FUNDING®
A Level-Funding Solution for Small Groups
ADVANTAGE

Cost Saver

Limited Benefit Plan
Coverage for Groups of Two or More

Unique concept for group benefits

- ***Unlimited physician benefits***
- ***Cash benefits for surgery and facility***
- ***NO MEDICAL UNDERWRITING***

Health Benefits Proposal Presented To
Sample

Presented By
Timothy Shrout Allied National Inc

Proposed Effective Date
8/1/2020

Cost Saver Funding Advantage - Plan 1

Plan Administered By
ALLIED™ NATIONAL

For more info visit us at: www.alliednational.com

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COST SAVER

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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 self-funding Plan allows you to save money by paying for the cost of small claims while providing you absolute financial protection if those claims grow larger.

The Cost Saver plan option is a unique limited benefit plan that provides valuable benefits at a cost that employers can afford.

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 receive money back from your insurer for being healthy?

The Cost Saver plan is for the employer who can no longer afford the escalating costs of a major medical benefit plan for its employees.

What are the advantages of the Cost Saver 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.
- Level-funding gives you one predictable monthly cost. You never pay more than your monthly payment.
- Stop Loss insurance fully protects you from larger claims.
- Provides valuable "first dollar" benefits to your covered members, plus indemnity payments when a hospitalization occurs.

What are my risks with this plan?

With the Cost Saver Funding Advantage plan, your only risk is not getting a refund at the end of your plan year. Any money left in your claim fund at the end of a healthy plan year is still 100% employer money.

Cost Saver provides valuable health benefits at a price that lets any employer provide benefits to employees and their families.

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COST SAVER - Plan 1
Maximum Cost Summary

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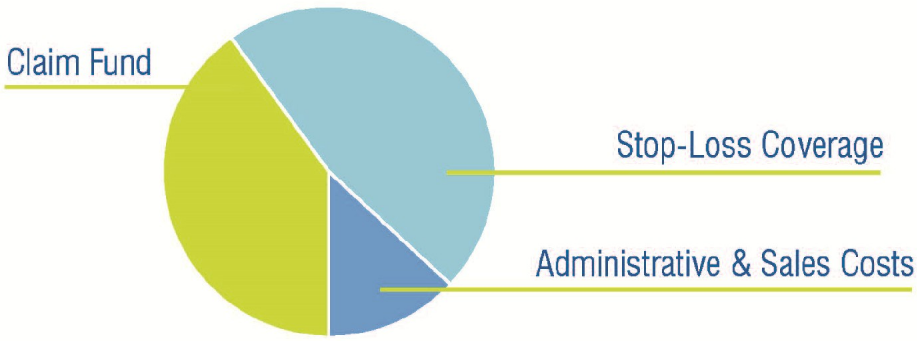
Your costs are made up of 3 charges:



Amounts vary by group size and benefits.

STOP LOSS COVERAGE: This is insurance protection 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.

ADMINISTRATION & SALES: Covers the administrative & 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 the employer during the plan year or run out period.

CLAIM FUND: 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.

Your Maximum Costs

This is the total maximum cost you will 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. 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:	$650	$7,800
Stop Loss Coverage:	$1,118	$13,416
Admin & Sales Costs:	$696	$8,352
Maximum Total Costs:	$2,464	$29,568

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COST SAVER

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BENEFIT PLAN DESCRIPTION

Plan Quoted:Cost Saver Plan 1
PPO Network:First Health

Cost Saver Benefits

DEDUCTIBLE	$250 per person per year (waived for Office and Urgent Care Visits)
COINSURANCE	100% for all benefits after deductible and any applicable copays to a maximum out of pocket of $2,500 per person in network.*

**Out-of-network benefits are paid at 125% of Medicare with no maximum out-of-pocket for balance billing.*

Outpatient and Physician Benefits	**Cost Saver Plan**		
Benefit Categories	**Plan 1**	**Plan 2**	**Plan 3**
Office Visits	$40 Copay per visit	$35 Copay per visit	$30 Copay per visit
Urgent Care	$60 Copay per visit	$55 Copay per visit	$50 Copay per visit
Other Physician, Lab and X-rays *(done outside the physician's office)*	$50 Copay	$50 Copay	$50 Copay
Emergency Room	$250 Copay	$250 Copay	$250 Copay
Outpatient Complex Imaging (MRI,CT, PET)	$300 Copay	$300 Copay	$300 Copay
Inpatient & Outpatient Surgery	$500 Copay	$500 Copay	$500 Copay
MAXIMUM BENEFIT	**UNLIMITED**	**UNLIMITED**	**UNLIMITED**
Facility Indemnity Benefits			
Outpatient Surgery Facility *(limit 3 per year)*	$1,000	$1,500	$2,000
Inpatient Surgery Facility *(limit 2 per year)*	$1,000	$1,500	$2,000
Inpatient Daily Benefit - Standard Room**	$500	$750	$1,000
Inpatient Daily Benefit - ICU**	$1,000	$1,500	$2,000
***Limited to 30 days of combined total inpatient days per year*			
MAXIMUM ANNUAL BENEFIT *(for all facility indemnity payments)*	**$35,000**	**$52,500**	**$70,000**

Please see the Summary Plan Description for complete details including benefits, exclusions and limitations.

Benefit Categories

Cost Saver pays benefits for covered services based on the type of service received by the member and the location where the service is received. Some of the most common types of services for each benefit category are listed below.

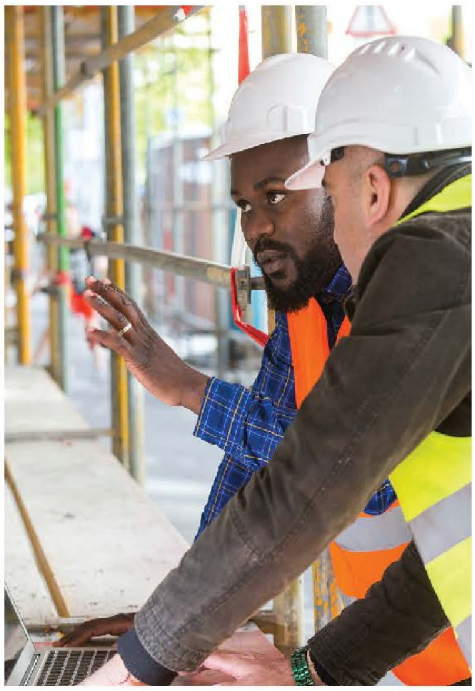
Outpatient Benefits

Office Visit

Most services performed in the doctor's office, including the office visit itself, consultations, immunizations, mammograms, pap smears and most diagnostic tests (x-rays and lab) are covered in this benefit category and subject to the office visit copay, up to $500 in benefits per visit. Surgical procedures, costing less than $500 and performed in the doctor's office, are also covered in this benefit category.

All Other Physician Services

Services performed by and/or billed for by a physician, not as part of an office visit, are covered in this benefit category and subject to a $50 copay, then subject to deductible. Items like medical supplies, surgical services, cardiovascular testing, reading of x-rays and MRIs, and ground ambulance service.



Facility

Outpatient Surgery

Outpatient surgical facilities are covered in this benefit category.

Inpatient Facility Benefit

Facility charges for inpatient stays are covered in this benefit category. The plan pays a daily benefit for all charges from the facility according to the room classification (e.g. ICU versus standard room). If admitted as an inpatient from the emergency room, the inpatient facility benefit and copay applies.

Extra Benefits

Teladoc

When you have Cost Saver, you have telephone and PC access to a provider 24/7. For minor health issues like a cold, flu, allergies or sprained ankle, Teladoc is rapidly becoming the favored way to seek immediate help. There's no copay or other charge for using your Teladoc benefit. See page 7 for more details.

LabCard

Allied's plan includes a discount Lab Card Program that gives members an opportunity to obtain outpatient laboratory testing services at no cost. Costs paid 100% by plan.

Rx Card

Cost Saver covers all generic drugs for a $15 copay. Brand and outpatient specialty drugs are available at a discount.

Cost Saver Plan - Services Not Covered by this Plan:
The following services are not covered under the Cost Saver plan. In addition to these services, the Plan includes additional exclusions and limitations (see Summary Plan Description for details).
1. Inpatient services - any charge for services that take place on an in-patient basis is limited to the daily indemnity benefit shown above. This includes any facility, physician, laboratory, diagnostic or imaging charges regardless of cause or diagnosis including pregnancy.
2. Outpatient Facility charges are limited to the indemnity benefit shown above. All other outpatient facility treatment charges are excluded. This includes dialysis, radiation treatment, chemo therapy and any other service not specifically listed above as included. Physician charges for outpatient surgery are covered as shown.
3. Brand Name and Specialty outpatient prescription drugs and chemotherapy drugs are available at a discount.
4. Any services for mental/behavioral health (inpatient or outpatient) including substance abuse/chemical dependency are not covered.
5. Rehabilitative therapy including speech therapy, physical therapy, occupational therapy and cardiac rehabilitation are not covered.
6. Skilled nursing, home health care and hospice are not covered.
7. Infertility testing and treatment are not covered.
8. Durable medical equipment, including hearing aids, orthotics and orthopedic devices, and prosthetics are not covered.
9. Covered services received in-network are paid based on the PPO allowable price. Out-of-network services are subject to the plan's fair and reasonable limitations.

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Cost Saver Plan 1 - First Health PPO

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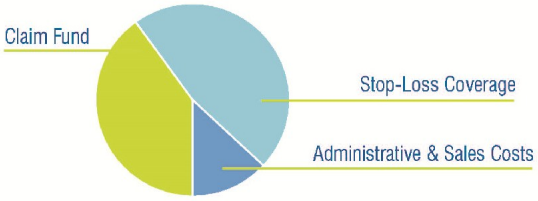
Level Funding Plan

Coverage Class	Monthly Cost	Number in Class	Totals
Employee Only	$176	7	$1,232
Employee & Spouse Only	$354	1	$354
Employee & Children Only	$350	1	$350
Full Family	$528	1	$528
		Monthly Bill Total	$2,464

PPO Access Fees are $6 per employee per month and are included in monthly costs..

Monthly Cost Summary

Maximum Claim Exposure: $650



Required Claim Fund Contribution:	$650
Stop Loss Insurance:	$1,118
Administration & Sales:	$696
Total Monthly Billed Amount:	$2,464

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

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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 major medical groups greater than 100 lives submitting experience data for underwriting and rates - please include the most recent 3 years of rates, enrollment and experience data including large claims information ($20,000+). Please contact Allied Sales for more information on experience rating.
- 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. Typical medical underwriting for a major medical case can take up to three weeks depending on how quickly missing information is received. 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 50 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 [!PhAllied Sales Support at 888-767-7133

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Funding Advantage - Important Proposal Information

The costs shown above are based on the SIC Code: 5331.

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.

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 - $2.45/member annually for plan years ending in 2018) fee. This is a short term fee set to expire in the next few years. Allied will provide each employer with appropriate instructions on filing and payment of these fees.

For all groups the ACA mandated Maximum Out-of-Pocket limit is handled administratively. For calendar year 2018, the Maximum Out-Of-Pocket is $7,350 per individual/$14,700 per family. For calendar year 2019, the Maximum Out-Of-Pocket is $7,900 per individual/$15,800 per family.

For HSA Qualified High Deductible Health Plans, out of pocket amounts are capped at the federally mandated annual limit. For calendar year 2018, the HDHP annual Out-Of-Pocket maximum is $6,650 for individuals/$13,300 for families. For calendar year 2019, it is increased to $6,750 for individuals/$13,500 for families.

For small groups in Nevada: State law requires aggegrate 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.

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GROUP CENSUS INFORMATION

Census information for this group: Average Age:37.1 Gender Ratio: Males make up 50% of group.

	Name	Gender	DOB	Age	Coverage	Class*	Plan Selection*
1		F		25	I	1	
2		M		30	I	1	
3		F		35	I	1	
4		M		40	I	1	
5		F		45	I	1	
6		M		50	I	1	
7		M		35	F	1	
8		M		39	C	1	
9		F		42	S	1	
10		F		30	I	1	

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