Alternate Funding for Healthcare Plans –
Designed for Small to Mid-Size Employers

KEY HEALTHY partners™
An Alternate Approach to Funding Healthcare Plans: Customized for Small to Mid-Size Employers

Employers, just like you, struggle to find affordable financing alternatives for their company’s healthcare costs. In the small to mid-size marketplace, limited options have left employers feeling as though there is no end in sight to annual rate increases. However, with Key Healthy Partners alternate approach to funding, you have the opportunity to gain control of healthcare costs — minimizing risk and maximizing potential savings.

Designed through a unique combination of underwriting, risk management and alternate funding, Key Healthy Partners allows you to offer your staff an outstanding benefit program at a competitive price. The Key Healthy Partners alternately funded program meets all of the federally mandated benefit requirements and complies with all of the newest Healthcare Reform Legislation. Furthermore, Key Healthy Partners is a turnkey program, including claims administration, stop loss protection, case management and chronic disease management with nurse outreach and member contact. Best of all, Key Healthy Partners includes some of the best PPO networks.

With alternate funding comes comprehensive reporting. For the first time, you will be able to see where every claim dollar is spent. Not only does that eliminate surprises throughout the year and at renewal, it also allows you to target specific areas within your package such as plan design selections and pharmacy utilization. We combine the underwriting and plan pricing to determine a maximum monthly liability, allowing you to budget for the cost of the program with a consistent monthly payment. Additionally, your liability is insured through Stop-Loss protection that includes both specific and aggregate coverage.

“With Key Healthy Partners™ alternate funded health plans, you can regain control and minimize your risk while maximizing your potential savings.”
Rate increases for fully insured small group plans are higher than they have been in five years, even though medical cost inflation rates have dropped into single digits. It seems unfair that premiums continue to increase even if employees and their families experienced no major health problems. The standard response to cries of unfair increases is typically centered on the excuse of “risk pooling”—where healthy employees, who actually use less in annual healthcare services, help pay for unhealthy populations in other employer groups.

With Key Healthy Partners™ alternately funded healthcare plans, you only pay for the claims incurred by your group. Furthermore, your employees receive the same if not better coverage than they would from a fully insured plan.

Advantages of Alternate Funding with Key Healthy Partners™:
- Lower rates for preferred risks
- Complete transparency as to where each plan dollar is spent
- Integration of Healthcare Risk Management principals throughout the plan
- Wellness and Chronic Disease Management, including employer reporting
- Complete control of your healthcare program by making informed decisions on benefit designs and strategies
- Employer financial rewards for good claims experience
- Improved employee attendance, reduced absenteeism, and greater productivity
- Stabilization of rates over multiple years
- Elimination of fully insured premium taxes
- All wellness related services covered at 100% — no co-pay, no deductible, no annual limit
How Key Healthy Partners Works

**PLAN CLAIM FUND**

Employee contributions will be set to fund 100% of the maximum potential plan costs. Seventy-five percent of the contributions are used to pay for the Aggregate Stop Loss Insurance, the Aggregate Accommodation Cash Flow Protection, administration, underwriting and distribution costs. The remaining 25% of the contributions is deposited to the Plan Claim Fund. This 25% is utilized first to fund claim payments. If this 25% is not enough to fund all the claim payments, the Stop Loss Insurance will provide the additional dollars to fund all claims in excess of the first 25%.

If the paid claims are less than 25% of the total contributions to the Plan, a Plan Claim Fund Surplus will occur. The calculation to determine if a Plan Claim Fund Surplus exists will be calculated at the end of the six months following each Plan anniversary. Therefore, the Stop Loss Contract is referred to as a 12/18 Contract. Claims which are incurred in 12 months under the Plan but paid in 18 months will be used to determine if a Claim Fund Surplus exists.

Should there be a positive balance in your Claim Fund at the end of your plan year when all covered claims have been processed (including run out), you may use these monies to reduce the following year’s expenses — Real savings for you!

**Key Healthy Partners™ Helps Limit Your Liability:**

**Specific Stop-Loss Protection**: Reinsurance for individual group members

If a member’s claims exceed a pre-determined limit, your plan is reimbursed for that individual’s additional covered claims. This helps ensure your claim fund is not used up entirely by one individual.

**Aggregate Stop-Loss Protection**: Reinsurance for your collective group of employees

If your group were to accumulate more claims than its monthly premium, your plan is reimbursed for additional covered claims. This ensures the group never pays more than its guaranteed annual plan maximum.

**Aggregate Accommodation Cash Flow Protection**:

The monthly aggregate accommodation provides aggregate coverage with a monthly maximum instead of your standard annual maximum. The annual maximum is divided by twelve months to determine a monthly maximum amount. If your group were to accumulate more claims than its monthly maximum, your plan is reimbursed for the additional covered claims. This ensures the group never pays more than its guaranteed monthly and annual plan maximum.
All Key Healthy Partners™ plans include the American Health Data Institute (AHDI) as a component of your monthly administration.

AHDI was created to provide employers with demystified healthcare data. AHDI has been utilizing a patented process of population and disease management since 2002 and this process identifies members likely to be of the highest risk down to the lowest risk. Once identified, it is determined whether those individuals are meeting standard of care requirements for their health conditions. In addition to identifying care standards suitable to the condition, the process provides necessary interventions to improve the healthcare consumption characteristics of the population. In addition to member care management strategies being employed, the process identifies high quality, cost effective providers who have proven through episodic care analysis an efficient and effective way to deliver care. This patented, proven and creative solution has consistently reduced healthcare costs and increased the health status of the population.

Creating healthier employees is extremely beneficial to an alternately funded healthcare plan like Key Healthy Partners™ because your monthly investment is based on your group’s expected claims; so the lower your anticipated claims, the lower your monthly fee.

Utilization Management And Chronic Disease Management

AHDI has been successfully managing chronic conditions for employers for almost a decade. AHDI selected 27 of the most common chronic diseases that have been identified as leading cost drivers on employer benefit plans. Each of the 27 chronic conditions has established care standards that include telephone communication with Health Care Navigator™ Registered Nurses or Certified Health Educators. These care standards are compiled as the best practices as defined by the medical community.

The Utilization Management and Chronic Disease Management programs have a comprehensive set of reports that track care standards, financial indicators and contact information. The chronic disease program has maintained a consistent return on investment within three years of implementing the program and an increased return on investment over five years. On average, the program will reduce claim costs from 7-17% depending on the prevalence of chronic disease in a population and the employer’s support for compliance with the program.

Employers are realizing improved plan performance and lower healthcare expense as the result of the patented and proven care systems for population health management. Below is proven experience on how the patented approach has delivered results for employers.

Key Healthy Partners™ Product Performance

Small & Mid-Size Group Healthcare Costs (10-150 employees)
Frequently Asked Questions

What type of plans are offered?
Key Healthy Partners™ has in-network coinsurance levels of 100% to 60%, in-network deductibles of $250 to $10,000, access to over 20 physician networks around the country and consumer-driven health plans: Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA). In addition, all proposals come with a Three Year Controlled Healthcare Budget™. This unique approach allows employers to save money on their overall health plan and offer better benefits for 91% of the employee population.

What is the lag time for claim payments?
The average claim lag period is 29 calendar days from the date of service until the provider/member receive payment. Our contract is structured so that you have six months after the close of the policy year to capture all claim activity. We have not had a claim exceed that time frame.

How have renewals been performing?
Looking across our book of business:
- 10% of clients enjoyed rate decreases
- 13% of clients performed well enough to receive premium refunds
- Over the last three years, renewals have been priced below trend

What type of reporting capabilities are available?
You will receive high-level management reports that will allow you to make informed decisions on the direction of your plan of benefits.

How does the application process differ from fully-insured?
Each employee will complete a brief and confidential medical application. These simple forms will ask questions regarding health history, such as recent hospitalizations and current prescriptions. We would be happy to walk you through the plan offerings and answer any questions you may have.

What else do I need to know?
Stop Loss insurance for this alternately-funded program is provided by Companion Life Insurance Company. Plan administration is performed by . Key Healthy Partners™ is governed principally by the federal Employee Retirement Income Security Act (ERISA).
Key Healthy Partners™ offers you flexibility when designing your healthcare plan.

**Key Healthy Partner’s Benefit Plan Options**

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* Must have at least a 10% differential between in and out-of-network.

**Prescription Drug Benefit Choices**

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Family Deductible and Coinsurance Limit
- Two times

Lifetime Maximums
- Unlimited

Physician Office Visit/ Specialist Visit
- $20/$35
- $30/$45
- Deductible/Co-Insurance

Wellness
- Paid at 100% – no co-pay, no deductible, no annual limit

Alternate Funding for Healthcare Plans — Designed for Small to Mid-Size Companies
General Exclusions to the Plan*:
Covered expenses do not include and no benefits are payable for the following:

1. Charges that are not for the care or treatment of an accident or illness except as specifically provided for in this plan.
2. Cosmetic surgery or related hospital admissions, unless made necessary:
   • by an accidental injury,
   • for correction of congenital deformity within six years of birth,
   • for re-constructive surgery as necessary for the prompt treatment of a diseased condition.
3. Charges for or in connection with treatment of teeth or periodontium or treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, except as provided herein.
4. Charges or disabilities for or in connection with an injury arising out of or in the course of any employment for wage or profit.
5. Services or disabilities covered by or for which the participant is entitled to benefits under any Worker’s Compensation or similar law.
6. Services and supplies in a hospital owned or operated by the United States government or any government outside the United States in which the participant or dependent is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to federal law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are covered herein and which are not incurred during or from service in the Armed Forces of the United States.
7. Charges that the participant is not legally required to pay for or charges which would not have been made if this coverage had not existed.
8. Charges that are in excess of the reasonable and customary rates and/or that are not medically necessary for the treatment of the diagnosed illness or injury as determined by the plan. A claim will not be subject to this reasonable and customary exclusion where the claim is subject to a contracted PPO network payment.
9. Charges for a covered person that are reimbursed, that could be reimbursed, or that could have been reimbursed by any public program, such as Medicare or Medicaid, even if the person could have, but does not, elect to be covered by that public program.
10. Pre-existing conditions for the applicable period except as provided herein.
11. Treatment made necessary as the result of illegal use of narcotics or use of hallucinogens in any form unless prescribed by a physician as provided herein.
12. Treatment made necessary by or a disability arising from war, declared or undeclared, or any act of war. An act of terrorism will not be considered an act of war, declared or undeclared.
13. Eyeglasses, contacts, hearing aids, or examinations for prescriptions or fitting of eyeglasses, contacts, hearing aids or charges for radial keratotomy, except for the first pair of glasses or contact lenses following cataract surgery unless specifically stated in the plan.
14. Elective, voluntary abortions except in the case of incest, rape, or congenital deformities of the fetus as determined by prenatal testing.
15. Expenses related to travel, whether or not recommended by a physician, except as provided herein.
16. Custodial care whose primary purpose is to meet personal rather than medical needs and which is provided by persons with no special medical skills or training. Such care includes, but is not limited to, helping a patient walk, getting in or out of bed, or taking normally self-administered medication. The plan administrator shall determine, based on reasonable medical evidence, whether care is custodial.
17. Treatment or services provided by anyone other than a physician as defined herein unless specifically stated in the plan.
18. Investigatory and experimental treatment, services, and supplies.
19. Hospital services performed in a facility other than as defined herein.
20. Services or supplies that are primarily educational in nature including education, training, and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home, unless specifically provided herein.
21. Organ transplants which are considered experimental in nature.
22. Charges resulting from attempted suicide or intentionally self-inflicted injury while sane or insane, unless charge results from a medical condition such as depression.
23. Charges for injuries, illness, or disability resulting from, or which occur as a part of, the covered employee’s or dependent’s commission of, or attempt to commit, an illegal act, assault, felony, or act of aggression. The plan will not deny claims if the claims are the result of domestic violence.
24. Any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment or studies related to sex change.
25. Services of a physician, registered nurse, a licensed practical nurse, or a licensed physical therapist who usually resides in the same household or who is related by blood, marriage, or legal adoption to the covered person or the covered person’s spouse.
26. Charges for fertility or infertility treatment, including drugs and testing and related charges for artificial insemination, and for in vitro fertilization unless specifically stated in the plan.
27. Services or supplies provided for weight control, weight reduction and/or surgical treatment for obesity, including morbid obesity.
28. Charges for or disability resulting from reversal of sterilization.
29. Telephone consultations, charges for the completion of claim forms, or charges for failure to keep scheduled appointments.
30. Recreational or diversional therapy.
31. Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if prescribed by a physician.
32. Charges in connection with an illness or injury which was sustained while involved in a dangerous activity, including but not limited to, sky-diving, auto or motorcycle racing, bungee jumping, rock climbing, rappelling, or hang-gilding.
33. Expenses incurred outside of the United States if the covered person traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.
34. Charges for the care of weak, strained, flat, unstable or imbalanced foot; for a metatarsalgia, bunions, or bunion, except for charges for open cutting operation; care of corns, calluses, toenails, fallen arches, or chronic foot strain. However, the care of corns, bunions, calluses, or the care of toenails is covered when medically necessary because of diabetes or circulatory problems.
35. Supportive devices of the foot including but not limited to arch supports, pelvic/spinal stabilizers, heel lifts, foot pads, orthopedic shoes, inserts and strapping.
36. Care and treatment for smoking cessation programs, including smoking deterrent patches, unless medically necessary due to a severe active lung illness such as emphysema or asthma unless required as a wellness benefit.
37. A prescription drug such as, but not limited to, Viagra which is prescribed to treat male and female sexual dysfunction will not be a covered benefit under the plan unless specifically stated in the plan.
38. Aquatic and massage therapy.
39. Charges in connection with injuries sustained while legally intoxicated or under the influence of illegal drugs, whether or not charged with a violation of law, unless the injuries resulted from alcohol or drug addiction, which is a medical condition.
40. Biofeedback training.

*These are for illustration purposes only. The terms and conditions set out in the Plan Document control benefits, eligibility, exclusions and limitations of the benefit plan.