

Advanced Funding Stop Loss

Producer Communication #518

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Message

In response to market demand, Capital BlueCross will begin to offer Advanced Funding Stop Loss (AFSL) with its stop loss products sold through Avalon beginning 1/1/2011. Advanced Funding is the process by which claims in excess of a group's specific stop loss limit per member are not billed to the group. When claims for a member exceed the specific stop loss limit, reimbursement is made directly by the stop loss carrier (Avalon) for these claims and the group is not billed. Having AFSL is a significant benefit to the group as they will no longer be required to tie up their own money to pay large claims in excess of the specific stop loss and then seek reimbursement from Avalon.

Details

Advanced funding will be offered as a standard feature of Avalon stop loss with the following restrictions:

1. Senior plans will be excluded from AFSL
2. Groups must have stop loss through Avalon and medical through CBC to have AFSL
3. Group must have AFSL on all plans with Avalon if they elect to add this feature (except Senior)
4. Cannot offer advanced funding on Aggregating Specific stop loss product. This stop loss sets a specific level for each member and then an aggregate level above the specific that the entire group must meet before stop loss carrier pays claims.
5. Cannot offer advanced funding on level premium ASO products such as Interim Deposit. Groups in these financial arrangements are billed a set premium every month and would not experience the impact of a high claim during the year.
6. Cannot offer Advanced Funding on groups with a Laser.*
7. Pharmacy claims will not be part of AFSL but will be reimbursed post payment.

*Please be advised that Avalon Stop Loss customers who have a laser in their Stop Loss policy cannot receive an Advanced Funding arrangement. Combining the two options cannot be administered at this time. Avalon Stop Loss customers may add a laser member to their Stop Loss policy at the time of the New Sale or Renewal.

Laser: A Stop Loss feature that groups may use to reduce their monthly Stop Loss premiums, by carving a high cost claimant out of their total claims experience. Lasers may be completely excluded from the group's Stop Loss policy or have a greater specific deductible assigned to them. This feature is not required and is not offered at renewal unless at the request of the group as a cost savings strategy.

New Groups

All new groups to Avalon will be offered AFSL as a standard feature with their Avalon stop loss if their medical coverage is through CBC. Stop Loss paperwork must be submitted prior to the group's effective date for advanced funding to take place in the group's first month. An Avalon rates sheet, application (*Attachment A*) and AFSL Form (*Attachment B*) should be included in the paperwork for all groups that are new to Avalon. The newly revised application contains a check box that clearly indicates if a group has elected AFSL.

Existing Groups

Existing groups will have AFSL added as a feature to their stop loss product on their first renewal after 1/1/2011. If a group does not wish to add AFSL it should be communicated to the Account Executive. There is no additional fee for adding AFSL. An Avalon rates sheet and new AFSL form (*Attachment B*)

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should be included in the paperwork submitted for all groups that have existing Avalon stop loss. The AFSL form will clearly indicate if the group is electing AFSL.

Pharmacy

Pharmacy claims will not be included in AFSL. Pharmacy claims will still apply to the members' specific stop loss limit and will be reimbursed post payment by Avalon.

Billing

A report identifying members in excess of the specific stop loss level will be run for each group prior to their billing cycle. Groups will see stop loss credit reflected in their monthly/weekly bills.

CBI

CBI will continue to issue the groups a monthly letter that will identify any stop loss payments made by Avalon.

Producer Appointment

As a reminder, producer appointment is required to represent Avalon Insurance Company for stop loss products. If you are requesting a stop loss quote on behalf of your group, please advise your Preferred Agent. Your Preferred Agent will coordinate the appointment process with the CBI team.

Attachments

- **Attachment A** – Avalon Stop Loss Application
- **Attachment B** – Advanced Funding Stop Loss (AFSL) Form

Questions

Contact your Preferred Agency with any questions. Thank you.

EMPLOYER INFORMATION			
Full Legal Name of Employer		Employer is a	
Street Address _____ City _____ State _____ ZIP Code _____		<input type="checkbox"/> Corporation <input type="checkbox"/> Labor Union <input type="checkbox"/> Partnership <input type="checkbox"/> Association <input type="checkbox"/> Proprietorship <input type="checkbox"/> Trusteeship <input type="checkbox"/> Other _____	
Other Locations		Requested Effective Date ____ / ____ / _____	
Key Contact Person/Title at Employer			
Full Legal Name of Subsidiary or Affiliated Companies (under the common control through stock ownership, contract, or otherwise) Included for Coverage			
Address of Subsidiary or Affiliates			Nature of Employer's Business
Full Name of Employee Benefit Plan(s) (A signed copy of such plan must be attached to this request.)		Total Eligible Employees	Deposit Premium
Estimated Initial Enrollment		Retirees Covered	
Single _____ Family _____ Composite (total) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Over 65 Under 65	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
EMPLOYER'S THIRD PARTY ADMINISTRATOR			
Name	Address	Phone Number	Fax Number
LICENSED WRITING AGENT (ATTACH CURRENT COPY OF LICENSE[S] IF NOT ON FILE)			
Name	Address	Social Security Number or Tax ID	
AGGREGATE STOP LOSS INSURANCE			
Accepted <input type="checkbox"/> Yes <input type="checkbox"/> No	Aggregate Stop Loss Includes (not included unless checked)		
	<input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Other _____		
Benefit Period Eligible			
Eligible Employer Losses from Plan Incurred from _____ through _____ and paid from _____ through _____			
Losses Incurred Prior to the Effective Date will be Limited to the Amount Reimbursable as set Forth in the Schedule of Insurance			
Aggregate Percentage Reimbursable (excess of deductible) _____ % Minimum Aggregate Deductible \$ _____ Loss Limit per Member \$ _____			
Maximum Aggregate Benefit (excess of deductible) \$ _____ Monthly Aggregate Stop Loss <input type="checkbox"/> Yes <input type="checkbox"/> No Aggregate Terminal Liability <input type="checkbox"/> Yes <input type="checkbox"/> No			
SPECIFIC STOP LOSS INSURANCE			SPECIAL LIMITATIONS
Accepted <input type="checkbox"/> Yes <input type="checkbox"/> No	Specific Stop Loss Includes (not included unless checked)		
	<input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Other _____ Advance Funding <input type="checkbox"/> Yes <input type="checkbox"/> No		
Benefit Period			
Eligible Employer Losses from Plan Incurred from _____ through _____ and paid from _____ through _____			
Losses Incurred Prior to the Effective Date will be Limited to the Amount Reimbursable as set Forth in the Schedule of Insurance			
Specific Deductible (per Member) \$ _____ Specific Percentage Reimbursable (excess of deductible) _____ %			
Maximum Specific Stop Loss (per person in excess of specific deductible) \$ _____ Aggregate Specific Fund \$ _____			

DISCLOSURE STATEMENT

Avalon Insurance Company will consider the data below to be representations regarding statements that materially affect either the acceptance of risk or the hazard assumed by the company in connection with the employer's application for coverage. Note that without Avalon Insurance Company's review and approval of each risk, the Participating Employer's Losses will not be reimbursable under the Stop Loss Reimbursement Contract; therefore, please answer the following questions.

- 1. Has an eligible employee or dependent received or expected to receive more than 50% of the Specific Deductible in expenses in the last 12 months? Yes No
- 2. Will any former employee or dependent be continuing coverage under the plan in accordance with Federal, State, or Local law on the effective date of this contract, if issued? Yes No

If "Yes" to questions 1 or 2, list name, status, prognosis, and amount of claim (attach, sign, and date on a separate sheet if needed)

Name _____ Date of Birth ____ / ____ / _____ Sex Male Female Status (Ee, Dep, COBRA, Retiree) _____
Diagnosis _____ Prognosis _____ Amount of Claim _____

- 3. Are expected benefits available from the prior insurer for presently disabled eligible employees and/or dependents? Yes No
- 4. Are any eligible employees or dependents presently disabled or confined in a hospital or similar facility? Yes No

Please explain any "Yes" answers to questions 3 or 4 (please attach, sign, and date a separate sheet if needed)

Medical Plans Covered: PPO Comprehensive Traditional Keystone Health Plan® Central Rx SeniorSM

Application is hereby made for Aggregate and Specific Stop Loss Reimbursement through Avalon Insurance Company. This application must be accepted and approved by Avalon Insurance Company or its authorized representative prior to any contract being in existence. It is understood and agreed by the Applicant/Plan Sponsor that:

- 1. The Employer is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "company" health care plan;
- 2. The Third Party Administrator retained by the Applicant will be considered the Applicant/Plan Sponsor's Agent, and not Avalon Insurance Company's Agent;
- 3. All documentation requested by Avalon Insurance Company must be submitted prior to any approval of this Participation Agreement and must be received by Avalon Insurance Company within ninety (90) days of the effective date;
- 4. Avalon Insurance Company will evaluate the Employer's risk, and may require adjustments of rates, factors, and/or special limitations to accommodate for abnormal risks;
- 5. Premiums are not considered paid until the premium check is received by Avalon Insurance Company and at the rates set forth in the Schedule of Insurance;
- 6. Premiums will not be paid from the Employee Benefit Plan's assets;
- 7. This application and disclosure statement will be attached to and made a part of any Stop Loss Reimbursement Contract issued by Avalon Insurance Company in connection with this application;
- 8. The Employee Benefit Plan(s) attached shall be the basis of any Stop Loss Reimbursement Contract provided by Avalon Insurance Company and such Employee Benefit Plan(s) conforms with applicable State and Federal laws;
- 9. Any reimbursement under the Stop Loss Reimbursement Contract provided by Avalon Insurance Company shall be based on covered expenses paid by the Plan Sponsor in accordance with the Employee Benefit Plan(s) attached;
- 10. The Employer's Losses for Plan benefits for any employee who is not at his or her customary place of employment (or scheduled vacation) on the Effective Date of the Stop Loss Reimbursement Contract will not be eligible for reimbursement under the contract until such employee returns to active, full-time employment for at least one (1) full working day; and
- 11. The Employer's Losses for Plan benefits for any dependent, COBRA beneficiary, or retiree who is confined in a medical facility on the Effective Date of the Stop Loss Reimbursement Contract will not be eligible for reimbursement under the contract until such person is discharged from the hospital or similar facility.

In making this request for Stop Loss Reimbursement Contract, the Applicant/Plan Sponsor represents that such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant/Plan Sponsor to the proposed contract. Accordingly, this request will be part of the contract if accepted by Avalon Insurance Company or its authorized representative.

Dated at _____ this _____ day of _____ Signature _____



AVALON USE ONLY	
DATE RECEIVED	
AMOUNT RECEIVED	
DEP. DATE	BY
CHECK RETURNED TO GROUP	

Stop Loss Verification Form

SSR# _____

Marketing Rep/Coordinator
CBI Rep/Coordinator

Group Name _____

Marketing Contact _____

Group Number - CBC _____

00

**8 digits first two 00

Effective Date of Stoploss: _____

Renewal date of Stoploss _____

Paid Dates: _____

From - To

Incurred Dates: _____

From - To

Specific Deductible: _____

\$

Aggregating Spec Fund _____

\$

Advanced Funding YES NO

* ***No Advanced Funding for groups with an Agg spec fund.***

** ***Senior and RX will be excluded from Advanced Funding.***

Contract Type: Ex. Paid, 12/12 _____

Products Covered (PPO,KHP,RX,etc) _____

use only lines of business to be
included in stoploss

Stoploss Carrier Name: _____

* Please note if this group is:

an existng NCAS group or
an existing CBC group

Broker Name: _____

Individual who provided information - _____