Employer Administrative Guide

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

Welcome to *Healthy*Advantage

Thank you for selecting *Healthy*Advantage for your employee health benefits program. By combining the administrative expertise and customer service of Group Benefit Services, Inc., HealthyAdvantage is proud to bring together the products and services you need to establish and manage your self-funded employee health plan.

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About This Guide

This Employer Guide is provided as a resource for you to effectively manage your self-funded plan. We encourage you to read the guide thoroughly to gain an understanding of the administrative and financial aspects of your plan.

This guide should answer most of your questions. However, we understand that certain situations will require further clarification or assistance. Please contact Group Benefit Services, Inc. and a professional customer service representative will gladly assist you. Please refer to the Customer Service section of this guide for directions on who to call for specialized assistance.

While we have made every effort to provide you with a complete guide to your self-funded plan, this Guide is subject to change without notice. Any changes to the guide will be provided to you.

We look forward to a long and mutually rewarding relationship with your business.

How *Healthy*Advantage Works

Self-Funding Combined with Excess Loss Insurance

Employers who participate in *Healthy*Advantage establish an employer health plan sanctioned under ERISA federal law. The employer 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 plan.

In a self-funded arrangement, the employer 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 with Excess Stop-Loss insurance to reimburse expenses that exceed certain claims experience levels. These amounts, respectively, are called the “aggregate attachment point” (the employer’s maximum claim liability) and the “specific deductible” (the employer’s liability for any one covered person).

What are My Costs?

With *Healthy*Advantage , participating employers pay a monthly bill, similar to a monthly fully-insured premium bill. The monthly-billed amount covers all financial responsibilities for the employer’s plan. The monthly billing has two components:

- **Total Fixed Costs** which include:
  - *Excess Stop-Loss Premium* – This premium provides insurance to reimburse any covered expenses over the annual aggregate attachment point and specific deductibles. This insurance protects the employer from large claims as well as total claims that exceed their annual maximum budget costs.
  - *Administrative Costs* – This is the charge for marketing and administrative services such as: claim processing and payment, customer service, case management, access to provider networks and consultant fees.
- **Monthly Claim Fund** – *Healthy*Advantage employers are required to make monthly claim fund deposits to pay their groups’ anticipated claims for the year. The employer will receive a monthly Aggregate report to compare their claim deposits with actual claim payments on an accumulative basis. This enables the employer to track the financial performance of their plans. Any unused claim fund deposits at the end of the contract period are returned to the employer.

“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 has contributed, the Excess Stop-Loss insurance reimburses all eligible excess claims expenses.

The claim fund deposits are credited to the employer’s claim account and are held in a bank account reconciled each month by Group Benefit Services, Inc. (GBS). At the end of the contract period any money not spent on the employer’s health claims will be returned to the employer.

What if Claims are More than I have Prefunded?

The employer’s liability will not exceed the sum of the monthly billed amounts unless the enrollment decreases

in such a way that the group has not funded up to the minimum attachment point. The employer would be responsible for funding up to the minimum attachment point at the end of the 12-month plan year.

Excess Stop-Loss Insurance Protection

Excess Stop-Loss is insurance for the employer's health benefit plan. Excess Stop-Loss does not pay benefits to employees. It reimburses the employer's plan when costs exceed pre-established limits based on expected claims. Excess Stop-Loss insurance offers two protections for self-funded employer plans.

1. Specific Excess Stop-Loss Coverage

When a single covered participant experiences large claim amounts, Specific Excess Stop-Loss insurance protects the employers plan for any claims that exceed the specific deductible level for that participant.

2. Aggregate Excess Stop-Loss Coverage

The Aggregate Excess Stop-Loss Policy reimburses the employer benefit plan for eligible claims. In the case where the employers annual claims reserves have been depleted.

The Excess Stop-Loss policy also provides the employers benefit plan monthly cash advances to pay eligible claims if the employers benefit plan reserves have been depleted for a certain month.

Rate and Deductible Guarantee

Excess Stop-Loss premium rates and specific deductibles are guaranteed for one year at a time (unless there are significant changes to the demographics of the group during the contract period). Guarantee terms and periods appear in the Schedule of Insurance of the Excess Stop-Loss policy. Enrollment of new employee or reduction of a plans participants is greater than 10% of the original enrollment there may be a need to increase the plan's Excess Stop-Loss premium.

*Healthy*Advantage: Products and Services

*Healthy*Advantage is an innovative program that conveniently combines the products and services needed to enable employers, like you, to self-fund their employees' health benefits. *Healthy*Advantage 's products and services are provided by:

Group Benefit Services, Inc. (GBS)

GBS, located in Hunt Valley, Maryland, is a licensed Third Party Administrator (TPA) specializing in the administration of employee benefit plans for employers of all sizes. As the TPA for *Healthy*Advantage , GBS provides the following services:

- ERISA plan documentation and Summary Plan Descriptions (SPD's) for covered employees
- Processes enrollment activity and distributes ID cards and SPD's to employer for distribution to covered employees
- Monthly billing for all fixed costs and employer prefunding for claims
- Financial reporting to employers to assess their plan's financial performance
- CarePlus™ Medical Management (hospital precertification, hospital discharge, Better Beginnings™ maternity program, large case management and disease management services)

- Access to substantial health care discounts through *Healthy*Advantage Preferred Provider Networks
- Banking and accounting for customer claim prefunding accounts and HSA/HRA accounts
- Claims processing and payment in accordance with plan benefits
- COB and subrogation recoveries
- For employers having 20+ employees, COBRA Administration (optional service)
- Customer service (for you, your employees and medical providers)
- Administering employer Excess Stop-Loss coverage

Please Note: Neither Excess Stop-Loss Carrier nor GBS acts in the capacity of an ERISA fiduciary

Continued Participation in the Plan

Due to your employee's and their dependent's good health, a self-funded employer plan was an option for your company to save money while providing your employees with health care benefits.
We analyze the cost performance of the plan on a yearly basis to assure that self-funding your employees health benefit plan is a viable option.

Participation and Eligibility Review

On the annual renewal date of your Excess Loss Policy, your company must have a minimum of 5 employees participating in your health benefit plan.

Upon renewal, GBS will request the required documentation to review the Excess-Loss Policy.

Continuation of Coverage

COBRA - Consolidated Omnibus Budget Reconciliation Act

A federal law, referred to as COBRA, was passed in 1986. This law requires employers, who employ 20 or more full and part-time employees for at least 50% of its typical business days during the previous calendar year, to offer continuation of the group's plan to employees who may lose coverage for one of several reasons.

COBRA is designed to protect individuals who would otherwise lose their health insurance coverage. A person who elects COBRA continues on the employer's plan at the group rates. The terminated individual must pay the monthly cost to the employer. The employer may charge the individual a small administrative fee (2% of the monthly cost) to defray the administrative expense. If you are unsure whether your company is required to comply with COBRA, please contact your legal advisor.

*Healthy*Advantage program complys with the COBRA Continuation mandate for employers with 20 or more employees. At the time of initial implementation and at each subsequent renewal, employers are required to inform GBS whether they are subject to the COBRA regulations. *Healthy*Advantage program does not provide continuation coverage options for groups not subject to COBRA.

Following COBRA election, employees will be reinstated under a COBRA division of group billing. GBS will also invoice each continuee individually and upon receipt of premium payment will, on a monthly basis, reimburse the employer for premiums paid on their behalf. If premiums are not paid by the COBRA continuee by the end of the grace period a retroactive termination credit will be given to the employer on the next invoice cycle.

COBRA Guidelines

- COBRA law requires an employer to notify employees, who qualify for coverage under COBRA, within 14 days of the event that terminates coverage.
- It is the employee's responsibility to notify the employer, within 60 days, of a change in status of a dependent, which may entitle the dependent to a COBRA continuation.
- The covered employee, spouse or dependent child must make his or her election to continue coverage no later than 60 days from the latter of the date of the notice from the plan administrator or the date of termination.

How to Request COBRA Coverage

- COBRA requires employers to provide the terminated employee or dependent their COBRA continuation notice and election form within 14 days of their termination date.
- The terminated individual must submit a signed and dated election form to extend coverage. GBS must receive the election form within 60 days of the termination date.
- Once a continuation option is selected, the start date of the continuation will coincide with the termination date.
- A terminated employee may elect to continue coverage for up to 18 months (29 months if disabled) from the date of any of the following qualifying events:
    1. Termination of employment for any reasons other than gross misconduct
    2. Reduction in work hours to less than full-time status
        - If the covered employee's spouse and/or dependent child also loses coverage for the above events, they too may continue coverage for up to 18 months
        - If the covered employee's dependent spouse or child loses coverage due to one of the reasons listed below, coverage may be continued for a maximum period of 36 months
    3. Covered employee divorces or legally separates from spouse
    4. Covered employee is entitled to or is receiving Medicare benefits (under certain circumstances)
    5. Covered employee dies
    6. Dependent child loses dependent status
- If during the initial extension period, a second qualifying event listed above (3, 4, 5, or 6) occurs, continuation of coverage may be extended for up to a maximum of 36 months from the date of the first qualifying event described in items 1 or 2.

Early Termination of COBRA Coverage

COBRA coverage may end earlier than the 18-month period. Such coverage will end on:

1. The first day for which timely monthly cost payment is not made.
2. The date upon which the employer ceases to provide any health plan to any employee.
3. The date upon which the qualified beneficiary becomes covered under another group health plan not maintained by the employer.
4. The date that the qualified beneficiary is first entitled to Medicare.
5. The date on which coverage is terminated for a cause. Termination for cause (ex., fraud or misrepresentation) will end the coverage of a qualified beneficiary in the same manner that the coverage ends for employees who have not undergone a qualifying event.

Military Leave

There are several coverage alternatives for employees who serve in the military during their employment. In most situations, your employee will have government-sponsored health coverage while actively serving. Employees do have the right to continue existing employer-based health plan coverage for themselves and dependents for up to 24 months while in the military. Due to military coverage, his or her benefits under your self-funded plan may be terminated for the duration of duty unless otherwise requested. Be sure to notify GBS, in writing, within 31 days of a covered participant being placed on active duty.

Return from Active Duty

To reinstate coverage upon return from active duty:

- Submit a copy of the employee's discharge papers
- Send a letter to GBS stating that full-time employment has resumed
- Submit a fully completed Employee Election Form
- Benefits will become effective on the date of re-enrollment without additional condition exclusions (except service related injury or illness)

Group Plan Information

Notification of Group Plan Changes

Plan changes may only be made at the group's renewal date. If you obtained a quote to change the plan benefits, 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 date to provide sufficient time to make system changes and to issue new member ID cards and Summary of Benefits to the employees.

Ownership Changes

If your business undergoes a change in ownership, please contact GBS for a new Employer Application Form. You need to complete this form and return it to GBS.

Group Address Changes

If your business moves to a new address, please notify GBS as soon as possible. Depending on the new location, your costs may be adjusted. If the new location is outside the original state, and is not located in a state where *Healthy*Advantage is offered, coverage may be discontinued.

Monthly Costs and Invoicing

Monthly Payments

Premium invoicing is issued on the 1st of the month prior to the coverage month. Payments are due by the first of the coverage month and must be submitted by the employer, not by the individual employees (even if employees pay a portion of the premium). Write your group number on the memo section of your check and attach a copy of your invoice summary.

General Billing Information

All payments for your benefit plan are due on the first of the month. We suggest that you mail your payment so GBS receives the payment prior to the 1st of the month.

For example: Payment for April 1st should be received by GBS no later than March 31st. This procedure will eliminate interruption in coverage.

Failure to make a payment on the first of the month will result in your benefits and claim payments being suspended on the first of the month that the payment is due.

In the case where claim payments or authorization for care are suspended, your employees should be notified by the plan administrator.

GBS will notify you on the first of the month that payment is late. GBS will also provide a benefit cancellation letter on the 20th of the month. This termination of benefits will take place on the first of the month following the month that payment has not been received.

Employee and Dependent Billing Coverage Codes

Coverage codes are part of your Billing Detail Report. These codes indicate the medical coverage we have on record for your employees. Review this information for accuracy. Please call GBS if you have any questions or if there is a discrepancy. The coverage codes for your self-funded plan are as follows:

P00: Participant Only
F00: Participant and Spouse
P99: Participant and Children
F99: Family

Invoice Adjustments

Adjustments on your billing statement will reflect changes in the make-up of your self-funded employee plan.

Monthly billing amounts can change if:

- A new employee is added to the group
- An employee is terminated
- An employee makes a change in the type of coverage selected or coverage level (i.e., individual to family)
- Changes are made to the plan's benefits at renewal

We require invoice payments to be remitted as billed. If you add an employee, dependent or spouse, do not adjust your monthly cost until the change appears on your bill. You will be back-billed and/or will receive credit for changes on the next statement generated after the changes are processed. Please call GBS if you need clarification about your billing.

Checks Returned Unpaid

If your bank notifies you that your check has been returned to your bank unpaid, please be aware of the following procedures:

- GBS will automatically redeposit your check and apply a $25.00 redeposit fee.
- If the check does not clear, we make a second attempt to cash your check. If the payment does not clear our bank on the second attempt, a $50.00 return check fee will be applied.
- We will advise you in writing of the check number and the amount of the returned item. Subsequent payments must be submitted by cashier's check or money order for 6 months.

- You may receive the next month's invoice before we have resolved the outstanding non-sufficient funds issue. Pay this invoice as due. Withholding payment of the next month's invoice may result in a lapse of your coverage.
- If the check does not clear on the second try, your benefits and services will be suspended.

Filing Claims

We suggest that all employees are educated concerning their health plan benefits. You will discover that your company will save money and will have a more satisfied employee if you implement a benefit education program. Your employees can find details on filing for claim reimbursements and receiving benefits in their Summary Plan Description (SPD). Encourage your employees to read their SPD prior to utilizing the plan's benefits.
Employees may also contact GBS directly for assistance. While GBS will not guarantee your self-funded plan benefits over the phone, their customer representatives can help your employees understand their benefits and the claim process.

The SPD advises the employees of the following:

- If a planned treatment or service is a covered expense.
- Specific instructions on how to pre-certify. The telephone number for precertification is listed on the member's Identification Card.

How to Submit Medical Claims

- Encourage your employees to use a provider in the *Healthy*Advantage network. This ensures that your self-funded plan is charged the best, negotiated price available.
- For all submissions, make sure key identification information is provided, including the group number and the employee's I.D. number. This information is located on the Member ID Card and on the Benefit Summary in the Summary Plan Description.
- Make sure itemized bills are submitted with a claim form. Balance due statements are not acceptable. Each itemized bill should include:
  - Date of service
  - Type of service
  - Diagnosis
  - Amount charged
- On behalf of your self-funded plan, GBS may request information concerning the coverage with a previous carrier in order to provide creditable coverage.

How to Submit Pharmacy Claims

- Encourage your employees to use a pharmacy associated with the network indicated on their identification card. This ensures that your self-funded plan is charged the best, negotiated price available.
- Instruct your employees to send receipts for any prescription drug purchases outside the network along with a Direct Reimbursement Claim Form to the address provided on the claim form. Please note that injectable drugs other than insulin and Imitrex are not covered under the prescription drug card but may be considered for possible coverage under the medical portion of the self-funded plan. Employees should contact GBS with any questions regarding their claims.

Seeing a Doctor or Filling a Prescription Before Receiving ID Cards

Even though you don't have your ID card at this point, your coverage is in effect and you can seek health care services and get your prescription drugs. Here are some steps you can take to seek medical services or fill a prescription.

If you need to visit a doctor, out-patient urgent care facility, lab, imaging center, hospital, etc.

1. Ask the medical provider to contact Group Benefit Services (GBS) at (410) 832-1333 or toll-free at (800) 337-4973) if outside of Maryland to verify your eligibility and benefit coverage.
2. GBS Claim Customer Service hours are Monday through Friday, 8:00 AM – 8:00 PM.
3. The provider will need your Employer's name

If you need to fill a prescription

1. You have 3 options for filling a prescription before you receive your ID card:
   a. Ask the pharmacist to give you a small supply to hold you over until you receive your ID card.
   b. Ask your doctor if they have samples they can provide to you.
   c. Have your prescription filled and pay for it out of pocket and get reimbursed after you receive your ID card:
   - If you receive your ID card WITHIN 7 days of filling your prescription, you can take your ID card back to the pharmacy and ask them to reprocess the prescription and give you a refund (subject to any deductible or copay that may apply).
   - If you receive your ID card AFTER 7 days of filling your prescription, you will need to complete a Claim Form and submit to GBS along with your pharmacy paid receipt. GBS will reimburse your cost (subject to any deductible or copay that may apply).

If you need to mail a claim form for reimbursement, please mail it to:

Group Benefit Services, Inc.
Attention: Claim Department
P.O. Box 4368
Lutherville, MD 21094-9998

Renewal Contract Terms

First Year Monthly Costs

When you implemented your *Healthy*Advantage plan, you provided a census of your group. The initial monthly cost assigned is based on the age of your employees at the effective date of the plan, the types of coverage's selected, the location of your business and expected future medical claims of the group. The monthly cost charged to an employer group depends primarily on the specific benefit plans the group has selected, and other factors such as:

- Age and gender of employees
- 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

Renewal Review

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 members of the employer's group, changes in coverage, and changes to the make-up of the group, including census and coverage changes. 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 participating in the plan to determine if participation requirements are being met.

Employer Claim Fund Refund

Claim funds not used for claim payment accumulate in the employer's claim account. At the end of the contract period the employer willbe returned any unused claims fund.

Costs Subject to Change Annually

Claim Prefunding

Required claim prefunding is adjusted at the start of the new plan year based on changes in anticipated claim costs for the coming year. Employers that have accrued savings in their claim prefunding account for the prior contract period will have the savings amount returned at the completion of the contract period.

GBS Administration Fees

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

Group Plan Termination

Notification to Terminate Plan

To terminate your *Healthy*Advantage plan, submit your written termination request to GBS at least 30 days prior to your contract renewal date.

Plan Termination Reasons

Your *Healthy*Advantage plan, including your Excess Stop-Loss policy may be terminated for the following reasons:

- Monthly payment is not received by GBS on the date it is due.
- There is evidence of fraud or misrepresentation.
- There is non-compliance with plan provisions.
- The business is no longer engaged in the same business that it was on the date it was effective.
- The business moves to a state where *Healthy*Advantage is not available.
- The group submits a voluntary written request for termination.

Refer to your Excess Stop-Loss policy for termination provisions specific to coverage.

Lapsed Coverage

- If GBS does not receive your monthly payments within the month of the due date, benefits for all employees terminate as of the last day of the month for which the premium was paid and claims will not be paid (The due date is always the first of the month.)
    - All monthly payments must be remitted to GBS at the following address:
      Group Benefit Services, Inc. - T/A *Healthy*Advantage
      6 North Park Dr, Suite 310
      Hunt Valley, MD 21030
    - Please be advised that all checks are automatically deposited and cashed by our bank, regardless of the status of your plan. Cashing of a check on a lapsed plan does not guarantee coverage nor approval for reinstatement
- GBS does not notify employees that their HealthyAdvantage coverage or ancillary coverage is terminated. It is your responsibility to advise your employees of your plan's termination.

Termination Due to Company Closing

Coverage terminates on the last day of the month following the closing of your business or the last day of the month for which premiums have been paid. Please send GBS notification in writing.

Early Termination Provision

In the event of early termination, the Plan Sponsor shall forfeit any unused claims funds remaining in their account and all benefits end the last day of the month for which payment has been received. The Excess Loss policy will cease as of the date of termination and any unpaid claims will be the responsibility of the Plan Sponsor.

Reinstatement Provision

In the event of termination, the employer may request reinstatement within 5 days following the date of termination. However, reinstatement is at the sole discretion of GBS and the stop-loss carrier. Consideration will include prior premium payment 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.

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

Premium Payments:
Group Benefit Services, Inc. - T/A *Healthy*Advantage
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.

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

***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.