SISLINK®

Group Hospital Confinement Insurance

...spanning the gap in medical benefits

How can Employers rise to meet the challenge of maintaining affordable health care plans for their employees and minimize the impact of increased cost sharing to employees?

Employers believe it is good business practice to provide health care benefits because they believe people are their most important asset and that there is a direct link between employee wellness, workforce absenteeism, and productivity. They also believe it is their responsibility to protect employees from the risk of catastrophic loss resulting from the expense of a serious illness.

However, the cumulative effect of years of explosive health care cost increases now threatens the employer-based system and rising costs are hampering the ability of American companies to compete in a global economy.[1]

- Healthcare costs continue to shift from employers to employees, not only as higher premiums, but as increased out-of-pocket cost-sharing also..[3]
- Financial pressures on families increase sharply when out-of-pocket spending for health care services exceeds 2.5% of family income meaning many families must make difficult trade-offs with respect to other necessities.[2]
- 99% of people with medical bill problems had out-of-pocket expenditures of $1,000 or less![2]

Is this a familiar scenario?

A divorced mother of two had health care coverage through her employer and her children were covered by their father's employer, yet out-of-pocket medical expenses often pushed her close to the financial edge.

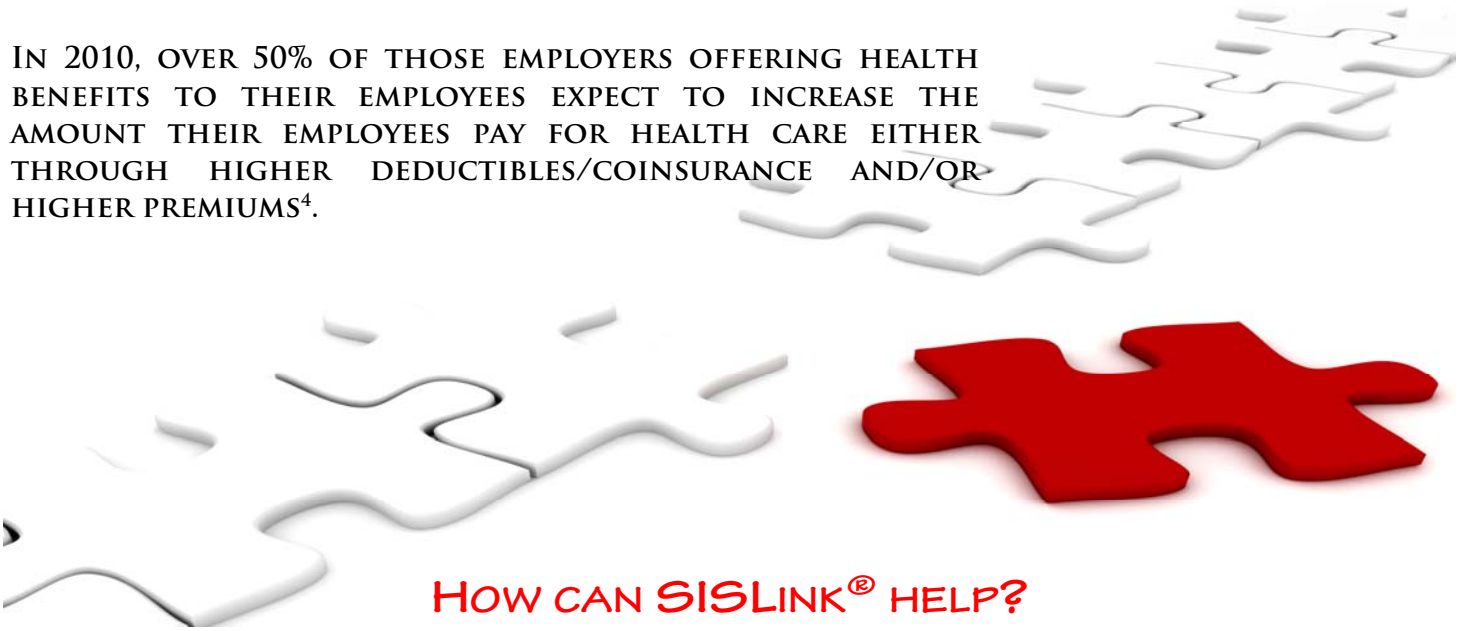
"Did it (medical debt) put me in the position of losing my house? No, because it wasn't thousands and thousands of dollars. But it definitely put me in a dicey position, and had I been really sick, then we would have been in real trouble. And I think a lot of people are in that same boat. We're all one broken leg, one bad fall or one case of pneumonia from the house of cards completely falling down."[2]

The answer is easy...

SISLINK®

[1] Health Care Reform: The Perils of Inaction and the Promise of Effective Action, A Report to Business Roundtable by Hewitt Associates LLC, September 2009
[2] Living on the Edge: Health Care Expenses Strain Family Budgets, Research Brief No. 10, December 2008, Center for Studying Health System Change
[3] May 2009 Milliman Medical Index Research Report

In 2010, over 50% of those employers offering health benefits to their employees expect to increase the amount their employees pay for health care either through higher deductibles/coinsurance and/or higher premiums[4].



How can SISLink® help?

SISLink® is a hospital confinement insurance policy designed as a supplement to the employer's group Major Medical/Comprehensive coverage to enhance overall benefits for employees and their dependents.

It can reduce, or in some cases eliminate, the out-of-pocket expenses an employee or his dependents may incur as a result of an accidental Injury or Sickness.

The benefits provided by *SISLink*® help pay for out-of-pocket expenses incurred due to a covered Hospital Confinement or covered out-patient medical procedures, based on the plan of benefits designed by the employer. For an expense to be eligible under *SISLink*®, it must:

- be Medically Necessary and result from the treatment of an Injury or a Sickness;
- be covered by the Covered Person's Major Medical/Comprehensive Policy; and
- be applied by the Major Medical/Comprehensive Policy to its deductible, co-payments, and/or coinsurance provision.

SISLink® plans can be customized to meet the specific needs of each employer, enabling them to provide employees with peace-of-mind when faced with an unexpected Injury or Sickness. *SISLink*® can be offered either on a voluntary or employer-paid basis. Minimum group size is 5 lives. (Note, Florida, California and Vermont require at least 51 or more eligible lives).

SISLink® can be paired with most Major Medical/Comprehensive policies subject to some basic guidelines:

- The Major Medical/Comprehensive plan can not have a separate deductible for maternity;
- *SISLink*® is not available for use when a Health Savings Account (HSA) exists;
- Employer's can opt to offer multiple *SISLink*® plans when:
  - the employer has one major medical plan offers one *SISLink*® plan as an employer-paid base plan and offers a second plan as a buy-up option; or
  - the employer has more than one medical plan, in which event they can offer one *SISLink*® plan for each medical plan option.

[4] "Health Care Reform: The Perils of Inaction and the Promise of Effective Action" report to U.S. Business Roundtable by Hewitt Associates, LLC; September 2009

Hospital Confinement Insurance

The Hospital Confinement Insurance pays a calendar year benefit, up to the maximum benefit selected, for each Covered Person who incurs eligible out-of-pocket expenses due to a hospital in-patient confinement.

Benefits available for Hospital Confinement Insurance range from a minimum of $500 to a maximum of $10,000.

Expenses eligible under the Hospital Confinement Insurance benefit include:

- In-patient hospital stays;
- In-patient surgeries;
- Physician's in-hospital charges; and
- Hospital emergency room treatment for injuries and hospital emergency room treatment for Sicknesses if the Sickness results in a Hospital Confinement within 24 hours of the Hospital emergency room treatment*

*Covered under Hospital Confinement Insurance only if coverage is not purchased with the Out-Patient Benefit.

The following example illustrates how Hospital Confinement Insurance benefits would be paid when *SISLink*® is combined with a high deductible group major medical/comprehensive plan. This example is for illustrative purposes only. Each Insured Person's experience under the coverage may be different based on the plan selected and their specific situation.

A Hospital Stay + Surgery = $28,500 Total Expense

	Medical Plan **without** *SISLink*®	HD Medical Plan **with** *SISLink*®
Deductible:	$1,000	$2,500
Coinsurance (20% to $4,000):	$4,000	$4,000
Out-of-Pocket (deductible & coinsurance combined):	$5,000	$6,500
SISLink® Plan $5,000 Hospital Confinement Insurance benefit:	n/a	$5,000
Total Out-of-Pocket Expense:	$5,000	$1,500
Savings with *SISLink*® :		**$3,500**

In the example above, the Insured Person's responsibility under a low deductible major medical plan is $5,000 ($1,000 for his deductible and $4,000 for his coinsurance.)

Under the high deductible major medical plan, his responsibility is $2,500 for his deductible and an additional $4,000 for expenses applied to his 20% coinsurance provision, bringing his total out-of-pocket responsibility is $6,500.

However, with the implementation of a *SISLink*® Plan that includes a $5,000 Hospital Confinement Insurance benefit, the Insured Person can save $3,500, reducing his total out-of-pocket responsibility to $1,500!

Out-Patient I Benefit (Optional)

Out-Patient I benefits range from a minimum of $200 to a maximum of $2,500, provided the maximum benefit selected is not greater than the amount of Hospital Confinement Insurance selected.

The Out-Patient I benefit pays on a "per person per Sickness or Injury" basis, up to a maximum of four "occurrences" per family per calendar year. This maximum applies to the entire family unit, regardless of the number of covered persons within the family unit. An "occurrence" is the treatment, or series of treatments, for a specific Sickness or Injury. All expenses related to the treatment of the same or related Sickness or Injury will accrue toward the out-patient maximum for one occurrence, regardless of whether such treatment is received in more than one calendar year period. If, however, a Covered Person is treatment-free, at any time, for at least 90 consecutive days, they may qualify for an additional out-patient maximum benefit if the family maximum per calendar year has not been met.

Out-patient benefits may include, but are not limited to:

- Hospital emergency room treatment of Injury or Sickness
- Out-patient Surgery in an out-patient surgical facility, emergency facility or physician's office;
- Diagnostic testing including, but not limited to, x-rays, diagnostic lab, MRI's, and CT scans;
- Out-patient radiation therapy or chemotherapy; and
- Physical therapy or chiropractic care

The following example illustrates how Out-Patient I benefits would be paid when *SISLink*® is added as a companion plan to a high deductible group major medical/comprehensive plan. This example is for illustrative purposes only. Each Insured Person's experience under the coverage may be different based on the plan selected and their specific situation.

Out-Patient MRI = $1,800 Total Expense

	Medical Plan **without** *SISLink*®	HD Medical Plan **with** *SISLink*®
Deductible:	$1,000	$2,500
Coinsurance (20% to $4,000):	$160	$0
Out-of-Pocket (deductible & coinsurance combined):	$1,160	$1,800
SISLink® Plan $2,500 Hospital Confinement Insurance benefit:	n/a	$1,800
Total Out-of-Pocket Expense:	$1,160	$0
Savings with *SISLink*® :		**$1,160**

In the example above, the Insured Person's responsibility under the high deductible major medical plan is $1,800 for expenses applied to his deductible. His total out-of-pocket responsibility is $1,800.

However, with the implementation of a *SISLink*® Plan that includes a $2,500 maximum Out-Patient I benefit, the Insured Person can save $1,160, eliminating his total out-of-pocket responsibility entirely!

Out-Patient II Benefit (Optional)

Out-Patient II benefits are available as an alternative to Out-Patient I benefits. Available benefit limits range from a minimum of $250 to a maximum of $2,500, provided the maximum benefit selected is not greater than 50% of the amount of Hospital Confinement Insurance selected.

The Out-Patient II benefit pays on a "per person per calendar year" basis, with a family maximum limit of two (2) times the "per person" limit. This maximum applies to the entire family unit, regardless of the number of covered persons within the family unit, however, the benefit payable for no one person within the family unit can exceed the "per person" limit.

Out-patient benefits may include, but are not limited to:

- Hospital emergency room treatment of Injury or Sickness
- Out-patient Surgery in a out-patient surgical facility, emergency facility or physician's office;
- Diagnostic testing including, but not limited to, x-rays, diagnostic lab, MRI's, and CT scans;
- Out-patient radiation therapy or chemotherapy; and
- Physical therapy or chiropractic care

Physician Office Visit Benefit (Optional)

If selected by the Employer as part of the plan design, this benefit will pay for medically necessary charges incurred when, as a result of an Injury or Sickness, an Insured Person receives treatment by a Physician in the Physician's office, Hospital, emergency facility, or out-patient facility, when expenses are billed separately as an office visit by the Physician.

The Employer can choose from two Physician Office Visit Benefit structures:

- $15 per visit up to the lesser of $120 per Calendar Year or 8 visits per person/family per Calendar Year; or

- $20 per visit up to the lesser of $240 per Calendar Year or 12 visits per person/family per Calendar Year.

Physician Office Visit Benefits do not include expenses incurred for routine health or check-up examinations, routine well child visits, or other charges incurred during the course of a routine physical examination or check-up.

This benefit pays in addition to any Physician in-hospital charges paid under the base policy.

Wellness Benefit (Optional)

If selected by the Employer as part of the plan design, this benefit will pay for routine health or check-up examinations, routine well child visits and other charges incurred during the course of a routine physical examination or check-up. Wellness benefits include services performed at Hospital, out-patient facility, laboratory, diagnostic testing facility and Physician services.

The Employer can choose a maximum Calendar Year benefit per person/family of $100, $200, or 500. This maximum applies to the entire family unit, regardless of the number of covered persons within the family unit.

Term Life and AD&D Benefit (Optional)

Available in all states where the *SISLink*® plan is available *EXCEPT for MD & NC.*

Term Life and AD&D Benefit
The Employer may choose to include either $5,000, $10,000, $15,000, or $20,000 of Term Life and AD&D coverage for each covered employee. Benefits reduce by 50% at age 70 and another 50% at age 75.

Dependent Term Life Benefit
Spouse coverage equals 50% of the employee's term life insurance amount.
Child coverage equals 25% of the employee's term life insurance amount for dependents age 6 months and up and 2.5% for infants 14 days to 6 months.
Dependents' life coverage terminates when base medical coverage eligibility ceases.

Limitations - Term Life and AD&D
Death due to suicide is not covered for two years (one year in Colorado, Missouri or North Dakota) from the insured's effective date.

Term Life and AD&D Rider Exclusions
No benefit will be payable for any Accidental Death or Dismemberment Loss caused by or contributed to by:

1) Suicide while sane or insane (while sane in Colorado or Missouri) is not covered under the Term Life Insurance Benefit for two years from the Insured Person's Effective Date. In such event, the Company will only pay a benefit equal to the premium paid;
2) Sickness, bodily or mental health, or diagnostic medical or surgical treatment;
3) infection, except pyogenic infections resulting from an accidental Injury or resulting from the accidental ingestion of a contaminated substance;
4) attempted suicide or intentional self-inflicted Injury or Sickness while sane or insane (while sane in Colorado or Missouri);
5) declared or undeclared war or acts thereof;
6) military service for any country or organization, including service with military forces as a civilian whose duties do not include combat; war or any act of war whether declared or undeclared. Upon notice to the Company of entering the armed forces, the Company will return to the Insured Person, pro-rata any premium paid, less any benefits paid, for any period during which the Insured Person is in such service;
7) participation in a riot or insurrection. "Participation" means taking an active part in common with others. "Riot" means any use or threat to use force or violence by three or more persons without authority of law;
8) Insured Person's commission or attempted commission of a felony, assault or illegal action;
9) voluntary taking of any poison, drug, sedative or narcotic or inhalation of any kind of gas unless prescribed by a Physician and taken according to the prescribed dosage; or
10) legal intoxication where the blood alcohol content of the Insured Person exceeds the legal limit of the state in which the accident took place;
11) an on the job Injury that is covered by Workers' Compensation;
12) participation in any non-occupational activity in which an Insured Person purposely exposes themselves to an increase in bodily Injury. These activities include but are not limited to:
    a. belaying and repelling rock climbing;
    b. flying ultra-light aircraft;
    c. hang-gliding, skydiving, scuba diving, para-sailing;
    d. motorized vehicle stunt driving, racing, jumping drag racing and demolition;
    e. bungee jumping;
    f. any hazardous activity for exhibition purposes; or
    g. flying as a pilot, crew member, or passenger in any aircraft, except as a fare-paying passenger in any regularly scheduled commercial aircraft flying between established airports on a regularly scheduled route.

ELIGIBILITY

All full-time employees working at least 20 hours or more per week and engaged in an eligible occupation, their lawful spouse, and their unmarried, dependent children who are under 19 years of age (24 if a full-time student). Dependent eligibility may vary by state.

Additionally, in order to be eligible, each person must be covered under a group Major Medical/Comprehensive Medical plan that includes coinsurance and deductible.

INELIGIBLE OCCUPATIONS

Professional Athletes	Ironworkers	Deep Sea Divers
Mining & Quarrying	Window Washers	

In addition, Professional Employer Organizations (PEO's) are considered an ineligible industry, however, they may be eligible subject to underwriting approval based on receipt and review of an underwriting questionnaire.

EFFECTIVE DATE

The effective date of an employee's coverage will be on the first day of the month following approval of an eligible person's enrollment form and payment of the first premium, provided he has met the eligibility requirements of, and is covered under, a group Major Medical/Comprehensive plan.

The effective date of coverage for an eligible Dependent will be on the first day of the month following the Company's acceptance of the enrollment form, however if the employee's coverage has not yet become effective, the effective date for Dependent coverage will be the same as the effective date of the employee's coverage.

Newborn children, adopted children or children placed for adoption will be covered on their date of birth, adoption or placement for adoption for a period of 31 days, as long as the employee's coverage was in force on that date. If, during this 31 days, the insured employee notifies the Company in writing and pays any premium that may be due, coverage will continue. If notification and premium payment is not received within the first 31 days after birth, adoption or placement for adoption, employees may not apply for coverage unless they qualify as a Special Enrollee or until they are allowed to enroll during an employer sponsored period of open enrollment (see Late Enrollees below).

LATE ENROLLEES

If an eligible employee does not apply for coverage on their initial eligibility date, they may not apply for coverage until the next policy anniversary date, unless: (a) they are allowed to enroll in, or change their enrollment in the employer's Major Medical/Comprehensive Policy because they qualify as a Special Enrollee as defined by law; or (b) they are allowed to enroll in the employer's Major Medical/Comprehensive Policy during an employer sponsored period of open enrollment.

TERMINATION OF COVERAGE

Coverage terminates on the earliest date any of the following events occur: For any Insured Person: (a) on the date the policy is terminated; (b) as of the premium due date when the required premium remains unpaid, subject to the grace period; (c) on the premium due date following the date the Insured ceases to be an employee of the policyholder; or (d) on the premium due date following the date the Insured's coverage under a group Major Medical/Comprehensive Policy is no longer in effect. For an Insured dependent spouse: on the premium due date following the date the spouse ceases to be an eligible spouse. For an Insured dependent child: on the premium due date following the date the child ceases to be an eligible child.

DEFINITIONS

Hospital means a legally authorized and operated institution for the care and treatment of sick and injured persons. It must have graduate registered nurses (RN's) on 24 hour call and organized facilities for diagnosis and surgery either on its premises or in facilities available to it on a contractual prearranged basis. The following do not qualify as a Hospital: an institution, or part of it, which is used mainly as a facility for rest, nursing care, convalescent care, care of the aged, or for remedial education or training.

Hospital Confinement means the Insured Person is admitted to the facility as an overnight bed patient for a minimum of 15 consecutive hours.

Injury means a bodily injury sustained by an Insured Person caused by an accident, directly and independently of all other causes, that occurs while the policy is in force. All injuries sustained by an Insured Person in any one accident are considered a single injury.

Insured Person means either an Insured or an Insured Dependent. An Insured is an employee of the policyholder whose coverage under the policy has become effective and has not been terminated. Insured Dependent means any of the following: (a) the lawful spouse of an Insured whose coverage under the policy has become effective and has not terminated; and, (b) the unmarried dependent child or children of an Insured or of an Insured's spouse (including stepchildren, legally adopted children, grandchildren, and foster children) who are under 19 years of age (24 if a full-time student), or such higher ages as approved in writing by the Company.

Major Medical/Comprehensive Policy means any one of the following types of policies or plans which provide benefits for Hospital Confinement for an Insured Person on his/her effective date of coverage, and such policy or plan requires the Insured Person to pay a deductible and/or portion of coinsurance: group or blanket insurance plans; group Blue Cross, Blue Shield or other group prepayment coverage plans; coverage under labor-management trusteed plans; union welfare plans; employer organizational plans; employee benefit organizational plans, or other arrangements of benefits for persons of a group. "Major Medical/Comprehensive Policy" does not include Medicare or Medicaid.

Medically Necessary means a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if: (a) it is provided only as a convenience to the Insured Person or provider; (b) it is not appropriate treatment for the Insured Person's diagnosis or symptoms; (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is part of a plan of treatment that is experimental, unproven or related to a research protocol. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Sickness means a disease or illness, or more than one disease or illness, resulting from the same or related causes or conditions, including all complications thereof and all related conditions and recurrences resulting in medical expenses insured under the policy or otherwise resulting in a claim for benefits while the policy is in force with respect to the Insured for whom the claim is made.

EXCLUSIONS

Benefits will not be paid for losses caused by or resulting from any one or more of the following:

- Declared or undeclared war or any act thereof;
- Suicide or intentionally self-inflicted Injury or any attempt thereat, while sane or insane (while sane in Colorado and Missouri);
- Any Hospital Confinement or other covered treatment for Injury or Sickness while an Insured Person is in the services of the armed forces of any country. Orders to active military service for training purposes of two months or less do not, for the purposes of this exclusion, constitute service in the armed forces of any country. Upon notification to the Company of entering the armed forces of any country, the Company will return to the Insured, pro rata, any premium paid less any benefits which have been paid, for any period during which the Insured Person is in such;
- Confinement in a Hospital or other covered treatment provided in a facility operated by an agency of the United States government or one of its agencies, unless the Insured Person is legally required to pay for the services;
- Confinement or other covered treatment for Injury or Sickness which is not medically necessary;
- Confinement or other covered treatment for Dental or Vision care not related to an accidental Injury;
- Mental or nervous disorders;

EXCLUSIONS (continued)

- Alcoholism, drug addiction, or complications thereof;
- Any Hospital Confinement or other covered treatment for Injury or Sickness for which compensation is payable under any Worker's Compensation Law, any Occupational Disease Law, the 4800 Time Benefit Plan or similar legislation;
- Any Hospital Confinement or other covered treatment for Injury or Sickness that is payable under any insurance that does not require Deductible and/or Coinsurance payments by the Insured Person;
- Any Hospital Confinement or other covered treatment for Injury or Sickness for which benefits are not payable under the Insured Person's basic Major Medical/Comprehensive Policy;
- Any Hospital Confinement or other covered treatment for Injury or Sickness if, on the Insured Person's effective date of coverage, the Insured Person was not covered by a Major Medical/Comprehensive Policy. Our sole obligation will then be to refund all premiums paid for that Insured Person;
- An Insured Person engaging in any act or occupation which is a violation of the law of the jurisdiction where the loss or cause occurred. A violation of the law includes both misdemeanor and felony violations.

LIMITATIONS

Pre-Existing Condition Limitation: This product does not have a pre-existing condition limitation, however, a condition must be covered under the Insured's Major Medical/Comprehensive Medical Plan in order for benefits to be payable under this plan. Therefore, any pre-existing condition limitation applied to the Major Medical/Comprehensive Medical Plan would, in effect, limit coverage under this Plan.

Pregnancy: Pregnancy is covered the same as any other illness for insured employees and their insured spouses if it is covered under their group Major Medical/Comprehensive Plan, but pregnancy (except for complications of pregnancy) is not covered for dependent children, unless required by state law.

WHAT YOU NEED TO KNOW

- Covered employees will receive a C**ertificate of Insurance** outlining their plan of benefits and the terms, conditions and limitations of the coverage.
- Each covered employee will also receive an **ID card** that can be presented to medical providers along with the Major Medical/Comprehensive plan ID card. *Payment of benefits will be made to the medical provider when an assignment of benefits exists*, so employee's may have little or no up-front out-of-pocket costs when they present their *SISLink*® ID card to a provider.
- **Claiming benefits** is an easy process. The Covered Person must submit a claim form (only one per calendar year is required), and either the Covered Person or the provider must submit copies of fully itemized bills and copies of the corresponding EOB's (Explanation of Benefits) from the underlying major medical carrier.

Frequently Asked Questions

Who determines the benefit plan design that is available to employees?

The employer chooses the benefits and plan structure that are to be made available to it's employees. Some rules for plan design do apply:

- The maximum Hospital Confinement benefit that can be purchased cannot exceed the total of the individual in-network deductible and individual in-network coinsurance maximum under the employer's underlying group major medical/comprehensive coverage; and
- The maximum Out-Patient I benefit must be less than or equal to the Hospital Confinement benefit, subject to a maximum benefit available as noted in the section of this brochure that describes the optional Out-Patient I benefit.

How does the Out-Patient 1 Benefit work?

Each covered family unit has a maximum of 4 out-patient benefits per occurrence per calendar year. *This maximum applies to the entire family unit, regardless of the number of covered persons within the family unit.* If a Covered Person has employee only coverage, they have 4 occurrences to use in a calendar year. If they have dependent coverage, there are 4 occurrences to be used in the calendar year for their entire family unit. It is NOT a "per person per occurrence" maximum.

An occurrence happens when a Covered Person is treated on an out-patient basis for an eligible medical expense. It does not matter how many doctors you see or what period of time the treatments span; all expenses related to the treatment of the condition for which the Covered Person is diagnosed with will accrue towards their out-patient maximum for one occurrence. If, however, at any time the Covered Person goes treatment-free for 90 consecutive days or more for that condition, then resume treatments, the new round of treatments will be considered a new occurrence.

The easiest example of this is a broken arm in January that requires insertion of plates & screws. The Covered Person has out-patient surgery on their arm and is released from care by the doctor in March. They incur out-of-pocket expenses and their out-patient *SISLink*® coverage pays up to the benefit maximum. In November of that same calendar year, the Covered Person goes back to the doctor to have the plates finally removed. They have another out-patient surgery resulting in out-of-pocket expenses. Even though this surgery was related to the broken arm injury in January, they have been treatment-free for 90+ days, therefore, it would be considered a new occurrence and *SISLink*® would respond up to its benefit maximum. Documentation of the Covered Person's treatment-free status may be required from their physician.

What if a Covered Person is not 90 days treatment-free for a condition where they have already received their maximum Out-Patient 1 benefit, but a new calendar year has begun?

While a Covered Person has 4 occurrences per calendar year, if they are not treatment-free for 90+ days going into a new calendar year, the condition for which they are being treated does not qualify for a new "occurrence" by the simple fact that it is a new calendar year. The Covered Person needs to realize that they may be out-of-pocket for expenses related to the treatment of that condition.

In fact, they should note that some conditions may never qualify as a new occurrence, regardless of how many calendar years are involved. For example, a cancer patient may be receiving chemotherapy or radiation therapy on an out-patient basis. The rounds of therapy may be such that they could be separated by 90 days or more, however, the patient would still be under the care and treatment of the physician during the time between therapy rounds, thus they would not be considered treatment-free.

Physician Office Visit charges and expenses related to Wellness Visits are not covered under the Out-Patient Benefit. Are these expenses ever eligible for coverage?

Most major medical plans offer reasonably low co-pays for physician office visits, as well as some type of benefit for wellness/preventive care. In order to keep the cost of the program down and to discourage over-utilization which could ultimately impact the performance of the major medical program, we have chosen not to include coverage for these types of expenses, however, coverage for these expenses is available by optional riders, as described herein.

Frequently Asked Questions (continued)

What is excluded under SISLink®?

For an expense to be eligible under *SISLink®*, it has to be covered by the Covered Person's major medical plan. If an expense is denied by the major medical plan, but would otherwise have been an eligible expense under *SISLink®*, it will not be covered by *SISLink®*. A couple of simple examples to illustrate this are:

- The major medical plan limits diagnostic testing to a maximum of $500 and does not cover testing in excess of this amount. If diagnostic testing expenses in the amount of $750 are incurred due to an illness or injury, and the major medical plan pays $500, the remaining $250 would not be reimbursable or payable by *SISLink®* because it would be denied under the major medical insurance plan.
- The major medical plan has a pre-existing limitation provision and denies benefits because the Covered Person was not able to show proof of creditable coverage. Those expenses that were denied would be ineligible under *SISLink®*.

In addition to the above, *SISLink®* does not cover:

- Expenses that are not medically necessary and do not result from the treatment of an illness or an injury;
- Physician office visit charges, unless the Physician Office Visit benefit has been purchased;
- Expenses related to wellness, unless the Wellness Benefit has been purchased;
- Charges for well newborn care after birth;
- Durable medical equipment, unless it was dispensed to the insured person in the hospital or at the physician's office;
- Pregnancy for a dependent, other than a covered dependent spouse;
- Confinement or other covered treatment for Dental or Vision care that is not related to an accidental injury;
- Expenses related to the treatment of mental or nervous disorders;
- Expenses related to treatment of alcoholism, drug addiction, or complications thereof;

This is not a complete list of exclusions under the *SISLink®* plan. For a full list of exclusions, terms and conditions, Covered Persons should refer to their certificate of insurance.

When filing a claim, what constitutes a "fully itemized bill"?

A fully itemized bill is one that includes a diagnosis code and has charges broken down by date of service and procedure code.

A diagnosis code is also called an ICD-9 code. This is a standardized medical code that a physician or a provider assigns based on your condition/diagnosis. Most providers, except for hospitals, use a standard billing form called a HCFA. This form is usually not given to the patient, but is used to bill insurance carriers and would include the diagnosis code. Hospitals utilize a UB04 form to bill insurance companies, which will include the diagnosis code on it. A sample diagnosis code might be 465.9 (upper respiratory infection).

A procedure codes is also called a CPT code. It is a standardized code used by physicians and other providers to denote the type of services performed. An example code might be 99212 which denotes an office visit charge. Hospitals do not use CPT codes.

When can employees enroll in the SISLink® plan?

Enrollment in the *SISLink®* plan follows those guidelines established for enrollment in your group major medical plan.

If an employee does not elect to enroll in the *SISLink®* plan when it is first made available to them, they will not be able to enroll in it until the next allowable period of open enrollment, unless they qualify by law as a "special enrollee" due to certain qualifying events.

UNDERWRITTEN BY:

FIDELITY SECURITY LIFE INSURANCE COMPANY
Kansas City, Missouri

Rated A-Excellent, based on an analysis of financial position and operating performance, by A.M. Best Company, an independent analyst of the insurance industry. (For the latest rating, access www.ambest.com.)

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MARKETED BY:

This brochure contains a brief description of the plans of insurance offered to qualified employers. The exact provisions governing the insurance are contained in the master policy issued to each group on form number M-9054, policy series MG-100. Some provisions, benefits, exclusions or limitations listed herein may vary depending on your state of residence. This product is not available in all states.