

# FUNDING<sup>®</sup>

A Level-Funding Solution for Small Groups

# ADVANTAGE

*Unique health plan solutions  
for your business*

Health Benefits Proposal Presented To  
XYZ Lawn

Presented By  
Gary Ashley Allied National

Proposed Effective Date  
8/1/21

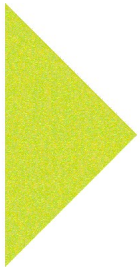
Freedom Traditional Plan

Plan Administered By



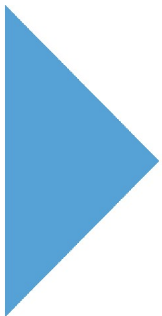
For more info visit us at: [www.alliednational.com](http://www.alliednational.com)

*The rates shown in this proposal are preliminary rates based on information presented.  
Rates are NOT final until approved in writing by Allied Underwriting.*



## What is the Allied Funding Advantage plan?

Funding Advantage is a unique answer for employers trying to save money on the cost of group health insurance. A level-funding Plan allows you to save money by paying for the cost of small claims while allowing you to manage the risk if those claims grow larger.



## Who is the plan for?

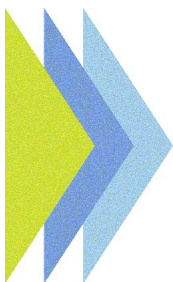
The Funding Advantage plan is for employers with 2 or more employees who feel they pay too much premium for too little in benefits. Do you want to receive money back from your insurer for being healthy?

If the answer is YES, then the Funding Advantage plan could be the right alternative for you.



## What are the advantages of the Funding Advantage plan?

- You don't buy insurance for benefits you don't use. Your unused claim fund is yours at the end of the plan year.
- Stop Loss insurance fully protects you from larger claims. The monthly payments cover your costs for the plan.
- Tele and video health access; online access to account details and claims. Allied HealthCare Assistant to help you deal with chronic or serious health issues.



## Can I receive money back with this plan?

With Funding Advantage level funding, you have the potential to receive money back at the end of a plan year. Each month your monthly payment helps to create your claim fund. The unused money in your claim fund is yours after claims are paid for the plan year. There are no back end charges or fees once the plan year is over.

*Large claim risk managed by stop-loss insurance with run-out coverage, subject to policy exclusions, solvency of insurance carrier, policy effective dates, mid-year Plan termination and other policy terms and conditions.*

*Refund subject to claims experience, run-out claims, mid-year Plan termination and the terms and conditions of the administrative agreement.*



Freedom Traditional Plan



Maximum Cost Summary

Your costs are made up of 3 charges:



Amounts vary by group size and benefits.

<p><b>STOP LOSS COVERAGE:</b> This is insurance protection for larger claims for individuals (total claims for any specific individual above \$10,000) or for total aggregate claims exceeding the annual maximum claim fund. Stop Loss coverage provides you with complete protection from unexpected claims during the plan year and the run out period, under a 12/21 contract.</p>	<p><b>ADMINISTRATION &amp; SALES:</b> Covers the administrative &amp; sales expenses of your coverage including claims processing, billing, underwriting services, customer service, PPO fees (if applicable), monthly claims reporting and compensation for the broker/benefit consultant for their role in establishing and servicing the plan. There are no other fees to employer during the plan year or run out period.</p>
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<p><b>CLAIM FUND:</b> This is your money used to pay smaller dollar claims. The claim fund total shown below is the MAXIMUM amount of claims payable by you for the plan year based on this census and benefits. You will never have to pay more in claims than this maximum amount. Any unused money is refunded to you after all claims have been paid for the plan year. Choose from different funding options (depending on your group size) to meet your monthly cash flow needs.</p>
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Your Maximum Costs

This is the total maximum cost you could pay for your Funding Advantage Plan. It is based on the census and benefits shown in this proposal. You will never pay more than this amount regardless of the total claims paid for your plan or the funding option you choose for your Claim Fund. The Claim Fund is your money and any unused money is still yours after claims are paid for the plan year. If this plan is issued in conjunction with other self funded benefit plans for this employer, then the claim fund from all plans will be used to set the aggregate stop loss attachment point.

	Monthly	Annual
Maximum Claim Fund:	\$1,563	\$18,756
Stop Loss Coverage:	\$4,761	\$57,132
Admin & Sales Costs:	\$2,211	\$26,532
<b>Maximum Total Costs:</b>	<b>\$8,535</b>	<b>\$102,420</b>



### Freedom Traditional Plan BENEFIT PLAN DESCRIPTION

#### Freedom Traditional Plan

Office Visit Copay: \$30 - Unlimited Visits

Deductible: \$2000

Coinsurance: 80%

Total Out-of-Pocket\*: \$4,500

Copays, Deductible & Coinsurance all apply to the Total Out-of-Pocket. All benefits are calendar year. Family limit for Deductibles and Out-of-Pocket max is 2 times individual limit.

Deductible Credit: Credit is given for deductible amounts satisfied under prior creditable coverage during the 90 days prior to effective date or the current calendar year, whichever is greater.

Prescription Drug Card Benefit: INCLUDED: Formulary Plan, \$0 Ded, No Annual Max. See benefit description for full benefit details.  
(adm.code:!)

\$500 Supplemental Accident Benefit: Not Included

HealthChoices Program Discount: Not Included

Occupational Coverage for Owners: Included

Pregnancy as any other illness: Included

Medicare Primary?: No

MultiLocation Factor: 0.9 This rate factor has been used to account for multiple locations or other case characteristics in this quote.

Proper rating of this plan requires the use of SIC codes. No SIC code entered for this client. Standard industry assumed for this quote.

#### FREEDOM TRADITIONAL PLAN Information

This plan uses Medicare allowable charges as its basis for reimbursement of physicians and facilities. For this proposal, physician reimbursement is set at 125% of Medicare allowable & facility reimbursement is set at 150% of Medicare allowable. In some cases, providers may not accept this amount as payment in full for services rendered. There is no contractual discount arrangement with providers. The member is free to see any provider of their choice. Members will be responsible for normal copays, deductible and out-of-pocket expenses. The plan will protect members from a balance bill from a provider for any amount in excess of the allowable reimbursement.



Freedom Traditional Plan

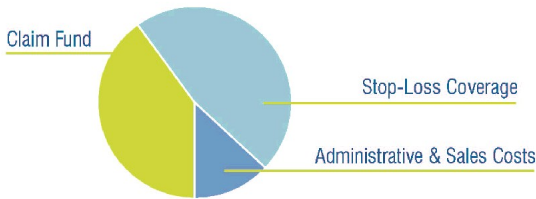


Level Funding Plan

Coverage Class	Monthly Cost	Number in Class	Totals
Employee Only	\$478	11	\$5,258
Employee & Spouse Only	\$943	0	\$0
Employee & Children Only	\$703	3	\$2,109
Full Family	\$1,168	1	\$1,168
Monthly Bill Total			\$8,535

Monthly Cost Summary

Maximum Claim Exposure: \$1,563



Required Claim Fund Contribution:	\$1,563
Stop Loss Insurance:	\$4,761
Administration & Sales:	\$2,211
<b>Total Monthly Billed Amount:</b>	<b>\$8,535</b>

Amounts vary by group size and benefits.

About the Level Funding Plan

Level funding provides you the most stable way to fund your self funded benefit plan. Your maximum costs, as shown above, are billed to you monthly. You will never be asked to contribute more to the plan, regardless of claims. If claims exceed the claim fund at any time, the Aggregate Stop Loss insurance then pays additional claims through an accommodation loan or an aggregate claim at the end of the plan year.

Level Funding advantages:

- Stable, level monthly payments
- No claims calls when claims exceed the maximum
- Unused claim fund money is yours for refund or use in the next plan year
- Aggregate Accommodation and Stop Loss protection at the maximum claim exposure



## HEALTH PLAN OVERVIEW



Freedom Traditional Plan	
BENEFIT	Choose Any Provider - No Network or Penalties
Calendar Year Deductible	\$2000 per Individual <i>(Family Deductible is 2 times the Individual Deductible)</i>
Coinsurance	80% Paid by Plan
Calendar Year Total Out Of Pocket Maximum <i>(copays, deductibles and coinsurance count towards Calendar Year Total Out Of Pocket Maximum)</i>	\$4500 per Individual <i>(Family Limit is 2 times the Individual Limit)</i>
Doctor's Office Visit Copay <i>(see next page for more info on office visit benefit)</i>	\$30 - Unlimited Visits then paid at 100%.
Urgent Care Copay <i>(benefits payable same as for Doctor's office visit)</i>	Doctor's office visit copay plus \$20.
Non Surgical Out Patient Expenses	After Deductible Plan pays 80%
Surgical Procedure Expenses	After Deductible Plan pays 80%
Inpatient Admissions	After Deductible Plan pays 80%
Emergency Room Services	After Deductible Plan pays 80%
Preventive Services	Plan Pays 100% of Covered Charges
Lifetime Maximum Benefit	Unlimited

**PRESCRIPTION DRUG FORMULARY PLAN**

You're covered under the following RX Benefit: Formulary Plan, \$0 Ded, No Annual Max

TIER	DESCRIPTION	Benefit
0	Over the Counter	\$3 Copay
1	Generic	\$10 Copay
2	Brand Name	\$30 Copay
3	Non-Formulary	\$50 Copay
4	Specialty Pharmacy*	0 Copay* if using HealthCare Asst

- Rx Deductibles (if any) are waived for Tiers 0 & 1.
- Mail Order Benefit: All plans include mail order discounts - 90 day supply for 2x normal copay.
- All Copays & Coins cease once a member has reached their calendar year maximum out-of-pocket amount.

*\*Specialty Pharmacy is \$0 Copay if using Allied HealthCare Assistant program (HSA plans must still meet deductible), otherwise member cost sharing is 50% up to \$1,000 per month. Specialty pharmacy includes, but is not limited to, select drugs for treating enzyme deficiency, hemophilia and multiple sclerosis, as well as select types of drugs like blood modifiers (e.g. Epogen & Procrit), growth hormones, IGIV and Interferons."*

**Doctor's Office Visits:** The office visit benefit, when selected, applies to services performed in the doctor's office (office visits and urgent care visits subject to deductible on HSA plans) such as exams, consultations, diagnostic testing, x-rays, allergy antigen injections, chiropractic treatment and surgical services. After the office visit copay, these services are paid at 100% to a total benefit of \$500 per visit. Expenses in excess of this benefit, diagnostic testing and x-rays not performed in the doctor's office are subject to deductible and coinsurance (except laboratory testing done through Quest Diagnostics is paid at 100%). For PPO plans, out-of-network office visits are subject to applicable out-of-network deductible and coinsurance. For plans with two or four annual office visit limits, additional visits are subject to deductible and coinsurance. For Direct Primary Care plans - if the Specialist Office Visit Only Copay benefit is selected, non specialist office visits are subject to deductible and coinsurance.

**Maximum Benefits by Expense**

Nervous, Emotional or Mental Disorders or Disease Care including Alcoholism and Chemical Dependency Care <i>(if the Plan Sponsor employed an average of 51 employees during preceding calendar year, this benefit covered same as an any other sickness)</i>	Up to 31 Inpatient Treatment Days per Calendar Year
	Up to 26 Outpatient Visits per Calendar Year
Rehabilitative care (physical therapy, speech therapy, occupational therapy) following an accident or injury	Unlimited
Habilitative Care (physical therapy, speech therapy, occupational therapy) for congenital development problems, developmental delay and autism	40 Visits per Calendar Year
Hospice Care	One Benefit period limited to six continuous months.
Home Health Care	40 visits per Calendar Year limited to one visit per day.
Orthopedic Manipulation including massage therapy and acupuncture	20 visits per Calendar Year limited to one visit per day.

This is a limited, summary description of your plan benefits. For a complete listing of all benefits, including limitations and exclusions of the plan, please refer to the Summary Plan Description that is issued to all plan participants.

**Plan Reimbursement Information**

This plan uses Medicare allowable charges as its basis for reimbursement of physicians and facilities. For this proposal, physician reimbursement is set at 125% of Medicare allowable & facility reimbursement is set at 150% of Medicare allowable. In some cases, providers may not accept this amount as payment in full for services rendered. There is no contractual discount arrangement with providers. The member is free to see any provider of their choice. Members will be responsible for normal deductible and out-of-pocket expenses. The plan will protect members from a balance bill from a provider for any amount in excess of the allowable reimbursement.



## ENROLLMENT AND UNDERWRITING REQUIREMENTS

The following are required for enrollment and underwriting for the Funding Advantage plan:

### Employers:

- Please complete, sign and date the employer information statement.
- Have each of your employees complete, sign and date an employee enrollment form. All new hires on or before the effective date must also complete enrollment even if still in their waiting period. Check to see that all questions on the enrollment forms are answered completely and accurately.
- Any eligible employee or dependent not enrolling for coverage MUST complete a waiver form. An employee waiving coverage because they are covered under another employer's major medical plan will not be counted against the group's participation requirements.
- Include a preprinted company check made out to Allied National for the first month's costs as shown on the rate proposal.
- For groups less than 25 enrolled employees, include a complete copy of the firm's most recent State Quarterly Unemployment Tax report containing employee names, Social Security Numbers and earnings. This provides Allied Underwriting with information necessary to verify employee participation and eligibility.
- For currently insured groups, include your most current billing statement that includes your renewal rates from your current carrier.
- Please give all of the above pieces to your agent so he or she can send the forms to Allied to begin processing.

### Agents:

- Allied's guideline for a timely Funding Advantage new case submission is a minimum of ten days before the requested effective date. To be considered a complete submission the employer information statement, current plan information (benefits, current & renewal rates), employee enrollment cards/waivers and participation documentation (on groups with less than 25 participants) is required. Submissions without these components are considered prescreen quote requests and not treated as a new case submission.
- You must be appointed with the plan's stop loss carrier. If not, please contact Allied Sales Support at 888-767-7133 for information.
- In addition, submit a copy of the benefit and rate proposal used for the group.
- Please submit all pieces from the employer to one of the addresses below. When submitting forms by fax or email, it is extremely important that forms be legible and that forms that are filled out by hand be completed in ink.

*Note: All papers must be filled out and signed in ink, dated and received by Allied before the requested first of the month effective date. Priority processing will be given to companies who submit legible, fully completed forms.*

Please send all information to your local General Agent or:

ALLIED NATIONAL  
UNDERWRITING DEPARTMENT  
P.O.BOX 29187  
SHAWNEE MISSION, KS 66201-9187  
Fax: 913-945-4397 Email: uas@alliednational.com

QUESTIONS? Please call Allied Sales Support at 888-767-7133





## Funding Advantage - Important Proposal Information

The costs shown above are based on the SIC Code: 9999. For this industry: Eligibility for this plan is subject to underwriting review. Please contact Allied for more information.

The rates for this proposal are based on available medical application info.

Funding Advantage stop loss insurance coverage is provided by Companion Life Insurance Company (Rated A+ by A.M. Best) or Fidelity Security Life Insurance Company (Rated A- by A.M. Best). This proposal is not a solicitation to purchase stop loss coverage but an illustration of costs under this self-funded program. Selection of the appropriate carrier is made according to group size and state at the time of underwriting. At that time Allied will prepare for the client an application with the appropriate insurance company with final rates and terms of coverage. Specimen stop loss policies are available upon request.

Proposal and rates are preliminary pending completion of underwriting. Final rates are issued ONLY after submission of the group for underwriting and final underwriting approval is given.

Rates will be surcharged at time of underwriting: 1) if an employer sponsors any type of HRA or supplemental gap plan that effectively lowers the employee's out of pocket costs shown in this proposal; 2) for dual or multi plan offerings; 3) for groups with higher than average dependent child content.

By signing the contract, the contractholder acknowledges that this plan is self-funded.

If the group terminates mid-contract, all stop-loss coverage will cease and any claims not yet paid as of the date of termination, regardless of incurred date, will not be covered under the stop loss contract.

Any claimant who is disclosed as terminated as of the effective date is excluded from coverage and will be subject to medical underwriting if they rejoin the plan.

The information contained in this proposal is limited. More information may be obtained by reviewing the Funding Advantage plan brochure and the Guide to Self Funding available at [www.alliednational.com](http://www.alliednational.com).

This proposal does not include costs for Affordable Care Act taxes, fees or assessments that may be required of the employer. This includes, but is not limited to the Patient Centered Outcomes Research Institute (PCORI). Allied will provide each employer with appropriate instructions on filing and payment of these fees.

For small groups in Nevada: State law requires aggregate deductible levels to be a minimum of \$4,000 per employee. Preliminary rates may not be at this level. Once a group has been underwritten by Allied and small group status verified, final rates will be issued that conform with this requirement. This is subject to change with new pending regs.

Direct Primary Care plans are available only for members that are actively under the care of a DPC physician or practice. Rates are determined by scope of services provided by the DPC physician for each member.



## GROUP CENSUS INFORMATION

Census information for this group: Average Age:45.7 Gender Ratio: Males make up 53.33% of group.

Name	Gender	DOB	Age	Coverage	Class*	Plan Selection*
DERR STEVEN	M	11/7/1993	27	I	1	
GILLETTE WILLIAM	M	5/17/1980	41	I	1	
HICKEY ELIZABETH	F	1/22/1976	45	C	1	
KHAM BENJAMIN	M	7/19/1988	33	I	1	
LAGOS SALAS DECEMBER	F	12/2/1978	42	C	1	
LEE CHRIS	M	10/8/1969	51	F	1	
NELSEN NELS	M	10/15/1970	50	I	1	
NGUYEN JULIE	F	8/22/1990	30	I	1	
NGUYEN-THAI THU HA	F	11/6/1969	51	I	1	
PADILLA NORA	F	10/11/1952	68	I	1	
RATIGAN KEVIN	M	8/31/1973	47	I	1	
SALOMON GERARDO	M	5/7/1966	55	I	1	
SHIH HSUN	F	3/8/1971	50	I	1	
WATKINS WILLIAM	M	7/24/1964	57	I	1	
WHITMAN BRENDA	F	11/16/1981	39	C	1	

\*Use class or write in plan selection to designate proper plan for each employee when proposing dual or triple choice plans.