Simplified
Funding Concepts

Your health plan. Calibrated.

Simplified Funding Concepts

for groups of 10 to 50 employees

100% of remaining claim fund balance returned to the Plan Sponsor at the end of the claims run-out period

Simplified Funding Concepts is a self-funded health benefit plan coordinated with stop-loss insurance protection for employers with 10 to 50 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.

THE IHC GROUP

Brochure SFC 1218

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

Plan administrative expenses, such as billing, customer service and claims payment, are also included as part of the monthly payment.

Stop-loss insurance

The IHC Group's program includes the protection of stop-loss insurance underwritten by Westport Insurance Corporation.

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. If claims do not exceed the employer's annual funding limit (annual Aggregate Attachment Point) at the end of the claims run-out period, 100% of the unused claims funds remaining in the claims account are returned to the Plan Sponsor (employer).

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.

[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.

<table>
<tr><td>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.</td><td>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</td></tr>
<tr><td>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.</td><td>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
◦ $4,000 / $8,000
◦ $5,000 / $10,000
◦ $6,000 / $12,000
◦ $6,550* / $13,100*
◦ $7,150* / $14,300*
◦ $7,900 / $15,800

*Amount subject to change based on Health and Human Services Department guidelines</td></tr>
<tr><td>Coinsurance Percentage
After the deductible has been satisfied, the plan will pay the selected percentage of in-network covered charges.</td><td>◦ 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</td></tr>
<tr><td>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.</td><td>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
◦ $5,500 / $11,000
◦ $6,000 / $12,000
◦ $6,500 / $13,000</td></tr>
</table>

[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 Cigna 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 Cigna network.

Prescription Drug Coverage Benefits

You can decided 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.

PPO network options

Options include a national PPO network, as well as SFC's innovative platform using a version of referenced based pricing. Contact your broker for more information on network availability.

[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

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.

About 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 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.)

About 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 includes three insurance companies (Standard Security Life Insurance Company of New York, Madison National Life Insurance Company, Inc. and Independence American Insurance Company), and IHC Specialty Benefits, Inc., a technology-driven full-service marketing and distribution company that focuses on small employer and individual consumer products through general agents, telebrokerage, call centers, advisors, private label arrangements, independent agents, and through the following brands: www.HealtheDeals.com; Health eDeals Advisors; Aspira A Mas; www.PetPartners.com; and www.PetPlace.com.

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.

Simplified Funding Concepts

Simplified Funding Concepts (“SFC”) FAQ

1. **What is SFC?**
SFC is a program that covers employees under a self-funded health benefit plan ("plan"), coordinated with Specific and Aggregate stop-loss insurance protection.

2. **What is the minimum and maximum sized group under the SFC program?**
The minimum group size is 10 covered employees and the maximum is 50 covered employees.

3. **Are there any options for employer groups with under 10 or over 50 covered employees?**There may be options under the SFC program for groups with over 50 covered employees. Contact your sales representative for details. Currently, under the SFC program, new groups with less than 10 covered employees are not eligible.

4. **What does the stop-loss insurance protection do?**
Stop-loss insurance provides protection to the employer against catastrophic losses incurred under the plan. It prevents the claims of one covered individual from exhausting the group’s entire claims fund. If the individual's covered claim exceeds the pre-determined threshold (Specific Deductible per covered person), the specific stop-loss insurance reimburses the plan for the excess amount.
In addition, stop-loss insurance provides protection when covered claims for all covered employees and their dependents exceeded the Aggregate Attachment Point at the end of the policy year. The stop-loss carrier reimburses the claims account for the excess amounts. The policy includes a Monthly Cumulative Accommodation for Aggregate Stop-Loss benefit that will provide a monthly reimbursement, helping to limit the employer's maximum claim liability.

5. **What are the plan’s administrative costs to COBRA?**
If it is a group of 20 or more at the time of enrollment, there are no administrative fees for the employer.

6. **What are the plan’s PPO network options?**
The plan administrator partners with multiple national networks such as Cigna. Your sales representative can provide a full list of PPO network partners available.

7. **Does the SFC plan include prescription drug coverage?**
Yes. There are two options:
    - The Standard Formulary: covers generic medicines, listed brand medicines and unlisted brand medicines.
    - The Value Formulary: covers all generic medicines and listed brand medicines. Unlisted brand medicine not covered.

8. **Are there any minimum participation or contribution requirements?**
Yes. 75 percent of employee participation of those not covered elsewhere at the time of initial enrollment and 50 percent of ALL full-time eligible employees, regardless of employee’s waivers.

Employer contribution requirements:
- 50 percent for EE only
- 25 percent for EE and 25 percent for dependents

9. **Are there any industries not eligible for coverage through the SFC program?**
   Yes, currently Asbestos Manufacturing, Explosives Manufacturing & Handling, METs, Marijuana/Cannabis Services, Mining and Non-Taft Hartly Unions are not eligible for coverage through the SFC program. The industries ineligible for coverage can change without notice.

10. **Do groups with multiple locations qualify for coverage?**
    Yes. Multiple location groups qualify if the secondary site(s) has a physical location. An employee working from home is not considered a secondary location. Groups with multiple locations must have at least 75 percent of its employees located in the state where SFC is available and the stop-loss policy will be issued.

11. **Are there any limitations on how many in a group can be working remote if there is not a secondary physical location?**
    In the event that there is a decent population of teleworkers residing outside the group situs state, further underwriting or evaluation may be required to ensure proper pricing.

12. **Under the plan options, is there a dual choice option?**
    Yes, for groups with at least five employees taking each benefit plan.

13. **Does the plan offer a deductible credit?**
    The plan will give credit for any calendar year deductibles satisfied, in whole or in part, under the Employer's previous plan of benefits, provided the Plan Member submits sufficient evidence of having satisfied them.

14. **Does the SFC program cover 1099 employees under the plan?**
    Yes. The employee will need to provide the most current 1099 form (typically from the previous year as they will not appear on the wage and tax statement. They must also work a minimum of 30 hours a week, be solely and actively engaged in the business of the employer and as a whole, not comprise of more than 50 percent of the group.

15. **Does the SFC program have a class carve out?**
    Yes, as long as there is a class distinction (i.e. salary vs. hourly employees, management vs. non-management).

16. **At the end of the claims run-out period, what happens to the monies remaining in the employers claim account?**
    The remaining claim fund balance is returned to the plan at the end of the claims run-out period. As an example, on a 12/24 stop-loss policy contract, eligible claims incurred within the 12-month policy period year and paid within 24 months. The claims run out period is the 12 months following the expiration date of the stop-loss policy. Any monies remaining in the claims account at the end of the claims run out period are considered plan assets and belong to the plan sponsor. These funds may be used in a limited manner. The employer should consult their tax consultant.

17. **Is the SFC program underwritten?**
    Yes, employee health statements are required to for the stop-loss insurance carrier to asses and rate its risk. The information is not used to determine employee or dependent eligibility for coverage under the employer's health benefit plan, or in any other discriminatory fashion.

18. **Who is the stop-loss carrier?**
    Westport Insurance Corporation ("Westport") underwrites the stop-loss insurance. Westport, a Swiss Re Corporate Solutions carrier, 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.) Westport is not a member of The IHC Group. The stop-loss benefits, limitations and exclusions are detailed in Westport's Policy Form series RS2016.

19. **Who is the administrator of the SFC plan?**
The Loomis Company ("Loomis"), 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.

20. **How does an employee access ID cards, plan documents, claims information, etc.?**
    - **a.** The employer gets an email from Loomis via SFC@loomisco.com, which includes *temporary* ID cards and the plan endorsement, which must be signed and sent back to the broker.
    - **b.** After Loomis has received the premium check, the employer gets an email from SFC@loomisco.com with a username and password to access the employer account.

    The employer account contains the plans:
    - **Summary of Benefits and Coverage** (SBC)
    - **Summary Plan Description** (SPD)
    - **Loomis Administrative Packet**
        - Contact list
        - Procedures for: eligibility, billing and funding, COBRA
        - Overview of Caremark's prescription drug coverage
        - Forms for: employee enrollment, termination and member change notification.
    - **Additional Information Packet**, containing:
        - CVS: Caremark Mail Order Form
        - Loomis: Medical Claim Form
        - Loomis: Sample EOB

    Employee account and permanent ID Cards
    Once the employer account is activated, employees may begin setting up a member account online. They will receive their permanent ID cards within 10 to 14 business days. The ID Cards will include the plan's contact information for claims and customer service, PPO network, CVS Caremark and additional providers.

21. **Does the stop-loss insurance carrier, plan administrator or IHC help prepare tax documents?**
No, the employer should consult their tax consultant or attorney for assistance.

About The IHC Group
Independence Holding Company (NYSE: IHC) 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 since 1980. The IHC Group owns three insurance companies (Standard Security Life Insurance Company of New York, Madison National Life Insurance Company, Inc. and Independence American Insurance Company), and IHC Specialty Benefits, Inc., a technology-driven insurance sales and marketing company that creates value for insurance producers, carriers and consumers (both individuals and small businesses) through a suite of proprietary tools and products (including ACA plans and small group medical stop-loss). All products are placed with highly rated carriers.

"IHC" and "The IHC Group" are the brand names for plans, products and services provided by one or more of the subsidiaries and affiliate member companies of The IHC Group ("IHC Entities"). Plans, products and services are solely and only provided by one or more IHC Entities specified on the plan, product or service contract, not The IHC Group. Not all plans, products and services are available in each state.

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Simplified
Funding Concepts

Are you concerned the small group self-funded market is too complicated?

We can help get you started. Are you already an expert in self-funding? Then it's time to investigate the advantages of partnering with IHC Specialty Benefits.

SFC provides all the pieces that a qualified group of 10-50 covered employees needs to implement a self-funded health plan, from plan administration provided by third party administrators, to securing stop-loss insurance coverage through a highly rated carrier.

Questions? Interested in learning more? Ready to sell? Contact me!

Name: ________________________

Email: ________________________

Phone: ________________________

Simplified Funding Concepts is a self-funded health benefit plan coordinated with stop-loss insurance protection for employers with 10 to 50 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. The program is not available in all states. Westport is not a member of The IHC Group.

About The IHC Group
Independence Holding Company (NYSE: IHC) is a holding company that is principally engaged in underwriting, administering and/or distributing group and individual disability, specialty and supplemental health, pet, and life insurance through its subsidiaries since 1980. The IHC Group owns three insurance companies (Standard Security Life Insurance Company of New York, Madison National Life Insurance Company, Inc. and Independence American Insurance Company) and IHC Specialty Benefits, Inc., which is a technology-driven insurance sales and marketing company that creates value for insurance producers, carriers and consumers (both individuals and small businesses) through a suite of proprietary tools and products (including ACA plans and small group medical stop-loss). All products are placed with highly rated carriers.

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THE IHC GROUP

Simplified
Funding Concepts

Fourth quarter renewals are approaching. Avoid the stress of last-minute sales by shopping your groups now. See how promoting Simplified Funding Concepts (SFC) from The IHC Group makes it easier.

- **Designed for groups of 10 to 50 covered employees,** The IHC Group's SFC program provides coverage under a self-funded health benefit plan coordinated with employer stop-loss insurance protection. The employer's risk is limited to the group's monthly payment.
- Many small groups are seeking alternatives to Obamacare and fully-insured plans. With a single monthly payment applying to the claims fund, fixed administrative costs and the stop-loss insurance premiums, **SFC may be a good alternative for many of your group health clients.**
- **Adjustable commission** based on stop-loss premiums
- **100% return of unused claims account funds** at the end of the claims run-out period
- **12/24 stop-loss insurance contract** (12 months coverage with a 12-month run-out: Covers eligible claims incurred within 12-month contract period and paid within 24 months).
- For groups of 20 or more, **The Loomis Company administers COBRA benefits** with no additional administrative charges

SFC helps to ensure that your groups get a competitive price based on the overall health of its workers ... and the return of their unused funds in their claims account.

For more information, contact:

Name: Email: Phone:

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Simplified Funding Concepts

THE IHC GROUP

Self-funding/stop-loss made simple

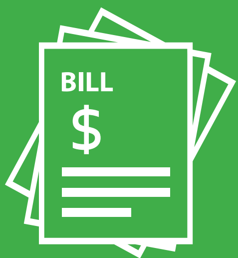
The IHC Group's Simplified Funding Concepts program coordinates a self-funded employee health plan with stop-loss insurance protection.

The program is suitable for businesses of

10 covered lives up to **50 covered lives**

Any unused money left in the claims fund at the end of the claims run-out period belongs to the business.

The IHC Group's self-funded plans qualify as Minimum Essential Coverage, thereby satisfying the ACA's individual mandate.



With both specific and aggregate stop-loss premiums included, the business pays one monthly bill.

All administrative fees are included in the monthly bill, with no hidden or non-disclosed charges.

To learn more about The IHC Group's Simplified Funding Concepts program, and find out if a self-funded health plan is right for your group, contact:

Name:

Phone:

Email:

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Avoid Last-Minute Stress. Q4 Prep Begins Now.

Pull your feet out of the sand and put December on your mind. Fourth-quarter renewals are coming soon, and it's time to take action. **Simplified Funding Concepts ("SFC") makes it easy.**

SFC provides all the pieces that a qualified group of 10-50 covered employees needs to implement a self-funded health plan, from plan administration provided by third party administrators, to securing stop-loss insurance coverage through a highly rated carrier.

1. **Send us a census** for each renewing group.
2. **We will generate a quote** and get back to you.
   Tip: For a more accurate rate, try to include member medical information.

Let us help you help your clients.

Ready to get a quote? Have questions? Contact me now!

Name:____________________

Email:____________________

Phone: ____________________

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4th quarter renewals aren't far off.

Shop your groups now by promoting Simplifed Funding Concepts ("SFC"), a health benefits program for self-funded employer groups of 10 to 50 covered employees.

SFC offers incredible sales potential for you, because healthy employee groups often seek options to Obamacare and typical fully-insured health benefit plans. Among SFC's selling points are:

1. A single payment per month, which includes the fixed administrative cost
2. Stop-loss insurance protection
3. 100% return of unused claims account fund balance after the end of the contract period

Ready to get a quote? Contact me now!

Name:____________________ Email:____________________ Phone: ____________________

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THE IHC GROUP

Simplified
Funding Concepts

Let Us Compete for Your Group Business **Now!**

Self-Funded Health Benefits Plan From IHC Specialty Benefits

Open enrollment season is underway, and we're ready to serve you with a self-funded product that is better than ever. Why?

- **New plan options**, delivering more competitive rates
  - Innovative platform combines a **traditional PPO plan with components of reference-based pricing**, powered by Allied Advocate
  - Additionally, there is a **new prescription value formulary program** with two plan options that offer lower rates by covering all generic medicines and only listed brand medicines.
    - Generic $10/Brand $40/ Non-Preferred Brand not covered/Specialty $150
    - All covered prescription drugs apply to the plan deductible and coinsurance
- **100 percent of remaining claims fund balance returned** to the plan sponsor at the end of the claims run-out period
- **Fast turnaround time** on prescreens Exceptional commission structure
- **Multiple network options** available, including our national network partner

For more information, contact your IHC representative.

About The IHC Group
Independence Holding Company (NYSE: IHC) 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 since 1980. The IHC Group owns three insurance companies (Standard Security Life Insurance Company of New York, Madison National Life Insurance Company, Inc. and Independence American Insurance Company), and IHC Specialty Benefits, Inc., a technology-driven insurance sales and marketing company that creates value for insurance producers, carriers and consumers (both individuals and small businesses) through a suite of proprietary tools and products (including ACA plans and small group medical stop-loss). All products are placed with highly rated carriers.

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THE IHC GROUP

Simplified
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Why choose self-funding with Simplified Funding Concepts and The IHC Group?

Save money

Self-funding is designed so that your client only pays for the health care that the group actually uses. The Employer keeps the savings when medical claims for the group are less than the plan's pre-determined funding limits.

Limit risk

Your client's business is protected by stop-loss insurance. If the group's medical claims are higher than expected, employer stop-loss insurance protection reimburses for covered expenses exceeding the Specific Deductible and Aggregate Attachment Points. Also, Simplified Funding Concepts' stop-loss insurance protection is medically underwritten at the time of enrollment so your client will know if a self-funded program is right for them.

Secure quality

Choice of comprehensive coverage options to provide an employee benefit plan that meets the needs of your client's group.

1. One payment per month 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, unused remaining funds in the claims account are returned to the employer.

For more information, contact:

Name:____________________ Phone:____________________ Email:____________________

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Simplified
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State Availability

KEY

Available

Not Available

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