AGENT GUIDE

GROUP HOSPITAL CONFINEMENT
SUPPLEMENTAL INDEMNITY INSURANCE

Underwritten by Fidelity Security Life Insurance Company
Arranged through Special Insurance Services, Inc.

For agent training purposes only. Not for use with consumer sales. Not to be disseminated to the public.

SECTION 1: PLAN DESCRIPTION

Fidelity Security Life Insurance Company, headquartered in Kansas City, Missouri, specializes in niche insurance market products. The company has been 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.

Target markets are employer groups who wish to reduce the overall cost of providing health care coverage for their employees while continuing to provide a Major Medical/Comprehensive Policy for their employees, with minimal impact on the majority of their employees' out-of-pocket exposure.

SISLink is designed to complement comprehensive major medical insurance plans by helping to cover out-of-pocket expenses, such as deductibles, copays and coinsurance. The SISLink base plan offers benefits to help cover hospital confinement stays. Outpatient, physician office visit and wellness riders also are available, allowing employers to customize a plan for their employees.

SISLink may be sold to any employer group that has a Major Medical/Comprehensive Policy in place for employees. This supplemental policy covers portions of the expenses employees and their families incur due to treatment of injuries and illnesses under their major medical or comprehensive health insurance as a result of the application of deductibles and coinsurance.

Underlying Major Medical/Comprehensive Policy coverage is required.

Basic Product Features:

- Expenses must be covered by the insured's Major Medical/Comprehensive Policy for benefits to be paid under this product.

- Provides coverage for medically necessary eligible out-of-pocket expenses related to the insured's Major Medical/Comprehensive Policy's co-insurance and deductibles up to the maximum benefit selected, provided such expenses are the result of treatment for an injury or illness.

- Includes a range of benefit maximums available to allow plan designs that correspond with the insured's Major Medical/Comprehensive Policy's out-of-pocket expenses.

- Basic product benefits are for in-hospital charges only, including emergency room treatment for an injury or for a sickness, if the sickness results in a hospital confinement within 24 hours. Optional outpatient, physician office visits and wellness benefits may be added via rider.

- Uses itemized bills and primary major medical plan's EOB (explanation of benefits) as a basis for determining what is covered.

This product does not pay 100% of out-of-pocket expenses. See Benefits and Limitations/Exclusions section for details.

SECTION 2: BASE POLICY

Inpatient hospital confinement

In order for the hospital confinement benefit to be paid, the expense must be covered by the insured's Major Medical/Comprehensive Policy.

Benefits include:

- Coverage for in-hospital confinement out of pocket expenses, including emergency room treatment for an injury or for a sickness if confined within 24 hours of treatment
- Coverage for eligible out-of-pocket expenses resulting from the treatment of an injury or sickness.

Benefits are limited based on the per-calendar-year and per-covered-person maximums and should coincide with the deductibles/copays/coinsurance established with major medical coverage. Maximum inpatient benefit level should not exceed the total of the individual in-network deductible and coinsurance maximum under the Major Medical/Comprehensive Policy. Routine nursery care (well baby care) for dependent children is not a covered expense under the Hospital Confinement Benefit.

Benefit Amount Options:		
$500	$3,000	$7,000
$1,000	$3,500	$8,000
$1,500	$4,000	$10,000
$2,000	$5,000	
$2,500	$6,000	

Note: This coverage may not cover 100% of out-of-pocket expenses.

Base Hospital Benefit for Sickness or Accident Emergency Room Treatment

Benefits are also payable for hospital emergency room treatment for Injury and Sickness. Benefits for emergency room treatment due to Sickness require that the Sickness result in Hospital Confinement within 24 hours of the Hospital emergency room treatment, otherwise it would apply to the Outpatient Benefit Rider (if included).

Pregnancy benefits

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 Policy. But pregnancy (except for complications of pregnancy) is not covered for dependent children, unless required by state law.

Out-of-country care

If a covered person has to be hospitalized or must see a physician while out of the United States, benefits will be paid under the SISLink plan only if the benefits are not excluded under the Major Medical/Comprehensive Policy. An Explanation of Benefits (EOB) from the Major Medical/Comprehensive Policy is also required.

SECTION 3: OPTIONAL RIDERS

Outpatient Benefits

The employer must choose between Outpatient I and Outpatient II. How the benefits work and claim scenarios for each rider are on the following pages.

Outpatient benefit rider I

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

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

Outpatient benefits may include, but are not limited to:

- Hospital emergency room treatment of injury or sickness;
- Outpatient surgery in an outpatient surgical facility, emergency facility or physician's office;
- Diagnostic testing including, but not limited to, x-rays, diagnostic lab, MRI's, and CT scans; Outpatient radiation therapy or chemotherapy;
- Physical therapy or chiropractic care; and
- Durable medical equipment if dispensed to the insured person in a hospital or provider's office

The Outpatient Benefit Rider I does not, however, cover the office visit charge which typically results in a $15 -$25 co-pay. In order to have this type of charge covered, the Physician Benefit Rider would need to be issued with the Policy.

Outpatient benefit rider II

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

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

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

- Hospital emergency room treatment of injury or sickness;
- Outpatient surgery in a out-patient surgical facility, emergency facility or physician's office;
- Diagnostic testing including, but not limited to, x-rays, diagnostic lab, MRI's, and CT scans;
- Outpatient radiation therapy or chemotherapy;
- Physical therapy or chiropractic care; and
- Durable medical equipment if dispensed to the insured person in a hospital or provider's office

The Outpatient Benefit Rider II does not, however, cover the office visit charge which typically results in a $15 -$25 co-pay. In order to have this type of charge covered, the Physician Benefit Rider would need to be issued with the Policy.

OUT-PATIENT BENEFIT RIDER I (Claim Scenarios)

The out-patient benefit will pay, up to the maximum benefit elected, for covered expenses applied to your major medical deductible (including co-pays) or coinsurance percentage. This benefit is a "per occurrence" benefit with a calendar year limit of 4 occurrences per family unit. If you, or your covered dependent have an out-patient lab procedure that, in the absence of this benefit, would cause you to be out of pocket a fairly small amount, you might want to consider not having the provider bill us, and pay the provider yourself. This way, you will not use all of your occurrences or events up early in the calendar year for small items, then realize you do not have anything left to help offset that large item you may need it for at the end of the year. If you do not have any large items come up, you can always file for reimbursement of your previous items at the end of the calendar year. The following illustration, which is based on an out-patient benefit of $1,000, may help you understand this benefit better:

In January - you go in to the doctor for the flu. You have $100 in x-ray charges assessed, all of which are applied to your deductible.

In March – you go to the doctor for strep throat. You have $80 in lab charges assessed, all of which are applied to your deductible.

In July – you go into the hospital for surgery. You meet your major medical deductible at this point.

In August – you go to doctor because you have an eye irritation. The doctor runs a lab culture to rule out pink-eye. Your 20% coinsurance amount is $10 for this service.

In October – you go to the doctor because you are feeling tired, and the doctor runs blood work. Your 20% coinsurance for this service is $20.

If at this point, either you, or your provider, file for reimbursement of the January, March, August and October events, as they occur, you will have used all four of your occurrences for the calendar year.

If you then injure your knee in December and have an MRI and subsequent arthroscopy, totaling $5,000, of which your 20% share would be $1,000, you would have no further out-patient benefit to assist you with the large bill. Had you waited on filing the original four items, you would have had $1,000 of this expense paid by the plan, and you could have then filed three of the other events at your choosing. See the following table:

Events filed as they occur:			**Events filed at end of year after Dec. event:**		
EE Portion	SISLink Pd	EE Balance	EE Portion	SISLink Pd	EE Balance
$100	$100	$0	$1,000	$1,000	$0
$80	$80	$0	$100	$100	$0
$10	$10	$0	$80	$80	$0
$20	$20	$0	$20	$20	$0
$1,000	$0	$1,000	$10	$0	$10
$1,210	$210	$1,000	$1,210	$1,200	$10

In the above example, your wise use of your benefit would have meant the difference between being out of pocket $1,000 or $10.

OUT-PATIENT BENEFIT RIDER II (Claim Scenarios)

These examples are only for illustrative purposes. The example assumes a $2,500 outpatient II benefit.

Employee Only - the max benefit is $2,500 per calendar year, regardless of how many claims submitted in the year.

Employee plus Spouse - the max benefit is $5,000 (max of $2,500 per person per calendar year, regardless of how many claims submitted in the year).

Employee plus Children - the max benefit is $5,000 (max of $2,500 per person per calendar year, regardless of how many claims submitted in the year).

Employee plus Family - the max benefit is $5,000 (max of $2,500 per person per calendar year, regardless of how many claims submitted in the year).

Example 1

Occurrence	**Out-of-Pocket Cost**	**Benefit Amount**
Employee (MRI)	$2,750	$2,500
Child (blood work)	$2,000	$2,000
Child (stitches)	$1,000	$500
Spouse (x-ray)	$500	$0
Total	**$6,250**	**$5,000**
		Total Paid by Insured = $1,250

Example 2

Occurrence	**Out-of-Pocket Cost**	**Benefit Amount**
Employee (x-ray)	$750	$750
Employee (blood work)	$1,500	$1,500
Child (stitches)	$1,500	$1,500
Spouse (x-ray)	$800	$800
Child (MRI)	$450	$450
Total	**$5,000**	**$5,000**
		Total Paid by Insured = $0

SECTION 3: OPTIONAL RIDERS Continued

Physician Benefit Rider

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

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

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

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

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

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

This rider pays benefits for physician's services for treatment of an injury or sickness. Services must be received in a physician's office, hospital, emergency facility or outpatient facility. The provider must use an office visit/consultation code in order for benefits to be paid under this rider.

The employer may choose from the following two benefit amounts:

- $15 per visit (up to $120 or 8 visits per family, per calendar year)
- $20 per visit (up to $240 or 12 visits per family, per calendar year)

This rider pays in addition to the base policy.

Note: Benefits for outpatient treatment performed in a physician's office may be payable under both the Outpatient Benefit Rider and Physician Benefit Rider. The intent of the Outpatient Benefit Rider is to cover treatment, supplies and other non-physician related outpatient charges, while the Physician Benefit Rider covers the physician's services (office visit charge).

Wellness Benefit Rider

If selected by the Employer as part of the plan design, this benefit will pay for routine health or check-up examinations, routine well child visits and other charges incurred during the course of a routine physical examination or check-up. Wellness benefits include services performed at a hospital, outpatient facility, laboratory, diagnostic testing facility and Physician services. The provider must use a wellness code in order for benefits to be paid under this rider.

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

SECTION 3: OPTIONAL RIDERS Continued

Term Life and AD&D Benefit Rider

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 $5,000, $10,000, $15,000, or $20,000 of Life and AD&D coverage for each covered employee. Benefits reduce by 50% at age 70 and another 50% at age 75.

Dependent Term Life Benefit

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

Limitations - Term Life and AD&D

Death due to suicide is not covered for two years (one year in Colorado, Missouri or North Dakota) from the insured's effective date.

Term Life and AD&D Rider Exclusions

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.

No benefit will be payable for any Accidental Death or Dismemberment Loss caused by or contributed to by:
1) Sickness, bodily or mental health, or diagnostic medical or surgical treatment;
2) infection, except pyogenic infections resulting from an accidental injury or resulting from the accidental ingestion of a contaminated substance;
3) attempted suicide or intentional self-inflicted injury or sickness while sane or insane (while sane in Colorado or Missouri);
4) declared or undeclared war or acts thereof;
5) 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;
6) 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;
7) Insured Person's commission or attempted commission of a felony, assault or illegal action;
8) 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
9) legal intoxication where the blood alcohol content of the Insured Person exceeds the legal limit of the state in which the accident took place;
10) an on the job Injury that is covered by Workers' Compensation;
11) 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, crewmember, 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.

SECTION 4: ELIGIBILITY AND UNDERWRITING GUIDELINES

Who is covered?

Four coverage options are offered with SISLink:

- Employee only
- Employee plus spouse
- Employee plus children
- Employee plus family

Newborn children, adopted children and children placed for adoption are covered on their date of birth, date of adoption or placement for adoption for a period of 31 days. Coverage for such child may be extended beyond the initial 31-day period by notifying Special Insurance Services, Inc. in writing within 31 days of the child's birth, adoption or placement for adoption. The insured must pay any required additional premium.

Employer eligibility

Employer groups must meet these criteria in order to offer SISLink to their employees.

They must:

- be sitused in an available state or have a clearly defined division in an available state (requires home office approval prior to quoting).
- offer a Major Medical/Comprehensive Policy to employees that contains out-of-pocket expense responsibilities such as deductibles, coinsurance and/or copay requirements.
- meet the product's group size and participation requirements. Minimum group size in most states is 2 enrolled lives.
- not be in one of the ineligible industries classes (see list).

Premium payment

SISLink may be written to payroll groups only.

Ineligible industries

Deep Sea Divers
Ironworkers
Mining & Quarrying
Professional Athletes
Window Washers
Employee Leasing Companies
Temporary Staffing Agencies

Employee eligibility

Employees are required to meet the following criteria to be eligible for coverage.

They must be:

- A W-2 employee of an approved employer group.
- 18 years of age or older.
- Covered under a Major Medical/Comprehensive Policy (not including limited medical plans).

In order for a spouse or dependent child of an employee to be covered, he or she must:

- Meet the definition of an insured dependent.
- Be covered under a group Major Medical/Comprehensive Policy, not including limited medical plans.
- For a spouse, be 18 years of age or older.
- For a child, be under age 26, regardless of financial dependency, residency, student status, or marital status. (Dependent eligibility may vary by state.)

Employees are not eligible for coverage if the plan would exceed the overall individual inpatient out-of-pocket expenses under their Major Medical/Comprehensive Policy. 1099 employees of any arrangement are not eligible for coverage.

Coverage will automatically be extended to domestic partners if mandated by state law. In states where it is not mandated, the Employer may still choose to extend coverage to domestic partners at the time of initial group enrollment.

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.

Underwriting Guidelines for Referrals to Special Insurance Services (prior to quoting)

- 5,000 or more eligible lives
- Any quote request that deviates from the general guidelines above

SECTION 5: ADMINISTRATIVE GUIDELINES

Policy issue guidelines

SISLink is a group product consisting of a master contract issued to the employer and certificates issued to participating employees.

Dual plan option

One SISLink plan may be selected for each major medical plan offered by the employer.

Employee buy-up option

If an Employer purchases a SISLink plan and pays 100% of the employee only cost, he may also select an additional plan with higher benefit limits that the employee can choose to purchase as a buy-up option. The maximum inpatient benefit amount for both the Employer-paid plan and the employee buy-up option may not exceed the total in-network out-of-pocket expense under the major medical plan.

Guaranteed issue

SISLink is a guaranteed-issue product. Employer groups must be covered under a Major Medical/Comprehensive Policy and meet participation requirements to qualify. Employers are responsible for selecting a plan that complements their Major Medical/Comprehensive Policy.

Participation requirements

Minimum group size is 2 enrolled lives, subject to state specific minimums.*

Groups with less than 5 lives at inception or renewal will be subject to a monthly billing fee of $20.

*In Florida and Vermont, the minimum group size is 51 eligible employees at inception and every annual anniversary. "Eligible" means an employee covered under a group Major Medical/Comprehensive Policy.

California Policy Form

Policies for California domiciled groups will be issued under policy number series MG-115. This policy form includes a mandatory mammography benefit. Also, an Outline of Coverage **MUST** be presented to any prospective insured at the time the product is presented to them by the agent during enrollment meetings. California also has separate enrollment forms, so please contact your marketing representative to verify you are using the correct forms to enroll groups in this state.

Rates

- Rates for SISLink are age-banded (under 40, 40-49, and 50+) and are based on the employee's attained age on the effective date. A quoting tool/rater is available through your marketing representative.
- SISLink may be sold only to employer groups.
- Premiums for the SISLink plan may be employer-paid, employee-paid or any combination.
- Rates are reviewed on an annual basis.
- For groups of 25 or more eligible employees, composite rates are available. The premiums must also be at least 50% employer-paid.
- Dual Option composite rates are not available.

Waiver of premium

There is no waiver-of-premium provision for this product.

Pre-existing conditions

This product does not specifically contain a pre-existing condition limitation. However, if a condition is not covered under the major medical plan, no benefit is available under the SISLink plan.

Policy effective dates

The following guidelines apply to the effective date of the policy:

- The application date must be earlier than the coverage effective date.
- All policies take effect on the first day of the month.

Certificate effective dates

The following guidelines apply to individual certificate effective dates:

- The enrollment form date must be earlier than the coverage effective date.
- Coverage takes effect on the later of the first day of the month following the acceptance of employee enrollment forms by the Company or the employee's effective date under the employer's Major Medical/Comprehensive Policy.
- The waiting period for employee coverage availability will match the group's Major Medical/Comprehensive Policy.
- In no event will coverage for any person take effect before the effective date of the group policy.

Note: An electronic file may be submitted in lieu of enrollment forms, subject to prior written approval from the carrier. Certain guidelines and criteria must be met for electronic enrollment. Contact your marketing representative to obtain these guidelines.

Backdating

Individual coverage may not be backdated. Employer groups may qualify for special handling and be backdated to the 1st of the month in which coverage is to be effective, if applications are signed and dated by the 1st and received no later than the 7th day of the month in which coverage is to be effective.

Section 125 compatibility

Employers are urged to check with their tax adviser to determine if SISLink is compatible with their IRS Section 125 plan.

Health Savings Account (HSA) compatibility

SISLink is not an HSA-compatible product.

Portability
SISLink is not a portable product. When an employee leaves the employer, his or her coverage under the SISLink plan will terminate, unless otherwise mandated by state laws.

Assignment of Benefits
It is important to note, if the insured person presents the SISLink ID card to a provider and executes an "assignment of benefits", the carrier is obligated to honor that assignment of benefit and must pay the provider, whether or not the insured person paid the provider at the time of service. By taking an active role in their healthcare usage, and choosing when and when not to use the assignment of benefits option, as well as when and when not to file for benefits in accordance with their own financial needs, the employee can maximize the out-patient benefits to the fullest.

Note: Assignments are global and apply to all insurance a person has. If provider bill says benefits are assigned, we must pay the provider unless the provider indicates the bill has been paid in full and releases us from the assignment.

SECTION 6: SUBMITTING BUSINESS

Enrollment requirements
We will need a New Business Submission Form, the Employer Application, and the Employee Data Collection Forms. Some forms are state specific; contact your marketing representative for the appropriate forms. Once the enrollment is completed, you should submit the entire enrollment package to Special Insurance Services, Inc. in order for your case to be issued.

It is important that all enrollment forms for one group are sent at the same time so the group master policy and all certificates can be provided to the employer in one package. This helps to ensure the business is processed correctly.

Business submission methods
Completed applications and enrollment forms may be submitted via overnight mail, regular mail, or faxed to 1-972-960-0377.

Please note: <u>You must provide the original employer application containing the employer's signature</u>.

Policy delivery
Once the group application has been processed, the group master policy and employee I.D. cards will be mailed, as a group, directly to the employer. Certificates for the employees will be sent to the employer electronically.

State Availability
SISLink is not available in all states. Some provisions, benefits and limitations or exclusions listed herein may vary by state.

SECTION 7: LIMITATIONS AND EXCLUSIONS
The following standard limitations and exclusions apply to the SISLink product:

Pre-existing conditions are not excluded under this policy. However, a condition must be covered under the insured's Major Medical/Comprehensive Policy in order for benefits to be payable under this plan. Therefore, any pre-existing condition limitation applied to the Major Medical/Comprehensive Policy would limit coverage under this policy.

Pregnancy is covered the same as any other illness for insured employees and their insured spouse. Pregnancy (except for complications of pregnancy) is not covered for dependent children unless required by the state.

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

Exclusions

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

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

SECTION 9: CLAIM INFORMATION

Claims may be filed by submitting a claim form, a fully itemized bill with diagnosis and procedure codes and the Major Medical/Comprehensive Policy insurance carrier's Explanation of Benefits (EOB) by mail, fax, or email to:

Special Insurance Services, Inc.
P.O. Box 250349
Plano, Texas 75025-0349
Phone: (972) 788-0699 or (800) 767-6811
Fax: (214) 291-1301
Email: customerservice@specialinc.com

Completed claim forms are required once a year.

Itemized bills must include diagnosis codes, procedures codes and dates of service. Balance due statements cannot be used to process claims.

The following information must be included on the EOB:
- Deductible
- Co-pay
- Coinsurance
- Dates of service

An insured may follow up on the status of a claim by calling the customer service department at Special Insurance Services, Inc. at (800) 767-6811.

Creation of advertising and marketing materials

Advertising is anything intended to generate interest in a specific insurance product, company or agent. This includes, but is not limited to, the following: web site information and other online services; product brochures; newsletters; agent recruiting materials; prospecting letters; print, radio, television and all forms of media advertising; illustration or presentation materials; and business cards and stationery.

Do not publish, advertise or promote any material concerning Special Insurance Services, Inc., SISLink or Fidelity Security Life Insurance Company or our contracts unless we approve and authorize such use in writing.

Please plan sufficient time to allow for the review and approval process.

Written approval from Special Insurance Services and Fidelity Security Life Insurance Company must be obtained before such material may be published or used in any way.

For example, you are authorized to use a comparison statement between a competitor's product and those offered by Fidelity Security Life Insurance Company only if that statement has been approved in writing by Special Insurance Services and Fidelity Security Life Insurance Company prior to use.

Marketing materials and forms usage

The insurance industry is state-regulated. For that reason, policies issued often vary by state regarding both the availability of a product and the forms required to sell the policy.

If you have any questions regarding product availability or the differences in form requirements, please consult your marketing representative at SIS. Under no circumstances should an agent assume that policies available in one state are available in another state, or that the required forms are the same.

SECTION 11: POLICY DEFINITIONS

The following policy definitions are used with the SISLink policy. State variations may apply.

Coinsurance means the dollar amount of covered hospital medical expenses, after the deductible, that is not payable under the insured person's Major Medical/Comprehensive Policy.

Deductible means the dollar amount that applies to all of the covered medical expenses under the insured person's Major Medical/Comprehensive Policy.

Employer means the policyholder and includes any division, subsidiary or affiliated company wholly owned by the policyholder and named in the policyholder's application.

Employer group means any firm, corporation, partnership or sole proprietorship that is actively engaged in business, is not formed primarily for the purpose of buying health insurance and has established a bona fide employer-employee relationship. The employer is required to be officed in, or have a clearly defined division in, an available state.

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. A hospital is not an institution, or part of it, that is used mainly as a facility for rest, nursing care, convalescent care, care of the aged or for remedial education or training.

Hospital confined means the insured person is admitted to the facility as an overnight bed patient for a minimum of 15 consecutive hours.

Immediate family member means an insured or an insured person's spouse, parent, child, grandparent, brother, sister, in-law or any person residing in the insured person's home.

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

Insured Person means either an Insured or an Insured Dependent. An Insured is an employee of the policyholder whose coverage under the policy has become effective and has not been terminated. Insured Dependent means any of the following: (a) the lawful spouse of an Insured whose coverage under the policy has become effective and has not terminated; and, (b) the dependent child who is under 26 years of age, or such higher ages as approved in writing by the Company.

Late enrollee is a person who did not apply for coverage on his or her initial eligibility date.

Major medical/comprehensive policy means any one of the following types of policies or plans that provides 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: a group or blanket insurance plan; a group Blue Cross, Blue Shield or other group prepayment coverage plan; and coverage under a labor management trusteed plan, union welfare plan, employer organizational plan, employee benefit organizational plan or other arrangement of benefits for persons of a group. A major medical/comprehensive policy is not Medicare or Medicaid and does not include any limited medical plan.

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

Policyholder means the employer in whose name the policy is issued.

Physician means a qualified licensed physician other than an insured person or a member of his immediate family. Physician includes all providers of medical care and treatment to the extent that they are licensed to perform services provided in the policy. This includes, but is not limited to, medical doctors, chiropodists, chiropractors, dentists, optometrists, osteopaths, podiatrists and psychologists.

Pregnancy means a pregnancy that is terminated by childbirth, other than an elective cesarean section or an elective abortion. "Complications of pregnancy" means a condition that, while affected by pregnancy, is still classed by accepted medical standards as a sickness, disease or injury apart from the normal bodily changes that accompany pregnancy; a non-elective cesarean section; an extra-uterine or ectopic pregnancy; or a spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

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

Underwritten by:

Fidelity Security Life Insurance Company
Kansas City, MO 64111
Policy form number: M-9054
Policy number: MG-108
Fidelity Security Life Insurance Company has been rated A- (Excellent), based on an analysis of financial position and operating performance, by A. M. Best Company, an independent analyst of the insurance industry.

For training purposes only. Not for use with consumer sales. Not to be disseminated to the public. The features of the products presented in this training piece are for the majority of states. Refer to the state specific policy form for exact benefits, limitations, exclusions and other provisions applicable to the state of solicitation. You must know the specifics of the product for the state and present them accurately to each customer.

FREQUENTLY ASKED QUESTIONS

What is SISLink?

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.

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

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

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 7^{th} 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.