NATIONAL
HEALTH BENEFITS

NATIONAL HEALTH BENEFITS
2021 SMALL EMPLOYER PARTNERSHIP PROPOSAL

Employer Sponsored, Employee Self-Funded Healthcare
Fully Compliant PPACA

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1 | INTRODUCTION

COMPANY OVERVIEW

WHY CHOOSE NATIONAL HEALTH BENEFITS

In order to survive and succeed as a business today, companies are looking at every expense line in their operating plan and searching for ways to streamline their processes and cut costs. For many businesses, saving money on healthcare is a great way to impact savings and increase profits. Our self-funded plans allow businesses to give their employees affordable healthcare options that are fully ACA compliant. Our plans are available at a fraction of the cost of traditional health insurance, and they offer perks for employees such as no deductible, low copays, and access to the largest network of medical professionals in the United States. We even offer our plans to part-time employees (although cancellation limitations may apply). We hope you find the following pages of information helpful and pertinent as you begin to make your benefit provider selections. We look forward to the opportunity of serving you and your company.

NATIONAL HEALTH BENEFITS COMPANY OVERVIEW

National Health Benefits offers employer-sponsored self-funded healthcare plans at a fraction of the cost of traditional major medical insurance providers.

Here are some of our exciting features that we offer our clients to provide convenience and compliance.

WE OFFER COMPETITIVELY LOW PRICES

National Health Benefit plans are typically far less expensive than most comparable health insurance options available today. These low cost options allow participation rates to grow within companies (that may have many low-wage employees) who are looking for recruitment and retention tools.

WE PROVIDE MANY OPTIONS FOR ENROLLMENT

It is more important than ever to have several platforms for employees to engage, enroll and utilize when it comes to their healthcare needs. National Health is proud to offer online, in-person or phone enrollments. Representatives are available to assist your employees in both English and Spanish languages.

OUR PLANS ARE FULLY TAX A & B COMPLIANT

When our Basic and MVP Plans are offered together on the same election form, this offer satisfies both the Tax A and Tax B Requirements of the Affordable Care Act. This process helps eliminate penalties and fines levied by the IRS. Additionally, we've added our Mega Plan and our HealthShare Connection + Mega Plan to our company offering to give employees better access to healthcare services at a truly affordable cost.

WE OFFER LOW MONTHLY MAINTENANCE FEES

Any *eligible* employee working 30 or more hours per week must be made an offer of coverage by their 60th day of employment. If an *eligible* employee waives their right to coverage, a $15 monthly maintenance fee for that employee will be assessed to keep the company in compliance. Large Employers with groups of individual locations (separate EIN numbers) will be charged a $50 monthly fee for each location if there are no eligible employees on file.

2 | BASIC PLAN

PREVENTATIVE HEALTH & WELLNESS PLAN

PLAN PRICING:

$60 MEMBER

$120 MEMBER + FAMILY (UNLIMITED)

- Preventative Health & Wellness Benefits (See Explanation of Benefits, page 3)
- Prescription Discount Card
- Total Telehealth package through MeMD available by phone or video chat
  - Urgent Care Telehealth - FREE
  - Men's & Women's Telehealth Services - FREE
  - Talk Therapy - $65 Copay per session
  - Teen Therapy - $65 Copay per session
  - Telepsychiatry - $229 First Session, $99 Follow Up
  - 24/7/365 Phone or Video Appointments
  - Prescription writing as necessary

PLEASE NOTE:

The Basic Plan is only available as an individual plan for employees of companies looking to fulfill the ACA requirement. This plan is not available to be purchased as a stand alone product for individual contractors or companies with 10 or fewer employees.

MEMBER ID & PRESCRIPTION CARD

NATIONAL HEALTH BENEFITS

GROUP NAME:
GROUP NUMBER:
MEMBER NAME:
MEMBER NUMBER:
PRESCRIPTION CODE:

PHCS

Every employee choosing the Basic or Mega coverage will receive a Member ID Card to present during their wellness visit (Basic Plan) or in-office outpatient visits (Mega Plan). This card will be especially helpful when using a doctor in-network with PHCS. In-network visits are highly recommended, but never required.

The Basic Plan is National Health's most affordable monthly benefit plan available to employees of large and small businesses. This plan offers one in-person annual well check per year where adult patients can learn more about their overall health and wellness. This appointment covers preventative treatments only such as screenings, counseling, and immunizations.

This program also includes additional wellness covered services for women and children which may require multiple appointments.

If an employee selects the Basic Plan for their healthcare coverage and needs to see a doctor for sick care, they must utilize our Total Telehealth services provided by MeMd for the care to be covered. Seeing a medical professional is as easy as downloading the MeMd App and inputting symptoms where requested.

MeMD appointments are free of charge and can be utilized 24/7/365 a year. Behavioral telehealth appointments can be made for the above listed copays.

EXPLANATION OF BENEFITS

SUMMATION OF SERVICES OFFERED

The following services are offered in accordance with the requirements of the **Tax A portion of the Affordable Care Act**. These preventative services make up what is commonly referred to as Minimum Essential Coverage.

Most of these adult applicable services can be offered during a yearly well check with a general practice doctor. Women's and children's wellness exams can take place over multiple visits.

This coverage also includes one colonoscopy every 5 years for adults over 50, and one annual mammogram for women age 40 and older.

COVERED PREVENTATIVE SERVICES FOR ALL ADULTS

- Blood pressure screening
- Cholesterol screening
- Type II Diabetes screening
- Syphilis screening
- HIV Screening
- Sexually transmitted infection prevention counseling
- Tobacco use Screening for all adults and cessation interventions

- Diet counseling
- Immunizations and vaccines (Hepatitis A&B, Herpes, Zoster, Influenza, Measles, Mumps, Tetanus, Rubella, Human Papillomavirus, Meningococcal, Pneumococcal, Diphtheria, Pertussis)
- Abdominal aortic aneurysm one-time screening for age 65-75

- Obesity screening
- Depression screening and counseling
- Aspirin use for men ages 45-79 and women ages 55-79 to prevent CVD when prescribed by a physician
- Colonoscopy (Colorectal cancer screening for adults starting at age 50, limited to one every 5 years)

BASIC PLAN CONTINUED
PREVENTATIVE HEALTH & WELLNESS PLAN

WOMEN'S SERVICES

- Breast cancer mammography screening every year for women age 40 and over
- Breast cancer chemo prevention counseling
- Cervical cancer screening
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for women
- Gonorrhea screening
- Syphilis screening
- Chlamydia infection screening
- HIV screening and counseling
- Human Papillomavirus (HPV) DNA testing every three years for women with normal cytology results who are age 30 or older
- Osteoporosis screening over age 60
- Tobacco use screening and interventions
- Sexually transmitted infections counseling
- Wellness visits

PRENATAL/POSTNATAL

- Anemia screening on a routine basis
- Bacteria, urinary tract and infection screening
- BRCA counseling and genetic testing for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies
- Folic acid supplements
- Gestational diabetes screening
- Hepatitis B screening
- Routine prenatal visits
- Rh-incompatibility screening including follow-up testing
- Expanded counseling for pregnant tobacco users
- Delivery, C-Section, Inductions not covered at this time

NEWBORNS

- Hearing screening
- Immunization vaccines for children from birth to age 18 with variable doses, according to recommended ages and populations
- Cervical Dysplasia screening and vaccines for Diphtheria, Tetanus, Pertussis, Hepatitis A & B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella
- Congenital Hypothyroidism screening
- Gonorrhea preventive medication for eyes
- Hemoglobinopathies or sickle sale screening
- Phenylketonuria (PKU) screening
- Iron supplements for newborns to 12 months when prescribed by a physician

ALL CHILDREN

- Autism screening for children, limited to two screenings up to age 24 months
- Vision screening, 5 and younger
- Developmental screening for children under the age of 3 and surveillance throughout childhood
- Lead screening
- Dyslipidemia screening
- Height, Weight and Body Mass Index measurements
- Obesity screening and counseling
- Hematocrit or Hemoglobin screening
- Oral health risk assessment, up to age 10
- Depression screening, 12 and older
- Alcohol and drug use assessments
- Blood pressure screening
- Sexually transmitted infection prevention counseling and screening for adolescents
- Tuberculin testing

3 | MEGA PLAN

IN-OFFICE OUT-PATIENT PLAN, VISION AND DENTAL

PLAN PRICING:

$140 MEMBER
$240 MEMBER + 1 (SPOUSE/DEPENDENT)
$360 MEMBER + FAMILY MEMBERS 2-5
(EACH ADDITIONAL MEMBER: $25)

- NO DEDUCTIBLE
- Preventative Health & Wellness Check (as included in the Basic Plan above)
- Prescription Discount Card
- In-Office Copay Program for Providers
- PHCS Network of Healthcare Providers (highly encouraged but never required)
- Total Telehealth package through MeMD including
  - Urgent Care Telehealth - FREE
  - Men's & Women's Telehealth Services - FREE
  - Talk Therapy - $65 Copay per session
  - Teen Therapy - $65 Copay per session
  - Telepsychiatry - $229 First Session, $99 Follow Up
  - 24/7/365 Phone or Video Appointments
  - Prescription writing as necessary

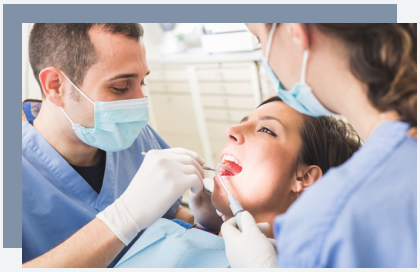
PLEASE NOTE:

Once a Mega Plan is selected as an employee, you may not downgrade your coverage until your next Open Enrollment Period or a qualifying event (such as birth in the family, death, or termination from position) occurs. The one exception to this rule would occur if a Full-Time employee experiences a loss of hours resulting in a change of status to a Part-Time employee. If an employee returns to a Full-Time Status after 90 days (of a Part-Time Status) a new Election Form will be required to change their coverage options. If a new Election Form is not completed, the employee would return to coverage options previously elected from their original form. **Upgrades may occur at any time.**

National Health Benefits customers have access to the PHCS MultiPlan Network, providing in-network access to a wide variety of medical practitioners and specialists. If a doctor isn't currently a part of the PHCS Network, we are happy to contact the practitioner to see if they would like to join the network or arrange to work directly with us.

OFFICE VISIT ASSISTANCE COPAY PROGRAM	CO-PAY	COVERED BILLED CHARGES
General Office Visit	$25	Up to $1000
Specialist/ Behavioral Health Office Visit	$25	Up to $1000
Chiropractic/ Physical Therapy Office Visit	$25	Up to $1000
Urgent Care Visits	$50	Up to $2000
Lab Work	$25	Up to $2000
Out-Patient Testing	$200	Up to $2000
Dental	$25	Up to $1500
Vision	$25	$100 Office & $100 Glasses

THIS IS A NO DEDUCTIBLE PLAN. CLAIMS ARE PAID FROM THE FIRST DOLLAR BILLED.



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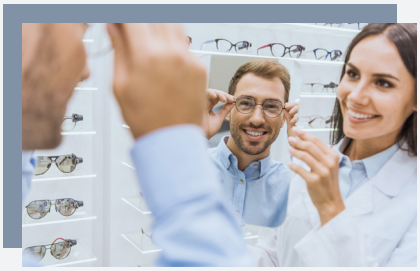
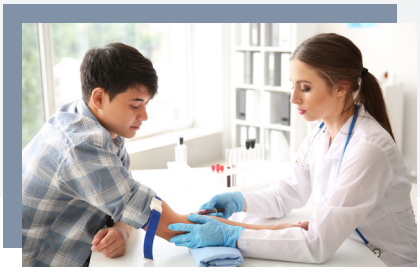
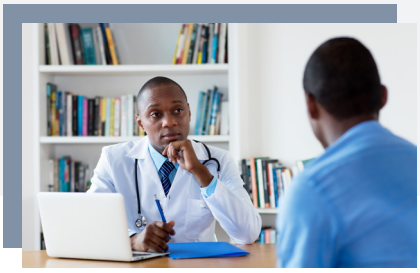


VISION

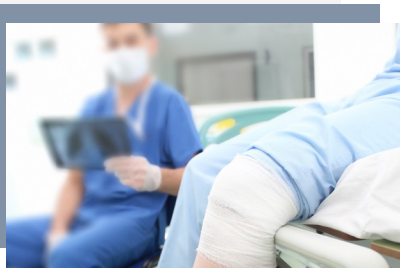
CHIROPRACTIC



LAB WORK



OFFICE VISITS



OUT PATIENT TESTING

4 TOTAL TELEHEALTH

BY MEMD FOR BASIC AND MEGA PLANS

Our Total Telehealth solution makes it easy for members to access best-in-class care whenever and wherever, while driving down overall healthcare costs. **The following telehealth plans are available as a part of both the Basic and Mega Plans by National Health Benefits.**

MEDICAL HEALTH

Urgent Care
Men's Health - NEW
Women's Health - NEW

BEHAVIORAL HEALTH

Talk Therapy
Teen Therapy - NEW
Psychiatry - NEW

TOTAL TELEHEALTH CONTINUED
Medical Care Powered by MeMD

TOTAL TELEHEALTH:
Medical Care

- **URGENT CARE**
- **MEN'S HEALTH**
- **WOMEN'S HEALTH**

URGENT CARE TELEHEALTH SERVICES

No one wants to go to work sick or take unnecessary time out of their day. And no business owner wants sick employees spreading their illness around the workplace. Still, when employees miss work, there's a real cost to your business, from lost productivity to the extra burden on co-workers who must pick up the slack.

THE ISSUE

Nearly **75% of all doctor, urgent care and ER visits are either unnecessary or could be handled safely and effectively over the phone or computer** – at a fraction of the cost, according to the American Medical Association. Moreover, a year-long study by Humana indicates medical outcomes with telehealth are just as good as, if not better than, inperson care.

THE SOLUTION

While not meant to replace primary care, telehealth is ideal for many common illnesses and minor injuries. All of the medical providers in our national network are board-certified, credentialed in accordance with NCQA guidelines, and average over 16 years of relevant clinical experience.

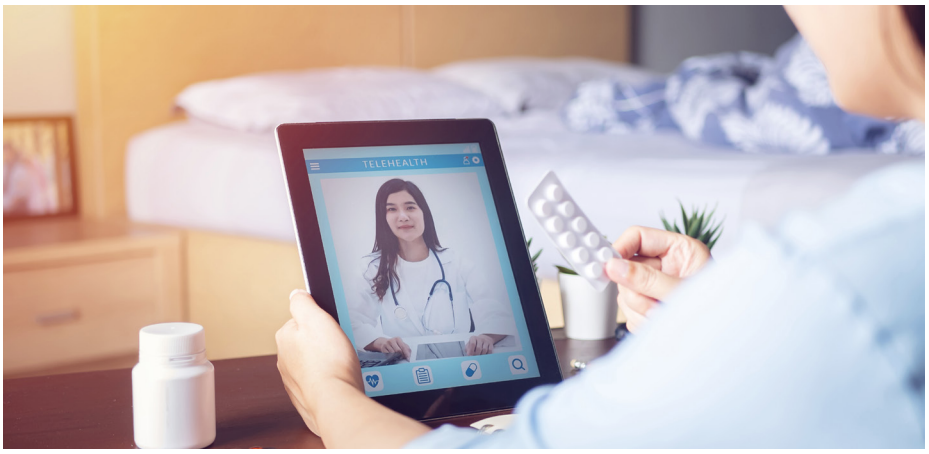
Available 24/7/365, we ensure members get back to their days – quickly and easily. When needed, providers e-prescribe medications to the member's pharmacy of choice.

- Providers are available 24/7 to treat common illnesses & minor injuries
- Medications can be e-prescribed to the member's pharmacy
- Reduce the number of unnecessary trips to the ER or urgent care
- Deliver high-quality care at the touch of a button

HOW IT WORKS

- Members log on to MeMD to request a video or phone visit.
- First-time patients are connected with a care coordinator for a quick intake and to ensure the video connection is working, if requested or required.
- Then, they connect with a healthcare provider who assesses their symptoms, recommends treatment and e-prescribes any needed medications.
- The entire process is completed in under 15 minutes.

TOTAL TELEHEALTH CONTINUED
Medical Care Powered by MeMD



MeMD

TOTAL TELEHEALTH:
Medical Care

- **URGENT CARE**
- **WOMEN'S HEALTH**
- **MEN'S HEALTH**

WOMEN'S TELEHEALTH SERVICES

Women are known to put themselves last, so it's no surprise that they put off treatment of health concerns. This is especially true when they're self-conscious or embarrassed about a personal health issue, but delaying care may make matters worse down the line. While typically private, many of these needs and concerns can directly impact workplace productivity, absenteeism and satisfaction. To make matters worse, even the best health plans often omit the services women want and need most.

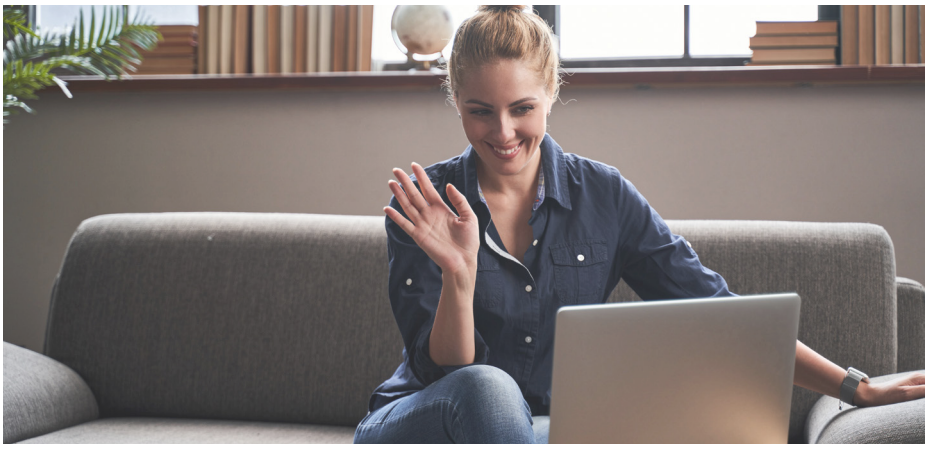
› Skin Issues
› Birth Control
› Low Sex Drive*
› Vaginal Dryness
› Mastitis
› Pain during Intercourse*
› Urinary Tract Infection
› Sexually Transmitted Diseases
› Premenstrual Syndrome
› Pelvic Pain, Incontinence & Endometriosis
› Hot Flashes
› Yeast Infection
› Eyelash Thinning
› Smoking Cessation*
› Premenstrual Syndrome

MEN'S TELEHEALTH SERVICES

Men's health needs are highly specific – and highly private. In many cases, men put off treatment for common conditions, even if their health concerns are causing distress and embarrassment, diminishing their self-esteem or affecting their relationships. Men's health services are high in demand but not widely discussed. While typically private, many of these needs and concerns can directly impact workplace productivity, absenteeism and satisfaction. What's worse, many of these issues point to an underlying medical condition that should be addressed sooner rather than later.

› Erectile Dysfunction*
› Hair Loss
› Performance Anxiety*
› Smoking Cessation*
› Sexually Transmitted Diseases
› Enlarged Prostate
› Skin Issues

*These conditions often have a psychological basis and are best addressed through a combination of telehealth and telebehavioral health.



MeMD

TOTAL TELEHEALTH:
Behavioral Health

- **TALK THERAPY**
- **TEEN THERAPY**
- **PSYCHIATRY**

BEHAVIORAL HEALTH

Every business owner has witnessed the effects of behavioral health issues in the workplace. They drag down productivity and erode company culture. If left untreated, mental health concerns can even drive up medical costs.

THE ISSUE

- One in five Americans is dealing with a mental health issue, yet fewer than half receive treatment (Mental Health America).
- While 81% of U.S. employers offer mental health benefits, a national provider shortage, narrow networks and the stigma of therapy are major roadblocks to care.
- Mental illness and substance abuse cost employers $79-$105 billion each year in lost productivity, absenteeism, and increased medical and disability costs (Center for Prevention and Health Services).

THE SOLUTION

MeMD's national provider network includes licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, and other equivalent licensed professionals. Our teletherapy solution removes the barriers of traditional in-person care, providing much-needed mental health care through talk therapy in the comfort and privacy of home, or anywhere else a member chooses.

- Access to a therapist in as few as 24 hours.
- Comprehensive care is built into the program with our unique screening tool, which helps pinpoint issues and measure progress.
- A treatment plan is developed by therapist with the patient's input and is an ongoing, collaborative and continuous process that helps guide the course of care, with mutually agreed upon goals.

HOW IT WORKS

- Members seeking care can schedule a 50-minute therapy session in as few as 24 hours.
- Using a phone, computer or mobile device, they connect with a provider from their desired location.
- Provider and patient jointly develop a treatment plan to address the member's specific needs with mutually agreed upon goals.
- Outcome-based care is built into the program with the Behavioral Health Screen, an optional multi-dimensional assessment tool that benchmarks progress and improvement.

5 | SUPPORT

FREQUENTLY ASKED QUESTIONS

Q. DO I HAVE TO CHOOSE WHICH PLANS I OFFER MY EMPLOYEES?

No, **all benefit plans available** from National Health Benefits (and in conjunction with HealthShare Connection) **will be offered on each employee's election form.** These plans are set up to offer a wide coverage and price range for employees that may have different healthcare needs within the same company. The main choice an employer needs to consider on an employee's election form is the amount they would choose to contribute towards each of the different benefit plans.

Q. WHAT ARE THE EMPLOYER CONTRIBUTION REQUIREMENTS?

As an employer of 49 or fewer full-time employees, the Affordable Care Act regulation does not apply to Small Businesses in the same way that it applies to Applicable Large Employers (ALE). National Health Benefits programs are, however, bound by the laws of the ERISA Act. This legislation requires that self-funded benefits are "employer sponsored". We've set a minimal Employer Contribution at $30 per employee, per month, however an employer is free to increase that amount at their discretion.

Q. WHO MUST BE OFFERED COVERAGE IN MY COMPANY?

As an employer of 49 or fewer full-time employees, offering healthcare coverage is not mandated by the Affordable Care Act at this time. However, the ERISA Law governs the self-funded benefits that are offered through National Health Benefits. The ERISA Act proposes that a plan be employer-sponsored thus a contribution from the employer on behalf of the employee has been set at $30 per active employee, per month at National Health Benefits. Additionally, if healthcare benefits are offered to any one employee of the company, they must be offered to all eligible employees at the time they become eligible for healthcare coverage (by their 90th day of employment). If the company grows in size to exceed 50 full-time employees or the equivalent there-of (6000 monthly hours), guidelines from the ACA will then apply.

Q. CAN PART-TIME EMPLOYEES HAVE ACCESS TO THESE BENEFITS?

Absolutely! Our healthcare plans can be offered to both full-time and part-time employees at the discretion of the employer. Please be aware that once a benefit plan is elected during Open Enrollment, that plan must be maintained as active until the following Open Enrollment occurs during the next calendar year. The only opportunity for an employee to downgrade or change their coverage with National Health Benefits during the calendar year would be after a qualifying event such as birth, death or divorce in the family, or if an employee becomes terminated from the company.

Q. HOW ARE PAYMENTS PROCESSED

National Health Benefits sends out monthly invoices on the first of every month. Payments are processed by ACH withdrawal on the 10th of the month. Employers should review their online invoice and contact National Health Benefits with any changes by the fifth of the month to avoid any errors in the billing process.

Q. CAN I CANCEL COVERAGE AT ANY TIME?

If you have decided to choose another healthcare partner to take over your benefit needs, National Health Benefits requires a 30 day written notice with explanation for termination of services.

6 | HEALTHSHARE
CONNECTION + MEGA PLAN

COST-SHARING MEMBERSHIP FOR MEDICAL EXPENSES

HealthShare Connection is a non-insurance alternative for managing large healthcare costs. This is a membership-based cost-sharing program, whereby members can have their approved medical expenses paid by the community (with a minimal portion paid by the member). This plan **combines** the HealthShare Connection Plan (extended care related expenses) with **all of the benefits of** National Health Benefits' Mega Plan (first-dollar coverage for out-patient medical needs) to deliver a well-rounded alternative to traditional health insurance.

WHAT IS MEMBERSHIP?

HSC offers membership to a cost-sharing community of like-minded individuals for the purpose of sharing legitimate healthcare expenses between members. Our members lead a healthy lifestyle and agree to established guidelines put forth by HealthShare Connection that encourage good health (and in turn, fewer medically necessary treatments). Members will not be excluded based on pre-existing conditions, but limitations may apply.

- Membership is voluntary but must be active in order to participate in shared expenses.
- Members can submit medical expenses due to a "**need**" caused by an injury or illness.
- The need becomes **shareable** (if not covered by the Mega Plan) after a member contributes a small portion of the medical expense. We call this portion a **non-shareable amount.**

HOW DOES IT WORK?

1. An individual or family joins the HealthShare Connection Cost-Sharing Community by electing membership. The **member** begins to contribute monthly to sharing in the medical **needs** of the community by paying their appropriate fees.
2. When the member or family member has an eligible medical **need**, they pay their **Non-Shareable Amount (NSA)** and the remaining bills are submitted to the community by using their membership card at time of service.
3. A member's NSA of $1500 can become less if any National Health coverage has been utilized for medical needs (up to $1500). Members can use their National Health coverage for doctors appointments, testing, urgent care and more.
4. The community shares the membership funds with the member for their eligible **need.**

HEALTHSHARE CONNECTION CONTINUED
COST-SHARING MEMBERSHIP FOR HEALTHCARE NEEDS

HSC HealthShare Connection

HSC + MEGA PLAN PRICING AVAILABLE BEGINNING JAN 1, 2021	Under 30 years old	Over 30 years old
MEMBER	$290	$320
MEMBER + SPOUSE	$565	$615
MEMBER + FAMILY UP TO 5 MEMBERS	$850	$900
(EACH ADDITIONAL FAMILY MEMBER)	$25	$25

MEGA PLAN:

- PHCS Network of Doctors
- Unlimited Telehealth - No Copay
- Behavioral Telehealth
- Prescription Discount Card
- Doctors & Specialist Office Visits
- Dental & Vision
- Limited Lab Work
- Out-Patient Testing
- Urgent Care Visits

HEALTHSHARE:

- Surgery Care
- Emergency Room Procedures
- Covid-19 Related Care
- In-Patient Hospital Care
- Outpatient Procedures
- Extended Lab Work
- Extended Out-Patient Testing
- Accident Care
- Maternity (See Limitations)

MEMBER NEEDS & NSA

A **need** is typically related to a new injury or illness when it causes a large medical expense due to evaluation, treatment and/or medication. Examples of shareable needs may be: broken bones, lacerations, fractures, cyst removal, infectious diseases, stroke, heart attacks, cancer, liver disease, gastrointestinal issues, medically necessary surgery and more services defined in the HealthShare Connection Member's Resource Guide.

Members can have unlimited **needs** throughout the year as long as there are funds in the account to cover the need. For the first three needs of a member (or five needs of a family of members), there is a **Non-Shareable Amount** (NSA) of $1500 which the member must pay before HSC may start contributing towards medical expenses. This NSA becomes less if the member has used any services from the Mega Plan and had monies paid towards the need by way of copays, doctors visits, or other medically necessary treatments.

HEALTHSHARE CONNECTION CONTINUED
COST-SHARING MEMBERSHIP FOR HEALTHCARE NEEDS

HSC
HealthShare Connection

KEY TERMS	DEFINITION
HEALTHCARE COST SHARING	A membership-based non-insurance arrangement established for the purpose of sharing legitimate medical expenses between members.
MEDICAL NECESSITY	The accepted health care services and supplies provided by health care entities that are appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
MEMBER	An employee of a member business, or dependent thereof, who has agreed in writing to abide by the requirements of the HSC organization and is thereby eligible to participate in the sharing of medical needs with other members.
MEMBERSHIP	Term applies universally to both member businesses, member organization and/or members, depending on context used.
MEMBERSHIP REQUIREMENTS	The required principles and ongoing behavioral code attested to by members, as required for membership.
MEMBERSHIP YEAR	The effective period of time in which a member is eligible for participation in healthcare cost sharing. Open Enrollment will be held every year from October 15 to December 15 regardless of when a plan first comes into effect. A membership year begins January 1 and lasts until December 31 of that calendar year. A member's Non-Shareable Amount will reset every year on January 1.
MINIMUM ESSENTIAL COVERAGE (MEC)	Minimum Essential Coverage (MEC) is a requirement of the Affordable Care Act. Membership in HealthShare Connection does not provide Minimum Essential Coverage as required by any federal or state law. This MEC coverage is provided under the ERISA based plan provided through National Health Benefits.
MONTHLY SHARE	The monthly contribution to the benevolence fund facilitated by HSC by participating businesses in order to maintain their employees' active membership in medical cost sharing. Participating employees may be required to contribute, at the employer's direction, via payroll withholding.
NEED	A medical necessity that exceeds the Member's Non-Sharable Amount (NSA) caused by an injury or illness to an eligible member or participating dependent.
NON-SHARABLE AMOUNT	The annual Non-Sharable Amounts will be $1500 per need for the first 3 needs for an individual member, and $1500 per need for the first 5 needs for a family of members.
PRE-APPROVAL	To be considered for cost sharing, the member or Provider **MUST** notify HealthShare Connection **IN ADVANCE** (Pre-Approval) by calling the Pre-Approval hotline for any services and procedures, and complete the Pre-Approval itemized form, and diagnostics listed below, except in the case of true emergencies. The Sharing Member, their Physician, or their representative should call the Pre-Approval hotline as soon as the need for admission or services is recognized, and at least seven (7) days prior to admission whenever possible.
PRE-EXISTING MEDICAL CONDITIONS	Any pre-existing medical condition is any condition for which the patients already received medical advice or treatment prior to enrollment in HSC. Events, that result from a Pre-existing Medical Conditions are subject to sharing limitations (as presented in the HSC Guidelines) unless 36 months immediately prior to membership effective date has passed without any signs or symptoms of the condition, without any treatment needed, without any medication prescribed or taken, and without any suspicion by the patient or doctors that the condition is resurfacing. This applies whether or not the cause of the symptoms is unknown or misdiagnosed (except as provided in these guidelines).
SHAREABLE AMOUNT	The amount of the need expense request that remains after the member's Non-Shared Amount (NSA) has been met, and falls within the Guidelines for sharing within the membership.
SHARING / SHAREABLE	An eligible Need that meets the requirements as determined by the HSC Membership Guidelines .

HSC

7 | SUPPORT

FREQUENTLY ASKED QUESTIONS

Q. ARE THE HEALTHSHARE CONNECTION PLANS INSURANCE BASED?

HealthShare Connection is not an insurance program. Contributions do not guarantee any payments. Contributions from members are not required, and are completely voluntary. No expenses will be shared for someone who is not making monthly contributions. If a member is not sharing expenses, he or she should not expect to have their expenses shared. Members should remember that 90% of all contributions go for actual medical expenses of all members.

Q. WHAT ARE THE CONDITIONS OF MEMBERSHIP?

Members must be employed by an HSC member employer, as well as meet and abide by the ethical and moral statements of the Sharing Guidelines. This applies to all member dependents asking to share under HSC. Spouses, domestic partners, and dependent children are also able to participate, as noted in the Sharing Guidelines, and by their abiding by the ethical and moral statements of HSC.

Q. WHAT KINDS OF MEDICAL EXPENSES ARE NOT SHAREABLE?

Examples of medical expenses that are not shareable would include any non-medically necessary procedures, expenses for conditions that existed prior to membership as well as most cosmetic surgery or procedures.

Q. WHAT ARE THE LIMITS OF SHAREABLE EXPENSES?

While there are no lifetime or annual limits on shareable expenses, there may be times that the monthly shareable expenses exceed contributions. There are also limits on the share of monthly contribution payable for any one member. These details are found in the HealthShare Connection Member Resource Guide. There can be limits on other expenses, like maternity, cancer, expenses due to smoking, illegal drugs or illegal activities. Additionally, there will be no shareable amounts available during the first 2 months of membership for any new member with HSC, however benefits related to the StarMed Mega Plan will be in effect from the first day of membership on the plan.

Q. HOW DOES NATIONAL HEALTH BENEFITS WORK WITH HSC?

National Health Benefits is a plan that focuses on first dollar coverage for employees in need of medical services. However, coverage maximums are set to limit coverage to most out-patient visits and non-surgery related care. When medical issues demand in-patient coverage and/or surgery care, HSC becomes available to help share those additional medical costs for a specific "need". Using a third party claims administrator (Cornerstone Claims), National Health Benefits and HSC can work together to make a seamless transition between the two companies and their provider capabilities.

Q. CAN THE HEALTHSHARE PROGRAM BE OFFERED INDEPENDENTLY?

Currently, the HealthShare Connection program can only be offered in conjunction with the National Health Benefits Mega Plan. The two plans work together to offer a more complete program for employers who are seeking to provide affordable and innovative healthcare options for their employees and the two plans work best when partnered together.

Q. WHAT IS THE PRE-APPROVAL PROCESS?

To be considered for cost sharing, the member or Provider **MUST** notify HealthShare Connection **IN ADVANCE** (Pre-Approval) by calling the Pre-Approval hotline for any services and procedures, and complete the Pre-Approval itemized form, and diagnostics listed below, except in the case of true emergencies. The Sharing Member, their Physician, or their representative should call the Pre-Approval hotline as soon as the need for admission or services is recognized, and at least seven (7) days prior to admission whenever possible. To contact Pre- Approval, the hotline number can be found on the HealthShare Connection website or on your membership ID card.

THANKS FOR ALLOWING US TO SHARE OUR VISION OF INNOVATIVE, LOW-COST HEALTHCARE SOLUTIONS. WE'VE THOUGHT LONG AND HARD ABOUT THE FUTURE OF HEALTHCARE: WHAT PEOPLE NEED, WHAT PEOPLE USE AND HOW TO BEST SERVE OUR CLIENTS. WE BELIEVE THAT PEOPLE WANT EASIER SOLUTIONS, MEDICAL EXPENSE ASSISTANCE REQUIRING LESS PAPERWORK AND LESS GUESSWORK. WE BELIEVE THAT PAYING FOR MEDICAL EXPENSES SHOULD BE PAINLESS AND THAT TOGETHER, WE CAN DO BETTER THAN WHAT HAS BEEN DONE IN THE PAST. WE WOULD LOVE THE OPPORTUNITY TO SERVE YOU AND YOUR COMPANY.

NATIONAL HEALTH BENEFITS

CONTACT:
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nationalhealthbenefits.org

H|S|C
HealthShare Connection

CONTACT:
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