MERITAIN HEALTH℠

An Aetna Company

The Protect Plans

through Meritain Health, an Aetna Company

Safe and Simple

Fixed-Cost Self-Funded Medical Coverage

Plus Refund Assisters℠

www.ProtectPlans.Info

PPGUIDE-20170803

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Why Self-Fund?

There's nothing wrong with traditional health care coverage. You pay a monthly fee and outsource all your medical plan needs to an insurance company or HMO. You know what you'll pay each year and your carrier does all the work. But ask yourself, when claims are less than expected who keeps the savings? When it comes to traditional coverage, the winner is the insurance carrier, not you.

Fortunately, you have another option: fixed-cost self-funded medical coverage. You pay a monthly fee and outsource all your health plan needs. You know what you'll pay each year and your third party administrator does all the work. Best of all, when claims are less than anticipated, you—not the carrier—are the winner.

Self-funding delivers other advantages, too. You can offer the same plan to employees in different states because self-funded plans are governed by federal law. And the monthly cost is often comparable to—or less—than traditional insurance.

With great advantages comes great responsibility. With self-funded health plans, you (the plan sponsor) are responsible for claims. That's why "pure" self-insurance is better suited for extremely large companies with big pockets. For the rest of us, stop-loss coverage caps liability if claims are higher than anticipated.

Upside opportunity. Downside protection.

That's the beauty of self-funding with stop-loss coverage. When claims are higher than expected you're protected; when they're lower you reap the savings.

Keep the savings or gift it to an insurance company.

The choice is really that simple.

Why the Protect Plans?

Self-funding comes with some risk and can seem complicated. However, the risk is easily managed and the experience can be straightforward. That's what the Protect Plans deliver: safe and simple fixed-cost self-funded medical coverage with the added advantage of our unique package of Refund Assisters℠.

Safe

Claims, billing and other operations are provided through Meritain Health, an Aetna company and one of the nation's largest third party administrators. Stop loss coverage is provided by highly rated carriers on which you can rely.

Simple

Eight quality PPO plans. One broad and deep national network. That's keeping things simple and straightforward.

Fixed-Cost

Your monthly costs are determined upfront. Your responsibility for claims is capped, too. And composite rates mean you even know the medical premium of new hires.

Self-Funded

You keep 100% of any surplus claim fund dollars. Unlike some self-funded programs, we don't deduct a fee from your refund.

Plus Refund Assisters℠

Self-Funding offers the possibility of refunds when claims are lower than anticipated. The Protect Plans help you seize that potential with Refund Assisters℠: wellness, transparency and cost review programs that maximize your benefit dollars.

What we do is simple.

We protect your employees' health and your bottom line.

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What to Know

Your broker can help you determine if self-insurance is right for you. Here are some items to help your discussion.

Heads you win, tails you don't lose.

Terms

Just like with traditional health insurance there are certain terms you need to know when discussing fixed-cost self-funded medical coverage.

Claims Fund: the portion of your monthly payments set aside to cover claims. The rest of your monthly payments go towards stop-loss coverage, administration, operations, and to legally required fees and taxes.

Claims Fund Surplus: the unused dollars in your **claim fund** after eligible claims are paid out during the contract period.

Composite Rates: the cost of coverage is averaged over the entire group as opposed to varying by age. Each employee pays the same rate, adjusted only for the number of their dependents and location. Composite rating helps you better budget your benefit dollars.

Contract Period: the time during which eligible claims must be incurred and paid for in order to be eligible and covered by your benefit plan. The Protect Plans use a 12/18 contract period. This means eligible claims are those incurred during the **plan year** (12 months) and paid for no later than 18 months from the start of the plan year. The six months following the plan year is often called a **run-out** period. Claims submitted or remaining unpaid after this 18 month period are the insured's responsibility, not yours or the **stop-loss insurance** carrier's.

Fixed-Cost: a self-insured arrangement in which employers pay a set amount each month towards administration, stop-loss coverage and claims expenses, with no additional charges if claims are higher than anticipated.

Plan Year: the first 12 months of your coverage starting with your initial effective date or your renewal date.

Run-Out: the designated time following the **plan year** in which all claims must be submitted and paid. The Protect Plans offer a generous six months run-out.

Self-Funded or Self-Insurance: benefit arrangements in which the employer is responsible for claims payment instead of an insurance company. When claims are lower than anticipated, the employer gets the savings.

Stop-Loss Insurance: protects self-insured employers from excessive claims. There are two types: **specific** stop-loss steps in when any individual's claims exceed a specified amount; **aggregate** stop-loss pays eligible claims once your **claims fund** is exhausted. **Excess-loss insurance** is another name for this coverage.

Getting Your Refund

Getting refunds sounds good. But how do you get them? Simply.

It's your refund. You get it all.

Monthly Payments

It all begins with the plan year. Each month you'll make monthly payments that pay for administration and operating expense, stop-loss coverage, taxes and regulatory fees, and your claims fund.

The Claims Fund

Eligible claims—those covered by the benefit plan, incurred during your plan year, and submitted and paid for within the contract period—are reimbursed from your claim fund. If eligible claims exceed what's in the claims fund, it's not a problem. Stop-loss coverage pays them.

Your Refund

If claims paid out in the contract period are less than what you paid into your claims fund you receive a check for 100% of this surplus.

But what about?

Claim Timing: Not a Problem

Claims can pile up before you pay enough into the claims fund. Some programs make you pay the shortfall; an unanticipated hit to your bottom line. The Protect Plans protect you from this painful bill. We advance these claims costs, then apply future contributions to the claims fund to balance things out.

Claims Past the Contract Period

With self-funding, each plan year is distinct and separate. Claims incurred in one plan year cannot be paid out of another year's claims fund. Employees need to have claims paid by the end of the contract period. Late claims are their responsibility to pay, not yours or the stop-loss carrier.

Underwriting Matters

When it comes to self-funded coverage, assessing the health and likely claims for your group is critical.

Underwriting determines your monthly charges for expected claims. Your refund is based on the difference between actual claims and those expected claims.

That's why groups applying for self-funded coverage are fully underwritten. All employees and their dependents will be asked to answer health questions—and it's critical they provide complete and accurate answers. Otherwise the stop-loss carrier may modify your rates or treat claims related to these undisclosed conditions as ineligible (this is called "lasering.") Members are responsible for all claims related to any lasered condition.

Consult Your Broker

The Protect Plans can deliver tremendous benefits to employers, both large and small. Simple and safe, they feature competitive rates, offer the opportunity—and provide tools—for earning refunds, all while helping employees improve and manage their health. Your broker understands your needs and the options available to you. As important, your broker can help you understand the responsibilities and obligations that come with the benefits of a fixed-cost self-funded medical plan.

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The Protect Plans Deliver

Self-funding with stop-loss protection is the right choice for many businesses. The Protect Plans offer Refund Assisters℠ so you can make this choice with confidence.

Refund Assisters℠

Getting benefit dollars back when claims are lower than expected is why many employers move to fixed-premium self-insurance programs. Too often, however, these programs do too little to make those refunds a reality. The Protect Plan program is different.

Wellness

The best way to reduce health care costs is to stay healthy. That's why the Protect Plans pay members to get a biometric screening and provide all members with easy-to-use online wellness coaching. In addition, they provide cash rewards to members with specified chronic conditions who adhere to proven health-improving, cost-cutting regimens.

Telemedicine

Think of them as 21st century house calls: a private conversation between you and your doctor conducted online. At a far lower cost than seeing a doctor in their office. The Secure Plans offers Teladoc, one of the largest, most trusted telemedicine providers.

Expense Review

Every business owner knows it's important to monitor spending. That's why we engage experienced health plan executives and actuaries—independent of our administrator and stop-loss carriers—to review overall program expenses. As a result, you can expect smarter spending of benefit dollars.

Anyone can offer refunds.
Our Refund Assisters℠ help deliver them.

An All-Star Team

Getting the most from your benefit dollars means working with the best team. That's why the Protect Plan program brings together best-in-class experts with the focus and skills you can count on for outstanding performance.

Reliable Plan Administration

One of the largest third party administrators in the country, **Meritain Health**, an independent subsidiary of Aetna, providing seamless integration with the Protect Plans' national network of quality health care hospitals, pharmacies, doctors and other providers.

Meritain Health is responsible for:

- Membership services.
- Employer services.
- Claim payments.
- Utilization review.
- Case management.
- Run-Out management.
- Billing.
- COBRA administration.
- Production and distribution of legally required documents*
- Wellness
  - with cash rewards for members completing annual biometric screenings and managing specified chronic conditions
- Chronic condition management.
  - featuring financial rewards for members with specified conditions managing and improving their health

**This is not inclusive of all plan notice requirements to which you may be subject.*

Broad, Strong Networks

The Protect Plans PPO plans boasts an extensive medical network from Aetna, one of the nation's largest managed care companies: the Aetna Choice POS II (Open Access) network. And our prescription benefits, managed by ScripWorld, are accessed through Catamaran's large, national pharmacy network. Together with Aetna's Institute of Excellence Transplant Facilities™ they assure members have ready access to quality, cost-effective care.

Nationwide, Aetna's networks has over:

- 8,200+ hospitals
- 3,000,000+ physicians and specialists

Explore the network:
www.aetna.com/docfind/custom/mymeritain

Stop-Loss Coverage

Stop-loss coverage limits your exposure for eligible claim payments. It's your safety net. When self-funding, you need to be confident your stop-loss carrier will be there when you need them. Which is why the Protect Plans bring you A.M. Best Rated carriers you can count on.

Refund Assisters℠ and an All-Star Team are how we keep our commitment to you.

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PROTECT HSA PLANS

HSA-compatible plans with a wellness twist.

Health Rewards

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual biometric screening will receive a $100 cash reward.

Chronic Condition Compliance Rewards: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain who completing specified, proven steps will receive a reward of up to $100 per year.

Plan Name	PROTECT HSA 3000	PROTECT HSA 4000	PROTECT HSA 5000
Maximum Lifetime In-Network Benefits	No Lifetime Maximum (Unlimited)		
Annual Deductible	In-Network / Out-of-Network		
Single	$3,000 / $5,000	$4,000 / $6,000	$5,000 / $7,000
Family	$6,000 / $10,000 (Embedded)	$8,000 / $12,000 (Embedded)	$10,000 / $14,000 (Embedded)
Annual Out-of-Pocket Maximum	In-Network / Out-of-Network		
Single (Includes Deductible)	$5,000 / $7,000	$5,500 / $8,000	$6,000 / $9,000
Family (Includes Deductible)	$10,000 / $14,000	$11,000 / $16,000	$12,000 / $18,000
Office Visits	In-Network / Out-of-Network		
	20% / 30%	20% / 30%	20% / 30%
Telemedicine through Teladoc	$10 Co-pay*	$10 Co-pay*	$10 Co-pay*
Professional Services	In-Network / Out-of-Network		
• Lab & X-Ray • Maternity	20% / 30%	20% / 30%	20% / 30%
Hospital & Facility Services	In-Network / Out-of-Network		
Hospital Inpatient	20% / 30%	20% / 30%	20% / 30%
Emergency Room Facility	$250 Co-pay* (waived if admitted)	$250 Co-pay* (waived if admitted)	$250 Co-pay* (waived if admitted)
Emergency Room Physician Services	20% / 30%	20% / 30%	20% / 30%
Urgent Care Center (Physician Services)	$150 Co-pay* then covered 100% / 30%	$150 Co-pay* then covered 100% / 30%	$150 Co-pay* then covered 100% / 30%
Prescription Drugs • 30-Day Retail Supply • Mail Order available • In-Network Only Prescription Drug Benefit: Covered Prescription Drug costs apply towards the Network Out-of-Pocket Maximum	**Co-pays apply only after satisfying the Annual Deductible:** Tier 1–Generic Drugs: $10 Tier 2–Preferred Brand-Name Drugs: $35 Tier 3–Non-Preferred Drugs (Non-Formulary): 50% Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to $300 Co-pay per prescription		
Preventive Care (In-Network Only) • Well Baby & Well Child: 100% coverage • Adult Preventive/Wellness Exam: 100% Coverage	0% Not Subject to Deductible		

* Co-pays apply after meeting the annual deductible

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PROTECT CO-PAY PLANS

Comprehensive benefits with low-cost office visits.

Healthier Plans

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual biometric screening will receive a $100 cash reward.

Chronic Condition Compliance Rewards: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain who completing specified, proven steps will receive a reward of up to $100 per year.

Plan Name	PROTECT 500 CO-PAY	PROTECT 1000 CO-PAY	PROTECT 2000 CO-PAY	PROTECT 3000 CO-PAY	PROTECT 4000 CO-PAY
Maximum Lifetime In-Network Benefits	No Lifetime Maximum (Unlimited)				
Annual Deductible	In-Network / Out-of-Network				
Single	$500 / $2,500	$1,000 / $3,000	$2,000 / $4,000	$3,000 / $6,000	$4,000 / $6,000
Family	$1,000 / $5,000 (Embedded)	$2,000 / $6,000 (Embedded)	$4,000 / $8,000 (Embedded)	$6,000 / $8,000 (Embedded)	$8,000 / $12,000 (Embedded)
Annual Out-of-Pocket Maximum					
Single (Includes Deductible)	$1,500 / $4,500	$3,000 / $5,000	$4,000 / $6,000	$5,000 / $7,000	$6,000 / $8,000
Family (Includes Deductible)	$3,000 / $9,000	$6,000 / $10,000	$8,000 / $12,000	$10,000 / $14,000	$12,000 / $16,000
Office Visits					
	Primary Care $25 Co-pay / 30% Specialty $50 Co-pay / 30%	Primary Care $25 Co-pay / 40% Specialty $50 Co-pay / 40%	Primary Care $25 Co-pay / 40% Specialty $50 Co-pay / 40%	Primary Care $25 Co-pay / 40% Specialty $50 Co-pay / 40%	Primary Care $25 Co-pay / 40% Specialty $50 Co-pay / 40%
Telemedicine through Teladoc	$10 Co-pay	$10 Co-pay	$10 Co-pay	$10 Co-pay	$10 Co-pay
Professional Services	In-Network / Out-of-Network				
• Lab & X-Ray • Maternity	10% / 30%	20% / 40%			
Hospital & Facility Services	In-Network / Out-of-Network				
Hospital Inpatient	10% / 30%	20% / 40%			
Emergency Room Facility	10% / 30%	20% / 40%			
Emergency Room Physician Services	10% / 30%	20% / 40%			
Urgent Care Center (Physician Services)	$150 Co-pay (Deductible waived) then covered 100% / 40%				
Prescription Drugs • 30-Day Retail Supply • Mail Order available • In-Network Only Prescription Drug Benefit: Covered Prescription Drug costs apply towards the Network Out-of-Pocket Maximum	Tier 1–Generic Drugs (Deductible waived): $10 Tier 2–Preferred Brand-Name Drugs: $35 Tier 3–Non-Preferred Drugs (Non-Formulary): 50% Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to $300 Co-pay per prescription				
Preventive Care (In-Network Only) • Well Baby & Well Child: 100% coverage • Adult Preventive/Wellness Exam: 100% Coverage	0% Not Subject to Deductible				

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Exclusions & Limitations

Following is an abbreviated list of exclusions and limitations. Please refer to the Summary Plan Description ("SPD") for comprehensive details. Defined terms are "Capitalized" and can be found in the SPD. Please note that in listing services or examples, we do not intend to limit a list of services or examples unless we state specifically that the list "is limited to".

- Any amounts in excess of maximum amounts stated in the SPD.
- Charges in excess of Eligible Expenses as detailed in the SPD.
- Services or supplies that are not medically necessary.
- Services received before your effective date.
- Services received after your coverage ends.
- Any conditions for which benefits can be recovered under any workers' compensation law or similar law.
- Services provided by a local, state or federal government agency, unless you have to pay for them.
- Services you receive for which you are not legally obligated to pay.
- Services for which no charge is made to you in the absence of insurance coverage.
- Services not listed as covered in the SPD.
- Alternative Treatments such as acupressure, aromatherapy, hypnotism, Rolfing and art therapy.
- Cosmetic Procedures.
- Custodial care.
- Dental and orthodontic services except as specifically stated in the SPD.
- Devices, appliances and prosthetics except as specifically stated in the SPD. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo esophageal voice prosthetics.
- Replacement of prosthetics and Durable Medical Equipment ("DME") due to misuse, malicious damage, gross neglect or when lost or stolen.
- Domiciliary care.
- Experimental or Investigational Services, except for services for persons who have been accepted into an approved clinical trial for cancer, or a life threatening Sickness or condition.
- Eye surgery performed solely for the purpose of correcting refractive errors (such as intact corneal implants). Also, Surgery that is intended to allow you to see better without glasses or other vision correction such as LASIK.
- Eyewear including the purchase cost and fitting charge for eyeglasses and contact lenses unless specifically stated in the SPD.
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Foot care that is routine. Examples include the cutting and removal of corns or calluses; hygienic and preventive maintenance foot care; treatment of flat feet; shoe orthotics; shoe inserts; and arch supports. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which benefits are provided under the diabetes services in the SPD. This exclusion does not apply to preventive foot care for those who are at risk of neurological or vascular disease arising from diseases such as diabetes.
- Foreign language and sign language interpreters, except as required by law.
- Genetic testing, except as specifically stated in the SPD.
- Growth hormone therapy.
- Health club memberships.
- Infertility services (including sterilization reversal).
- Medical supplies, except as specifically listed in the SPD.
- Non-injectable medications given in an outpatient or office setting.
- Nutritional counseling except as specified listed as covered in the SPD.
- Obesity reduction services through surgical and non-surgical treatment, except as specifically stated in the SPD.
- Over-the-counter medications and treatments.
- Pain management services using multi-disciplinary pain management programs provided on an inpatient basis.
- Personal care attendant's services.
- Personal comfort items.
- Pharmaceutical products and prescription medication products beyond the specified supply limits and/or specifically excluded in the SPD.
- Pharmaceutical Products or prescription medication products for outpatient use that are filled by a prescription order or refill except as specifically stated in the SPD.
- Pregnancy through a surrogate and any services or supplies provided in connection with a surrogate Pregnancy.
- Private duty nursing.
- Psychosurgery.
- Respite care.
- Sex transformation operations.
- Smoking cessation programs that are stand-alone multi-disciplinary smoking cessation programs, except as covered in the SPD.
- Snoring treatments, both medical and surgical treatment, except as when provided as part of treatment for documented obstructive sleep apnea. Also limited is upper and lower jawbone surgery including that for obstructive sleep apnea.
- Travel or transportation expenses, even if prescribed by a Physician.
- Weight loss programs.
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. This exclusion does not apply to mammography.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.
- Health services for organ and tissue transplants, except those described under Transplantation Services in the SPD.
- Out-of-Network health services provided in a foreign country, unless as required as Emergency Health Services.
- Out-of-Network Preventive Care except as required by law.
- Medicare eligibility results in Benefit payment pursuant to Medicare rules.
- Claims submitted for health services beyond 12 months from the date of service, except as required by law.
- Services performed by a Provider who is a family member by birth or marriage or resides at same residence.
- Dental and orthodontic services except as specifically stated in the SPD.

The Protect Plans enable a partnership between you, your physicians and with Meritain Health. To make this partnership effective, however, we need to work a specified Network of Physicians, Hospitals and other Providers of medical services. At the same time we recognize that you may wish to obtain treatment from a Provider outside of this Network. Therefore, we provide some coverage for the Out-of- Network Providers, but much less than the coverage provided when you remain in our Network. Specifically, the Out-of-Network Benefits have separate Deductibles and Out-of-Pocket Maximums than the Network Benefits. The allowed amount for Out-of-Network Claims is equal to 110% of Medicare allowable rates. Only the allowed amount is applied to the Out-of-Network Deductible and/or Out-of-Pocket Maximum. You will be responsible for any billed charges in excess of the Medicare allowed rate. The difference in billed charges from a Network Provider compared to an Out-of-Network Provider can be substantial and these excess amounts are the responsibility of the insured. These amounts are NOT SUBJECT to any Out-of-Pocket Maximum limitations. Please be sure to verify if your Provider is in the Aetna Network prior to receiving services.

For complete Benefits information visit www.ProtectPlans.Info

This brochure provides abridged information about benefits, exclusions, and limitations. For costs and complete information on coverage, you must refer to the SPD about how the Protect Plans work, accessing benefits, benefit limits, service area benefit limitations, pre-service benefit confirmation, compliance rules, and eligible expenses. ***It is recommended that plans consult with their own experts or legal counsel to review all applicable federal and state legal requirements that may apply to their group health plan. By providing this publication and any attachments, Meritain Health is not exercising discretionary authority over the plan and is not assuming a plan fiduciary role, nor is Meritain Health providing legal advice.***