Employers Advantage

Self-Funded
Group Medical Program

Featuring Medical PPO Networks

Cofinity®

PHCS

Administered by CAM Administrative Services, Inc.

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Employers Advantage Overview

This program is an excellent solution for small employers trying to reduce the cost of group health coverage while maintaining an attractive option for their employees. With traditional fully insured programs premiums are set for the plan year and are remitted to the insurance company on a monthly basis. If claims do not exceed the premium the insurer retains this money. Employers Advantage features level funding and aggregate only stop loss coverage. Level funding consists of a predetermined portion of the claims along with excess loss insurance premium and administrative costs on a monthly basis. When eligible claims exceed the employer's claims funding, funds are released by the excess loss carrier to the employer's claim fund to reimburse claims. At the end of the run out period funds in excess of the claims that were paid from the employer's claims fund are returned to the employer. This concept allows the employer the opportunity to control cost with limited exposure.

Self-Funded Group Medical Program

This turnkey employer sponsored program provides small/midsize employers an opportunity to reduce the cost of group medical coverage while offering a comprehensive plan to their employees. This program offers:

- Group size: Minimum of 5 enrolled employees to maintain coverage under the plan.
- Competitive composite rate structure.
- The predictability of level monthly costs.
- Wide selection of plan designs including HSA's.
- Cofinity PPO Medical Network
- PHCS/MultiPlan travel/student/out of state network
- Catamaran Pharmacy Benefit Manager
- Includes many free generic drugs through the **medtipster/free program**.
- Medically underwritten to ensure this product is appropriate for the group.
- No pre-existing condition limitations.

- Aggregate stop loss insurance provides protection to the employer from claims that exceed the employer's claim liability.
- 12/21 Aggregate stop loss includes 9 months of run out coverage.
- Unused claim funds are returned to the employer at the end of the run out period.
- ERISA plan that is exempt from some of the new federal Affordable Care Act regulations.
- Program administration performed in CAMADS Southfield, MI office.

Three Elements of Level Funding

Employer Claims Fund:

Maximum annual claims costs are predetermined and the employer pays 1/12 of this cost each month (based on those enrolled in the plan) for the 12 months of the plan year. Once all eligible claims have been paid during the plan year and the 9 month run-out period, any unused dollars in the claims fund are returned to the employer.

Aggregate Stop Loss:

Reimburses eligible claims that exceed the Claims Fund which are incurred and paid during the plan year; as well as claims incurred during the plan year and paid during the 9 month "run-out" period following the end of the plan year.

Monthly Accommodation – If at any time the money necessary to pay eligible claims is not in the claims fund the excess loss carrier will release money to the claims fund to reimburse these claims. Subsequent monthly payments into the claims fund will be used to repay these released funds.

Administrative Fees:

Compensates CAM Administrative Services, Inc. (CAMADS) for items such as proposal preparation, medical underwriting, eligibility management, utilization management, claims adjudication, claims check/EOB processing, excess loss coordination, production of plan documents, distribution of materials (plan documents, ID cards etc.) to employers, monthly group invoicing, access to PPO and pharmacy networks, and agent compensation.

How the Program Works

Pricing/Underwriting

Proposal pricing is based on the group's census, location, and plan design selected; this proposal includes employer claims cost, aggregate stop loss premium and administrative costs. Final pricing is based on medical applications completed by those enrolling in the plan and the employer's disclosure statement. Additional questionnaires may be required to finalize underwriting.

Implementation

Employer enters into an Administrative Service Agreement with CAMADS to administer their program. Additional agreements and documents are required for participation in this program. CAMADS will establish a "Claims Fund" for the employer which will be used to pay eligible claims incurred by those enrolled in the plan. Enrolled employees will be issued ID cards and other required coverage documents, all of which will be sent to the employer.

Operation

CAMADS will enroll employees in accordance with the employer's eligibility requirements. Based on each month's enrollment CAMADS will invoice the employer for the total monthly cost which will be appropriately allocated to the employer's claims fund, aggregate stop loss premium, and administrative fees. Additionally, CAMADS will provide eligibility management, PPO network access, pharmacy network access, and utilization management services to the employer. CAMADS will also facilitate transactions between the employer and the stop loss carrier pertaining to monthly accommodations and claim reimbursements. CAMADS will process and pay eligible claims from the employer's claims fund in accordance with the plan design selected by the employer.

Reporting

CAMADS provides all reporting to the stop loss carrier in order to facilitate any monthly accommodations and/or aggregate claims. The employer will receive reporting on all claims paid during the plan year and the 9 month run-out period. This reporting provides the information necessary to fully track the claims fund and to understand where the claims fund dollars are spent. With this information, the plan can be designed to contain costs and address specific needs of the employee population.

Plan Year & Run Out Liability

The plan year runs for 12 months from the effective date. Claims incurred during the plan year will be paid during the plan year and through a 9 month run-out period. Any balance in the claims fund is returned to the employer at the end of the run-out period.

Important Information about this Program

- Payment of monthly invoice is due on the first of the month; failure to do so will result in the disruption of medical and pharmacy claims.
- The employer is responsible for the timely reporting of eligibility changes (new hires, termination, reduction in hours, disability, layoff, addition of dependent, divorce etc.) to CAMADS. Additionally, it is the employer's responsibility to insure that only employees who meet the plans eligibility requirement are enrolled in the plan. Failure to properly report eligibility may result in the denial of an excess aggregate claim by the stop loss carrier.
- Plan pricing may be modified or coverage terminated if it is determined that the employer or an employee committed fraud or has misrepresented a material fact.
- Any monthly accommodations are paid back when the cumulative attachment point exceeds your cumulative eligible expense.
- The Plan is secondary to any motor vehicle insurance coverage.
- Work related illness and injuries are not covered except as noted in the Plan Document.
- Termination of the plan prior to the expiration date will result in the forfeiting of any excess loss coverage (unless cancelled by the carrier for failure to meet minimum enrollment requirement of 5 enrolled employees).
- The employer is responsible for the payment of the Transitional Reinsurance fee and the PCORI fee.

The following is a summary of Employers Advantage medical plan exclusions.

- Charges for services and supplies that are not medically necessary
- Acts of declared or undeclared war, civil war or invasion
- Comfort/Convenience Items and services
- Routine Dental, vision and hearing care
- Treatment of weak, strained or flat feet, instability or imbalance of the feet, tarsalgia, metatarsalgia, corns, calluses, bunions or toenails except for related surgical procedures
- Services for cosmetic reasons, except for covered reconstructive surgery
- Services, supplies or treatment for gender assignment or change
- Fertility treatments
- Diagnosis care or treatment of sexual dysfunction or impotence (except as covered under the prescription drug benefit)
- Charges for the reversal of voluntary sterilization
- Voluntary abortion, except (a) the life of the mother would be in danger if the fetus were carried to term, or (b) complications of voluntary abortion
- Services provided by another plan such as any state, federal municipal or other governmental law, regulation, or program (including a governmental plan of health insurance) unless the Covered Individual is required to pay those charges and unless specifically covered under the Plan.
- Expenses for any illness, disease or injury arising out of, or in the course of , any employment for wage or profit or for which you are entitled or would be entitled to benefits , had such policy been elected, under any Workers' Compensation or Occupational Disease Law or similar law or policy
- Alternative Treatments including but not limited to hypnotherapy, massage therapy, and music therapy
- Services not recommended by a physician
- Expenses for care outside of the United States if travel was for the sole purpose of obtaining medical services
- Any hospital stay that is not for the treatment of a sickness or injury
- Hospital Emergency Room charges that were not related to an emergency
- Respite Care and outpatient private duty nursing
- Charges deemed in excess of Usual, Customary and Reasonable
- Charges payable by a third party because it is legally liable for the expense including but not limited to liability insurance, motor vehicle insurance and other sources that would pay medical benefits if the Plan did not exist.
- Services for treatment resulting from a Hazardous Activity
- Services provided by a person who resides in the participant's home or is a Relative of the participant.
- Charges for family for marriage counseling
- Court ordered testing or treatment
- Charges for preventive services provided by an out of network provider
- Expenses resulting from complications of a treatment not covered by the Plan (other than abortion)
- Services, supplies or treatment (including surgery) for weight reduction

Please consult the plan document, excess loss schedule, policy and riders, administrative services agreement, and joinder agreements for full details.