Simplified
Funding Concepts

Your health plan. Calibrated.

Simplified Funding Concepts

with plans for groups of 5 to 75 employees

Options to help you control costs while still delivering valuable health insurance benefits.

Simplified Funding Concepts is a self-funded health benefit plan coordinated with stop-loss insurance protection for employers with 5 to 75 covered employees. The stop-loss insurance is underwritten by Westport Insurance Corporation ("Westport"). The stop loss benefits, limitations and exclusions are detailed in Westport's Policy Form series RS2016. Westport is rated "A+ ("Superior") by A.M. Best Company, Inc., a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meeting policyholder obligations. Westport is not a member of The IHC Group. The SFC program is not available in all states.

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.

IHC Specialty Benefits
A Member of The IHC Group

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. You can choose to receive 100% or 50% of your unused claims account funds at the end of the claims run-out period.

Administration

Plan administrative expenses, such as billing, customer service and claims payment, are also included as part of the monthly payment. Your administrative costs are adjusted based on whether you choose to receive 100% or 50% of your unused claims account funds at the end of the claims run-out period.

Stop-loss insurance

The IHC Group's program includes the protection of stop-loss insurance underwritten by Westport Insurance Corporation. Stop loss insurance reimburses plan expenses exceeding certain pre-determined amounts, subject to plan and policy terms and conditions.

Simple process

1. The 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. Either 100% or 50% of the unused funds remaining in the claims account are returned to the Plan Sponsor (employer) if claims do not exceed the employer's annual funding limit (annual Aggregate Attachment Point).

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 claims 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 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, the stop-loss carrier reimburses the claims account for the excess amounts at the end of the policy year. 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 a 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 will be returned to the Plan.[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.

Claims account refund options help you manage costs

100% or 50% Claim Refund Options

Employers who select to have 100% of the unused Claim fund refunded will typically have higher administrative expenses. Employers who select to have 50% of the unused Claim fund refunded will typically have lower monthly administrative expenses. Talk to your broker to help decide which option is best for your business.

[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. The claims run out period is the 12 months following the expiration date of the stop loss policy.

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, 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 deductible and coinsurance.	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. 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. Not all deductible options are available in all markets. The out-of-network deductible is two times the in-network deductible amount.	**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* $7,150* / $14,300* **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.	**In-network** / **Out-of-network** 100% / 70% 90% / 70% 80% / 60% 70% / 50% 50% / 50%
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. In-network and out-of-network out-of-pocket maximums accumulate separately. 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. The out-of-network out-of-pocket maximum is 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.	**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

[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.

Benefits

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	In-network: 100% coverage (deductible waived) for the first $500 in charges, per provider per day, thereafter charges apply to the deductible and coinsurance. Out-of-network: Charges apply 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 20 visits for each therapy. Subject to deductible and coinsurance

[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 Aetna network.

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

Prescription Drug Coverage Benefits

You can decide between two prescription drug formulary options, The Standard Formulary and The Value Formulary. A formulary is a list of medicines that are included on a prescription benefit plan. The plan will cover the medicines that are on this list, provided they are being used appropriately. The Standard Formulary: Covers generic medicines, listed brand medicines and unlisted brand medicines. The Value Formulary: covers all generic medicines and listed brand medicines. Plans of this type do not cover unlisted brands. Copay and percentage amounts below indicate the plan member's responsibility.

The Standard Formulary – Plan Copay and Coinsurance Options:

Option 1[NQ]	Generic: $10 copay; Brand: Subject to the plan deductible and coinsurance; Specialty drugs: $150 copay
Option 2	All covered prescription 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

The Value Formulary – Plan Copay and Coinsurance Options:

Option 6[NQ]	Generic: $10 copay; Brand Formulary: $40 copay; Specialty drugs: $150 copay
Option 7	All covered prescription drugs apply to the plan deductible and coinsurance.

General Information

The following provides a brief overview of the 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.

Network options

National network partners as well as SFC's innovative platform using a version of referenced based pricing, powered by Allied Advocate, are available. Contact your broker for more information on network availability.

This IHC Referenced Based Pricing (RBP) plan is not a PPO network plan, members are free to access providers of their choice. RBP is a medical bill repricing plan. There may be some cases where the provider does not accept the repriced amount, and the member will be responsible for the balance of the billed amount.

[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.

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 is described as either of the following, depending upon which definition is included in the Plan Document:

- 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
- UCR will be based on the charge for the given service/supply by a provider to the majority of clients. However, the 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 contract's policy year, the full Specific Deductible per covered person will not be reduced and will apply as if the policy were inforce for the entire policy year. In addition, no aggregate stop-loss benefits will be payable and premium for stop-loss will not be refunded.

Self-funded Plan Exclusions Summary

The following is a partial listing of the 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

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 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 RS2016 underwritten by Westport Insurance Corporation.

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 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.

This plan will be administered pursuant to ERISA regulations, regardless of whether ERISA applies.

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.

Specific and Aggregate Stop-Loss Insurance

Westport Insurance Corporation underwrites the stop-loss insurance described in this brochure.

Westport Insurance Corporation

Westport Insurance Corporation, a member of Swiss Re Corporate Solutions, has been providing in-depth product knowledge and solutions to customers since 1975. We are a direct writer for stop-loss insurance for self-insured employer groups. Westport is rated "A+ (Superior)" by A.M. Best Company, Inc.

A.M. Best Company Inc., is 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.)

IHC Specialty Benefits, Inc

IHC Specialty Benefits, Inc. (IHC SB) is a technology-driven, full-service marketing and distribution company that focuses on small employer and individual consumer products through general agents, telebrokerage, advisor centers, and private-label arrangements. IHC SB conducts business under the following brands: Healthedeals.com; Advisors; and PetPlace.com. For more information about IHC SB visit http://www.ihcgroup.com/companies.

The IHC Group

Independence Holding Company (NYSE: IHC), formed in 1980, is a holding company that is principally engaged in underwriting, administering and/or distributing group and individual specialty benefit products, including disability, supplemental health, pet, and group life insurance through its subsidiaries (Independence Holding Company and its subsidiaries collectively referred to as "The IHC Group"). The IHC Group consists of three insurance companies (Standard Security Life Insurance Company of New York, Madison National Life Insurance Company, Inc. and Independence American Insurance Company). We also own the following agencies: (i) PetPartners Inc., our pet insurance administrator; (ii) IHC Specialty Benefits, Inc., a technology-driven full-service marketing and distribution company that focuses on small employer and individual consumer products through its call center, career agents, and Independence Brokerage Group; and (iii) The INSX Cloud Platform through My1HR, our wholly owned Web Based Entity. Our InsureTech division is comprised of our call centers, field and career agents, in-house MarTech artificial intelligence capabilities and domains, including www.healthedeals.com; www.healthinsurance.org; www.medicareresources.org; www.petplace.com; and www.mypetinsurance.com.