Consultant Product Guide

Delivering quality healthcare services to meet the needs of today's healthcare consumer.

Healthy**Advantage** is an exciting new approach for employers to fund their employee health plan. By combining the expertise of Paramount Consulting Group (PCG) and the state-of-the-art administrative capabilities of Group Benefit Services, Inc. (GBS), ***Healthy*****Advantage** delivers an innovative solution to help employers curb the rising cost of providing health care benefits to their employees.

Consultant Product Guide

This guide is provided to assist you, the Consultant, in developing a comprehensive understanding of the *Healthy*Advantage program and to assist you to be more successful in the marketplace. We encourage you to read the manual thoroughly to gain an understanding of the financial aspects of self-funding, the advantages of this program, and the roles for Consultant compliance, assist you in meeting your clients' benefit needs at an affordable cost, and how to obtain a *Healthy*Advantage quote.

*Healthy*Advantage is governed principally by the federal Employee Retirement Income Security Act (ERISA).

*Healthy*Advantage is a program of services for self-funding employers, marketed and administered by GBS, a leader in providing innovative benefit solutions to employers of all sizes.

The determination of all claims for benefits under the self-funded plan will be determined based on the Summary Plan Description. The Stop Loss carrier will not be involved in the determination of claims for benefits under the self-funded portion of the plan and is not considered a fiduciary with respect to the self-funded plan benefits.

This manual provides a brief general outline of the benefits available under *Healthy*Advantage Stop Loss coverage. For complete details of benefits, limitations and exclusions, and the full items and conditions of the coverage, please refer to the Stop Loss policy.

Table of Contents

Overview 4
- What is *Healthy*Advantage? 4
- Self-Funding Philosophy 4
- Providing Accurate Information 4
- Self-Funding Combined with Stop Loss Insurance 4
- What are the Employer's Costs? 4
- Employers "Maximum Costs" 5
- How Can the Employer Save Money? 5
- What if Claims are More than the Prefunded Balance? 5
- Stop Loss Insurance 5
  - *Specific Stop Loss Coverage* 5
  - *Aggregate Stop Loss Coverage* 5
- Rate and Deductible Guarantee 5
- How are Aggregate, Annual Employer Contributions, and Specific Stop Loss Limits Determined? 6
- Benefit Plan Options 6
- Health Savings Account (HSA) Plan 6
- Health Reimbursement Arrangement (HRA) Plan 6
- ERISA and State Mandated Benefits 6
- Preferred Provider Network Access 6

***Healthy*Advantage Website** 7
- Join Our Team! 7
- Consultant Fee Payments 7
- Consultant of Record Changes 7

Quoting and Selling *Healthy*Advantage 8
- Simple to Quote-Online Quoting Tool 8
- Getting Started with the Quoting Tool 8
- Census Template 8
- What's in the Initial Quote? 8
- Presenting *Healthy*Advantage to your Client 9
- Evaluating Groups – Underwriting and Sales Support 9
- Individual Underwriting - Underwriting Tool 9
- Underwritten Proposal 9
- Claims Experience Underwriting 10
- Final Underwritten Proposal 10
- Avoid Delays 11
- Accepting, Issuing and Declining Groups 11
- Rates 12
- Rate Guarantee 12

Underwriting Guidelines 12
- Plan Effective Date 12
- Participation Requirements 12
- Waiting Periods 12
- Required for all Employees 12
- Serious Condition List 13

Eligibility 13
- Group Eligibility 13
- Maximum Enrollment on Continuation Coverage 13
- Occupational Eligibility 13
- Ineligible Industries 14
- Employee Eligibility 14
- Dependent Eligibility 14

Enrolling Employees and Dependents 14
- Adding Employees 15
- Adding a Spouse 15
- Adding Newborns, Adopted Children, or Children Under Legal Guardianship 15
- Late Enrollees 15
- Effective Dates of Coverage 15

Financial and Billing 15
- Monthly Payment by the Employer 15
- Claim Prefunding 16
- Employer Fund Accounting 16
- Advance Funding Provision 16
- Early Termination Provision 16
- Reinstatement Provision 16

Claim and Plan Services 16
- Employee Claim Submission 16
- Plan Claim Payment 16
- Prescription Claims 17
- Stop Loss Claims 17
- Health Plan Management Reports 17
- Plan Coverage Changes 17
- COBRA Continuation Services 17

Renewal Contract Terms 18
- Costs Subject to Change Annually 18
  - *GBS Administration Fees* 18
  - *Excess Stop-Loss Premiums* 18
- Plan Termination Reasons 18

Customer Service Contact Information 19
- Enrollment and Billing Department 19
- Claim and Customer Service Department 19

Overview

What is *Healthy*Advantage?

*Healthy*Advantage is a self-funded health benefit program providing employers with a cost effective and secure opportunity to save on health care expenses for their employees and dependents. *Healthy*Advantage brings together products and services that small employers need to establish and administer their self-funded health plans. *Healthy*Advantage provides benefits of self-funding to small groups who are disadvantaged by small group fully-insured rate regulations and costs (community experience rated, mandated benefits and expenses).

Self-Funding Philosophy

Under federal law, employer groups that have self-funded plans are virtually exempt from state regulation in administering their health plans. Self-funding reduces the burdens and added costs of state regulations.

State regulations benefit some fully-inusred groups whose health costs are higher than the norm. However, groups with expenses less than the norm must pay substantially higher premiums to subsidize groups with serious health problems. *Healthy*Advantage was designed to provide an alternative that helps these groups capitalize on their good health by self-funding their benefit costs.

Providing Accurate Information

The most important service you provide to your clients is complete information about their options. The decision to self-fund should be made only when the employer has a complete understanding of how self-funding can result in savings and the impact medical problems have on the group's health care costs. Self-Funding may not be the best option for groups with serious medical problems.

How *Healthy*Advantage Works

Self-Funding Combined with Stop Loss Insurance

Employers who participate in *Healthy*Advantage establish an Employer Benefit Plan sanctioned under ERISA federal law. The Employer Benefit Plan establishes rules for employee and dependent participation in health coverage and defines the benefit plan offered to the group. *Healthy*Advantage integrates the products and services needed by the Employer Benefit Plan.

In a self-funded arrangement, the Employer Benefit Plan assumes responsibility for the cost of the benefits included in the Summary Plan Description (SPD). Each participating employee receives a copy of the SPD, which includes benefit information similar to a fully-insured group certificate of coverage. *Healthy*Advantage provides the Employer Benefit Plan with Stop Loss insurance to reimburse for expenses that exceed certain cost levels. The Stop Loss insurance may provide an "aggregate attachment point" (the Employer Benefit Plan's maximum claim liability) and, required in many states, a "specific deductible" (the Employer Benefit Plan liability for any one covered person).

What are the Employer's Costs?

With *Healthy*Advantage, participating employers pay a monthly bill, similar to a monthly fully-insured premium bill. The monthly billing has two components.

- Fixed Costs which include:
  - Stop Loss premium – This premium can provide insurance to reimburse any covered expenses over the annual aggregate attachment point and specific deductibles. This insurance can protect the Employer Benefit Plan from large claims as well as total claims that exceed their annual maximum budget costs.
  - Administrative costs – This is the charge for establishing and maintaining the Employer Benefit Plan including administrative services such as claims processing and payment, customer service, case management, access to provider network(s) and consulting fees.
- Monthly Claim Fund – *Healthy*Advantage Employer Benefit Plans are required to make monthly claim fund deposits

to pay their anticipated claims for the year. The Employer Benefit Plan will receive a monthly report to compare their claim deposits with actual claim payments. This enables the Employer Benefit Plan to track the financial performance of their plans. Any unused claim fund deposits are refunded to the Employer Benefit Plan.

Employers "Maximum Costs"

The monthly bill the employer pays is designed to cover the maximum cost of the health plan. This way, if covered plan claim expenses exceed the amount the Employer Benefit Plan has contributed, the Stop Loss insurance reimburses all eligible excess claims expenses.

How Can the Employer Save Money?

The employer may experience several kinds of savings through *Healthy*Advantage:

- *Healthy*Advantage costs are based on a generally healthy pool of employers whose health expenses are less than the norm. The monthly and annual maximum cost paid by a *Healthy*Advantage employer will often be less than a fully-insured premium for the same group.
- Money may be refunded. Fully-insured health plan premiums are not refundable. Under a *Healthy*Advantage plan, any unused funds in the claims funds will be returned to the Employer Benefit Plan.
- Larger groups can choose the benefits for the plan that are most important to their employees.
- Tax advantage savings of HSA and HRA plans.
- A National PPO network.
- *Healthy*Advantage Provider Choice Rewards.

Self-Funded Plans are exempt from a large portion of State premium taxes and certain PPACA fees. Under PPACA, Fully-Insured Plans pay an Insurance Fee, both Fully-Insured and Self-Funded Plans pay a Patient Centered Outcomes Research Institute fee (PCORI fee) and a Transitional Reinsurance Payment (TRP).

What if Claims are More than the Prefunded Balance?

At times, covered claims can exceed the amount the Employer Benefit Plan has deposited in its prefunded claim account. In this case, due to the aggregate accommodation provision of the Stop Loss policy, amounts are advanced by the stop loss insurance carrier to cover any shortfall. However, if an Employer Benefit Plan terminates the Stop Loss policy before advances are repaid, the Employer Benefit Plan will be liable for unpaid amounts.

Stop Loss Insurance

Stop Loss is insurance for the Employer Benefit Plan. Stop Loss does not pay benefits to employees. It reimburses the Employer Benefit Plan when costs exceed pre-established limits based on expected claims. Stop Loss insurance may offer two protections for self-funded Employer Benefit Plans.

1. Specific Stop Loss Coverage

When a single covered participant experiences large claim amounts, Specific Stop Loss insurance insures the Employer Benefit Plan for any claims that exceed the Specific deductible level. Some states do not require Specific Stop Loss for Self-funded benefit plans.

2. Aggregate Stop Loss Coverage

The Aggregate Claims Provisions pays the Employer Benefit Plan when the sum of covered benefits paid for the year exceed the aggregate annual attachment point. The policy may also provide monthly advances if claims exceed the balance in the Employer Benefit Plans claim fund through the purchase of aggregate accommodation insurance.

Rate and Deductible Guarantee

Stop Loss premium rates and annual employer contributions are guaranteed for one year at a time (unless there are significant changes to the demographics of the group during the contract period). Terms and periods appear in the Schedule of Insurance of the Stop Loss policy.

How are Aggregate, Annual Employer Contributions, and Specific Stop Loss Limits Determined?

*Healthy*Advantage quoting software requires that group plan information be entered into an actuarial model that calculates the plan's expected claims. Expected claims may be adjusted based on medical underwriting prior to the final rate offer. The Employer Benefit Plans monthly claim prefunding, Stop Loss premium, and administrative/marketing costs are determined by GBS and the Stop Loss insurance carrier. The Stop Loss policy must satisfy applicable state laws with regard to specific and aggregate limits.

Benefit Plan Options

*Healthy*Advantage offers a wide variety of PPO/HSA/HRA (Preferred Provider Organization, Health Savings Account, Health Reimbursement Arrangement) plan options to fit any groups health plan needs. In addition, groups may offer dual plan options to their employees to provide them the opportunity to select the benefit package that meets their specific needs.

Health Savings Account (HSA) Plan

An HSA plan is a tax-advantaged health plan that can make health insurance more affordable for both the employer and the employee. *Healthy*Advantage offers an optional HSA plan with a high deductible designed to comply with federal requirements. An HSA savings account can be used to offset the deductible or pay for other benefits permitted under Federal regulations. With a *Healthy*Advantage HSA plan, your healthy group could enjoy extensive health care expense coverage plus all the cost-savings benefits of self-funding.

HSA Advantages for Employers include:

- Tax deductible contributions
- In addition to any Employer contribution, Employees may be able to contribute to the HSA.
- Tax favored treatment available on HSA funds (tax deferred, tax free withdraws, interest earnings is tax free)
- Great flexibility in HSA plan designs
- The employer creates a more attractive package for employees who may be reluctant to accept a high deductible plan. Funds deposited into an HSA are owned by the employee.

Health Reimbursement Arrangement (HRA) Plan

An HRA plan is an employer-funded (tax deductible) arrangement provided to employees for reimbursement of employer specified medical expenses authorized by Section 105 of the Internal Revenue Code. These specified expenses can include copays, deductibles, wellness and more.

Advantages for Employers include:

- Tax deductible contributions
- No need to pre-fund the account – pay claims as incurred.
- Since the Employer makes the contributions into the HRA fund, the employer retains ownership of the funds if they are not used to reimburse claims.
- Greater flexibility in HRA plan designs
- The employer creates a more attractive package for employees who may be reluctant to accept a high deductible plan

ERISA and State Mandated Benefits

Self-funded employer plans are not required to offer coverages mandated by state law. However, federal law mandates, such as COBRA, TEFRA and minimum maternity stay do apply. Despite their exemption from state mandated benefit laws, *Healthy*Advantage plan designs include many of these state-mandated benefits for competitive reasons.

Preferred Provider Network Access

*Healthy*Advantage plans offer access to large local and national preferred provider networks to take advantage of discounted rates. Because *Healthy*Advantage includes no gate-keeper requirements, no referral is necessary to see specialist or ancillary providers.

*Healthy*Advantage Website

GBS designed a website specifically for the *Healthy*Advantage program. The URL for the website is www.gbshealthcare.net. If you are new to self-funding, the *Healthy*Advantage website defines what self-funding is, discusses why you would want to introduce this product to your clients and prospects and gives a library full of resources, forms, tutorials and agreements. This website is also where you will go to do your instant online quoting and where you will go to see instruction and information on our online underwriting tool.

Join Our Team!

The first step to offering the *Healthy*Advantage program to your clients and prospects is to get registered with us.

To "Join Our Team", do the following:

- Visit the website at www.gbshealthcare.net
- Select "New User" on the top middle of the home page
- Complete all of the required information (noted with a *)
- You must have a recruiter code. If you do not know your recruiter code, please contact us
- You must upload, in PDF only, your current license you wish to quote in (up to 5), your current E&O and a completed W-9. You will not be able to quote in a state where you don't hold a current license.
- You are required to complete and sign the Sales Agreement.
- Once you select "Submit" you will receive an "Thank you" message. After our compliance department reviews your documents, you will receive an email with a link and instructions on how to create a username and password that will allow you to enter our online quoting tool.

Consultant Fee Payments

Consultant fees are paid on the 15th day of each month and are earned and paid on any group payment received within the previous month.

The fees will be paid per group and can vary by case. The New Business Transmittal that you must provide for each group will state how you receive your fees for that group.

To ensure timely and accurate payments, please report any change in address, including email address, to GBS' Department of License Compliance at (410) 832-1300 or (800) 638-6085.

Payments paid to an agency can only be changed to pay another entity by obtaining a written release from the current agency or by obtaining a Broker of Record letter from the group. All changes would be effective the first of the month following 45 days from the receipt of the request.

Consultant of Record Changes

The Consultant of Record change must be requested in writing on the groups' letterhead and signed by an officer or owner of the company. Letters cannot be dated more than 60 days prior to the receipt date.

Consultant of Record changes are effective the first of the month following 45 days from the receipt of the groups request, providing the new Consultant is appointed with the carrier. If not, the effective date of the change will be delayed until such appointment is complete. The Group, new Consultant and the previous Consultant will all be mailed confirmation letters of the change.

Quoting and Selling *Healthy*Advantage

This section contains information and answers to frequently asked questions about quoting and submitting new business. It is intended to provide step-by-step advice to make your first and following cases easy to present and sell.

Simple to Quote-Online Quoting Tool

After you become a registered consultant, you will have access to our online quoting tool. This tool gives you online, 24x7 access to obtain an initial proposal for your clients and prospects up to 175 lives.
This tool keeps a database of all of the groups that you have quoted on, and keeps a record of the groups that you quoted multiple times. If you have a census change for a group, you can edit the census right in the tool and click "Get this Quote", the PDF is generated within seconds.

Getting Started with the Quoting Tool

The quoting tool is very user friendly and requires minimal group information in order to obtain an instant self-funded quote.

When you first login to the quoting portal, you will have two options:

- *View Existing Quotes* - You can see a listing of all of your existing quotes. When you click on the "+" sign next to the group name, you will be able to see each quote you have for that specific group. The first quote is the most recent. This is handy if the group has a census change or the SIC may have been wrong the first time.
- *Quote New Group* - Selecting this option brings you to the input page where you enter the group demographic information, choose a network, and enter the group census.

For additional information, please refer to the "Online Quoting Tool Guide" located in the Product Library on the GBS *Healthy*Advantage website at www.gbshealthcare.net.

Census Template

We have included a census template that you can download and save on your desktop. If you wish to upload a census, you must use this template in order for the quoting tool to work.
After you complete the census template with the employee information, save it as the group name. When you are ready to upload the census, select the "browse" button, go to where you have the census saved and click ok. Before you can quote, you must select "Upload Census". Once you do that, the census grid at the bottom is filled in. You will notice that it calculates the number of Individuals, Employee/Spouse, Employee/Child and Family that your group has.
You do not have to upload a census, you can type in the information in the census grid if you prefer.
Once you are satisifed with your quote, select "Get This Quote."

What's in the Initial Quote?

After you have entered all of the required information and either uploaded or entered your census, you select "Get This Quote". The quoting tool takes about 20-30 seconds to generate an initial proposal. The quote will be displayed as a PDF.

The file will contain:

- Cover Page
- Information on self-funding and the *Healthy*Advantage product
- The Assumptions page (what we based the quote off of, i.e. specific deductible, SIC, effective date, etc.)
- Benefit and Rate Comparison for all 20 plans
- Contingencies
- Underwriting Requirements (if the group wants to move on to Underwriting, this sheet explains what is needed)
- Services Agreement (if the group wants to move forward and do individual Underwriting, they will have to sign this form allowing them to enter the Underwriting tool).

If the group does decide they want to move forward with Underwriting, they will need to send the following documents in while the group is completing their individual applications:

- Renewal Premium and notice and last bill from the current carrier
- Current plan benefits

Presenting *Healthy*Advantage to your Client

You know your clients' needs and motivations best. However, many Brokers who have been successful with *Healthy*Advantage follow the same general themes presenting the program to clients and prospects:

- *Healthy*Advantage offers a great savings opportunity for healthy groups...the plan may even get a refund!
- The group's cost of trying the program for a year is limited to the maximum cost – the maximum cost compares favorably to fully-insured premiums
- Gives Employers more control over their health plan
- Besides standard plan options, the combination of *Healthy*Advantage Qualified High Deductible Health Plans (QHDHP) with an HSA Option offers both Employers and Employees financial equity in their benefit program.

Evaluating Groups – Underwriting and Sales Support

If you are unsure whether a group will qualify when underwritten, our underwriters will prescreen particular conditions or answer questions for you. We are committed to helping you become familiar with our underwriting criteria and process (see the following section Underwriting Guidelines for details).

Our underwriters are experienced with group business. We have developed specific standards for underwriting *Healthy*Advantage that acknowledges differences between self-funded risk and fully-insured risk. In some cases, self-funding may permit more liberal risk acceptance or a lesser rating than would occur in fully-insured products. Therefore, it may be prudent to ask questions of our underwriters even where experience suggests an unfavorable answer.

- Target your prospects by focusing on eligible groups with five or more employees.
- Discuss *Healthy*Advantage using the point of sale materials provided.
- These include:
  - Employer Brochure
  - Sample Client Proposal
- Gather information needed to request a proposal.
- Obtain an Initial Proposal for your specific client.
- Present the proposal along with application materials provided to your client.
- These materials include:
  - Employer Application
  - Employee Enrollment Form with Health Questionnaire

Individual Underwriting - Underwriting Tool

If the group does not have claims experience and after seeing the initial proposal they want to move forward, they will need to go through individual underwriting. Before they can be added to the Underwriting Tool, you must have a signed Services Agreement for each group. The consultant is also required to sign a Services Agreement. The consultant is only required to sign the Services Agreement one time and not on every case.
For information and a tutorial on how to set up a new client in the Underwriting Tool, please see the Underwriting Tool section on the GBS *Healthy*Advantage website at www.gbshealthcare.net.

Underwritten Proposal

After the group has completed all of their Personal Health Questionnaires (PHQ), the consultant will submit the group to Underwriting through the Underwriting Tool. This is done by selecting "Submit to Underwriting" under the client management section of the Underwriting Tool.

Underwriting will review the group within 2-3 business days of receiving the submission. After they review the case, our underwriting team will receive a rating result. The rating result consists of individual risk scores for all employees that

completed a PHQ and an overall group risk score. Underwriting reviews the risk score and based on their review, puts the rating factor into the Underwriting Portal of the online quoting system and generates an Underwritten Proposal.

The Underwritten Proposal contains the following:

- Cover Page
- Information on self-funding and the *Healthy*Advantage product
- The Assumptions page (what we based the quote off of, i.e. specific deductible, SIC, effective date, etc.)
- Benefit and Rate Comparison for all 20 plans
- Contingencies
- Plan Service Agreement (PSA) - This will need to be completed in its entirety and signed by the group and the consultant
- Cigna Agreements (Network Services Agreement; LifeSource Agreement; Pharmacy Benefit Management (PBM) Agreement. - These agreements need to be signed by the group.

If the group wishes to move forward after seeing the Underwritten Proposal, please return the signed PSA and Cigna documents to your representative. GBS will review and forward the documents to Cigna for review and to start their implementation process.

At this point, the employer will select which plans to offer their employees. Depending on the group size, the employer may select up to three plans. If the group is between 5-9 employees they may only elect one plan; if they have between 10-14 employees they may select up to two plans; if they have 15 or more employees they may select up to three plans. The only difference is with HealthySolutions, this plan design is stand alone and cannot be offered with any other plan design.

Claims Experience Underwriting

If the group is currently self-funded or can obtain 2-3 years of claims experience, they do not have to go through individual underwriting and will be rated by our underwriting team based on their claims experience. The underwriting team will need their current rates, renewal rates and 2-3 years of detailed claims history in order to thoroughly review the risk of the group.

Final Underwritten Proposal

After the group has completed underwriting and receives their underwritten proposal, they will select the plans they want to offer their employees. At this time, the group conducts an enrollment period and each employee picks which plan they want to enroll in.

The consultant will collect this information and enter it on the Underwriting tool census that they generated when they submitted the group. You can add a column for each plan that the group has chosen and next to each employee, mark which plan they are selecting by entering the coverage level.

Relationship Type	Tobacco Use	COBRA	Subscriber SSN	Member SSN	Address	City	State	Daytime Phone	Email	Date of Hire	PPO 5000	QHDHP 4000
E	N	N	000-00-0000		111 Main Street	Baltimore	MD	410-555-1111	test@test.com		FAM	
S	N	N		000-00-0000								
C	N	N		000-00-0000								
C	N	N		000-00-0000								
E	N	N	111-11-1111		121 South Street	Baltimore	MD	410-555-5555				EE

The consultant will then submit the plan selection census to underwriting. Underwriting will review the census and update the proposal based on the final enrollment. Once underwriting has completed this, they will create a Sold Case Submission packet for the group which will include the final documents necessary to get the group to the Account Installation and Management teams.

The Sold Case Submission package will include the following documents:

- Cover Page
- Assumptions
- Notice of Acceptance for all plans that were selected
- New York Surcharge
- Stop Loss Application

The consultant will have the group sign the Notice of Acceptance for each plan, complete and sign the New York Surcharge and sign the Stop Loss Application. The group must also give us a current Wage and Tax report. Once the group has signed all of the documents, the consultant will hand the final documents in to the Underwriting team. The underwriting team will review all of the documents one more time to make sure everything is accurate and accounted for. If all documents are accurate and accounted for, underwriting will release the group to the Account Installation and Management team. At that point they review all of the documents and get the group ready for implementation.
The GBS Underwriting team will email a letter to your client informing them that their group information has been submitted to the Account Installation and Management team.

The implementation of the group takes up to 10 business days from the time that the Account Manager receives all of the paperwork.

Avoid Delays

Below is a list of the most commonly missed items when submitting a group application. Omitting any of these items causes a delay in approval and issuance:

- The first month's cost payable to GBS
- A copy of the employer's renewal premium notice and most recent billing statement from the current carrier for the period up to the requested effective date
- State Reconciled Quarterly Wage and Tax Statement
- Missing information on each full-time employee's (those requesting coverage, in waiting periods and waiving coverage) Employee Election Form, such as:
  - Signature and Date
  - Medical questions left blank
  - Details to medical questions answered "yes"
  - Waiver of Coverage section not completed
  - Dependent's names, birth dates, height, weight and social security numbers
- Missing information on Employer Application such as:
  - Signature and Date
  - City and State
- A copy of the group proposal. This form must be signed and dated.
- GBS Plan Services Agreement (PSA) completed in its entirety and signed.
- Stop Loss Application
- Signed Network Agreements
- Submission is past the 10th of the month prior to the effective month. If the submission is past the 10th of the month prior to the effective month, the group and consultant are required to sign a late submission letter. This informs the group that they will not have ID cards and the group will not be set up in the network and pharmacy systems by the proposed effective date. We will also give the group an instruction letter for their employees to review if they have to see a medical provider or fill a prescription prior to receiving ID cards.

Accepting, Issuing and Declining Groups

Do not have your group cancel other health coverage until accepted for *Healthy*Advantage.

When your group is accepted to participate in *Healthy*Advantage, GBS will establish the employer's plan and forward employer and employee plan documents to your client which will include the following:

- New Client Welcome kit
- *Healthy*Advantage Employer's Administration Guide
- Stop Loss Insurance Policy/Excess Loss Policy
- Summary Plan Descriptions (SPD's) for each employee
- Employee ID cards (mailed to the employer for distribution to the employees)

Rates

The monthly cost charged to an employer depends primarily on the following factors:

- Age of employees
- Benefit Plan (s) selected
- Effective date
- Geographic location of the business
- Eligibility of employees for Medicare coverage
- Medical history of employees and dependents
- Type of industry in which the group is involved
- Expected future medical claims
- Specific Stop Loss deductible included in the contract

Rate Guarantee

Applicable rate guarantees are shown on the Stop Loss Policy's Schedule of Insurance. Rates determined at issue or renewal may be changed during the rate guarantee period only upon employee census change of more than 10%. In addition, we reserve the right to change rates should the business move to another location or make changes to the benefit plan. Coverage is renewed on an annual basis.

Underwriting Guidelines

Plan Effective Date

Effective dates shall begin on the first of the month for all groups. Completed new business submission forms should be received at GBS at least 20 days prior to the requested effective date. This allows the GBS and the carriers Underwriting department sufficient time to decide on the acceptance and rating of the proposed group and to finalize estimated claim prefunding requirements. It will also provide GBS sufficient time to implement the new group and issue the New Client Welcome kit, including the SPD and ID cards, etc.

We cannot guarantee timely action if the new group submission including employee election forms are incomplete or received late. We are requiring the group and the consultant to sign the late submission letter so they are aware of the ramifications of the paperwork and group information being sent in late.

Participation Requirements

- Employers must have a minimum of 5 enrolled employees.
- If the group has 5-9 employees, they may elect to offer one benefit plan; if they have 10-14 employees, they may elect to offer up to two benefit plans; if they have 15+ employees they may elect to offer up to three benefit plans.
- If an employee is in their waiting period, that employee must complete a PHQ.

Waiting Periods

Waiting periods for employees available are the first of the month following 30 days of employment. Only one waiting period may be chosen for all classes of employees. Waiting periods can only be changed at time of renewal.

In addition, all employees must:

- Satisfy the waiting period in effect as of their hire date.
- Abide by the waiting period chosen.

Required for all Employees

For underwriting purposes, the Employee Election Form is required for all employees employed at the time of application regardless of the waiting period chosen for current employees.

Employees and dependents choosing to waive coverage must also complete a Waiver Form indicating they are waiving coverage.

All eligible employees and their dependents who wish to participate, regardless of whether they are in waiting periods, must meet medical underwriting standards. If questions arise during underwriting, a telephone call is made to the employee.

Those waiving coverage do not need to completed medical questionnaires.

It is important that all medical history and pertinent information regarding the employee, spouse and dependents be fully disclosed on the Employee Election Form. Failure to do so may result in an increase in Stop Loss premium rates retroactively to the effective date of the group's coverage. Health questionnaires have been developed to help expedite the number of medical details post submission and minimizing the need to request medical records.

Serious Condition List

Depending on group size, *Healthy*Advantage may not be a viable option if any of the conditions below are present in a group:

- Alzheimer's Disease
- Alcoholism, Drug Addiction, Alcohol Abuse or Substance Abuse
- Aneurysm
- Brain Tumor or Abscess
- Cancer – Malignant
- Cardiomyopathy (Enlargement or Congestive Heart Disease)
- Crohn's Disease
- Cerebral Palsy
- Chronic Renal Failure
- Congenital Heart Defects
- Cystic Fibrosis
- Emphysema (COPD)
- Gastric Bypass/Balloon
- Hemophilia
- Hepatitis C
- Hemochromatosis (Iron Storage Disease)
- HIV+, AIDS, ARC
- Huntington's Chorea
- Hydrocephalus
- Leukemia or Hodgkin's Disease
- Liver Cirrhosis or Hepatic Failure
- Lou Gehrig's Disease, ALS
- Lupus Discoid or Systemic
- Meningitis, Encephalitis
- Multiple Sclerosis
- Muscular Dystrophy
- Organ or Bone Marrow Transplants
- Parkinson's Disease
- Paralysis
- Prosthetic Heart Valve
- Pending or recommended surgery (any)
- Pregnancy
- Spina Bifida
- Stroke (CVA) (TIA)
- Suicide Attempt

Eligibility

Group Eligibility

*Healthy*Advantage is designed for employers that have 5 or more full-time participating employees.

Employer groups formed primarily for the purpose of purchasing insurance are not eligible. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

- Seasonal businesses are not eligible. "Seasonal" is defined as operating fewer than six months every calendar year.
- Multiple locations groups (where some employees live in a state different from where the business is located) are eligible provided the principal business location is a state in which *Healthy*Advantage is available.

A telephone verification call may be conducted at the underwriter's discretion. These calls entail a short interview with the employer or employee conducted by an underwriter. The focus of this interview is to clarify information reported in the Group Health Questionnaire (GHQ) or the Personal Health Questionnaire (PHQ).

Maximum Enrollment on Continuation Coverage

At the time of application, no more than 20% of the total employees in the business may be on COBRA or other state continuation coverage.

Occupational Eligibility

*Healthy*Advantage is designed for stable, non-hazardous businesses. Certain industries may not be eligible for coverage. Final decisions on occupational eligibility based on Standard Industrial Classifications (SIC) are determined by the Excess Stop-Loss carrier. Ineligible industries are listed below.

Ineligible Industries

- Amusement Parks
- Auto Repossession
- Bail Bondsmen
- Blast Furnace
- Commercial Fishing
- Fireworks
- Legal Services
- Mining, Quarrying & Asbestos
- Professional Athletes
- Refuse & Sanitary Systems
- Water Transportation
- Wrecking & Demolition Involving Nonmetallic Minerals

Employee Eligibility

Any employee, including a proprietor or partner, who works for the employer at least 30 hours per week on a regular basis is eligible. In addition, employees must be 18 years old, a U.S. citizen or a legal alien who possesses a green card and a social security number and must reside in the U.S. There must be a formal employer-employee relationship that can be confirmed by demonstrating that the employer pays FICA wages and that wages are reported on Federal W-2.

Straight-commissioned employees under exclusive contract may be eligible but need to be pre-approved by GBS.

The following are not considered eligible employees under this plan (this list is not inclusive):

- Leased employees
- Temporary employees
- Seasonal employees
- Subcontractors
- Personal employees (i.e., nannies, gardeners)

Dependent Eligibility

Eligible dependents must be U.S. citizens or be legal aliens, who have a green card and a social security number and reside in the U.S. Eligible dependents include the lawful spouse and unmarried children of the employee who are legally listed as dependents for income tax purposes, or for whom a court order requires the employee to provide health insurance. Dependent children are eligible up to the age of 26. If divorced, the former spouse is not eligible for coverage.
An adopted child is eligible as a dependent when the self-funded plan participant has agreed to assume total or partial responsibility of support for a child in anticipation of adoption or legal physical placement of the child in the home. Legal documentation would be required to verify eligibility.

Common law marriage is basis for dependent eligibility only if recognized in the state and the burden of proof is on the covered participant.

The employer may elect to offer coverage to Domestic Partners and their legal dependents in accordance with *Healthy*Advantage guidelines. An affidavit and addendum will need to be completed and signed by the employer and plan participant.

Enrolling Employees and Dependents

Adding Employees

- All new employees must fully complete, sign and date the PHQ.
- If an Employee Election Form is submitted more than 31 days after the expiration of the waiting period, the employee must wait until the Employer's next Open Enrollment Period.
- The new employee's effective date of coverage is the first of the month following the expiration of the group's selected waiting period.

Adding a Spouse

- Employees may add a spouse by submitting a PHQ with spousal information indicating a change in coverage and including a copy of their marriage certificate to GBS within 31 days of the date of marriage.
- The effective date of coverage for the spouse will be the first of the month following the date of marriage.
- If notification is not received within 31 days of the date of marriage, the spouse cannot be enrolled until the employer's next Open Enrollment Period.

Adding Newborns, Adopted Children, or Children Under Legal Guardianship

- Employees may add a newborn or adoptee by submitting a PHQ with newborn or adoptee information indicating a change in coverage and including the date of birth or date of legal dependence within 31 days of the birth or date of legal dependence. GBS may ask for proof of legal dependency or birth certificate.
- The effective date is the child's date of birth or the date of legal dependency.
- If notification is not received within 31 days of the date of birth or legal dependency, the child cannot be enrolled until the employer's next Open Enrollment Period.

Late Enrollees

- Any employee who initially waived coverage or applies for coverage more than 31 days after the expiration of the group's waiting period.
- Any dependent who initially waived coverage or applies for coverage more than 31 days after the date of marriage, birth or legal dependency.

Effective Dates of Coverage

- The effective date of a new employee who applies for coverage on time is the first of the month following the employer's selected waiting period.
- The effective date of a new spouse when coverage was applied for within 31 days of the date of marriage is the first of the month following the date of marriage.
- The effective date of newborn or acquired children when coverage was applied for within 31 days of the birth or legal dependence is the date of birth or date of legal dependence.

Financial and Billing

Monthly Payment by the Employer

Each month, the Employer Benefit Plan is billed for the Fixed Costs, which include: Stop Loss insurance premium, administrative fees and consultant fees. In addition, the invoice includes the required claim prefunding amounts for each employee. The bill is due on the first day of each coverage month and the group must pay the amount billed. Any enrollment adjustments will be reflected on the following month's bill. Although there is a 30-day grace period for late payment of the premium, payment must be received by the 30th day or Stop Loss coverage and participation in all *Healthy*Advantage programs will be terminated.

Claim Prefunding

Except for very large groups, Employer Benefit Plans participating in *Healthy*Advantage must agree to pay a monthly claim amount to prefund anticipated claim costs for the Employer Benefit Plan. This amount is based on the maximum claim exposure of the Employer Benefit Plan. The expected claims are determined at initial underwriting and renewal.

Employer Fund Accounting

Funds paid by the Employer Benefit Plan to prefund claims are deposited into a special bank account established to pay claims and maintained and reconciled by GBS. By signing the GBS Administrative Services Agreement at the time of implementation, the Employer Benefit Plan authorizes GBS to pay claims from the claim account. In addition, GBS is authorized to pay Stop Loss premiums, administrative fees, risk management fees and Consultant fees from the Employer Benefit Plan's payment.

Claim funds not used for claim payment accumulate in the claim account. Six months after the end of the contract run out period, any funds not used, will be refunded to the Employer Benefit Plan.

Advance Funding Provision

Monthly advance funding is automatically provided with the Stop Loss policies. Advance funding provides reimbursement to the Plan's claim account for claims payable from the policy's specific or aggregate benefit any time during the policy year that the employer's prefunded claim account balance is insufficient. Advances are only available if the plan's Stop Loss premiums and monthly claim prefunding contributions are paid-to-date.

Early Termination Provision

In the event the group terminates their plan during the plan year (i.e., nonpayment or per request) all benefits end the last day of the month for which payment has been received. Any claims incurred but not paid by the termination date will be the financial responsibility of the group. The *Healthy*Advantage plan is a 12-month contract, designed to be entered into for the entire year. Should the group terminate the plan early, coverage ends the date of termination, and no claims prior to or after termination will be paid by GBS.

Reinstatement Provision

In the event of termination, the Employer Benefit Plan may request reinstatement within 5 days following the date of termination. However, reinstatement is at the sole discretion of GBS and the Stop Loss Insurance Carrier. Consideration will include prior premium and claim history. If reinstatement is approved, coverage will be reinstated retroactive to the termination date contingent upon receipt of all outstanding premiums, including the current month plus a $500 Plan reinstatement fee.

Claim and Plan Services

Employee Claim Submission

A claim form is required for claims submitted by employees. Bills from health care providers are accepted as an indication of loss. If the participant assigns benefits to the provider, GBS will pay benefits under the employer's *Healthy*Advantage self-funded plan directly to that provider. The itemized bills should always include the group number. If family members have the same first name, the date of birth and social security numbers should be indicated for the claimant. All medical bills should be sent within 180 days after an expense was incurred in order to be eligible for consideration and payment by the plan.

If an inpatient hospital stay or surgery is planned, the participant needs to follow the instructions for precertification or preauthorization which are included in his or her summary plan description. Penalties may be incurred if a precertification is not obtained.

Plan Claim Payment

As the primary risk bearer, the Plan becomes responsible for all claim decisions. However, plans that utilize claim adjudication services from GBS, as the third party administrator (TPA) typically elect to legally delegate claim authority for most claim decisions to GBS. For instance, GBS is often able to adjudicate all claims under a stated amount in cases where the claim determination is clear under the employee benefit plan document (Summary Plan Description). This delegation is set out in GBS' standard Administrative Services Agreement with *Healthy*Advantage employers. In rare cases where the terms of coverage do not produce a clear, black and white claim determination, GBS contacts the plan for the plan determination on the claim. Since the Plan's decision may be binding on later decisions to pay similar claims, it will be necessary for the plan to obtain the Stop Loss Insurance Company's approval to determine whether the claim or one like it would be payable under the Stop Loss insurance. By doing this, the plan may avoid the risk that Stop Loss may not reimburse amounts that have become the plan's obligation after Stop Loss limits are reached.

In addition, should a Plan elect to override the denial of a claim payment, the dollar amount paid will be considered income to the participant. In such case, the employer must add this amount as "bonus" wages on the employee's W-2.

Prescription Claims

At a participating pharmacy, participants will pay the appropriate copayment according to the Summary Plan Description. Prescription copays, coinsurance and ancillary charges apply toward medical deductibles.

Pharmacy non-network charges are based on the amount the plan would have paid a network pharmacy for the covered drug, less the network copayment, coinsurance and any applicable ancillary charges. To obtain a pharmacy non-network claim form please contact GBS.

Stop Loss Claims

In addition to administering the plan claims, GBS is also responsible for paying claims against the carriers Stop Loss insurance. GBS tracks each plan's claims payments on its system to determine when aggregate or specific limits are reached and a Stop Loss claim needs to be filed. Under its Administrative Service Agreement with the employer, GBS is responsible for filing Stop Loss claims on the plan's behalf. When Stop Loss claims are paid, they are credited directly to the plan's account so claims against the plan can be paid promptly.

Health Plan Management Reports

Clients will receive monthly reports to illustrate how their plan is financially performing. The Aggregate report will reflect their maximum claim fund liability vs. their actual claim payment expenses.

Plan Coverage Changes

Plan changes may only be made at the group's renewal date. If you obtained a quote to change the plan, the signed quote will provide sufficient written notice to amend the plan benefits. Also plan changes must be submitted 30 days prior to the requested change to provide sufficient time to make system changes and to issue new member ID cards and Schedule of Benefit certificates to the employees.

COBRA Continuation Services

*Healthy*Advantage plans comply with the COBRA Continuation mandate for employers with 20 or more employees. At the initial implementation and at each subsequent renewal, employers are required to inform GBS whether they are subject to the COBRA regulations. GBS offers COBRA Administrative Services as an optional service for a nominal monthly administrative fee of $2.50 per employee per month plus the 2% administrative percentage allowed by law.

Renewal Contract Terms

Plans may receive an offer for a subsequent plan period following the first year of coverage. Rates for this plan period reflect claims experience and changes in health status among participating members of the Employer Benefit Plan, changes in coverage, and changes to the make-up of the group, including census changes and other objective differences. Prior to the end of each plan period, GBS will require a current copy of the State Quarterly Wage & Tax Statement to verify the number of eligible employees and the number of participating in the plan to determine if participation requirements are being met. If the group fails to maintain the minimum participation level, the group will be provided 30 days written notice of termination.

Costs Subject to Change Annually

Required claim prefunding is adjusted at the start of the new plan year based on changes in anticipated claim costs for the coming year. Employer Benefit Plans that have accrued savings in their claim prefunding account for the prior contract period will receive a refund six months after the end of the contract run out period.

GBS Administration Fees

The fee charged by GBS for claim administration, medical management services, customer service and other services may be adjusted annually.

Excess Stop-Loss Premiums

The Excess Stop-Loss Insurance carrier may adjust charges for stop loss premiums. Any changes to the above costs will be reflected on the first monthly invoice of the subsequent contract period.

Plan Termination Reasons

An employer's participation in *Healthy*Advantage can be terminated upon notice for any of the following reasons:

- Any portion of the billed monthly cost is not received by GBS on the date it is due.
- The number of employees insured in a group is fewer than 5 persons.
- There is evidence of fraud or misrepresentation.
- There is non-compliance with plan or Stop Loss policy provisions.
- The business is no longer engaged in the same business that it was on the effective date
- All Stop Loss coverage in the state in which the group is located is terminated.
- The business moves to a state where *Healthy*Advantage is not offered.
- The group submits a voluntary written request for termination.

Refer to the Stop Loss policy for termination provisions specific to that coverage.

Customer Service Contact Information

GBS is Available to Provide Services Monday through Friday from 8:00 AM to 5:00 PM EST

Enrollment and Billing Department

- Assists with adding/terminating employees or dependents to the plan
- Changes your address
- Requests duplicate Member Identification Cards or Summary Plan Descriptions
- Checks on the status of a reinstatement request
- Provides assistance with monthly billing questions

Contact GBS Enrollment and Billing Department as follows:

Telephone: (410) 832-1300 or (800) 638-6085
Fax: (410) 584-7020

Correspondence Mail:
6 North Park Dr., Suite 310
Hunt Valley, MD 21030

Claim and Customer Service Department

- Get assistance with questions regarding the benefits provided by the plan
- Learn how to file a claim
- Inquire about the status of a claim
- Obtain information on the *Healthy*Advantage Preferred Provider Option (PPO) networks

Contact GBS Claims and Customer Service Department as follows:

Telephone: (410) 832-1333 or (800) 337-4973
Fax: (410) 584-9467
E-mail: *claims@gbsio.net* and *solutions@gbsio.net*

Claim Address:
P.O. Box 4368
Lutherville, MD 21094-4368

***Healthy*Advantage** is governed principally by the federal Employee Retirement Income Security Act (ERISA)

***Healthy*Advantage** is a program of services for self-funding employers, marketed and administered by Group Benefit Services, Inc. a leader in providing innovative benefit solutions to employers of all sizes.

The determination of all claims for benefits under the self-funded plan will be determined based on the Summary Plan Description. The carrier will not be involved in the determination of claims for benefits under the self-funded plan and is not considered a fiduciary with respect to the self-funded plan.

***Healthy*Advantage is brought to you by Group Benefit Services, Inc. (GBS)**
GBS is a national leader in the administration and management of employee benefit programs. We began in 1980 with a vision to offer businesses an efficient alternative to traditional health insurance plans and a commitment to lead the industry in customer service. We have built a solid reputation for delivering innovative, cost effective employee benefit solutions and outstanding customer service. GBS provides the administrative, claims adjudication, care management, customer service, reporting and technology services needed to professionally manage your *Healthy*Advantage plan.