Sample Layout

Your Company's Self-Funded Solutions

ABC COMPANY

The Right Fit for Your Community

When it comes to finding the right option for your self-funded health benefits plan, **ABC Company** has you covered. We can help you find the right design to meet your needs.

Plan Name	Plan #1	Plan #2	Plan #3	Plan #4	Plan #5
Benefit Period	Calendar Year	Calendar Year	Calendar Year	Calendar Year	Calendar Year
Plan Code	ABCD-0001	ABCD-0002	ABCD-0003	ABCD-0004	ABCD-0005
Product Type	PPO	PPO	PPO	CDHP	CDHP
Individual Deductible (In Network/Out of Network)	$9,000/$20,000	$4,500/$10,000	$6,000/$15,000	$6,000/$15,000	$3,500/$7,500
Coinsurance (In Network/Out of Network percent)	100/70	70/50	70/50	100/70	90/60
Individual Out-Of-Pocket Limit (In Network/Out of Network)	$9,000/$25,000	$8,500/$20,000	$9,000/$25,000	$6,000/$17,500	$7,000/$20,000
Deductible Type	Embedded	Embedded	Embedded	Embedded	Non-Embedded (Aggregate)
Family Multiplier	2	2	2	2	2
Physician Copay	$60 copay	$60 copay	$50 copay	ded + coins	ded + coins
Specialist Copay	$60 copay	$60 copay	$50 copay	ded + coins	ded + coins
X-ray/Lab Option	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Maternity and Routine Nursery Care	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Urgent Care Copay	$100 copay	$60 copay	ded + coins	ded + coins	ded + coins
Outpatient Advanced Imaging Copay	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
ER Visit Copay	ded + coins	$500 copay	ded + coins	ded + coins	ded + coins
Therapy Copay	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Alternative Medicine	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Inpatient Admission/Surgery Access Fees	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Teladoc	$0 Copay	$0 Copay	$0 Copay	ded + coins	ded + coins
Domestic Partner Coverage	Yes	Yes	Yes	Yes	Yes

These are summaries of proposed benefits and are a general description of plan highlights only. All benefits are subject to the plan conditions and limitations of the plan document. Limitation, exclusions and renewability apply and are described in the plan document. Coverage is not effective without written notification from **ABC Company**. Insurance coverage provided by or through by **ABC Company** or its affiliates. Insurance products are underwritten by **ABC Company**. Plans are administered by **ABC Company**.

Plan Definitions

BENEFIT PERIOD

Calendar Year – The 12-month period from January 1 to December 31 during which covered expenses can be applied to satisfy the deductible. The accumulation period resets every January 1.

INDIVIDUAL OUT-OF-POCKET LIMIT[1]

(in-network/out-of-network)

The individual out-of-pocket limit is the amount of covered charges the member must pay each year. The out-of-pocket limit

includes the plan deductible, coinsurance, copays, access fees, and prescription deductibles, coinsurance and copays.

LIFETIME MAXIMUM BENEFIT

Unlimited for essential health benefits (as defined by federal regulation)

Physician/Specialist Office Visit

Covered charges are paid in full after the in-network physician/specialist office visit copay. This includes charges for the visit, professional fees for allergy injections and certain non-surgical injections performed at the same office visit, and billed by the attending physician. Additionally, the copay applies to in-network manipulative therapy and includes procedures provided at the office visit. Diagnostic x-rays and labs are subject to deductible and coinsurance. Refer to the Covered Services section of this brochure for more information.

The physician/specialist office visit copay does not apply to preventive care services, allergy testing and allergy serum, or any surgical procedure. Coverage for preventive care services is described in the Covered Services section of this brochure. Surgical procedures, as well as services when a copay is not selected, are subject to the plan deductible and coinsurance.

Therapies

Speech, occupational and physical therapy

The therapy copay applies to in-network speech, occupational and physical therapies. Therapies provided at a physician/specialist office visit may also be subject to the separate physician/specialist office visit copay. Therapies received at a hospital are subject to the plan deductible and coinsurance, and count toward the maximum visit limit. If a copay is not selected, covered services are subject to the plan deductible
and coinsurance.

Alternative Medicine

Covered services are subject to the plan deductible and coinsurance. For a list of covered alternative medicine services, refer to the Covered Services section of this brochure.

Urgent Care Center

Covered charges are paid in full after the in-network urgent care center copay. This includes charges for x-ray, lab, pathology and radiology services performed at the same visit and billed by the urgent care center.

The urgent care center copay does not apply to preventive care services or any surgical procedure. Coverage for preventive care services is described in the Covered Services section of this brochure. Surgical procedures, as well as services when a copay is not selected, are subject to the plan deductible and coinsurance.

Emergency Room

Covered charges are paid in full after the copay. The copay is not waived if admitted as inpatient.

Charges for non-emergency treatment received in the emergency room, or services received when a copay is not selected, are subject to the plan deductible and coinsurance. Copays apply toward the out-of-pocket limit, but do not apply toward the plan deductible.

[1] The in-network out-of-pocket limit must be greater than the in-network deductible. However, if the 100/70 coinsurance option is selected, the in-network out-of-pocket limit and in-network deductible can be equal.

Outpatient Diagnostic X-Ray and Lab

Coverage includes in-network x-ray, lab, pathology and radiology services. This benefit does not apply to outpatient advanced imaging such as CT, CTA, MRA, MRI, NCI, PET, PET CT and 3D Rendering, which is subject to the outpatient advanced imaging benefit selected.

Note: Covered charges exceeding the maximum or services received out-of-network, may be subject to the plan deductible and coinsurance.

Outpatient Advanced Imaging

Covered charges are paid in full after the in-network outpatient advanced imaging copay. The copay applies per procedure and includes professional fees associated with the service. Additionally, the copay applies to the out-of-pocket limit; however, it does not apply to the deductible. Covered services received out-of-network may be subject to the out-of-network plan deductible and coinsurance.

Outpatient advanced imaging performed in the emergency room or urgent care center is instead subject to the emergency room copay or urgent care center copay, if selected.

Inpatient Admission and Outpatient Surgery Access Fees

A separate access fee applies to facility charges for each hospital admission, and to facility charges for each outpatient surgical visit. After these access fees are paid, covered charges are subject to the plan deductible and coinsurance. These access fees apply toward the out-of-pocket limit, but do not apply toward the plan deductible.

Covered Services

When medically necessary, eligible charges for the following services are payable under your self-funded plan design subject to the plan deductible, coinsurance and, for some out-of-network providers, Reasonable Fee[1].

Hospital and Provider Services

- Semi-private hospital room, board and general inpatient nursing care
- Intensive care unit
- Miscellaneous services and supplies provided by a hospital on an inpatient basis
- Miscellaneous services and supplies provided by a hospital or free-standing surgical center and related to outpatient surgery or outpatient treatment of injury
- Anesthetics and their administration
- Physician's fees, except as otherwise noted
- Emergency services
- Telemedicine services

Preventive Care Services

Covered preventive care services received in-network will be paid under your self-funded plan design at 100 percent.[2] Age and frequency schedules apply. Some out-of-network services are subject to the plan deductible and coinsurance. Covered preventive care services include, but are not limited to:

- Routine physical exam
- Blood and other laboratory tests
- Screening ECG (electrocardiogram)
- Immunizations
- PSA (prostate-specific antigen)
- Colorectal cancer screening
- Screening for tobacco use
- Women's preventive services
  - Well-woman visits, including prenatal routine office visits
  - Mammograms: baseline and annual
  - Screening for cervical cancer
  - Contraceptive methods and counseling
  - Breastfeeding support, supplies and counseling

Other Services and Supplies

- Prescription drugs (See page 7 for details on outpatient prescription drug benefits.)
- Blood and blood plasma, oxygen and rental of equipment for its administration
- Local licensed ambulance service to or from a hospital
- X-rays (not dental x-rays) and laboratory tests performed for diagnosis and treatment
- X-ray, cobalt, radioactive isotope therapy, radiation therapy, chemotherapy, and advanced imaging services, including but not limited to CT, CTA, MRA, MRI, NCI, PET, PET CT and 3D Rendering
- Artificial limbs and eyes
- Casts, splints, trusses, crutches and nondental braces
- Rental of a wheelchair, hospital-type bed or other durable medical equipment
- Habilitative and rehabilitative devices
- Routine maternity care and nursery, including complications of pregnancy
- Outpatient pre-admissions testing
- Hospice care
  - Maximum of 6 months while covered under this plan
- Home healthcare
  - Maximum of 100 days per year
- Skilled nursing care
  - Maximum of 81 days per year
- RN and LPN fees for private-duty nursing recommended by a physician
- Nondental treatment of temporomandibular joint dysfunction (TMJ)
- Chronic pain treatment programs
  - Maximum of 10 visits per year
- Hair prosthesis for alopecia resulting from cancer treatment that involves chemotherapy or radiation therapy
  - Maximum of one hair prosthesis per member, per year; covered charges are not subject to the deductible and coinsurance
- Gender dysphoria, excluding cosmetic services

Covered Services
(continued)

Therapies

- Habilitative and rehabilitative services, including speech, occupational and physical therapist's fees, when prescribed by a physician
- Routine maternity care and nursery, including complications of pregnancy
  - 60-visit limit per therapy, per year
- Manipulative therapy
  - 20-visit limit per year

Alternative Medicine

- Acupuncture, massage therapy and naturopathic services
  - 12-visit limit per therapy, per year
- Nutritional counseling
  - 3-visit limit while covered under this plan, except for diabetic counseling

Mental Illness, Nervous Disorders, Substance Abuse and Alcohol Abuse

Groups with up to 50 employees

- Outpatient expenses
  - 40-visit limit per year; 120 visits while covered under this plan
  - Covered charges are paid at 60 percent for an in-network provider; 50 percent for an out-of-network provider.
- Inpatient expenses
  - 20 days per year; 40 days while covered under this plan.
  - Covered charges are paid according to the in- and out-of-network coinsurance selected.

Groups with 51 or more employees

- Outpatient and inpatient expenses
  - Covered charges are paid the same as any other covered service.

Organ Transplants

- Designated transplant facility
  - Covered charges for approved transplant services, including organ procurement or acquisition, are paid at 100 percent
  - Coverage is provided for transportation, lodging and meals for a companion, subject to the following limits:
    a. Transportation benefit: maximum of $1,000 per approved transplant procedure
    b. Lodging and meals benefit: maximum of $250 per day; $10,000 while covered under this plan
- Nondesignated transplant facility
  - Covered charges for approved transplant services at an out-of-network facility, including organ procurement or acquisition, are paid at 70 percent.
  - No coverage is provided for transportation, lodging or meals for a companion.

For a complete list of preventive care services, visit **www.healthcare.gov/preventive-care-benefits** and **www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations**. In no event will benefits for preventive care services be less than that which is required by state or federal law, as applicable.

[1]Reasonable Fee is the lesser of the provider's actual charge, negotiated fee, or 150, 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. Refer to the proposal for details.

[2]Preventive care benefits are in accordance with guidelines from the U.S. Preventive Services Task Force, Health Resources and Services Administration, and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Precertification

To avoid penalties, precertification is required for all non-emergency inpatient services, and several outpatient services, surgeries and procedures. Refer to the plan document for a full list of precertification requirements.

- To precertify, the member or the attending physician must follow the instructions provided on the medical identification card.
- Failure to precertify will result in a $300 penalty per occurrence. This penalty will not count toward the plan deductible, or toward the out-of-pocket limit.
- Precertification does not guarantee self-funded plan benefits are payable. The person must be eligible at the time of service.

Emergency Admissions

Notification is required within 48 hours or the next business day of an emergency admission by calling the number shown on the ID card.

Out-of-Network Emergency Care

The member responsibility for out-of-network emergency care will be calculated using the lesser of: the billed amount or Qualifying Payment Amount[1], which is generally the median of the applicable contracted rates. This amount will be applied to the in-network deductible and in-network out-of-pocket limit.

Notice and Consent

Most out-of-network providers must notify a member that they are not in the patient's PPO network and obtain the patient's written consent before providing non-emergency care.

Continuity of Care

In certain situations, if an in-network provider becomes an out-of-network provider, and the member is a continuing care patient, we will provide the member with notice and an opportunity to elect continuing care from such provider. This election will allow the member to continue to receive in-network benefits, beginning on the date of the notice and continuing until the earlier of: 90 days from the date of the notice; or the date on which the member is no longer a continuing care patient with the provider.

Deductible Credit for New Groups

A member continuously covered under a prior individual or group health plan with a calendar-year deductible will be credited for any portion of the deductible satisfied under the prior plan during the same calendar year. Only plan designs with a deductible greater than $0 are eligible to receive deductible credit. Deductible credit will not be given if moving to or from a health plan with a plan-year deductible.

Credit is not provided for out-of-pocket amounts (other than amounts applied to the deductible), prescription drug card deductibles or for employees added to a self-funded plan after the group's initial effective date.

EARLY TERMINATIONS

If the administrative services agreement with **ABC Company** terminates before the end of the contract period, the employer is responsible for funding all covered claims, below the specific deductible, if applicable, that were incurred and not processed while the agreement was in effect.

[1]Unless a State All-Payor Model Agreement or specified state law dictates otherwise.

Enrollment

Annual Open Enrollment Period

Eligible employees may enroll themselves and their eligible dependents during the annual open enrollment period, which is the month prior to the start of the new plan year.

Waiting Period

The waiting period is the amount of time the employee must wait before he or she is eligible for coverage under your self-funded plan. The waiting period cannot exceed 90 days.

Timely Enrollees

Timely enrollees are eligible employees who complete and sign an Employee Eligibility Statement for themselves and/or their dependents during the employer's waiting period and prior to the end of the initial enrollment period. The initial enrollment period is the 31 days following the waiting period.

Special Enrollees

Special enrollees are employees or dependents who previously waived self-funded coverage, but may now be eligible because they have involuntarily lost their other coverage, had a benefit/coverage change or had alife-changing event. The enrollment period for a special enrollee is the 31 days following the special enrollment event (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program coverage). Special guidelines apply for special enrollees. For more details, ask your broker.

Exclusions and Limitations

Major Medical

No benefits are payable under your self-funded health benefit plan design for the following expenses:

- Services and supplies not prescribed by a physician or required to treat a covered condition, or in excess of the Reasonable Fee[1], or not medically necessary
- Surgery of the jaw (orthognathic); dental care and treatment, including pediatric dental care and treatment; hearing aids[2], eyeglasses, eyeglass frames and contact lenses; eye or hearing exams[2]; all other vision care services; some foot treatment
- Cosmetic surgery; hair prosthesis, except as specified under Covered Services; hair transplants; treatment for weight reduction[2]; treatment for abnormal male breast enlargement
- Charges the member is not legally required to pay; charges for missed or canceled appointments, stand-by charges or after hours; surcharges for weekend nonemergency office visits and home visits by a physician; treatment rendered by a member of the member's family; treatment, prescription drugs, services or supplies provided by a medical department, treatment center, pharmacy or clinic operated by or sponsored by a member's employer; occupational sickness and injury, except for members who are not covered by workers' compensation or similar coverage and are not required by law to have such coverage
- Pregnancy and all associated charges of a person who is not an eligible employee or dependent including, but not limited to, a surrogate; reversal of sterilization
- Non-prescription drugs[2]; imported drugs; any prescription drug containing bulk chemical powders; smoking deterrent medications[2]; restoration or enhancement of sexual activity
- Treatment received outside the United States, except emergencies; immunizations required for travel outside the United States; most treatment for snoring; excessive sweating; phonophoresis; surface electromyogram; therapeutic cold devices; x-rays or tests not related to diagnosis or treatment of sickness or injury, unless otherwise specified; treatment, services, supplies or prescription drugs designed or used to diagnose, treat, alter, impact, or differentiate genetic make-up or genetic predisposition, including but not limited to genetic therapy
- Most dietary supplements[2]; experimental/ investigational drugs or treatment; items for comfort or convenience; expenses at a health spa; services and supplies related to homeopathic medicine; family or marriage counseling, aversion therapy, training or other forms of education, except as otherwise specified in the plan document; custodial care
- Suicide, attempted suicide or intentional self-inflicted injury, if not the result of a medical condition; injury resulting from one's own illegal use of alcohol, drugs or over-the-counter medications, if not the result of a medical condition
- Acts of war; participation in a riot; commission of or attempt to commit a felony; engaging in an illegal occupation

[1]Reasonable Fee is the lesser of the provider's actual charge, negotiated fee, or 150, 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. May vary by state. Refer to the proposal for details.

[2]No benefits are payable under your self-funded plan design for these expenses, except as required under federal guidelines for preventive care.

Self-funded plans are administered by ABC Company.
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