Employer Pro★Med™

Effective Solutions for Small Group
Partially Self-Funded Healthcare Benefits

Small Group Self Funded Healthcare Benefits

An alternative approach to funding employee healthcare benefits
Designed for groups with 10 – 99 covered employees, but larger groups are also eligible

The Potential for Substantial Savings

Today's employers face the difficult challenges of trying to offer employees quality health benefits while at the same time keeping the cost of providing these programs from eroding their bottom line. With traditional health plans, employers pay fixed monthly premiums and the insurance company assumes all the risk. In doing so, the insurance company profits the most in those years when the employers' claim costs were lower than expected. For many employers with a stable benefit and financial history, there is an alternative: Self-Funding. Larger employers have historically established self funded plans that allow them to benefit when claim costs are favorable, but until now smaller employers haven't had that option because of their size.

Employer ProMed™ offers small employers a powerful, practical alternative to traditional approaches that allows them to reap the benefits enjoyed by larger employers. ***Employer ProMed***™ rewards small businesses for their good claim experience in a way that makes sense for smaller employers.

When you choose ***Employer ProMed***™ :

- Your plan benefits directly from favorable claims experience
- You pay insurance company profit & expense charges only on the portion of the cost used to purchase excess loss insurance
- You pay less state premium taxes
- You have the potential for improved cash flow
- You have greater control over plan design
- ***Employer ProMed***™ is governed by ERISA and is therefore exempt from certain state mandated benefits
- You receive detailed reports showing exactly where your benefit dollars are going

With its flexible funding approach, ***Employer ProMed***™ also offers you important advantages over a typical self funded plan:

- The level of risk is tailored to meet the needs and risk tolerance of businesses, like yours, with ten to ninety-nine covered employees*
- Innovative features help make your cash flow predictable and help limit your risk should you terminate the plan in the future

*minimum group size may vary by state.

How Employer Pro★Med™ Works for You

With ***Employer ProMed***™ your business funds claims for healthcare benefits and purchases "excess loss" insurance to help limit your exposure to risk. In other words, your company pays for the actual medical expenses that your employees incur. At the same time, by promptly reimbursing covered paid claims above certain dollar amounts, excess loss insurance helps protect you from the risk of large medical claims incurred by an individual and by your group as a whole.

Our excess loss coverage options, tailored to meet the needs of individual groups, allow even smaller employers to successfully self fund their employee medical benefits.

With ***Employer ProMed***™, just a portion of each dollar you would typically spend on premiums goes to an insurance company to purchase excess loss coverage. The rest goes into your Claim Fund (a checking account from which your claims are paid). Depending on the coverage you select, a majority of your cost may go into your Claim Fund.

Throughout the plan year, ***Employer ProMed***™ handles the administration of submitted claims, notifies you of payable claims, pays the claims from monies received from you, and processes excess loss reimbursements. At the end of the plan year, any unused monies in the Claim Fund are yours to apply against future plan costs. Depending on your claims, your savings can be quite substantial.

Employer ProMed™ helps limit the employer's liability through the use of two types of excess loss coverage called Specific Excess Loss and Aggregate Excess Loss. Both offer a choice of coverage terms that define when a covered claim must be incurred, and when it must be paid, in order to be eligible for reimbursement.

Specific Excess Loss Coverage

This coverage helps protect the employer from the risk of significant claims being incurred by one individual. If an individual incurs claims covered under your plan that exceed an amount predetermined by you (your Specific Deductible), the excess will be reimbursed immediately by the insurance company.*

*To be eligible for reimbursement, covered claims must be incurred and paid during the time frame established in your excess loss coverage.

Employer ProMed™ addresses the needs of the smaller business by offering a choice of Specific Deductibles ranging from $5,000 to $100,000 per covered individual.**

**The Minimum Specific Deductible may vary by state.

Aggregate Excess Loss Coverage

This coverage helps limit your benefit claim liability for your group as a whole. If the covered claims you pay under all Specific Deductibles for those insured under your group exceed an amount predetermined by us (your Aggregate Deductible), the excess will be reimbursed by the insurance company.* Your Aggregate Deductible is determined by a number of factors including the size and demographics of your group, your plan of benefits, and the Specific Deductible you choose. The excess over the Specific Deductible does not count toward your Aggregate Deductible. Prescription drug claims will accumulate toward the Aggregate Deductible only.

*To be eligible for reimbursement, covered claims must be incurred and paid during the time frame established in your excess loss coverage.

Monthly Aggregate Accommodation

This feature makes your budget more predictable. A cornerstone of our approach, Monthly Aggregate Accommodation puts a cap on your covered paid claims to assure that you are not burdened by the prospect of excessive claims early in your plan year. This cap, called your aggregate accommodation point, limits your outlay for covered claims on a year-to-date basis. Each month we compare the dollar amount of the covered claims you have paid during the plan year with your aggregate accommodation point. If your covered paid claims exceed your accommodation point, you are advanced the funds to cover the difference. In subsequent months, should your accommodation point exceed your covered paid claims, you are required to repay the advance.*

*There is a minimum annual aggregate deductible stated in your excess loss policy. Your monthly aggregate accommodation point may not go below one-twelfth (1/12) of that amount. Premiums must be paid in full to date to receive an accommodation. At the end of the contract period, your repayment obligation will equal the sum of all advances made during the contract period (net of repayments) less the actual amount of your Aggregate Excess Loss reimbursement. A final repayment of any balance due must be made within thirty (30) days of the end of the contract period.

Employer Pro★Med™ Gives you Control

Monthly and annual reports show you exactly where your money for health benefits is going. By using the reports – and by taking advantage of SIS's experience and expert advice – you can confidently adjust your plan through different deductibles and copayment levels to maximize potential savings without compromising your employees' satisfaction.

Quote Requirements

Manual quotes are available for groups 10-150 lives without experience. The rates are contingent upon the completion of enrollment forms (includes medical questions). Enrollment forms do not have to be completed in order to receive a quote; however, they may be completed for a pre-qualified rate.

The following information is required to receive a quote:

- Group Name, Address(es), SIC
- Employee Census to include birthday, gender, coverage tier, zip code
- Desired Specific Deductible and Incurred/Paid Contract

If the group has 50-150 employees and experience is available, the additional requirements are as follows:

- Monthly paid claims and corresponding enrollment for the past 24 months.
- Detailed shock loss data to include details for all claims paid at or above 50% of the specific deductible.
- The current schedule of benefits to include plan change information within the past 24 months.
- Current and renewal rates, specific levels and contracts to include specific and aggregate premiums rates, aggregate factors, administration fee (with all included services)

The quoted rates are subject to final approval. Current coverage should not be cancelled until written approval is received from Special Insurance Services, Inc. Excess loss coverage is underwritten by Fidelity Security Life Insurance Company.

Underwriting Guidelines and Information

Group Eligibility

Eligible groups are corporations, partnerships, and sole proprietorships where there is a clear employee/employer relationship. Companies that have been in business 3 months or less must provide the following in order to be considered as eligible employer groups: *Articles of Incorporation and/or Partnership and Proof of Establishment and Financial Viability Letter from their Financial Institution*

Ineligible and Special Consideration Groups/Industries

Special Consideration:
Religious Organizations
Metal/Coal Mining
Oil and Gas Exploration/Extraction
Tobacco Stores and Stands/Tobacco Products
Explosives
Asbestos Products
Long Haul Trucking
Commercial Sports
Legal Services
Medical Services

Ineligible:
Multiple Employer Trusts (MET's)
Multiple Employer Welfare Associations (MEWA's)
Associations
Taft-Hartley Trusts
Employee Leasing Firms
Professional Employer Organizations (PEO's)
Human Resource Management Companies

Employee Eligibility

All full-time employees are eligible (working at least 30 hours per week/48 weeks per year). Owners, sole proprietors, partners, officers, and directors are eligible only if they qualify as full-time employees. Part-time, temporary, and seasonal employees are not eligible for coverage. The actively at work provision may be waived for those employees who are disclosed and approved of at the time of underwriting.

Unless superseded by applicable law or regulation, eligible dependents of an employee are a lawful spouse and unmarried children from birth to age 19 (or age 25 if a full-time student at an accredited school, college, or university) and the employee is providing at least 50% of their support. A child means a child by birth, legal adoption, or legal guardianship or a stepchild for whom the employee provides more than 50% support and maintenance and resides in the covered employee's home.

Retirees can be eligible for medical benefits only if the group has 20 or more employees and has received underwriting approval. Retirees cannot comprise more than 10 % of those enrolled.

Contract laborers and employees paid on commission are eligible for benefits on the employer plan if more than 50% of their income is derived from that employer. Tax information may be required as proof of eligibility. A group cannot be comprised of more than 10% of 1099 employees. 1099 employees are eligible only on groups of 20 or more lives.

Participation

We require 75% of all eligible* employees, but not less than 50% of all full-time employees participating in the plan. If the employer contributes 100% of the employee premium, we require 100% participation. Participation will be verified throughout the lifetime of the account.

* Eligible employees are those full-time employees who do not have coverage elsewhere.

Case Submission Requirements

To facilitate the processing of the applications, please include the following:

- *Employer Group Application/Plan Service Agreement*
- *Self funding Employee Benefits Employer Certification*
- *Application for Excess Loss Reimbursement Coverage*
- *Employer Disclosure Notice (if applicable)*
- *Employee Enrollment Forms, Authorizations and Waivers. For protection of privacy, all spouses and dependents over age 18 applying for coverage are required to sign and date the form.*
- *Copy of Current Carrier Billing*
- *Copy of Current Carrier Billing Statement from 12 months prior or certificates of creditable coverage if pre-existing credit is desired at time of issue.*
- *Wage and Tax Report (most recent filing)*
- *Copy of Presented Proposal*
- *First Month's Premium and Total Costs*

Additional requirements may be requested by the underwriter to facilitate the processing of a new group. A group will not be issued coverage with outstanding requirements.

Medical Underwriting:

Upon review of initial medical information included in the employee enrollment forms, the underwriter may request additional information. This may be a phone call to the applicant and/or spouse, a medical questionnaire to be completed by the applicant, an Attending Physician Statement, a Paramed exam, or information from the Employer to include a Disclosure Notice. The medical risk will then be evaluated. Since self-funded groups are exempt from SGR and guarantee issue HIPAA legislation, a significant rate increase may result in a declination of the group.

Health Information Call

A call is made to the applicant when health history is provided on the application and more details are needed to most accurately assess the risk. This phone call is done in lieu of obtaining medical records. We will work with a designated contact person at the employer or agency to coordinate any calls that may be needed.

Groups should not cancel their present plan until they receive written confirmation from Special Insurance Services, Inc. We will not back date any effective date prior to the date of the application. Applications are valid for 6o days following signature date. All enrollment information must be in our office and complete by the tenth of the month to consider a first of that month's effective date. If the coverage is approved after the requested effective date, the underwriter will contact you to determine the appropriate effective date for your client.

Employer Pro★Med™

SIS

SIS **EXPERIENCED STAFF & SERVICE-ORIENTED ADMINISTRATIVE SERVICES:**

- **Access to strong regional and national PPO networks and URAC Accredited Medical Management Firms**
- **State of the Art Claims Adjudication Systems**
- **Your Innovative Partner – from Concept to Installation!**

Limitations & Exclusions (for all Plans):

PLEASE READ CAREFULLY – This is an outline only and not intended to serve as legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone and the complete terms of the benefits will be determined by the plan sponsor's Summary Plan Description. Except as otherwise described, no coverage is provided for:

Services and supplies that:

- are not medically necessary
- occur during or arise from employment
- are not ordered or prescribed by a physician
- are not rendered within the scope of a physician's license
- are furnished by a government plan or facility unless the person legally must pay
- are in excess of the usual, customary and reasonable charge
- are free of charge without this coverage
- are provided directly by the employer
- are rendered before coverage begins or after coverage terminates

Expenses incurred as a result of Injury or sickness caused by:

- war, military services, participation in a riot, commission of civil or criminal felony or attempted suicide or self-inflicted injury unless resulting from domestic violence or a physical or mental health condition

Expenses incurred for any of the following:

- experimental/investigational treatment
- plastic or cosmetic surgery,
- hair loss or hair growth treatment
- storage of blood products or blood products when replaced by donation
- marriage or family counseling and sex therapy
- items used primarily for comfort or generally used in the household
- custodial care or services by a relative
- treatment of teeth or supporting tissues
- pre-existing conditions
- eye exams for corrective lenses, surgery to correct eyesight, eye glasses, contact lenses, hearing exams, hearing aids/ fitting, vision therapy or eye exercises
- sex change operations or complications, artificial insemination or fertilization, testing and treatment for impotency or infertility, elective abortion, voluntary sterilization or its reversal, birth control (except birth control pills)
- physical exams for work, school, travel, immigration, to buy insurance, or family planning
- weight loss, obesity, diet, exercise, vitamins, nutritional or dietary supplements, growth hormones, smoking cessation, eating or sleep disorders, acupuncture or biofeedback, holistic or homeopathic treatment, tattoos, body piercing
- treatment for learning disabilities or developmental disorders
- flat feet, unstable or imbalanced feet, corns, calluses, toenails, bunions, spurs, hammertoes or similar conditions
- massage therapy or therapeutic restoration of abnormal function of nerve system and body structures by manipulation
- complications of non-covered treatments, dependent daughter maternity
- charges for postage, shipping, handling, travel, missed appointments, release of medical records
- charges incurred outside US or Canada, except while travelling
- services and supplies provided by an athletic trainer, personal trainer, yoga or similar credentialed individual

Employer Pro★Med™

Marketed By:

ARRANGED/ADMINISTERED BY:

SIS

SPECIAL INSURANCE SERVICES, INC.
6509 Windcrest Dr., Suite 200 ▪ Plano, Texas 75024
(972) 788-0699 ▪ (800) 767-6811 ▪ (972) 991-3936 fax
marketing@specialinc.com ▪ www.specialinc.com

	ProMed 1k Deductible: $1,000 (3x family) Coinsurance: 90% / 70% Coinsurance Out-Of-Pocket Maximums: $5,000 (3x family) Annual Maximum: $5,000,000 Lifetime Maximum: unlimited		ProMed 2.5k Deductible: $2,500 (3x family) Coinsurance: 80% / 60% Coinsurance Out-Of-Pocket Maximums: $5,000 (3x family) Annual Maximum: $5,000,000 Lifetime Maximum: unlimited		ProMed 5k Deductible: $5,000 (3x family) Coinsurance: 90% / 70% Coinsurance Out-Of-Pocket Maximums: $5,000 (3x family) Annual Maximum: $5,000,000 Lifetime Maximum: unlimited		ProMed 10k Deductible: $10,000 (3x family) Coinsurance: 100% / 70% Coinsurance Out-Of-Pocket Maximums: $5,000 (3x family) Annual Maximum: $5,000,000 Lifetime Maximum: unlimited	
Physician Services	**PPO**	**Non-Network**	**PPO**	**Non-Network**	**PPO**	**Non-Network**	**PPO**	**Non-Network**
Office Visits (PCP/Specialist)	$15/$40 copay **or** 90% after deductible	70% after deductible	$15/$40 copay **or** 80% after deductible	60% after deductible	$15/$40 copay **or** 90% after deductible	70% after deductible	$15/$40 copay **or** 100% after deductible	70% after deductible
In-Hospital Visits (limit 1 per day)	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Surgery (1 asst max: 25% of fee) /Anesthesiology/Urgent Care/Allergy Services	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
X-Ray/Lab	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Preventive Services	100%	70% after deductible	100%	60% after deductible	100%	70% after deductible	100%	70% after deductible
Hospital Services								
Room and Board	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Emergency Room/Emergent Care (copay waived if admitted)	$250 copay, then 90% after deductible	$250 copay, then 90% after deductible	$250 copay, then 80% after deductible	$250 copay, then 80% after deductible	$250 copay, then 90% after deductible	$250 copay, then 90% after deductible	$250 copay, then 100% after deductible	$250 copay, then 100% after deductible
Intensive Care (3x semi-private room rate)	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Outpatient Care/Lab & X-Ray/Dialysis/Chemotherapy	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Other Medical Services								
Organ Transplants	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Home Health Care (60 visits or $5000/yr max.)	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Skilled Nursing Facility (45 day/yr max.)	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Ambulance	90% after deductible	90% after deductible	80% after deductible	80% after deductible	90% after deductible	90% after deductible	100% after deductible	100% after deductible
Mental, Nervous and Substance Abuse Inpatient and Outpatient	90% after deductible	70% after deductible	80% after deductible	60% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Prescription Drugs -- Retail/Mail Order	Generic: $10/$20 copay Formulary: $25/$50 copay Non-Formulary: $40/$80 copay Specialty: 50% to a maximum $250 out-of-pocket		Generic: $10/$20 copay Formulary: $25/$50 copay Non-Formulary: $40/$80 copay Specialty: 50% to a maximum $250 out-of-pocket		Generic: $10/$20 copay Formulary: $25/$50 copay Non-Formulary: $40/$80 copay Specialty: 50% to a maximum $250 out-of-pocket		Generic: $10/$20 copay Formulary: $25/$50 copay Non-Formulary: $40/$80 copay Specialty: 50% to a maximum $250 out-of-pocket	