PSMACONNECT
Caring for the Caregivers

TAKING CONTROL OF YOUR HEALTH BENEFITS

PROGRAM OVERVIEW

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PSMA IS NOW PARTNERING WITH TRINITY MARKETING SERVICES TO OFFER YOU COST-EFFECTIVE HEALTHCARE SOLUTIONS!

Founded with the belief that integrity, compassion, and a commitment to service can reshape the alternative risk marketplace.

Trinity offers self-funded and level-funded solutions, allowing companies to better manage their health benefit plans and insurance risks. Our solutions are customized to each client's unique needs, providing greater flexibility and value than standard commercial policies.

MISSION

We are driven to help our clients succeed. In every interaction and with every solution, we act in our client's best interests striving to understand their needs, respecting their perspectives, and exceeding their expectations.

WHY CHOOSE THIS PROGRAM?

NOW AVAILABLE FOR 10+ ENROLLED

Benefit Management

Your plan, your way. Benefit plans designed to fit your needs utilizing nationally recognized provider networks with an emphasis on quality and compassion.

Cost-Effective Pharmacy Solutions

Pricing transparency, independent pharmacy advocacy, and 100% monthly rebate pass-through designed to save costs for the employer and member.

Medical Management

A suite of services to help members take control and share in the management of chronic medical conditions.

Concierge Member Advocacy

From finding a doctor to navigating cost-saving direct contracts and $0 copay options, getting straight answers to members is our priority.

2022 HEALTH BENEFIT PLAN COMPARISON

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This is a brief summary of benefits and limitations. For more information and full plan comparison, please visit **www.trinitymarketing.services.**

MEDICAL BENEFITS	PLATINUM	GOLD	SILVER	BRONZE	SILVER HSA	BRONZE HSA
DEDUCTIBLE:	$0/Single $0/Family	$1,000/Single $2,000/Family	$2,500/Single $5,000/Family	$5,000/Single $10,000/Family	$2,800/Single $5,600/Family	$5,000/Single $10,000/Family
OUT-OF-POCKET MAXIMUM:	$2,000/Single $4,000/Family	$4,000/Single $8,000/Family	$6,000/Single $12,000/Family	$8,550/Single $17,100/Family	$6,000/Single $12,000/Family	$7,050/Single $14,100/Family
PREVENTATIVE:	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible
PRIMARY CARE:	$0 Copay	$20 Copay	$35 Copay	$50 Copay	80% Coverage after deductible	70% Coverage after deductible
SPECIALTY CARE:	$35 Copay	$50 Copay	$75 Copay	70% Coverage after deductible	80% Coverage after deductible	70% Coverage after deductible
URGENT CARE:	$50 Copay	$75 Copay	$100 Copay	$100 Copay	80% Coverage after deductible	70% Coverage after deductible
EMERGENCY ROOM:	$150 Copay	90% Coverage after $250 Copay	80% Coverage after deductible	70% Coverage after deductible	80% Coverage after deductible	70% Coverage after deductible
INPATIENT SERVICES:	100% Coverage no deductible	90% Coverage after deductible	80% Coverage after deductible	70% Coverage after deductible	80% Coverage after deductible	70% Coverage after deductible
OUTPATIENT SURGERY:	100% Coverage no deductible	90% Coverage after deductible	80% Coverage after deductible	70% Coverage after deductible	80% Coverage after deductible	70% Coverage after deductible

PRESCRIPTION BENEFITS	PLATINUM	GOLD	SILVER	BRONZE	SILVER HSA	BRONZE HSA
RETAIL:[1]					80% Coverage after deductible	70% Coverage after deductible
Generic	$0	$0	$0	$0		
Brand	$50	$50	$50	$50		
Non-Preferred	$100	$100	$100	$100		
MAIL ORDER:[2]					80% Coverage after deductible	70% Coverage after deductible
Generic	$0	$0	$0	$0		
Brand	$125	$125	$125	$125		
Non-Preferred	$250	$250	$250	$250		
Specialty						
Preferred	$250	$250	$250	$250		
Non-Preferred	70% Coverage no deductible	70% Coverage no deductible	70% Coverage no deductible	70% Coverage no deductible		

Nondiscrimination Notice: Trinity Marketing Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Note: This document is for comparison only and is not an official plan document. Limitations and coverage maximums apply. See the Plan Summary for each plan and Summary Plan Document for more information.

[1] Retail is only available as a 30 day supply.
[2] Mail order for non-specialty is only available as a 90 day supply, and for specialty is only available as a 30 day supply.

WHAT'S NEXT

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In order to ensure a smooth enrollment process, steps 1-6 need to be completed at least 30 days before the effective date.

1. Sign final proposal and complete stop loss disclosure form.
2. Company's information and census added to enrollment portal.
   - If open enrollment, employees will receive an email with their login credentials to access the employee portal and complete their enrollment.
3. Final census reviewed and final rates confirmed.
4. Complete the Employer Agreement Packet and electronically sign.
5. Company is onboarded to TPA and network.
6. Company Administrator receives an email with portal login credentials in order to manage their employees' benefits.
7. Permanent cards will be created, printed and mailed.
8. Temporary cards available upon request and can take 2-5 business days after onboard.
9. Company Health Benefit Plan goes live on effective date.

REQUEST FOR INFORMATION

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- **Group Name & Address**
- **SIC code**
- **Effective Date**
- **Desired Network or DirectCARE (reference-based pricing)**
- **Census in Excel/csv (must include all fields below regarding employees and their dependents)**
  - First name, last name, date of birth, gender, zip code, full address, relationship, enrollment tier, plan identifier (if multiple plans currently offerred), and status
- **Number of eligible employees**
- **Number of enrolled employees**
- **Listing of COBRA eligible employees with name, coverage tier and end date for COBRA election period**
- **Current and Desired Plan Matrix(s)**
- **Latest or upcoming renewal packet from current carrier**
- **If currently self-insured:**
  - Network
  - TPA
  - PBM
  - Stop loss carrier
    - Contract basis
    - Aggregate & specific rates/factors
- **Claims data for the current and last 2 years, if available**
  - Claims Performance Dashboards
  - Cost & Utilization Reports
  - High Claimant (>$10k)/Trigger (50%)/Profile Reports

Please provide what you can, and we will let you know if we need anything else.

EMPLOYER FAQ

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How do I get a quote?
Contact Alera Group by calling **(877) 827-0292**, or emailing **aia_psmaserviceteam@aleragroup.com**.

What info do I need to provide to get a quote?
Please reference the *Request for Information (RFI)*. Keep in mind the following items are mandatory:

- Census of possible enrolled employees and their dependents
- Current plan designs
- Copy of most recent carrier renewal or invoice

What type of plan is this?
This is a level-funded, group plan and has to be offered to all eligible employees in your organization. With a level-funded plan, an employer pays the same monthly amount to cover the estimated cost for expected claims, the premium for stop-loss insurance that covers health care costs over a set dollar amount, and plan administration costs. If total claims costs are higher or lower than expected, we make adjustments at the end of the plan year in the form of a refund to the employer for lower claims or a premium increase on the stop-loss insurance renewal for higher claims.

What plan designs are offered?
Please reference the *2022 Health Benefit Plan Comparison*.

How many employees have to be on the plan to participate?
A minimum of 10 employees is required for the group to offer the plan, which must represent at least 50% of eligible employees.

Who is considered an eligible employee?
An eligible employee is a full-time, W-2 employee. Full-time employees work at least 30 hours a week.

What are the rates?
Contribution rates are determined on a group-by-group basis. Age, gender, location and the overall health of your group are all factored into the final rate that is provided.

Are there any pre-existing conditions exclusions?
There are no exclusions for pre-existing conditions; however, final rates may be affected.

Is there medical underwriting required?
Yes. Medical underwriting is required but there is no additional information needed other than the census.

How long does it take to receive a quote?
Quote turnaround time is 2-4 days.

How many days prior to our medical plan renewal can a quote be requested?
You may request a quote 90 days prior to renewal and no later than 30 days before renewal.

If our office meets the 10 enrolled requirement for the group medical option, can employees not enrolling in group medical enroll in the ancillary & worksite options?
Yes. Employees are not required to enroll in group medical to participate in other group offerings.

When can we start?
Your group can start on the first of any month.

When will our deductibles start over?
Your deductibles will either 1) reset on your plan year effective date or 2) on a calendar year basis, so January 1st.

How are we billed for the group medical options offered?
Your office will receive an invoice directly from the carriers on a monthly basis.

How does Trinity Marketing Services come up with the renewal rates?
The group's claims history and participation in health initiatives factor into the renewal rates.

What happens if we enroll in the plan and my employee enrolled count drops below 10 during the plan year?
Nothing. At renewal, if employees enrolled are under 10, Trinity Marketing Services will evaluate the existing group for renewal to see if they still qualify.

For further questions, please contact us