



...spanning the gap in medical benefits

A deductible and coinsurance program paying up to \$5,000 when hospital confined.



- ◆ The rising cost of health care is a real challenge to both employees and employers!
- ◆ The number of employers who believe controlling health care costs to be their #1 employee benefit priority, has risen from 71% in 2000 to 90% in 2005¹.
- ◆ Affordable health care coverage often means more risk to employees through increased deductibles and high out-of-pocket expenses.
- ◆ Employers struggle to provide meaningful and affordable health care coverage to their employees.

The Solution?



¹ Deloitte & Touche/ISCEBS surveys, "Top 5 Benefit Priorities 2000-2005."

HOW *SISLINK* WORKS

The benefits provided by *SISLINK* help pay for out-of-pocket expenses incurred due to Hospital Confinement, out-patient medical procedures, physician office visits, and routine wellness examinations, depending on the plan designed by the employer. The following are examples of how the Hospital Confinement and Out-Patient benefits work. These examples are for illustrative purposes only; exact figures will vary with the plan selected.

HOSPITAL CONFINEMENT CLAIM EXAMPLE:

Hospital Stay & Surgery = \$16,000 Total Expenses

	<u>Without HCB</u>	<u>With \$5,000 HCB</u>
Deductible	\$2,500.00	\$2,500.00
Coinsurance (20%)	\$2,700.00	\$2,700.00
Total Out-of-Pocket	\$5,200.00	\$5,200.00
<i>Hospital Confinement Benefit (HCB)</i>	\$0	\$5,000.00
Net Out-of-Pocket*	\$5,200.00	\$200.00

*After the deductible, if any, has been satisfied.

OUT-PATIENT CLAIM EXAMPLE:

Procedure: MRI = \$2,250 Total Expenses

	<u>Without OPB</u>	<u>With \$2,000 OPB</u>
Deductible	\$2,500.00	\$2,500.00
Coinsurance (20%)	\$0	\$0
Total Out-of-Pocket	\$2,250.00	\$2,250.00
<i>Out-Patient Benefit (OPB)</i>	\$0	\$2,000.00
Net Out-of-Pocket*	\$2,250.00	\$250.00

*After the deductible, if any, has been satisfied.

SAMPLE *SISLINK* CASE

CURRENT MEDICAL PLAN EXAMPLE

Plan Design	PPO - \$1,000 Deductible, 80/20 Coinsurance; \$2,000 Out-of-Pocket		
		<u># of lives</u>	<u>Monthly Cost</u>
Cost:	Employee Only	34	\$338.60
	Employee & Child(ren)	1	\$678.05
	Employee & Spouse	1	\$585.56
	Employee & Family	3	\$988.25
	Monthly Premium		\$15,740.76

PROPOSED MEDICAL PLAN EXAMPLE

Plan Design	PPO - \$3,000 Deductible, 70/30 Coinsurance; \$2,000 Out-of-Pocket		
		<u># of lives</u>	<u>Monthly Cost</u>
Cost:	Employee Only	34	\$234.70
	Employee & Child(ren)	1	\$499.98
	Employee & Spouse	1	\$431.80
	Employee & Family	3	\$727.24
	Monthly Premium		\$11,093.30

PROPOSED *SISLINK* PLAN EXAMPLE

	\$5,000 In-Patient Benefit; \$2,000 Out-Patient Benefit	
	Monthly Premium	\$2,970.96

SUMMARY

	<u>Summary</u>
Total Annual Cost of Current Plan:	\$188,889.12
Total Annual Cost of Proposed Plan and <i>SISLINK</i> Plan:	\$164,551.80
Total Annual Savings using the <i>SISLINK</i> Plan:	\$ 20,337.32

These examples are for illustrative purposes only; exact figures will vary with the plans selected and costs of plans.

BENEFITS

Employers can design a plan of coverage that best suits the needs of their Employees, based on the Deductible and Coinsurance particulars of their group Major Medical/Comprehensive Policy. Benefits available for the plan design include the base Hospital Confinement benefit, and optional out-patient, physician office visit, and wellness benefits. Benefits are outlined below.

HOSPITAL CONFINEMENT (Required)

This benefit helps pay the out-of-pocket expenses an Insured Person incurs for a Hospital Confinement due to injury or sickness, provided:

- ◆ the Insured is under the regular care and attendance of a Physician; and
- ◆ such expenses are covered by the Insured Person's Major Medical/Comprehensive Policy; and
- ◆ the Injury or Sickness begins after the effective date.

Such benefits are limited to the Deductible and/or the Coinsurance Amount the Insured Person is required to pay under their Major Medical/Comprehensive Policy, and include:

- ◆ In-patient Hospital stays
- ◆ In-patient surgeries
- ◆ Physician's in-hospital charges

Benefits will also be payable for Hospital emergency room treatment for Injuries and for Sicknesses if the Sickness results in a Hospital Confinement within 24 hours of the Hospital emergency room treatment.

Benefits are "per Insured Person per Calendar Year", and the Employer can choose a Maximum Calendar Year limit, from \$500 to \$5,000 (see Rate Sheet inserts for incremental amounts available.) The benefit selected cannot exceed the Insured Person's out-of-pocket responsibility under their Major Medical/Comprehensive Policy.

OUT-PATIENT BENEFIT (Optional)

This benefit is payable for expenses incurred for medically necessary out-patient treatment of an Injury or Sickness. Benefits are limited to the difference between the benefit paid by the group Major Medical/Comprehensive Policy and the actual out-patient expenses incurred, including Deductibles and Coinsurance. Benefits include treatment under the regular care and attendance of a Physician at a Hospital, an out-patient surgical or emergency facility, or a diagnostic testing facility or similar facility that is licensed to provide out-patient treatment.

Benefits are "per Sickness or Injury", subject to a maximum of four occurrences per person/family per Calendar Year. The Employer can choose a "per occurrence" maximum of \$200, \$500, \$750, \$1,000, \$1,500 or \$2,000 however, the maximum out-patient benefit chosen cannot exceed the amount of the base Hospital Confinement benefit.

Same or related conditions will apply to the same Injury or Sickness, unless separated by a period of 90 treatment-free consecutive days or more.

If an Employer chooses to include this Out-Patient benefit option in his plan design, the Emergency Room coverage afforded under the base Hospital Confinement benefit is no longer available, and treatment otherwise covered by the Policy will be included under the Out-Patient benefit instead.

PHYSICIAN OFFICE VISIT BENEFIT (Optional)

If selected by the Employer as part of the plan design, this benefit will pay for medically necessary expenses 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 outpatient facility, when expenses are billed separately as an office visit by the Physician. Benefits are limited to the difference between the benefit paid by the group Major Medical/Comprehensive Policy and the actual expense incurred, including Deductibles and Coinsurance, subject to the maximum benefit chosen by the Employer.

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)

Benefits are payable 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. Benefits are limited to the difference between the benefit paid by the group Major Medical/Comprehensive Policy and the actual expenses incurred, which includes any out-of-pocket expenses such as Deductible and Coinsurance.

Wellness Benefits include services performed at a Hospital, outpatient 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.



ELIGIBILITY

All active 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
Mining & Quarrying

Ironworkers
Window Washers

Deep Sea Divers

EFFECTIVE DATE

The effective date of an employee's coverage will be the first day of the month following approval of an eligible person's enrollment form, provided he: (a) is not confined at home or in a Hospital or medical institution; (b) is engaged in his Regular and Customary Activities; and (c) has met the eligibility requirements of, and is covered under, a group major medical/comprehensive medical plan.

If the eligible person is not engaged in his Regular and Customary Activities on the day coverage would otherwise begin, it will begin on the first day of the month following the day he is physically able to engage in his Regular and Customary Activities.

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, evidence of insurability will be required and the Pre-Existing Condition Limitation, if any, will apply.

In all other instances, if a Dependent is unable to engage in his Regular and Customary Activities when coverage would otherwise become effective, the coverage for that dependent will be deferred until the first of the month following the date his inability to engage in his Regular and Customary Activities ceases.

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 Insured dependent children:** 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 does 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.

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:

- ◆ the lawful spouse of an Insured whose coverage under the policy has become effective and has not terminated; and
- ◆ the unmarried dependent child or children of an Insured or of an Insured's spouse who are under 19 years of age (24 if a full-time student) and whose coverage under the policy has become effective and has not been terminated. Dependent children include stepchildren, legally adopted, and foster children. (Dependent child definition may vary by state.)

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 or 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 trustee 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.

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 service 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;
- ◆ 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 Medical plan, but pregnancy (except for complications of pregnancy) is not covered for dependent children, unless required by state law.



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.

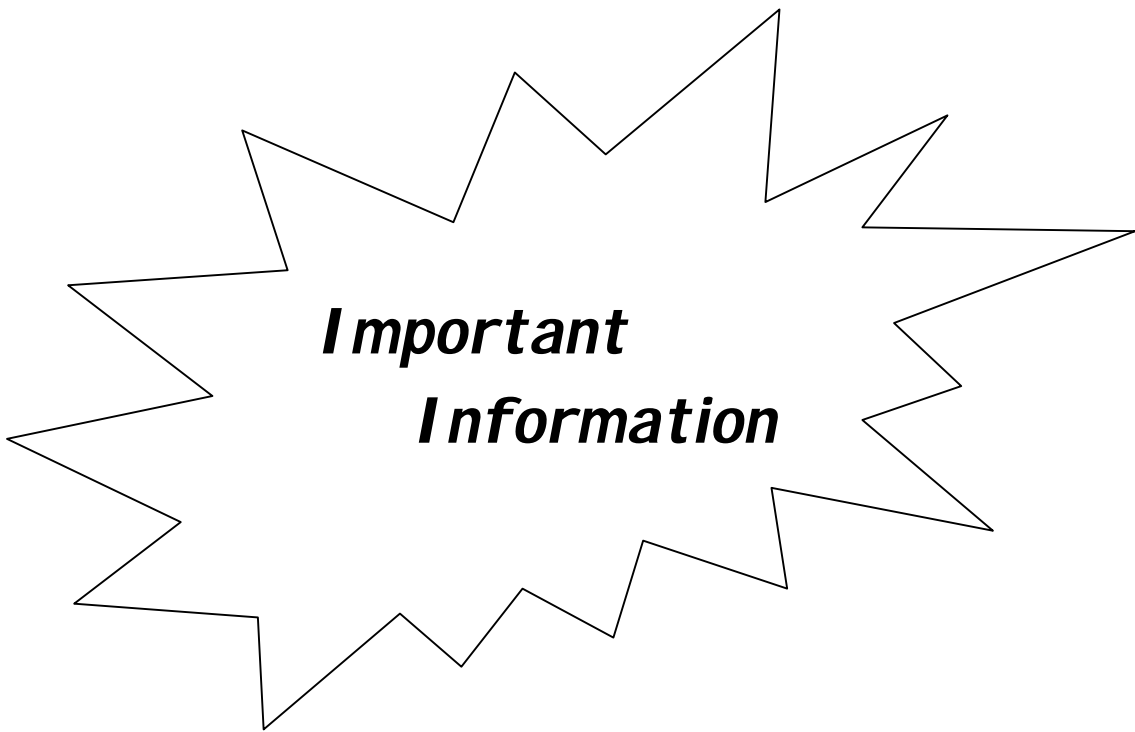
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This brochure contains a brief description of the plans of insurance offered to qualified employers. The exact provisions governing the insurance are contained in the master policy issued to each group on form number M-9054, policy series MG-100. Some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



**ROUTINE NURSERY CARE
FOR DEPENDENT CHILDREN***

*Routine nursery care for dependent children is NOT a covered expense under the Hospital Confinement Benefit.



New Features



In addition to the benefits already offered under *SISLink*, we can now offer employers the opportunity to select an Outpatient Prescription Drug Benefit and/or a Term Life & AD&D Benefit. These features are outlined below:

OUT-PATIENT PRESCRIPTION DRUG BENEFIT (RIDER FORM # R-02820)

Outpatient Prescription Drug Benefit

Member pays 100% of discounted price for drugs not on the formulary. Members receive up to a 40% discount off of brand and non-formulary drugs.

There are two plans for employers to choose from:

- | | |
|------------------|---|
| <u>Option 1:</u> | \$10 Generic Formulary Co-pay
\$15 Co-pay for Generic Formulary Oral Formulary Contraceptives |
| <u>Option 2:</u> | \$10 Generic Formulary Co-pay with \$50 Brand Formulary Co-pay
\$15 Co-pay for Generic Formulary Oral Formulary Contraceptives |

Benefits are subject to a Calendar Year Benefit Maximum of \$1,500 per Insured Person.

The Outpatient Prescription Drug Benefit is available in all states where the *SISLink* plan is available EXCEPT for MD, ME, NC & TN.

Limitations - Outpatient Prescription Drug

Dispensing Limits and Authorized Refills - Retail: the lesser of a 30-day supply or specified unit doses.

Outpatient Prescription Drug Policy Exclusions

Outpatient Prescription Drug benefits are not payable for the following items except as set forth in the rider:

- 1) All over-the-counter products and medications unless shown under the definition of Prescription Drug. This includes, but is not limited to, electrolyte replacement, infant formulas, miscellaneous nutritional supplements and all other over-the-counter products and medications;
- 2) Blood glucose meters and insulin injecting devices;
- 3) Depo-Provera, levonorgestral, condoms, contraceptive sponges, spermicides, sexual dysfunction drugs;
- 4) Biologicals (including allergy tests), blood products, growth hormones, hemophilic factors, MS injectables, immunizations, all other injectables unless shown under the definition of Prescription Drug;
- 5) Aerochamber, Aerochamber with Mask, Peak Flow Meter, all other medical supplies and durable medical equipment unless shown under the definition of Prescription Drug;
- 6) Liquid nutritional supplement, pediatric Legend Drug vitamins, prenatal Legend Drug vitamins, prescribed versions of Vitamins A, D, K, B12, Folic Acid and Niacin – used in treatment versus as a dietary supplement, all other Legend Drug vitamins and nutritional supplements;
- 7) Anorexiant; Any cosmetic drugs including, but not limited to, Renova, skin pigmentation preps, Any drugs or products used for the treatment of baldness, Topical dental fluorides;
- 8) Refills in excess of that specified by the prescribing physician, or refills dispensed after one year from the original date of prescription;
- 9) All newly marketed pharmaceuticals or currently marketed pharmaceuticals with a new FDA approved indication for a period of one year from such FDA approval for its intended indication;
- 10) Any drug labeled "Caution – limited by Federal Law for Investigational Use" or experimental drugs;
- 11) Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment;
- 12) Drugs needed due to conditions caused, directly or indirectly, by an Insured Person taking part in a riot or other civil disorder, or the Insured Person taking part in the commission of a felony;
- 13) Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war; or drugs dispensed to an Insured Person while on active duty in any armed forces;
- 14) Any expenses related to the administration of any drug;
- 15) Needles or syringes unless shown under the definition of Prescription Drug;
- 16) Drugs or medicines taken while in or administered by a hospital or any other health care facility or office;

- 17) Drugs covered under Workers' Compensation, Medicare, Medicaid or other governmental programs;
- 18) Drugs, medicines or products which are not Medically Necessary;
- 19) Brand Name Prescription Drugs (unless specifically provided for in the policy);
- 20) Diaphragms, Erectile dysfunction Legend Drugs, unless specifically listed in the definition of Prescription Drug, Infertility Legend Drugs;
- 21) Epi-Pen, Epi-Pen Jr., Ana-Kit, Ana-Guard, Glucagon-auto injection, Imitrex-auto injection;
- 22) Smoking deterrents, Legend or over-the-counter.

TERM LIFE AND AD&D BENEFIT (RIDER FORM #R-02818)

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, \$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 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.

Important Note: Some provisions, benefits, exclusions or limitations listed herein may vary depending on your state of residence.

NEW!!

OPTIONAL OUT-PATIENT II RIDER

As an alternative to the base out-patient benefit already offered under SISLink (OP I), you can now offer employers the opportunity to select our new Out-Patient II Rider.

- ❖ Per Person Per Calendar Year Benefit Maximums
- ❖ Benefits available: \$250; \$500; \$750; \$1,000; \$1,250; \$1,500; \$1,750; \$2,000; \$2,250; or \$2,500*
- ❖ Per Family Per Calendar Year Maximum – 2x Per Person Per Calendar Year Maximum

Pays up to the maximum benefit selected for medically necessary out-patient treatment of an Injury or Sickness. Out-patient benefits include treatment under the regular care and attendance of a physician at a hospital, physician's office (except those expenses allocated as a physician's office visit expense), out-patient surgical or emergency facility or a diagnostic testing facility or similar facility that is licensed to provide out-patient treatment. Benefits are limited to the difference between the benefit paid by your major medical plan and actual out-patient expenses incurred.

*The maximum benefit amount available per person for plan selection is limited to 50% of the In-Patient Benefit selected per person. For example, on a plan with a \$2,500 In-Patient Benefit, the Out-Patient II Benefit available would be limited to an amount equal to \$1,250 or less.

The Out-Patient II Benefit is a “per person per calendar year” benefit with a family maximum limit equal to 2 times the “per person” benefit.





FREQUENTLY ASKED QUESTIONS

What is SISLink?

SISLink is underwritten by Fidelity Security Life Insurance Company (Kansas City, Missouri) and is administered by Special Insurance Services, Inc. SIS is located in Plano, Texas and administers all aspects of the SISLink product for FSL, including policy/certificate issuance, premium collection and claims administration.

The benefits provided by SISLink will help you pay for out-of-pocket expenses you might be responsible for due to a hospital confinement or due to most out-patient procedures. For an expense to be eligible, it must meet three criteria:

1. First, it **must be medically necessary for the treatment of an injury or a sickness**. Expenses resulting from voluntary or elective surgeries, procedures or expenses due to wellness or preventive care, and those expenses designated as physician office visit expenses are not covered.
2. Second, the expense must be covered by your major medical plan and must have been applied towards your deductible or coinsurance provision under that plan. If an expense or procedure is not covered by your major medical plan, it will not be an eligible expense under SISLink. If an expense or procedure is covered by your major medical plan, but the charges for such are not applied to your deductible or coinsurance provision, it will not be an eligible expense under SISLink.
3. Third, the expense must be incurred while the SISLink coverage is in force.

What constitutes a major medical plan?

A major medical plan must be a group medical plan (whether a fully insured plan or an employer sponsored self-funded plan) that provides benefits for hospital confinements and requires you to pay a deductible and/or portion of coinsurance. A major medical plan does not include Medicare, Medicaid or government sponsored programs not typically considered major medical coverage (such as, but not limited to, veterans benefits, etc.)

Who determines the benefit plan design that was made available to me?

Your employer has chosen the benefits and plan structure that have been made available to you. They, along with insurance professionals, have reviewed and analyzed your major medical plan coverage and its associated costs, to determine the most effective SISLink plan(s) available.

How does the SISLink 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 you have employee only coverage, you have 4 occurrences to use in a calendar year. If you have dependent coverage, there are 4 occurrences to be used in the calendar year for the entire family unit. It is NOT a “per person per occurrence” maximum.

An occurrence happens when you are 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 you are diagnosed with will accrue towards your out-patient maximum for one occurrence. If, however, at any time you go 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. You have out-patient surgery on your arm and are released from care by the doctor in March. You incur out-of-pocket expenses and your out-patient SISLink coverage pays up to the benefit maximum. In November of that same calendar year, you go back to the doctor to have the plates finally removed. You have another out-patient surgery resulting in out-of-pocket expenses. Even though this surgery was related to the broken arm injury in January, you 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 your treatment-free status may be required from your physician.

What if I am not 90 days treatment-free for a condition where I have already received my maximum SISLink benefit, but a new calendar year has begun?

While you have 4 occurrences per calendar year, if you are not treatment-free for 90+ days going into a new calendar year, the condition for which you are being treated does not qualify for a new “occurrence” by the simple fact that it is a new calendar year. You need to realize that you may be out-of-pocket for expenses related to the treatment of that condition.

In fact, you 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.

How does the SISLink Out-Patient 2 Benefit work?

Each covered person has a maximum out-patient benefit per calendar year subject to a maximum benefit for all covered persons within a family unit that is equal to two (2) times the individual out-patient benefit maximum. This family maximum applies to the entire family unit, regardless of the number of covered persons within the family unit, however, in no event will the maximum calendar year out-patient benefit for any one person exceed the individual maximum.

For example, if you have a \$2,000 individual Out-Patient 2 Benefit and elect dependent coverage, the total out-patient benefit available to the entire family unit is \$4,000. Under this scenario, if you accrue \$2,500 in eligible out-patient expenses in a calendar year, then the Out-Patient 2 Benefit would cap for you at \$2,000 for the calendar year and any out-of-pocket expenses you have above that cap would be your responsibility. Your dependents, though, would still have \$2,000 available to them for eligible out-patient expenses which could be applied to charges for one specific dependent or applied to charges incurred by several dependents.

I see that Physician Office Visit charges and expenses related to Wellness Visits are not covered under the Out-Patient (1 or 2) 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 determining the most effective SISLink plan to offer to his employees, from both a benefit and cost perspective, your employer would have taken this into consideration. There are optional riders that would allow limited coverage for Physician Office visit charges and/or Wellness expenses, but there is an additional premium associated with these benefit riders. If your employer purchased these riders, office visits and wellness charges would be considered by SISLink.

Will I receive an ID card or some other proof of insurance?

Upon receipt of your enrollment form, SIS will issue you a certificate of insurance, outlining the plan benefits, terms, conditions and limitations. An ID card that you can present to providers at the time of service is also issued.

Both the ID card and certificate of insurance are sent to your employer, usually to a designated HR staff member, for distribution to you. For a new group, this process normally takes 8-10 business days. For new enrollees within an existing group, certificates and ID cards are usually handled within 5 business days.

If you need to see a doctor before you receive your ID card, you can contact the SIS Customer Service Department with your provider’s name, address and phone number. Simply explain the situation to the SIS representative and he/she can contact the provider on your behalf to explain the SISLink plan.

How do I file a claim?

When you enroll in the SISLink plan, you will receive a certificate of insurance, an ID card, and a claim form, along with specific instructions on how to file a claim. This form outlines the procedures you should follow and where you should send your claim. Simply stated, you will need to submit a completed claim form, itemized bills (NOT balance due statements), and EOB's that correspond to the itemized bills.

You must file one claim form per calendar year for each insured person for whom you are filing a request for claims reimbursement/payment on. The claim form has a section authorizing providers to release medical information to FSL/SIS if requested. We must have a current (no more than a year old) signature on file on this form in the event it is necessary to request medical records from your provider. Having this form already on file with SIS results in faster claim service.

Claims may be filed at any time, but must be filed no longer than 12 months from the date of service in order to be eligible for coverage.

Upon receipt of all required documentation, claims processing takes approximately 10 business days.

If you have any questions about this process, you can call the Customer Service Department at Special Insurance Services at (800) 767-6811, and representatives will be happy to assist you.

What is a diagnosis 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).

How do I get a diagnosis code when the provider will not submit it to me?

Due to HIPAA laws, physicians and providers normally will not print the diagnosis code on the billing form that is given to the patient unless the patient requests it. By law, the provider is required to provide this information to you if you ask for it. If you have asked your provider for a HCFA form and they indicated they can't give that to you, you simply need to explain that you need your diagnosis codes so you can file for insurance benefits, or ask the provider to file the bill with the insurance company on your behalf.

What is a CPT code?

A CPT code is a standardized code used by physicians and other providers to denote the type of service(s) performed. An example code might be 99212 which denotes an office visit charge. Hospitals do not use CPT codes.

What is the difference between an itemized provider bill and an EOB?

An itemized provider bill from the medical provider details the procedures performed and the dates of service of those procedures. This bill (unless it is the patient's copy, as explained above) should include the dates of service for each procedure performed, a CPT code for each procedure performed, a diagnosis code, and the charge for each procedure. Sometimes, a provider will send you a re-capped statement or a "balance due" statement. These types of bills do not contain the itemization the insurance company requires in order to process your claim.

An Explanation of Benefits, or EOB as it is commonly referred to, is a statement from your major medical insurance company outlining the charges they have processed, detailing what expenses were filed, the dates of service, how much was discounted due to PPO re-pricing, what expenses were not covered and why, what was applied to the deductible, how much was paid to the provider, and what the claimant's out-of-pocket responsibility is.

The EOB, along with the itemized bill, provides the insurance company with the information necessary to process your claim under the SISLink program.

I paid the provider, but SISLink paid them, too. Why?

When you go to a doctor or to the hospital, you are usually required to execute an Assignment of Benefits at the time of treatment. These assignments apply to any and all insurance coverage you might have. Provider bills indicate whether or not an Assignment of Benefits exists. SISLink benefits are “assignable” and when the insurance company is aware that benefits have been assigned to the provider, we are legally obligated to make our payments to that provider, whether or not you paid the provider at the time of service.

If your provider will not accept your SISLink ID card and requires you to make a payment at the time of service, you should ask them to stamp your bill “paid in full” or to provide you with a receipt indicating they have received a full or partial payment for the specific services rendered. Otherwise, benefit payment will go to the provider and you would need to contact them for a refund of any amounts paid by you up front that create an overpayment on your account.

Most providers, if they will file for insurance benefits from more than one carrier, should accept your SISLink ID card reducing, if not eliminating, their requirement that you pay for services up front. If your provider accepts your ID card and is still requiring you pay up front, it may be they did not understand the SISLink concept when they called in to verify insurance coverage. In this instance, you can ask your provider to call the SIS Customer Service department again, or you may contact SIS and request Customer Service call the provider to explain the benefits again. Ultimately, however, it is the provider’s decision whether or not to require payment from the patient at the time of service.

Can I buy SISLink coverage if I am covered by an HSA (Health Savings Account)?

Your employer determines the SISLink benefit plan design this is offered to you. If you are covered by an HSA, however, SISLink coverage is not available. SISLink coverage offsets amounts applied by your major medical plan to that plan’s deductible. HSA regulations require that the major medical have certain minimum deductible levels. By offsetting deductible expenses, SISLink would effectively bring the deductible levels down to a point that would invalidate the plan as HSA eligible.

I have already met my deductible and out-of-pocket maximum for the calendar year. If I elect to participate in the SISLink plan will I be paying for coverage I won’t be able to use?

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

If you do not elect to enroll in the SISLink plan when it is first made available to you, you will not be able to enroll in it until the next allowable period of open enrollment, unless you qualify by law as a “special enrollee” due to certain qualifying events. Whether or not, or for how long, you might be paying for coverage that might not be available in this situation, is dependent upon what point in the calendar year you met your deductible and coinsurance maximum and when the next period of open enrollment comes around.

What is excluded under SISLink?

For an expense to be eligible under SISLink, it has to be covered by your major medical plan. If an expense is denied by your 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:

1. Your major medical plan limits diagnostic testing to a maximum of \$500 and does not cover testing in excess of this amount. If you incur diagnostic testing expenses in the amount of \$750 due to an illness or injury, and your 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.
2. Your major medical plan has a pre-existing limitation provision and denies benefits because you were 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:

1. Expenses that are not medically necessary and do not result from the treatment of an illness or an injury;
2. Physician office visit charges, unless the Physician Office Visit benefit has been purchased;
3. Expenses related to wellness, unless the Wellness Benefit has been purchased;
4. Charges for well newborn care after birth;

5. Durable medical equipment, unless it was dispensed to the insured person in the hospital or at the provider's office;
6. Pregnancy for a dependent, other than a covered dependent spouse;
7. Confinement or other covered treatment for Dental or Vision care that is not related to an accidental injury;
8. Expenses related to the treatment of mental or nervous disorders;
9. 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, you should refer to your certificate of insurance.

The SISLink enrollment form asks for social security numbers for me and my dependents. Do I have to give this information out?

SIS is a professional third party administrator operating within the guidelines for privacy as established by HIPAA and required by law. All personal information provided to SIS is held in the strictest confidence and is used internally only for identification of an insured person. This information is NOT printed on any materials that are sent out of SIS's offices.

Each insured person is entered in the SIS database and assigned a unique master claim number that is in no way related to the person's social security number. This unique master number appears on all correspondence and EOB's issued by SIS for the SISLink plan.

SIS requires social security numbers on all employees and their covered dependents for two reasons:

1. First and foremost, SIS is required by federal law to report to the Center for Medicare Services on a quarterly basis certain data on individuals who may or may not be eligible for Medicare. The data SIS has to provide to CMS includes social security numbers, therefore we must obtain these in order to enter you and your dependents into our databases; and
2. Secondly, on occasion, a provider might call to check on payment status and may not have the master number to refer to. When this occurs, and the insured person is someone with a very common name (John Smith for instance), the provider will often give the SIS Customer Service representative the person's social security number so they can determine which John Smith in our database they are calling in regard to. SIS prides itself on being able to provide fast, quality customer service. Having the proper information on hand enables SIS to handle all inquiries quickly and efficiently.

When can I file for and get reimbursement for expenses related to my pregnancy?

An ob/gyn assesses a global fee for the pre-natal care and delivery costs associated with a pregnancy. This cost is not considered to be an "earned" cost to the ob/gyn until the time of delivery, even though your doctor may require you to pre-pay your estimated portion of the global delivery charge prior to actual delivery. It would not be uncommon for an ob/gyn to require that the patient's portion of the cost be paid in full by the 7th month of the pregnancy term.

The global fee includes all pre-natal check-ups and routine office visits associated with the pregnancy, as well as the physician's delivery fee. Expenses such as sonogram charges, non-routine lab work, and other non-routine diagnostic testing are usually not considered to be a part of the global delivery fee and are charged by the doctor independently of such fee.

You are eligible to file for and receive benefits for your covered pregnancy as follows:

1. Global fee – at the time of delivery;
2. Expenses outside the global fee – at the time the expense is incurred

Deposits or pre-payment arrangement terms that you may have made with your physician do not alter the above.

Expenses for the physician's global fee are applied to your in-patient hospital confinement benefit along with expenses charged by the hospital for labor & delivery, room & board, etc. Those expenses outside the global fee (such as those listed above) are applied to your out-patient expense benefit.