; 3) the employer modifies the Plan or Plan benefits, or selects a different network; or 4) benefits change due to applicable federal rules, regulations or taxes.

Usual, Customary and Reasonable (UCR) Fee

The UCR fee is only applicable when a Plan member receives medical treatment, services and/or supplies from a out-of-network provider. UCR means either of the following, depending upon which definition is included in the Plan Document:

- It means the cost of the medical treatment, service and/or supplies will be based on either a designated percentage of the Centers for Medicare and Medicaid Services Prospective Payment System amount; or
- It will be based on the charge for the given service/supply by a provider to the majority of his clients, but such charge must be one which is within the range of fees charged by the majority of providers of similar training and experience, for that service/supply within a specific, limited geographic or socioeconomic area as determined by the Plan

Employee and dependent eligibility requirements

An employee actively working at least 30 hours per week may enroll for coverage. An eligible employee may also enroll her/his lawful spouse and dependent children.

Termination of benefits

Coverage for an employee or dependent will remain inforce until: the required premium is not paid; employment is terminated; the employee or dependent no longer meet the eligibility criteria established by the Plan; or the employer terminates the group's coverage under the Plan. If the stop-loss insurance contract is terminated before the end of the policy year, no aggregate excess loss benefits will be payable.

Third Party Administrator

An independent administrative company is responsible for the self-funded Plan's benefit claims, billing, customer service and other administrative services. This administrative company is not a member of The IHC Group.

Independence American Insurance Company

Independence American Insurance Company underwrites the specific and aggregate stop-loss insurance described in this brochure. Independence American, a member of The IHC Group, is rated A- (Excellent) for financial strength by A.M. Best Company Inc., a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meet policyholder obligations. (An A++ rating from A.M. Best is its highest rating.)

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For more than three decades, member companies of The IHC Group have built a reputation of commitment to the markets they serve. With over one million customers, The IHC Group's focus is to be an innovative partner to small businesses, individuals and families.