

BENEFIT SUPPORT, INC.

Presents

An Alternate Funded Proposal

For

Your Company's Benefit.

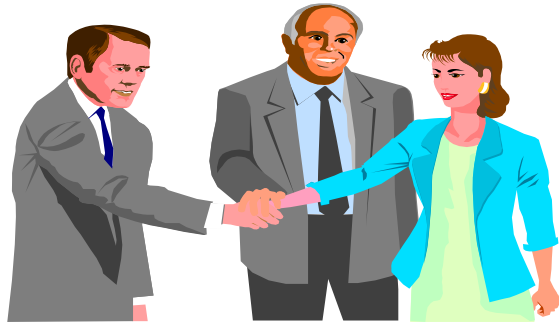


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305 Green St., (P. O. Box 2977), Gainesville, GA 30503

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INTRODUCTION

BENEFIT SUPPORT, INC. (BSI) specializes in the establishment and administration of alternate-funded employee benefit programs and possesses the expertise and systems to be responsive to any need or request. **BSI** provides administrative services and assistance to clients in all phases of employee benefit management.

Corporations have been described as groups of individuals joined together, voluntarily, to pursue a common goal. This is an apt description of BSI in that we are a carefully structured team, utilizing the unique disciplines and talents of each individual; bringing all to bear for the benefit of the client. We are dedicated to our common goal of providing our clients innovative, cost-effective means of designing, funding, managing and administering their employee benefit programs. **As a company, growth has never led to compromising our dedication to a client.** We operate under a rather simple two-part philosophy, i.e. that (1) health care costs, like any other cost associated with operating a business can be controlled and that (2) this control can be accomplished without the necessity of stripping away benefits from the covered individuals.

BSI retains customer services capabilities to handle any special request, assist in orientation or provide any other assistance required, on-site or from our offices. **Additionally, you will have a dedicated claims team assigned to your plan.** BSI will work closely with your representatives to ensure a smooth transition of your plan. Implementation is kept simple and to the point. We take care of the administration and on-going requirements. **From start to finish, Benefit Support, Inc. is beside you assisting in every step to a more efficient, affordable employee benefits program.**

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BENEFIT SUPPORT, INC.

SERVICES

PLAN DESIGN, INSTALLATION & COMMUNICATION

The first step of our relationship is to learn everything there is to know about your company's current benefit package and your goals for the future. Together, we will then customize a benefit plan to meet your company's specific management and personnel philosophies. Once a final determination of plan benefits has been made, BSI will provide all assistance needed in implementing the plan. This includes the writing of a prototype plan document, printing employee booklets and I.D. Cards as well as conducting employee meetings, if deemed necessary.

CLAIMS PROCESSING AND ADJUDICATION

BSI has developed a unique claims adjudication system supported by an experienced staff of professionals to ensure and safeguard the integrity of the plan. Each client receives a dedicated claims processing individual to handle their account. This allows for more personal and individualized service. Further, a funding report is provided monthly detailing plan expenses by participant, incurred date and processed date. The employer, the participant and the health care provider each receive a simple Explanation of Benefits for covered expenses that have been paid.

REPORTING AND BENEFITS ANALYSIS

You receive a complete computerized benefits summary which provides you with an analysis of claims by participant, payee, diagnosis, type of service and incurred dates. You are kept informed of every dollar that has been spent on a monthly basis.

RECORDKEEPING AND GOVERNMENT COMPLIANCE

BSI duplicates your current enrollment files and maintains an accurate listing of eligible participants. You will be invoiced monthly for insurance coverages and BSI remits premiums to the appropriate carrier. We handle all the administrative aspects of government compliance with state and federal agencies.

COBRA/HIPAA/FAMILY MEDICAL LEAVE ACT ADMINISTRATION

BSI is prepared to perform the complicated administrative functions of COBRA, HIPAA and The Family Medical Leave Act (FMLA) for your organization; informing you of changes in the regulations which directly affect your Plan. We also determine the COBRA rates, maintain accurate record-keeping and collect all the premiums. Valuable savings can be realized, as we pend any COBRA claims until receipt of the premium, thus assuring no claims are paid until the COBRA participant properly submits their premium.

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BENEFIT SUPPORT, INC.

SPECIALIZED EXPERTISE

Benefit Support, Inc.(BSI) operates as a Third Party Administrator. **THIRD PARTY ADMINISTRATORS**, better known as **TPAs** provide a wide range of benefit administration services, such as plan design, claims processing, renewal negotiations, etc. It is a relationship much like many firms which hire outside CPA firms to handle their accounting, or hire an outside law firm to be their general counsel. Accordingly, **BSI** offers personalized, flexible service to an employer.

Government laws and regulations over the past decade have made TPAs indispensable. *Each year, there are about 1,500 new laws, regulations, interpretations, opinions and major court cases issued by about 200 government authorities.* Only about 30% of these are publicly announced and only about 1% have official, comprehensive compliance instructions. TPAs take on the job of staying informed on such matters. This expertise makes firms such as **BSI** irreplaceable.

Lawyers and CPAs are trained to work from known entities. With new requirements coming so quickly without announcement and definitely without instruction or consistency . . .lawyers and CPA's are at a severe disadvantage.

Implementing a properly designed financially sound benefit plan involves many special skills. The following are a few examples:

- Detailed Knowledge of and Experience with Government Regulations.
- Highly Trained Claims Adjudicators
- Specialized Computer Systems
- In-depth Knowledge of Funding Arrangements & Alternate Medical Systems.

It takes an experienced and professional TPA, such as **BSI**, to combine and implement the skills necessary for a cost-effective group health plan. **BSI** will assist you in evaluating funding options and assist in designing a program that meets your specific needs. **BSI** will prepare a prototype Plan Document, issue management reports, adjudicate claims, collect and remit insurance premiums. An employer always needs and demands the most capable individuals and firms for their business. **WHY ACCEPT ANYTHING LESS FOR YOUR BENEFIT PLAN?** Whether purchasing machinery or benefits, you want to deal with a quality company that provides all the products and services necessary for a professional, quality program! Third Party Administration should not be an exception. **BSI's** services are critical in monitoring and controlling today's rising health care costs.

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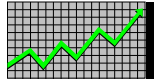
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MAJOR ADVANTAGES OF ALTERNATE-FUNDING



GOOD CLAIMS EXPERIENCE = IMMEDIATE SAVINGS

The experience of a medical benefit plan consists of fixed costs (administration fees and excess risk premiums) and claims cost. When claims are low, only the fixed costs and low claims are paid. There is no risk/profit for the insurance company. You retain plan funds and pay claims as they occur, rather than “pre-funding” claims through traditional insurance methods.



CORPORATE CASH FLOW IS IMPROVED

You determine how to fund the plan. You may make deposits only as needed to pay claims, thus keeping all excess moneys in your corporate cash flow. You may also make a pre-determined monthly deposit into your own bank account and invest these funds until needed to pay claims. *Interest is earned by you, not an insurance company.*



RESERVES ARE NOW HELD BY THE EMPLOYER

Reserves (*which are approximately 25-30% of the premium*) otherwise payable to an insurance company **can now earn interest for you instead of the insurance company.**



BENEFITS CAN BE DESIGNED TO FIT YOUR NEEDS

Within certain guidelines, there is almost total flexibility in the design of benefits. You have more control over your employee benefit program. You can pick and choose the benefits you feel appropriate and not be forced to offer certain coverages.



ADMINISTRATIVE EXPENSES WILL BE LOWER

Third Party Administrators normally charge lower fees than those charged by insurance carriers. Additionally, their fees are based on an employee per month fee, rather than a percentage of paid claims. Thus they are more likely to question claims instead of just paying them.



LIABILITY LIMITS PROVIDED TO FIT YOUR NEEDS

A variety of liability limits through stop-loss coverage can be offered. Usually the employer decides between lower fixed costs and higher liability limits, or higher fixed costs and lower liability limits.



YOUR ORGANIZATION'S IMAGE IS ENHANCED

Your plan is perceived by employees as “**Our Plan**” rather than an insurance company’s plan.

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GOVERNMENTAL REGULATION OF ALTERNATIVE FUNDED PLANS

Regulation of alternatively funded plans rests more with federal than with state government. These plans are under the jurisdiction of the U. S. Department of Labor (USDOL) and operate according to the Employee Retirement Income Security Act (ERISA), the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act (HIPAA), the Kassenbaum-Kennedy bill, signed into law on 8/21/96. As a rule the Federal Government has a reputation of stricter enforcement in these matters than do the various states. The following is from National Center for Policy Analysis (<http://www.public-policy.org/~ncpa/ba/ba/162.html>): *“Currently, about 140 million Americans receive their health insurance through (alternatively funded) self-funded health insurance. ERISA permits employers to design plans that fit both their employees’ needs and their companies’ finances. As a result of ERISA, more people are insured. By contrast, state control over traditional health insurance policies (group plans) offered within the state has resulted in higher premiums, forcing many employers to cancel their policies and leaving the employees uninsured”*. The report further states that, *“ERISA makes insurance more affordable. Self-funding (alternative funding) makes coverage more affordable for two reasons: ERISA limits the ability of states to mandate specific benefits and to tax health insurance plans.”*

FURTHER INFORMATION SUPPORTING THE PREVELANCE OF ALTERNATIVE FUNDING WITHIN INDUSTRY.

According to a Government Accounting Office survey performed by KPMG Peat Marwick and released late in 1996, self-funding (alternative funding) remains a popular method of providing employee medical benefits. That report said:

“In 1996, 91 percent of all employees were covered under a Fee For Service (FFS) plan that was self-funded; 98 percent of employers with 5,000 or more employees covered their workers in a self-funded FFS plan. Regardless of the type of plan, Fee For Service (FFS), Health Maintenance Organization (HMO), Point of Service (POS) and Preferred Provider Organization (PPO), more employers are self-funding benefits. In 1996, approximately 20 percent of employees who were HMO members were covered under a self-funded plan which was up from 15 percent a year earlier.”

The last sentence is of particular interest because HMOs have traditionally always been fully insured, but now even they are finding that employers are insisting that, if the HMO wants to maintain a relationship with the employer, it must also offer a method by which its benefits may be self-funded.

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THE QUESTIONS ... THE ANSWERS

- **WHAT IS ALTERNATE-FUNDING?**

Alternate-funding is a more cost-effective way of providing employee medical/dental benefits. It removes the “Insurance Company and/or HMO from the role of dominant player and relegates them to simply a funding vehicle for excess risk. The employer assumes the dominant role and the plan of benefits becomes what the employer wants to provide, rather than what the insurance company and/or state government mandates they must provide. Working with a professional specialty firm such as Benefit Support (BSI) to handle administration, medical management and claims payment the employer (Plan Administrator) assumes a predictable and known responsibility for benefits up to a predetermined level. Stop-loss coverage, arranged for by BSI, limits that liability on both the individual and group levels. This allows the employer to enjoy the benefits of alternate-funding while avoiding the danger of large, unpredictable claims.

- **WHAT ARE THE ADVANTAGES OF ALTERNATE-FUNDING?**

Utilizing alternate-funding, *employers frequently find they are able to exercise better control over the cost of their employee benefit programs.* Advantages can be achieved in the following areas:

- ◆ **Improved Claims Control**

The cost of paying claims is less, and the process receives a more thorough screening and monitoring. Efforts are continually made to identify over-utilization and abuses. **BSI** will work closely with your representative to ensure issues are addressed accurately and promptly.

- ◆ **Reduced Costs**

The insurer’s profit margin, premium taxes and risk charges, are reduced as alternate-funded plans need only cover the stop-loss claims risk, *a substantial insurance cost savings.*

- ◆ **Greater Flexibility**

The alternate-funded plan has greater flexibility in benefit design.

- ◆ **Improved Cash Flow**

Cash flow may be improved when moneys formerly held by the insurer in the form of claim reserves become available for the needs of the employer.

- ◆ **Freedom from State Regulations**

Alternate-funded plans are exempt from state regulation, thus costly state-mandated benefits are not required. While ERISA (Federal) compliance is required, ways are recommended and suggested in which it can be achieved.

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- **CAN MY COMPANY BENEFIT FROM ALTERNATE-FUNDING?**

It's easy to determine if alternate-funding will work for your company; see how closely your organization fits this criteria:

- 4 **Stable or Steadily Growing Work Force:**

A firm should be maintaining its size or growing.

- 4 **Predictable Claims:**

Your claims history should be fairly predictable, without great fluctuations between years. Your current insurance carrier should furnish you with a 3-year claims history for your review.

- 4 **Cash Reserves:**

Your company should have sufficient cash flow or reserves to handle month-to-month fluctuations in claims payments.

- **HOW CAN WE PROTECT THE COMPANY FROM UNFORESEEN CATASTROPHIC CLAIMS?**

That is exactly what stop-loss coverage does. *It sets a limit on the employer's liability, reimbursing the employer for claims that exceed that limit.*

Φ **Aggregate Stop-Loss Coverage:** This provides coverage should the claims for the entire covered group exceed *a predetermined limit*, called the aggregate attachment point or aggregate deductible.

Φ **Specific Stop-Loss Coverage:** This provides coverage should an individual's claims exceed *a predetermined limit*, called the specific deductible.

- **HOW DOES IT WORK?**

First, the employer must choose an employee benefit plan design. This is usually done with and through a Third Party Administrator (TPA), such as **BSI**. *Often this is simply a modification or a duplication of your current coverage.* **BSI** will prepare a prototype plan document (master contract) and arrange, negotiate with and select a reinsurer. **Benefit Support, Inc.** will operate the plan, provide the necessary materials, pay claims, prepare reports and handle other administrative duties. *The fees are normally far smaller than those charged by a traditional insurance carrier.*

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- WHEN I TRANSFER TO ALTERNATE-FUNDING, WHAT HAPPENS TO CLAIMS ALREADY INCURRED BUT NOT PAID WHILE I WAS COVERED BY THE OTHER COMPANY?

If the service took place while the old policy was in effect the insurance company should pay the claim, regardless of when it is filed. Check the “*Extension of Benefits*” provision of your current coverage for cases of disability or other unusual circumstances.

- WHAT IF I DECIDE TO LATER RETURN TO A FULLY INSURED PLAN, WHAT HAPPENS TO THE CLAIMS ALREADY INCURRED BUT NOT PAID UNDER MY ALTERNATE-FUNDED PLAN?

Most reinsurers now offer a “**Terminal Liability Provision**” which will place a predetermined limit on the group plan, regardless of the amount of claims still not paid. An employer will know exactly the maximum amount he may pay in the event he terminates his alternate-funded plan.

- WHAT HAPPENS IF A LARGE NUMBER OF INDIVIDUAL CLAIMS OCCUR IN ANY ONE MONTH, BUT DON'T EXCEED THE SPECIFIC LIMIT? WILL THIS DEVASTATE MY CASH FLOW?

No. Alternate-funded plans can purchase cash flow protection (specific and aggregate advancement) to prevent a large cash flow outlay. This is often called an aggregate accommodation or advancement. This places a cap on monthly claims the employer will have to fund. Any amount in excess of this amount will be paid by the reinsurer (*interest-free*) until which time the employer pays the carrier back or at the end of the plan year.

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CANDIDATES FOR ALTERNATE-FUNDING

Any financially stable company with approximately 25 or more full-time employees and a history of good claims experience should consider “Alternate Funding”. Although rates and factors are guaranteed for a 12 month period, the plan can be reviewed at any time during the Plan Year when a change in benefits and/or vendors is being considered. Sixty (60) days prior to the renewal date *Benefit Support, Inc.* will “shop the market” for the best possible terms for the next Plan Year...you do not have to wait for a notice of premium increase and then scramble to find a lower priced carrier...we do the homework for you.

To properly understand the difference between a Fully-Insured Plan and a plan utilizing the Alternate-Funding approach, we will illustrate how the premiums break down in either case.

Further, it must be recognized that Alternate-Funding is not a “product” but rather is a method of funding which reduces overall plan costs while still providing a limit on the maximum exposure of the client. Health benefits are self-funded but all claims above pre-determined limits are reimbursed by an insurance company. This allows the employer to plan and budget for future expenditures, confident that they will never face any unexpected claim liability.

A Typical Fully-Insured Plan

(100% Paid Premiums)

Expenses Include:

- **FUNDING FOR EXPECTED DAY TO DAY CLAIMS**

An actuarially established estimate of a particular group’s expected claims, based on the age/sex (demographics) of the group, type of business, location, previous claims experience, on-going medical conditions and medical inflation.

- **FUNDING FOR A RESERVE FOR UNANTICIPATED CLAIMS**

An additional amount (typically 25% of expected claims {above figure}) as a reserve in the event claims exceed the anticipated level.

- **PURCHASE OF STOP-LOSS INSURANCE (RE-INSURANCE)**

Insurance purchased by the insurance company from an insurance intermediary or through a reinsurance treaty for the amount exceeding the insurer’s normal “retention” level (normally the total of the above expected claims and reserve).

- **ADMINISTRATION**

The insurance company’s cost of providing booklets, ID cards, claims processing and adjudication services, fees paid to Utilization Review organizations, PPO access fees (where applicable), salaries of Administrative Personnel, Postage, Telephone and Facsimile expenses, etc.

- **MARKETING, OPERATING EXPENSES, PROFITS & TAXES**

The insurance company’s routine operating expenses, salaries paid to Marketing Personnel, Commissions paid to Managing General Agents, General Agents, and the Selling Agent, Profits and Premium Taxes paid to the State. In Georgia, the tax rate is 2 ½% of the total annual premium - which includes all the above costs.

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TYPICAL ALTERNATE FUNDED PLAN

Expenses Include:

- **FUNDING FOR EXPECTED DAY TO DAY CLAIMS**

Essentially the same calculations are made, except that these funds are retained by the client in their own Loss Fund, in a bank of their choosing, and claims are paid from this Loss Fund only when and as they are incurred.

- **FUNDING FOR A RESERVE FOR UNANTICIPATED CLAIMS**

Again, similar funding is set up, retained by the client in their Loss Fund for any unanticipated claims and is used only in that event. Normally this reserve is carried-over into ensuing Plan Years and can be used to reduce future Plan funding costs or to enhance benefits. In the rare event that claims utilize all these funds, the client simply starts the next Plan Year with no carry-over funds.

- **PURCHASE OF STOP-LOSS INSURANCE (RE-INSURANCE)**

In an Alternate Funded approach, the client (instead of the insurer) purchases insurance to protect the Loss Fund against catastrophic loss. This coverage is, typically, arranged for by the Third Party Administrator. As an aside, this premium amount is the only portion of an Alternate Funded plan which is subject to State Premium Taxes. No tax is paid on the Funding (above) or the following items.

- **ADMINISTRATION**

Typically a Third Party Administrator provides all the services previously provided by an insurance company. A major difference is that, in this case, the administrator is working **for the client** and not for the insurance company. This leads to more personalized responses to the client's needs instead of the insurance company's desires. Perhaps more importantly, it is an established fact that an independent Third Party Administrator can and will operate more efficiently and at lower cost than an insurance company with regard to administrative services.

- **MARKETING, OPERATING EXPENSES, PROFITS & TAXES**

These expenses are greatly reduced, in that marketing is usually performed by the employer's chosen insurance agent (who is paid on a commission basis), but the Managing General Agent's and the General Agent's involvement (and commissions) are eliminated entirely. The insurance company's role is now relegated to simply providing re-insurance protection for excess loss. The employer is also now free to design their own plan of benefits, to suit the need of its employee population and not to accept a "one size fits all" plan of benefits, either as offered by the insurer or mandated by the State. Premium taxes are also reduced in that they are only paid on the re-insurance premium instead of on the Total Funding (which includes claims, reserves and administration costs).

CONCLUSION

All in all, a much less expensive plan is created due to the elimination of many of the "Non-Benefit" items from the fully-insured plan design. Yet, the employer has the same safeguards as in a fully-insured program - and the advantage of paying claims only when and as they occur, rather than pre-funding them with the insurer. Further, should claims not exhaust all deposits (the usual result), the money in the Loss Fund account has not been spent and is, therefore, still available to apply to future costs, premium reductions or the addition of new benefits, as decided by the employer.

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THE MANAGED CARE ORGANIZATION (MCO) THE HEALTH BRIDGE

The success of a Managed Care Organization, the Third Party Administrator and the client employers is based on producing direct, measurable and immediate returns on the dollars being invested into the plan. So as to accomplish this task, THE HEALTH BRIDGE delivers:

1. A PROFESSIONAL RESOURCE

HEALTH BRIDGE'S managers are first and foremost, skilled managers. Additionally each is a medical professional; licensed as a Registered Nurse, having either Bachelor's or Master's level degrees; with additional experience and training in medical management issues. They are available to employees and their dependents through the Health "Bridgeline", a toll-free number answered by a qualified, trained professional 24-hours per day, 365 days per year without the use of "Voice Mail".

2. EASY IMPLEMENTATION

HEALTH BRIDGE'S resources are readily available to assist employers and their administrators in setting up the programming required to get started. Members of our management team have set up programs for employers throughout the United States.

3. TEAMWORK

Although HEALTH BRIDGE managers are technically external to the client company, they function as if they were a part of the employer's management team. When dealing with employees they function as the company nurse or specialized health consultant on call at all times. They emphasize the importance the employer places on individual employee well-being while carrying out the company's management philosophy.

4. NATIONAL SCOPE/LOCAL ORIENTATION

There is no state or locality that is beyond HEALTH BRIDGE's reach. However, HEALTH BRIDGE's managerial philosophy is one that integrates and coordinates local medical and other resources to achieve the employer's goals of providing high quality medical care without unnecessary or inappropriate treatments or therapies. We'll be there when needed to ensure a high standard of cost effective care for employees.

5. ACCOUNTABILITY RELATIONSHIP.

HEALTH BRIDGE is a managed health care program that will be best built through long term relationships. Regardless of the size of your company or HEALTH BRIDGE's, each employee's/employer's needs will always be the primary responsibility of one HEALTH BRIDGE manager. Direct contact with HEALTH BRIDGE's Chief Operating Officer is available on a 24 hour basis.

6. EXPERIENCE THAT COUNTS

Because our concentration is on the delivery of effective health care and related medical issues, what may be a new and perplexing problem for an employer/employee, will often be routine for HEALTH BRIDGE managers. There is no substitute for experience when seeking to provide for high quality "outcomes" in health care management.

7. EDUCATIONAL RESOURCE

HEALTH BRIDGE uses every opportunity to teach and instruct employers and employees in the effective management practices related to our work. Educational strategies focus on raising the level of quality in health care consumption at all levels through a one-on-one relationship with the HEALTH BRIDGE manager.

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8. CLIENT DEVELOPMENT AND ALLIANCES

As a client oriented organization, HEALTH BRIDGE provides the forum for its client employers to interact with other employers and their administrators interested in similar issues. It is not uncommon for employers considered to be competitors to find opportunities to work together and in their communities through HEALTH BRIDGE.

9. CREDIBLE INFORMATION SOURCE

HEALTH BRIDGE employs a comprehensive reporting system with minimal paperwork. These reports update claim administrators on the status of management activities, results, strategy implementation and return on investment.

10. NO CONTINUING OVERHEAD

Employer/employee members are able to access medical expertise on an as-needed basis, 24 hours per day, 365 days per year. However, there is no burden of an on-going overhead normally associated with a corporate medical staff. Members are able to use the services only as needed and pay only for services they use.

HEALTH BRIDGE provides Pre-Certification of Hospital Admissions, Inpatient Certification Review, Employee Medical Support Services, Assistance in Obtaining Second Opinions for Surgical Procedures (when requested), Medical Case Management (as needed).

“Someone is managing every health care problem in America today! Anyone who is serious about creating competitive advantage, reducing waste, and helping employees and dependents keep good health, should be asking themselves and others if that “someone” is the one who should be doing it for their employees and dependents.”

HEALTH BRIDGE’S FRONT PAGE GUARANTEE

We will always put the employer/employee relationship first. Without employers and their employees there would be no HEALTH BRIDGE.

We will listen.

We will discuss the cost effectiveness of our services at any time and never argue about a bill. If the value is not apparent - don’t pay the bill.

We will consistently bond employer and employees together as we work to ensure the highest quality cost effective care for patients.

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THE PREFERRED PROVIDER ORGANIZATION (PPO) Networks

Preferred Providers Organizations (PPOs) are structured networks of physicians, hospitals and other health care professionals (referred to as “providers”) who have contracted with the PPO management to provide high quality health care services within a cost-effective environment and at discounted fees. To become a “Participating Provider” the physician, hospital, etc. must supply detailed credentialing information for review and approval.

In the case of hospitals, this normally requires details on ownership, management, licensing, verification of accreditation by the Joint Committee on Accreditation of Hospital Organizations (JCAHO) or other such body, as well as evidence of the hospital’s ability to provide high quality care and its willingness to do so at reduced prices. One of two methods of compensation to the hospital are normally utilized; (1) a discount from billed charges , or (2) a “Flat Rate Per Diem” reimbursement. These reductions normally range from 25% to 40% below what would ordinarily be charged for the same services.

As to physicians and other professional individuals, they must supply a detailed Curriculum Vitae, to include:

- (1) State Licensure
- (2) Drug Enforcement Agency Licensure
- (3) Evidence of adequate Malpractice Insurance
- (4) Diploma from a recognized Medical School
- (5) Details on Residency and Internship.
- (6) If to be listed as other than a “General Practice” physician, details on Specialty Training and evidence of either Board Eligibility or Board Certification in that Specialty.
- (7) A signed application for appointment detailing the discounts on fees for service, agreement to file claims on behalf of the patient, agreement to accept PPO reimbursement fees as “payment in full” and agreement not to “balance bill” the patient.

The result of implementation of a PPO into an employer’s plan allows for a higher level of benefits when PPO providers are used. Normally a 20% benefit differential is utilized (90% In Network/70% Out of Network, or 80%/60%, for example) to reimburse for services provided. Use of a PPO provider is totally voluntary on the part of the employee/dependent but a 20% higher reimbursement generally will “steer” the patient to the quality provider. The larger percentage of employees that can be encouraged to use the PPO providers, the more successful the plan will be in containing and controlling the cost of health care and the result of this will be a lowering of plan costs into the future.

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