Midstate Chamber of Commerce

SL Healthplans LLC
Self Funded Marketing Experts

Self-Funded Program

A health-benefit program designed for your small- to medium-sized business

See plan inserts for specific product details and plan options

The Self-Funded Program provides tools for small-business employers to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. Stop-loss insurance for the Chamber Health Benefit Plan Self-Funded Program is underwritten by "A" rated insurance carriers.

Introducing: A realistic approach to employee health benefits

Now, you can gain control of your health care expenses while providing quality benefits to your employees. By combining the cost savings of self-funding with the stability of more traditional plans, our Self-Funded Program gives you the simplicity and cost savings you're looking for without the hassle of administering the program yourself.

Our teams of experienced professionals are ready to provide you and your agent with:

- Group market expertise
- Immediate access to support
- Quick resolution of issues
- Hands-on help at time of reissue

Simple. Safe. Savings.

Self funding used to be a concept only available to large employers. Not anymore.

Business owners like you enjoy the advantages of self funding. And now, with our Self-Funded Program, you get to experience those advantages without taking on added risk. It's an easy way for you to lower your costs while providing quality health care benefits to your employees.

SELF-FUNDED PROGRAM KEY ADVANTAGES:

One, predictable monthly payment

Your monthly payment is determined upfront and guaranteed not to increase for a full year as long as there are no changes to your group's benefits or enrollment

Plan administration and account management

Payments of claims, customer service and reporting is all done for you, leaving you to focus on your business

Quality benefits

- All employer-established benefit plans are minimum essential coverage
- Preventive services are paid at 100% when received from in-network providers, as recommended by the Affordable Care Act

Are you overpaying for group health care benefits?

Where do your premium dollars really go?

With fully insured health plans, all of your premium is paid to the insurance company. You don't have any control over how that money is spent. You won't see any of those premium dollars again, even in years when your group's claims are less than expected.

Our Self-Funded Program is different. Some of your monthly payment is used to run the daily administration of your plan, but portions of it are also used to pay your stop-loss insurance premium and to build your claims account. In years when claims are lower than expected, a portion of the difference between your group's anticipated and actual claims is credited back to you — and that adds up to significant savings.

Fully insured premium

Payments for our Self-Funded Program

How does it work?

We make it easy for you to put a self-funded health benefit plan to work for your business

For your everyday convenience, this plan behaves just like a more traditional, fully insured health benefit plan. You provide your level, monthly payment, and we handle the details.

The difference lies in where your premium dollars go. We manage your program to make sure you get the savings and simplicity you need by splitting your premium among the program's three components.

THE SELF-FUNDED PROGRAM'S THREE COMPONENTS

Plan administration

A third-party administrator handles the day-to-day functions of the program - Meritain TPA

Our third-party administrators will:

- Manage claims payments
- Provide reporting to help manage costs
- Handle your group members' customer service needs

Stop-loss insurance

When your group has higher-than-expected claims, stop-loss insurance kicks in to protect your finances

Stop-loss insurance:

- Protects your finances from higher-than-expected claims
- Helps you limit your business's financial exposure

Claims account

Money used to pay claims incurred during the coverage period.

Your claims account:

- Holds the funds needed to pay employees' claims
- Is protected from larger-than-expected claims with stop-loss insurance
- Depending on the plan selection you make, if claims are less than anticipated, we will either refund a portion of the difference between the balance of your claims account and your group's actual claims, or you can receive that amount in full*

Your business. Your plan.

Health benefit plans with features your group will actually use

We provide flexible options to help you select the plan designs that will benefit your group the most.[2]

- Deductible options range from $500 to $7,900[3]
- Coinsurance options: 100%, 90%, 80%, 70% and 50%
- Multiple office-visit copay options
- Health Savings account (HSA) and Health Reimbursement Arrangement (HRA) options available[4]
- Access to large, national networks, with discounts for using in-network doctors and hospitals
- Prescription copay options available
- Teladoc®: A convenient and valuable telehealth service that can save money for both you and your members[5]
- Preventive care coverage aligns with Affordable Care Act requirements
- COBRA administration
- Urgent-care and emergency-room copay options
- First-dollar diagnostic x-ray and lab options

Terms and provisions and exclusions of this program

Out-of-network services

If a covered person seeks non-emergency care at a doctor or hospital that is not part of your network, he or she will not receive network discounts and may incur additional expenses. This applies to prescriptions that are filled by an out-of-network provider as well.

For instance, copays are not accepted by doctors and hospitals that are not part of your network, and the covered charges will be handled as any other out-of-network service — subject to the:

- Maximum allowable amount — the most the plan pays for covered services. The covered person will be responsible for any balance in excess of this amount.
- Out-of-network deductible — two times the deductible.
- Out-of-network coinsurance — typically an additional 30% of charges.
- Out-of-network, out-of-pocket maximum — three times the in-network out-of-pocket maximum (except for 100% coinsurance plans)

Emergency care benefit

In emergency situations, covered charges will be handled as network services, no matter where services are performed. All charges are subject to the maximum allowable amount.

Emergency care benefit for Advantage plan

Covered charges will be handled as network services, no matter where the services are performed, subject to any applicable Maximum Allowable Amounts. When the facility is out-of-network, the plan will cover the member's transfer to an in-network facility once the member is stabilized. All follow-up visits after the condition has stabilized will be treated as nonemergency treatment and services under the plan.

Affiliated provider services

As long as a covered person uses hospitals and admitting physicians that are part of your network, his/her covered charges will be handled as network services even when affiliated physicians and other health care providers (e.g., radiologists, anesthesiologists, pathologists or surgeons) are not part of your network. All charges are subject to the maximum allowable amount.

Family deductible accumulations

Individual/Family

Covered expenses for each family member accumulate toward his or her individual deductible and benefits begin:

- For the family member — once his or her individual deductible is met.
- For all family members — once the combined amounts accumulated toward two or more individual deductibles reach the amount of the family deductible.

Utilization review

When inpatient treatment is needed, the covered person is responsible for calling the 800 number on the card to receive authorization. If authorization is not received, a penalty could be applied. No benefits are paid for transplants that are not authorized. Authorization is not a guarantee of coverage.

Out-of-pocket maximums

The family out-of-pocket maximum is the total dollar amount of covered charges that must be paid by you and your covered dependents before we will consider any out-of-pocket maximum for all covered persons under the same family plan to be satisfied.

The individual out-of-pocket maximum is the dollar amount of covered charges that must be paid by each covered person before any out-of-pocket maximum is satisfied for that covered person.

Employment waiting period

The employment waiting or affiliation period is the number of consecutive days an employee must be working before he/she is eligible to be covered. The following choices are available: 0, 30, 60 or 90 days.

New hires

For groups with a 0, 30 or 60 day employment waiting period, new eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date:

- First day of the billing month following the date of full-time employment, when the enrollment request is received within 31 days of this date.

For groups with a 90 day employment waiting period, newly eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date:

- The 90th day following the date of full-time employment, when the enrollment request is received within 31 days of the expiration of the employment waiting period.

Deductible credit

When coverage first begins, credit is given for any portion of a calendar-year deductible satisfied under the prior group plan during the same calendar year, except when the deductible credit is waived. However, no credit is given for past policy-year deductibles. The deductible credit option can be waived.

Summary of exclusions

The health benefit plan templates do not provide benefits for:

- Treatment not listed in the summary plan description
- Services by a medical provider who is an immediate family member or who resides with a covered person
- Charges for services, supplies or drugs provided by or through any employer of a Covered Person or of a Covered Person's family member.
- Treatment reimbursable by Medicare, Workers' Compensation, automobile carriers or expenses for which other coverage is available
- Routine hearing care, vision therapy, surgery to correct vision, foot orthotics, or routine vision care and foot care unless part of the diabetic treatment
- Charges for custodial care, private nursing, telemedicine or phone consultations with the exception of Teladoc® services if purchased as part of your plan.
- Charges for diagnosis and treatment of infertility
- Charges for surrogate pregnancy or sterilization reversal
- Charges for cosmetic services, including chemical peels, plastic surgery and medications
- Charges for umbilical cord storage, genetic testing, counseling and services
- Treatment of "quality of life" or "lifestyle" concerns including but not limited to obesity, hair loss, restoration or promotion of sexual function, cognitive enhancement and educational testing or training
- Over-the-counter drugs, (unless recommended by the United States Preventive Services Task Force and authorized by a health care provider), drugs not approved by the FDA, drugs obtained from sources outside the United States, and the difference in cost between a generic and brand name drug when the generic is available
- Complications of an excluded service
- Charges in excess of any stated benefit maximum
- Treatment of an illness or injury caused by acts of war, felony, or influence of an illegal substance
- Dental care not related to a dental injury
- Non-surgical treatment for TMJ or CMJ other than that described in the contract, or any related surgical treatment that is not pre-authorized
- Any correction of malocclusion, protrusion, hypoplasia or hyperplasia of the jaws
- Charges for cranial orthotic devices, except following cranial surgery
- Charges for medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the Diabetic Services provision in the Medical Benefits section
- Charges for devices or supplies, except as described under a Prescription Order
- Charges for prophylactic treatment
- Charges related to health care practitioner-assisted suicide
- Charges for growth hormone stimulation treatment to promote or delay growth
- Charges for treatment of behavioral health or substance abuse, except as otherwise covered in the Behavioral Health and Substance Abuse provision in the Medical Benefits section
- Charges for testing and treatment related to the diagnosis of behavioral conduct or developmental problems; charges for applied behavioral analysis
- Charges for alternative medicine, including acupuncture and naturopathic medicine
- Charges for chelation therapy
- Charges for experimental or investigational services

This brochure provides summary information for the health benefit plan templates. Please refer to the summary plan description for a complete listing of the benefits, terms and exclusions. In the event that there are discrepancies with the information in this brochure, the terms and conditions of the summary plan description and other plan documents will govern.

For more information, or to apply for coverage, contact your insurance agent.

Visit us on the web at:
www.midstatechamber.com

Contact me for more information:

For use for January 1, 2020 and later effective dates.