



A Lower-Cost Alternative To Traditional
Comprehensive Major Medical Insurance



Highlights

- Ø Employer Choice of Contribution to Premium
- Ø Available to Full-time, Part-time, Temporary and Seasonal Employees
- Ø No Medical Questions or Physical Examinations
- Ø Freedom to Choose Any Health Service Provider
- Ø No Deductibles-First Dollar Coverage
- Ø Fixed Benefit Amounts—Pays Benefits Directly to the Insured
- Ø Pays in Addition to Other Private Insurance
- Ø Optional Dental / Vision Coverage

Basic Benefits Health Insurance

The **Basic Health Insurance Benefit Plan** is a lower-cost alternative to comprehensive major medical insurance. It provides fixed benefits for basic health care expenses. *Basic Health Insurance* is not comprehensive major medical insurance and should not be considered a replacement for any existing major medical coverage. It is, however, a valuable alternative for employers who do not provide major medical insurance for all of their employees.

AFFORDABLE—*Basic Health Insurance* offers a solution to the problems of providing an affordable benefit program. Consider that the current national average monthly premium for full health coverage is \$281.91 single and \$755.66 family (Source: Kaiser Family Foundation's Employer Health Benefits Survey 2003). Compare those rates to the proposed monthly premiums in this proposal.

ACCESSIBLE—Most employer health plans limit eligibility to full-time workers. *Basic Health Insurance* allows the inclusion of part-time, seasonal and temporary workers. The *Basic Health Insurance* plan is guaranteed issue for all eligible employees—there are no medical questions or physical exams. The offer of an affordable and accessible insurance benefit plan like *Basic Health Insurance* helps attract and retain good employees.

Of the 43 million Americans who do not have health insurance, 24 million have jobs. (Source: US Census Bureau, March 2000) These uninsured workers are responsible for their own health care expenses. *Basic Health Insurance* provides valuable limited insurance benefits for uninsured employees—people who pay some or all of their own health care bills. All benefits are paid directly to the insured.

FLEXIBLE—*Basic Health Insurance* is flexible enough to be designed to meet the varying cost and coverage needs of different employers and their employees. The plan described in this proposal allows the employer to offer coverage on a contributory or voluntary basis. For contributory coverage, the employer pays at least 50% of the employee only rate for each eligible employee. Insured employees pay the balance of premium, including coverage for any family members, through payroll deduction. For voluntary coverage, employees pay the full premium through payroll deduction.

Two plans (Value and Enhanced) PLUS a Dental option are included in this proposal. The Dental option can be used as a standalone plan or added to either the Value or Enhanced plans. The employer can choose to make all plans available to all eligible employees or to designate plans for employees by class.



VALUE PLAN

<i>Insurance pays:</i>	<i>Basic Health</i>
Doctor's Office Visits	\$30
Diagnostic Tests	\$30
Child Wellness Visits	\$30
Hospitalization	\$100
Surgery (Inpatient / Outpatient)	\$500 / \$200

Doctor's Office Visits: \$30 per visit to a doctor's office for treatment of injury or sickness. 5 visits allowed per covered person per calendar year; 1 of which may be used for wellness care.

Diagnostic Testing: \$30 per visit to a doctor's office or outpatient facility for medically necessary diagnostic testing and x-rays of an injury or sickness. 3 visits allowed per covered person per calendar year; 1 of which may be used for wellness care.

Child Wellness Visits: \$30 per visit to a doctor's office for well child care at 11 specified age intervals from birth through age 5. Well child care includes physical exam, laboratory tests, immunizations, and vision and hearing screening.

Hospitalization: \$100 per day (overnight stays in hospital) for up to 100 days per confinement for injury or sickness. The benefit amount for hospitalization for confinement in an **Intensive Care Unit/Coronary Care Unit** is doubled for a maximum of 30 days per confinement. Benefits for **Mental Illness / Alcohol or Drug Abuse** confinements are payable at \$50 per day for a maximum of 30 days per confinement. Benefits for **Convalescent Facility** confinements are payable at \$50 per day for a maximum of 60 days per confinement; confinement must begin within 3 days of an inpatient hospitalization of at least 3 consecutive days.

Surgery: \$500 for 1 inpatient surgery and \$200 for 1 outpatient surgery (performed in a hospital or outpatient surgery center) per covered person per calendar year.

Emergency Room: \$100 each for 2 visits to the emergency room (when not hospital confined) for injury and 2 visits for sickness per covered person per calendar year.

Survivor Benefit: Dependent coverage will continue—premium free—for up to 18 months after the end of the month in which the insured employee's death occurs.



ENHANCED PLAN

<i>Insurance pays:</i>	<i>Basic Health</i>
Doctor's Office Visits	\$65
Diagnostic Tests	\$65
Child Wellness Visits	\$65
Hospitalization	\$300
Surgery (Inpatient / Outpatient)	\$2,000 / \$800

Doctor's Office Visits: \$65 per visit to a doctor's office for treatment of injury or sickness. 5 visits allowed per covered person per calendar year; 1 of which may be used for wellness care.

Diagnostic Testing: \$65 per visit to a doctor's office or outpatient facility for medically necessary diagnostic testing and x-rays of an injury or sickness. 3 visits allowed per covered person per calendar year; 1 of which may be used for wellness care.

Child Wellness Visits: \$65 per visit to a doctor's office for well child care at 11 specified age intervals from birth through age 5. Well child care includes physical exam, laboratory tests, immunizations, and vision and hearing screening.

Hospitalization: \$300 per day (overnight stays in hospital) for up to 100 days per confinement for injury or sickness. The benefit amount for hospitalization for confinement in an **Intensive Care Unit/Coronary Care Unit** is doubled for a maximum of 30 days per confinement. Benefits for **Mental Illness / Alcohol or Drug Abuse** confinements are payable at \$150 per day for a maximum of 30 days per confinement. Benefits for **Convalescent Facility** confinements are payable at \$150 per day for a maximum of 60 days per confinement; confinement must begin within 3 days of an inpatient hospitalization of at least 3 consecutive days.

Surgery: \$2,000 for 1 inpatient surgery and \$800 for 1 outpatient surgery (performed in a hospital or outpatient surgery center) per covered person per calendar year.

Emergency Room: \$300 each for 2 visits to the emergency room (when not hospital confined) for injury and 2 visits for sickness per covered person per calendar year.

Survivor Benefit: Dependent coverage will continue—premium free—for up to 18 months after the end of the month in which the insured employee's death occurs.



DENTAL / VISION PLAN BENEFITS

The Dental / Vision Plan Benefits can be added to either the Value or Enhanced Plan. Employees may also elect this coverage on a stand alone basis to complement other health coverage in force.

No employer contribution is required for the Dental / Vision Plan.

<i>Basic Health Insurance pays:</i>	
Vision Care	\$45 / annual exam \$100 set of frames/lenses
Dental Care	\$2,000 annual maximum \$500 periodontics maximum \$1,000 orthodontics maximum

Vision Benefits: \$45 for 1 annual eye exam per covered person per calendar year and \$100 toward a set of frames and lenses or contact lenses per covered person once every two calendar years.

Dental Benefits: Scheduled amounts are payable up to \$2,000 per covered person per calendar year for preventative and diagnostic care, restorative treatment, root canals, periodontics (\$500 lifetime maximum), oral surgery and orthodontia (\$1,000 maximum per course of treatment). Some benefits require a 12 month waiting period before benefits are available. (See Schedule of Benefits on page 6.)

Monthly Premiums

No employer contribution is required for the Dental/Vision Plan. Employees pay 100% of the premium through payroll deduction.

<u>Employee's Attained Age</u>	<u>Employee</u>	<u>Employee & Spouse</u>	<u>Employee & Child(ren)</u>	<u>Family</u>
Under 50	\$30.00	\$59.00	\$76.00	\$105.00
50-64	\$34.00	\$67.00	\$80.00	\$113.00
65+	\$39.00	\$76.00	\$85.00	\$122.00



Dental Schedule of Benefits

Category:	Basic Health Insur-
ance pays:	
Type 1: Preventive & Diagnostic	
a. Oral exams, including prophylaxis	\$ 48.00
b. Bitewings, per film	\$ 6.40
c. X-ray, panoramic or cephalometric	\$ 48.00
d. Sealants / topical fluoride	\$ 13.60
e. Space maintainers	\$144.00
Type 2: Major Restorative	
a. Crowns, bridges & dentures	\$240.00
b. Pre-fabricated crowns	\$ 80.00
c. Crown build-up procedures	\$ 64.00
Type 3: Minor Restorative	
a. Fillings	\$ 56.00
b. Crown, bridge and denture repairs	\$ 32.00
c. Relining or rebasing dentures	\$ 80.00
Type 4: Endodontics	
a. Root canals, apicoectomies	\$256.00
b. Root amputation	\$128.00
c. Therapeutic pulpotomy, retrograde fillings, apexification, hemisection	\$ 64.00
Type 5: Periodontics (\$500 Lifetime Maximum)	
a. Tissue grafts or bone surgery	\$128.00
b. Gingivectomy (per quadrant), periodontal scaling, periodontal splinting, root planning	\$ 80.00
c. Gingival curettage (per quadrant)	\$ 48.00
d. Gingivectomy (per tooth)	\$ 32.00
Type 6: Oral Surgery	
a. Surgeries Level 1 (ex. Removal of exostosis)	\$160.00
b. Surgeries Level 2 (ex. Removal of impacted tooth)	\$ 88.00
c. Surgeries Level 3 (ex. Simple extraction)	\$ 48.00
Type 7: General Anesthesia and IV	
a. IV, first half hour general, each additional 1/4 hour general	\$ 96.00
Type 8: Orthodontia (Per Course of Treatment)	\$1,000
Types 1 through 7 subject to annual maximum of:	\$2,000
Types 2, 5, 6a, 7 and 8 are subject to 12 month waiting period	



MONTHLY PREMIUMS

For contributory coverage, the employer pays at least 50% of the Employee Only rate for all eligible employees. Insured employees pay the balance, including premium for family members, through payroll deduction.

For voluntary coverage, employees pay 100% of premium through payroll deduction.

Value Plan

Contributory

Employee	\$ 30.25*
Employee & Spouse	\$ 54.08
Employee & Child(ren)	\$ 67.87
Family	\$ 91.70

*Employer pays at least 50% of this amount for each eligible employee.

Voluntary

<u>Employee's Attained Age</u>	<u>Employee</u>	<u>Employee & Spouse</u>	<u>Employee & Child(ren)</u>	<u>Family</u>
Under 30	\$23.15	\$41.87	\$67.28	\$86.00
30-34	\$29.65	\$53.57	\$73.78	\$97.71
35-39	\$33.31	\$60.06	\$77.44	\$104.20
40-44	\$37.24	\$66.89	\$81.38	\$111.02
45-49	\$41.31	\$73.89	\$85.45	\$118.02
50-54	\$45.88	\$81.77	\$90.02	\$125.91
55-59	\$54.09	\$95.69	\$98.23	\$139.83
60-64	\$70.22	\$124.01	\$114.35	\$168.15
65+	\$91.84	\$162.26	\$135.97	\$206.39

Enhanced Plan

Contributory

Employee	\$ 84.80*
Employee & Spouse	\$151.89
Employee & Child(ren)	\$185.07
Family	\$252.16

*Employer pays at least 50% of this amount for each eligible employee.

Voluntary

<u>Employee's Attained Age</u>	<u>Employee</u>	<u>Employee & Spouse</u>	<u>Employee & Child(ren)</u>	<u>Family</u>
Under 30	\$63.33	\$114.70	\$179.57	\$230.93
30-34	\$80.54	\$146.03	\$196.78	\$262.27
35-39	\$91.34	\$165.36	\$207.58	\$281.59
40-44	\$103.28	\$186.17	\$219.51	\$302.40
45-49	\$115.76	\$207.61	\$231.99	\$323.85
50-54	\$129.97	\$232.09	\$246.20	\$348.33
55-59	\$155.52	\$275.23	\$271.76	\$391.46
60-64	\$205.38	\$362.61	\$321.62	\$478.85
65+	\$276.16	\$487.76	\$392.39	\$603.99



ADMINISTRATION

Administrator. Towers Affinity Benefit Services (TABS), a division of Towers Administrators, Inc., will administer the program. TABS is a strategic alliance entity jointly created and managed by Affinity Group Underwriters and Towers Administrators.

Eligibility. All employees in an eligible class who have completed the required waiting period (30, 60, or 90 days, if elected by the employer) are eligible provided they:

- ³ are actively at work, performing all the normal duties of the job;
- ³ reside in the United States;
- ³ are not in full-time service of the Armed Forces.

Employees' dependents are also eligible. Spouses (if not legally separated or divorced) and children, including adopted and stepchildren who are unmarried and dependent on the employee for support, up to age 19 (26 if a full-time student), and provided they meet the above requirements as well.

Also dependents must be performing the normal duties of persons who are the same age and gender. Newborns are covered from birth provided we are notified of the birth and the appropriate premium is paid within 31 days of birth. Otherwise, the newborn is considered a late enrollee and may not be enrolled until the next open enrollment period.

Enrollment Process. Employees are given information about the plan design and rates by the employer. During the charter open enrollment period (or any subsequent annual open enrollment period), eligible employees may complete an enrollment form to participate in the plan. Open enrollment is available for new employees for 30 days following completion of any required waiting period (see Eligibility above).

Rate Increases / Policy Cancellation. No individuals can be singled out for cancellation or rate increase under the policy. The Policyholder (employer) has the right to cancel the policy on any premium due date by providing 31 days written notice. The insurance company has the right to cancel the policy by providing at least 31 days notice to the Policyholder.

Effective Date of Coverage. Coverage becomes effective on the first day of the month coinciding with or immediately following the date a completed enrollment form is received, provided that full premium for the coverage has been received.

Termination for Employees/Dependents. A covered employee automatically ceases to be insured on the occurrence of any of the following events:

- ³ he or she requests cancellation;
- ³ the end of the last period for which all required premium has been paid;
- ³ the date employment ends;
- ³ the last day of the month when the employee is pensioned or retired;
- ³ the date the employer ceases to offer the plan;
- ³ the date the policy terminates.

Spouse and children's coverage terminates concurrently with that of the employee, or earlier if they no longer qualify as a dependent, or if the employee requests termination of coverage.



ADMINISTRATION

Disability / Layoff / Leave of Absence Continuation. Coverage may continue, provided the appropriate premium is paid:

- ³ for up to two months after the employee ceases full-time work because of temporary layoff or leave of absence; or
- ³ for up to six months after the employee ceases full-time work because of injury or sickness.

Dependent coverage will continue provided the appropriate premium is paid under the same conditions above.

Coverage may not continue if the employee begins work for pay or profit with another employer.

COBRA Continuation. Employers with 20 or more employees are required to offer an extension of benefits as required by federal COBRA legislation. TABS can facilitate this service for the employer.

Survivor Benefit. Dependent coverage will continue with no premium required, for up to 18 months after the end of the month in which the employee's death occurs.

Reinstatement. An employee may qualify for reinstatement within 90 days from the date the employee was last eligible. He will be reinstated and eligible for coverage on the first day of the calendar month following a month in which he works and satisfies a new waiting period.

Premium Billings. Monthly billings will be sent to the employer. Self-accounting is also available for larger groups. The employer must pay as billed. Changes and adjustments should be noted by the employer when premium is remitted. Age adjustments will be processed on a common anniversary date. A modal billing fee of up to \$9.00 depending on group size will be reflected on each bill.

Payment of Claims. All claims, except for services and discounts provided under the dental discount card program, are paid directly to the insured employee. An Employer's Administration Kit will be issued which includes claim forms and instructions for filing claims.

Services and discounts under the dental discount program are at the discretion of the provider and are not the responsibility of Markel Insurance Company. The entire transaction is handled with the participating provider—there are no claims to file.

Evidence Of Coverage. The employer will be issued a group policy and act as Policyholder of the plan. All insured employees will receive a certificate of insurance and an identification card.

Pre-Existing Conditions Limitation (applicable to Hospitalization and Surgery benefits only). A "pre-existing condition" is defined as any injury or sickness for which diagnosis has been made, treatment has been recommended, treatment has been rendered, or expenses have been incurred within 6 months prior to becoming covered under the plan. It includes any condition manifesting itself in symptoms which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. Benefits under the Hospitalization or Surgery provisions of the plan are not payable for a "pre-existing condition" for the first 6 months following an insured's effective date.



Exclusions and Limitations Applicable To All Benefits

Benefits are not provided for injury or sickness of a covered person which results directly or indirectly, wholly or partly, from:

- • Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression;
- • War or any act of war, whether declared or undeclared, or sickness contracted or accidental bodily injury occurring while on full-time active duty in the Armed Forces of any country or combination of countries;
- • Occupational injury or sickness, or any injury or sickness otherwise covered by any Workers' Compensation Act, Occupational Disease Law or similar law;
- • Operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit;
- • Care or treatment related to intentionally self-inflicted injury or self-induced sickness;
- • Charges for which there is no legal obligation to pay, or no charge is made, or in the absence of coverage no charge would be made;
- • Charges incurred after termination of coverage;
- • Charges for care or services furnished by any agency or program funded by federal, state or local government except Medicaid;
- • Charges which are not medically necessary for treatment of sickness or injury;
- • Unless specifically provided for in the plan, charges for routine physicals or exams or routine immunizations when no injury or sickness is present;
- • Charges for medical care, services, or supplies which are not furnished or prescribed by a doctor;
- • Charges for experimental or investigational treatment, procedures for research purposes or practices when not generally recognized as accepted medical practices;
- • Charges for care, treatment, services or supplies that are not approved or accepted as essential to the treatment of an injury or sickness by any of the following:
 - • The American Medical Association,
 - • The U.S. Surgeon General,
 - • The U.S. Department of Public Health,
 - • The National Institute of Health;
- • Charges related to cosmetic surgery except
 - • to repair disfigurement because of an accidental bodily injury which occurs while covered under the plan, or
 - • for reconstructive surgery because of mastectomy which is performed within 12 months of the mastectomy because of malignancy and while covered under the plan, or
 - • for treatment of a congenital anomaly in a child born to the insured while covered under the plan;
- • Unless specifically provided for in the plan, dental care or oral surgery except for closed or open reduction of fractures or dislocation of the jaw;
- • Unless specifically provided in the Plan, charges for treatment of Mental Illness;
- • Unless specifically provided in the Plan, charges for treatment of Alcohol or Drug Abuse;
- • Unless specifically provided for in the plan, charges for refractions, eyeglasses or their fitting;
- • Hearing aids or their fitting;



Exclusions and Limitations Applicable To All Benefits (cont'd.)

- • Charges in connection with obesity, weight reduction, or dietetic control, except for morbid obesity or disease etiology;
- • Charges for treatment or services for Temporomandibular Joint (TMJ) Syndrome, orofacial, or myofascial syndrome whether medical or dental in scope;
- • Charges for reversal procedures in connection with previous male or female sterilization;
- • Charges for services related to educational or vocational testing or training;
- • Any charges for abortions which are not medically necessary;
- • Any charges for outpatient food, food supplements, or vitamins;
- • Any charges for prescription drugs or durable medical equipment;
- • Surgery to correct vision problems which are not caused by a sickness or injury;
- • Charges for treatment of male or female infertility; in vitro and in vivo fertilization of an ovum, or artificial insemination including but not limited to:
 - • • Drugs and medicines;
 - • • Diagnostic and surgical procedures including but not limited to:
 - • • • Aspiration of ovarian cysts;
 - • • • Harvesting or obtaining eggs;
 - • • • Other surgical treatment of infertility;
 - • • • Diagnostic laboratory and pathology procedures; and
 - • • • Diagnostic radiology, nuclear medicine and ultra sound procedures;
- • Charges made by a surgeon, nurse, dentist or doctor who:
 - • • Normally lives with the covered person;
 - • • Is a member of the covered person's family; or
 - • • Is the covered person's employer or another employee of the employer; or
 - • • Is contracted for or by a union, employee benefit association, trustee, or similar organization or the employee of a clinic contracted for or by any such organization;
- • Charges for custodial care;
- • Charges for care, treatment, services, supplies or confinements primarily for the convenience of the covered person, his doctor, his family or other providers;
- • Charges related to smoking cessation;
- • Treatment received outside of the United States except for emergency treatment while traveling;
- • The processing of nuclear fission or fusion, or the processing, use, handling or transporting of radioactive material, including but not limited to nuclear reactors or any weapon of war or explosive device employing nuclear fission or fusion.

Exclusions Specific to the Vision Care Benefits of the Plan

In addition, benefits are not provided for: any medical or surgical treatment of the eye; sunglasses, plan or prescription; safety lenses or goggles; orthoptics, vision training or aniseikonia.



Limitation/Exclusion Specific to Hospitalization and Surgery Benefits of the Plan

Benefits are not provided for injury or sickness of a covered person which results directly or indirectly, wholly or partly, from pre-existing conditions until covered under the plan for 6 continuous months. Refer to the definition of "pre-existing condition" in the Administration section.

Exclusions Specific to the Dental Care Benefits of the Plan

Benefits are not provided for any charges or expenses incurred by a covered person which result directly or indirectly, wholly or partly from:

- • Replacement of a tooth extracted prior to the covered person's effective date;
- • Dentures, crowns, inlays, onlays, bridgework or appliances or services for increasing vertical dimensions;
- • Denture or bridgework adjustments;
- • Replacement of a lost or stolen prosthesis or for a duplicate prosthesis;
- • Oral hygiene, diet or plague control instructions and programs;
- • Athletic mouth guards;
- • Temporary denture or bridge;
- • Failure to appear as scheduled for an appointment;
- • Tooth re-implantology not resulting from an accident;
- • Drugs except for injectable antibiotics administered by a dentist;
- • Procedures, services, or supplies, which do not meet accepted standards of dental practice;
- • Treatment initiated prior to coverage under the plan, except for comprehensive orthodontic treatment as defined by the policy; or
- • Expenses which are not specifically listed in the Schedule of Benefits.



Basic Health Insurance State Availability for Employer Groups

Available to employer groups with 2 or more eligible employees: AL, AK, AZ, AR, DC, DE, GA, HI, IL, IA, KY, MD, MI, MS, MO, MT, NE, NM, NC, ND, OK, OR, PA, RI, SC, SD, TN, TX, VA, WI, WY

Available to employer groups with 51 or more eligible employees only: CO, FL, IN, MA, NV

Pending: CA

Not Available: CT, ID, KS, LA, ME, MN, NH, NJ, NY, OH, UT, VT, WA, WV

IMPORTANT—This plan is not comprehensive major medical insurance. Policy forms are intended to comply fully with all applicable state insurance statutes and regulations. Because of differing state requirements, benefits, terms and conditions may vary by state from the description in this proposal.



Marketed By::



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Managed and administered by:

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Markel is rated "A" (Excellent) by A.M. Best & Company.