



## OptiMed Comprehensive Major Medical Partner Program Brochure

- 25% Employer Contribution Required
- Benefits Paid Directly to Provider
- Participation Requirements Apply\*

\* For groups of 25 or more employees. States that require a minimum of 51 employees include: California, Florida, New Jersey, Ohio, and Utah.

*This program is not available in all states, including Alaska, Montana, New York and the state of Washington. Please check with your OptiMed Group Sales Representative to confirm that OptiMed is available in the state or states in which you may have an interest in offering OptiMed.*

## OptiMed Health Plans

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Boca Raton, FL 33431  
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Atlanta, GA 30360  
**(866) 553-0862**

*Please obtain an official proposal from your OptiMed Group Sales Representative. OptiMed is not bound to accept proposals that were not issued by OptiMed.*

*Brochure valid for 31 days*

*CMMPv8.02-Std*



# IN THE NEWS

## ABOUT OPTIMED PLANS

We specialize in providing employers, agents and brokers alternatives to control the increasingly high cost of providing healthcare benefits. Our clients represent all walks of life, employing both the professional, skilled and the unskilled worker. Our health benefit packages provide a sense of security and comfort to employees worldwide by providing assurance that their health care needs are protected. At the same time, employers remain assured that they are providing a cost-effective benefit package that satisfies their employees' basic needs.

Moreover, the current healthcare crisis has created a paradigm whereby employers are forced to cut benefit costs without losing employees. High turnover may result in lost profits and productivity. OptiMed is a pioneer in the recognition that this crisis may be creatively addressed. The offering of an affordable benefits package can be an effective means of retaining employees, reducing turnover and increasing productivity through improved morale.

## OPTIMED/UGP: FEATURED ARTICLES

- The New York Times
- USA Today
- The Wall Street Journal
- Health Insurance Underwriter Magazine
- National Underwriter Magazine
- Benefit Selling Magazine
- Managed Care Magazine
- AMA Magazine
- Broker World
- California Broker Magazine
- Newsweek
- Time Magazine
- Los Angeles Times
- Employee Benefit Adviser Magazine
- Kiplinger Magazine
- Kaiser Network
- Benefits Marketing Online Magazine
- Benefits & Compensation Solutions Magazine
- Employee Benefit News
- Human Resource Executive Magazine



## OptiMed Comprehensive Major Medical Partner Program (CMMP Program)

### OPTIMED CMMP

The OptiMed CMMP program is fully customizable to help consultants meet the diverse needs of their clients. This program is a fresh approach to employee benefits, allowing brokers and agents to bring what is found in partially self-funded alternatives to the table. The CMMP program will provide employers with the simplicity and security found in traditional fully insured plans while providing the major upside in cash refunds attributable to good claims experience.

The OptiMed CMMP program is specifically designed for groups of 25 or more, with the exception of group reform states in which it may be offered for groups of 51 or more eligible employees.

### HOW THE CMMP PROGRAM WORKS

The CMMP program is based upon a partially self-funded platform with reinsurance protection that eliminates excessive uncertain claim liability. The CMMP program allows the employer remit one monthly premium like a conventionally insured program. The CMMP program premium will be constant and guaranteed for a 12 month contract period. Should claims exceed the amount of premium paid, the re-insurer makes up the difference so that the employer has no additional claim liability. The CMMP program will have no additional claim liability than with a regular conventionally insured program.

### THE REFUND

The most exciting feature of the OptiMed Comprehensive Major Medical Partner Program is the refund. An accounting is performed of claims versus premium allocated to the claim reserve fund. This accounting is completed at the end of the 15th month when the initial contract period and reinsurance coverage end. The refund is for the 12 month contract period, but paid at the end of the 15th month. All claim reserves not paid as a claim through the 15th month of the 12 month contract period are refunded in full to the employer. Each successive year is administered in the same fashion.

To determine the refund amount, premium is divided between program/administrative costs, such as the administration of the program (printing of booklets, ID Cards, claims adjudication, PPO network, customer service and reinsurance costs) and the claim reserve fund. The refund, if eligible, is only based off of the unpaid portion of the claim reserve fund not paid out in claims.

As in all group medical programs, the total monthly premium should be expected to fluctuate due to the normal inflow and outflow of employees which is due to hiring and terminations. This will change the initial assumed annual amount of total premium paid into the contract. The total premium amount based upon the actual 12 month population will be the amount to which the retrospective refund of the claim reserve fund will be calculated.

Claims are not eligible for payment if received after the 15<sup>th</sup> month of the 12 month contract period in which they were incurred.

### ELIGIBLE GROUP SIZE

The CMMP program is specifically designed for groups of 25 or more, with the exception of group reform states which requires groups with 51 or more eligible employees.

Please check with your OptiMed sales representative to confirm that OptiMed is available in the state or states in which you may have an interest in offering OptiMed. The CMMP program is not available in Alaska, New York, Montana and the state of Washington.



**OptiMed Comprehensive Major Medical Partner Program  
(CMMP Program)**

**CONTRACT PERIOD SUMMARY REFUND EXAMPLES**

POSITIVE CLAIM EXPERIENCE	
<i>The following calculation is preformed</i>	
1. Annual premium	+ \$1,000,000
2. Allocation into fixed account	- \$350,000
3. Allocation into claim account	+ \$650,000
4. Claim payments	- \$350,000
5. Total employer refund	\$300,000

NEGATIVE CLAIM EXPERIENCE	
<i>The following calculation is preformed</i>	
1. Annual premium	+ \$1,000,000
2. Allocation into fixed account	- \$350,000
3. Allocation into claim account	+ \$650,000
4. Claim payments	- \$750,000
5. Total employer refund	\$0

Please note: The refund is for the 12 month contract period but calculated and paid at the end of the 15th month.

The above figures are for illustrative purposes only and will vary on a case by case basis.



**CUSTOMER SERVICE UNIT**

- Provided in English or Spanish for the member’s convenience.
- Single, toll-free call-center number for all customer issues and benefits.
- Assisting members in locating and contacting new providers.
- Explanation of benefits, coverage, claims payment and claim history.
- Verification of coverage to providers.
- Addressing the provider’s expectations.

**PPO PROVIDER RELATIONS DEPARTMENT**

OptiMed will help answer the following questions:

- Is the provider accepting new patients?
- Is the office closed on specific days?
- What are the office hours?
- Does the provider offer bilingual staff assistance?
- Does the provider offer senior services?

**CUSTOMER SERVICE**

OptiMed customer service is standing by to assist members with an explanation of benefits and coverage. The member is walked through their benefit program, how it works and how to best maximize their benefit dollars. In addition, OptiMed customer service is also available to explain claim payment and claim history.

**COMMUNICATION IS KEY**

Effective communication is key in the successful rollout and implementation of any limited benefit plan. The purpose of offering a benefit program is to provide your employees a valuable benefit which will in return help boost retention rates. OptiMed feels we can bring our unique energy, superior service, attention to detail and experience at performing large scale enrollments to the table to best suit your needs.

**HOW CAN I LOCATE A NETWORK PROVIDER?**

<b>Step 1:</b>	<i>Contact OptiMed Customer Service (800-482-8770).</i>
<b>Step 2:</b>	<i>Member identifies their name, group and the type of doctor or facility they desire. OptiMed customer service will verify the member’s status, coverage and specific PPO network.</i>
<b>Step 3:</b>	<i>OptiMed customer service will search for providers. If requested, OptiMed will contact providers specific to the member’s zip code and verify that the physician/facility understands they are part of the PPO network and that they will accept the member’s coverage.</i>
<b>Step 4:</b>	<i>Member will make appointment and visit one of the providers within the PPO network.</i>
<b>Step 5:</b>	<i>Provider will submit a bill directly to OptiMed. OptiMed will assign the appropriate PPO reduction, helping the member save out of pocket expense, and then OptiMed will pay the provider directly. The provider bills the member, if there is an additional portion owed by the member.</i>

**Please Note: The member may log online and search for providers 24/7.**



**OPTIMED OFFERS A FULL SUITE OF OPTIONS FOR CLIENTS TO CONSIDER**

**ENROLLMENT SUPPORT OPTIONS**

- Customizable bilingual communication template pieces: letters, payroll stuffers, posters, enrollment kits.
- Telephonic both inbound and outbound options by trained enrollment specialists.
- Full online functionality in both HR and member online tools:
  - HR Tools:** full suite of online HR tools permitting terms and adds, report generation, eligibility and bill review.
  - Member Tools:** Member online suite permits enrollment, plan design review, ID card request and printing of temporary ID cards, EOB and claims history review.
- Train-the-Trainers Support: Includes outbound telephonic management training sessions.

**TELEPHONIC COMMUNICATION SUPPORT**

- Toll-free number, bilingual benefits call center, customer services staffed by trained claim examiners.
- Benefit explanations available before and after enrollment.
- Benefit verification In-Bound and out-bound provider relations including: Access & benefit verification.



**SIMPLE AND EASY PLAN ADMINISTRATION**

OptiMed’s integrated seamless and simple approach to the administration process frees employers from major headaches associated with health plan administration.

- One dedicated account executive available by phone and email.
- One dedicated billing contact available by phone and email.
- “Train-the-Trainer” support for the employer’s managers & HR.
- Single source administration allows rapid support and issue resolution.
- Online HR administration tools and options allow immediate administration including adds/terms, report generation and a host of additional tools.
- Online member tools allow plan design information review, provider searches, EOB & claim history review, ability to print temporary ID cards, online enrollment options and email support.
- Free dedicated website for each client, upon request.
- Automated data/file exchange options.
- Point-to-Point online billing and email billing options.
- Simple list billing or direct member billing options
- High level direct access to Claims Manager, Manager of Administration and Chief Financial Officer via telephone and email should the client have the need.



**(Note: This is not an insurance benefit)**



## OptiMed Major Medical Benefits Summary

### RECOMMENDED PLAN DESIGNS

PLAN TYPE		PPO	POS	EPO	HDHP
<b>DEDUCTIBLE</b>					
(IN/OUT NETWORK)	<b>SINGLE</b>	\$250/\$500	\$1,000/\$2,000	\$2000 In Network Only	\$2,500/\$4,500
(IN/OUT NETWORK)	<b>FAMILY</b>	\$500/\$1000	\$2000/\$4000	\$4,000 In Network Only	\$4,500/\$8,500
<b>COPAY/COINSURANCE</b>					
(IN/OUT NETWORK)	<b>SINGLE</b>	20%/30%	\$35/\$50/20%/50%	\$35/\$50/30%	90%/60% after deductible satisfied
(IN/OUT NETWORK)	<b>FAMILY</b>	20%/30%	\$35/\$50/20%/50%	\$35/\$50/30%	\$35/\$50/30%
<b>OUT OF POCKET MAXIMUM</b>					
(IN/OUT NETWORK)	<b>SINGLE</b>	\$1,500	\$2500/\$5,000 Excludes deductible	\$4500 Excludes deductible	\$2,500/\$6,500 Excludes deductible
(IN/OUT NETWORK)	<b>FAMILY</b>	\$2,500	\$5000/\$10,000 Excludes deductible	\$8500 Excludes deductible	\$5,500/\$13,000 Excludes deductible
<b>PHARMACY COPAY/COINSURANCE</b>		\$20/\$50 In Network Only	\$20/\$50 In Network Only	\$30/\$60 In Network Only	90% After deductible satisfied
<b>LIFETIME MAXIMUM</b>		\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000
<b>PRE-EXISTING CONDITION LIMITATION</b>		Yes	Yes	No	Yes
<b>CONSULT-A-DOCTOR</b>		No	No	No	No
<b>FREE WEBSITE</b>		Yes	Yes	Yes	Yes
<b>FREE ONLINE HR ADMINISTRATION</b>		Yes	Yes	Yes	Yes

### SAMPLE MONTHLY PREMIUM & CLAIM LIABILITY SEGREGATION

OptiMed may be able to match the client's current benefit plan designs.

MONTHLY PREMIUM	CENSUS	PREMIUM	TOTAL
EMPLOYEE	22	\$482.11	\$10,606.42
FAMILY	34	\$1,125.10	\$38,253.40
<b>TOTAL MONTHLY PREMIUM</b>			\$48,859.82
<b>TOTAL ANNUAL PREMIUM</b>			\$586,317.84
SEGREGATION OF MONTHLY PREMIUM	ADMINISTRATIVE COST		CLAIM RESERVE FUND
EMPLOYEE	\$175		\$325
FAMILY	\$385		\$715

- The above premium amounts are purely illustrative. Actual premiums will vary by group.

**Disclosures:**

*Certain states require a minimum of 51+ eligible employees. Before any presentation of a proposal, please check with your OptiMed sales representative to be certain that the program being proposed is appropriate for the state intended. This is not an offer of sale. No offering of this material should be given without the expressed approval of OptiMed, and any offering will be based upon state availability, underwriting guidelines, agent guide, and minimum group size and participation requirements being met. The OptiMed program is not available in all states, including Alaska, Montana, and the state of Washington. Please check with your OptiMed Group Sales Representative to confirm that OptiMed is available in the state or states in which you may have an interest in offering OptiMed.*



## OptiMed Major Medical Benefits Summary

### OptiMed CMMP Program Retrospective Refund Summary for Cash Management Solutions:

The CMMP retrospective premium refund will take into account claim liability factors of \$259.75 for each single employee and \$649.45 for each employee with dependents. Based upon the census presented there are 22 single employees and 34 employees with families.

Based upon the demographics quoted, this census develops an annual claim reserve fund of \$333,549.60. Eligible claims presented or received for payment will be funded out of this claim reserve fund.

At the conclusion of the 15<sup>th</sup> month, an accounting of the claim reserve will be performed. The employer will receive a 100% retrospective refund of any funds remaining unpaid in the claim reserve fund during the accounting performed in the 16<sup>th</sup> month. Should claim experience prove unfavorable and no unpaid funds remain in the claim reserve fund the employer will not be entitled to a retrospective refund or if there is a deficit, the employer will not be responsible for the deficit.

Please note: (The normal inflow and outflow of employees due to termination and the new hire process may change the original demographic assumptions and actual amounts allocated to the claim reserve fund.)

The accounting performed at the conclusion of the 15<sup>th</sup> month will be based upon the actual census demographics for the entire 12 month contract period, taking into account the premiums paid, allocations made to the claim reserve fund as indicated above and claims funded.

Example: Should the census remain constant through the 12 month contract period and a 50% paid claim loss ratio has been experienced, the following accounting will reflect the retrospective refund to the employer:

Deposited Funds into Claim Reserve Fund-	\$333,549.60
Paid claims (12 month contract period)-	\$166,774.80
Retrospective refund-	\$166,774.80

Please Note: Claims incurred during the 12 month contract period may be presented and must be received through the 15<sup>th</sup> month to be eligible for payment. The retrospective refund accounting will be preformed at the conclusion of the 15<sup>th</sup> month. The refund will be delivered in the 16<sup>th</sup> month. Claims incurred during the 12 month contract period that are presented or received after the 15<sup>th</sup> month will not be eligible for payment.

To be eligible to receive a retrospective refund, the group must be in force and premium paid throughout the entire 12 month contract period. Should the group terminate prior to the conclusion of the 12 month contract period the employer will not be eligible for any retrospective refund.

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### CONTINGENCIES

1. Actively-at-Work may be waived for health benefits only with full disclosure.
2. This quotation is based on the proposed plan of Medical/Rx benefits.
3. Quote assumes the use of PHCS as the Managed Care Network.
4. Specific Advance is included.
5. Retirees are not covered.
6. Minimum Covered Employees will be 75% of all eligible or 25 whichever is greater.
7. The underwriting information provided by or on behalf of the Insured, including the Disclosure Statement, is part of the Application for Excess Loss Coverage.
8. Any expenses relating to an employee or dependent required to be disclosed on the Disclosure Statement but not disclosed will not be eligible for reimbursement under this Policy.

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