90 DEGREE BENEFITS
A Turn For The Better

FUNDING® ADVANTAGE

A Level-Funding Solution for Small Groups

Effective 11/01/23

Unique health plan solutions for your business

Plan administered by:

ALLIED™ NATIONAL
A 90 Degree Benefits Company

www.alliednational.com

Do YOU Receive Money Back From Your Insurer for Being Healthy?

What is the Funding Advantage Plan?

Funding Advantage is a level-funded plan for employers who are trying to save money on the cost of group health insurance. A level-funded plan allows you to save money by paying for the cost of small claims with employer money, while providing you the opportunity for a refund for healthy plan years.

Who is the Plan For?

The Funding Advantage plan is for employers with good health experience who feel they are paying too much premium for too little in benefits. Do you receive money back from your insurer for being healthy? If the answer is NO, then Funding Advantage could be the right alternative for you.

How Does the Plan Work?

Funding Advantage saves you money by paying the claims of your employees with your own money instead of insurance premiums. Money left in your account is your savings and not insurance company profits. You're protected with stop-loss insurance that manages[1] the risk for large claims above your monthly cost.

- Stop-loss insurance: Protects you from serious or numerous claims.
- Monthly payment: Covers your monthly fixed costs including stop-loss insurance and the administrative and sales fees, PLUS 1/12 of your maximum annual claims fund cost. You're never subject to a cash call if claims go past your maximum contribution.
- After the nine-month run-out period: Any unused dollars in your claim fund are refunded to you.

How is This Plan Different?

If you're currently covered under a fully-insured plan, your monthly premium costs are locked in. Even if you're healthy and have no claims, you don't share in the savings, which are kept by the insurance company.

Level funding allows you to keep the savings when your group is healthy while stop-loss insurance caps your exposure. Level funding takes the guessing out of monthly costs. You pay one set monthly fee. After all of your claims are paid for the year, the unused money in your claim fund is returned to you.

#1 "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."

3 Reasons to Consider Funding Advantage Plans

1

You don't buy insurance for benefits that you don't use. Unspent claim dollars are yours at the end of the plan year.

2

Stop-loss insurance fully protects you from larger claims. You will never have to pay more than the maximum monthly costs.

3

Level funding means there are no surprise payments – just one monthly payment.

Can We Receive Money Back With This Plan?

With Funding Advantage level funding, you have the potential to receive money back.[2] Each month, your payment helps to build up your claim fund. The unused money in your claim fund is yours after claims are paid for the plan year. Your risk also is limited by stop-loss insurance.

You have the potential to receive money back at the end of the year!

#2 "Refund subject to claims experience, run-out claims, mid-year plan termination, and the terms and conditions of the administrative agreement."

How Funding Advantage Works

Three Types of Costs

Your Claim Fund

With level funding, you'll never pay more than the maximum claim cost for the plan year. After you've paid this amount each month, there are no other charges for claim payments. Aggregate stop-loss begins after your maximum claim cost. Once all claims have been paid for the plan year, any unused dollars in the claim fund are yours as a refund or for expenses in your next plan year as you determine.

Administrative & Sales Costs

These are the costs you pay for the administration of your group's health plan. Compensation also is paid to your agent from these costs for their role in helping you tailor your plan, managing your plan enrollment and ongoing servicing of your plan.

Stop-Loss Coverage

Stop-loss coverage protects your plan.

- **Specific Stop-Loss Coverage**
  Pays when the claims for any one person (employee or dependent) exceed a set dollar limit during the plan year.

- **Aggregate Stop-Loss Coverage**
  Pays when the overall claims for your group exceed a set dollar limit during the plan year. This is the ultimate protection that allows your maximum cost to be known and locked in for the year.

- **Accommodation**
  Aggregate accommodation is provided if claims exceed the accumulated MAXIMUM required funding level during the plan year. The stop-loss insurer will advance the money required to pay these claims at no extra cost. Employers will repay this loan through their normal monthly payments.

Reporting

Each month, you will receive an accounting report on all claims paid during the month and the plan year-to-date. Each quarter, you will receive a detailed utilization report about claims paid (subject to federal and state privacy regulations). This reporting provides the information necessary to fully track your claim fund and to understand where your claim fund dollars are spent (such as doctor's office visits, prescription drugs, outpatient services and hospitalizations).

Plan Year & Terminal Liability

Your plan year runs for 12 months from your effective date. Claims incurred during your plan year will be paid though a nine-month run-out period after the end of the plan year. Any remaining money in the claim fund at the end of the run-out period is refunded to you. Terminal liability coverage is built into the plan.

Benefit Plan Options

Freedom Hybrid

The Freedom Hybrid Plan allows members to choose the provider they want without restrictions or penalties. They can see a physician in their Preferred Provider Organization (PPO) network or go out of network – they will never be penalized for seeing an out-of-network provider. They also may visit any health care facility without any restrictions. Facilities will be reimbursed based on a multiple of Medicare allowable prices.

Freedom Traditional

This plan allows you the full choice of health care providers without restrictions or penalties. There are no preferred providers or networks required. See the provider YOU choose!

You still receive the value of PPO-like discounts for all medical services. The plan benefit option provides traditional major medical coverage where reimbursement to providers is reference-based on a multiple of Medicare allowed prices. There is no network and members are free to go to any provider for services. The only out-of-pocket expenses are normal copays, deductibles and coinsurance.

Freedom Essentials

Freedom Essentials is a major medical option, similar to Allied's Freedom Traditional Plan. By requiring the addition of the HealthChoices benefit (see page 8 for details), excluding specialty Tier 4 drugs and lowering certain benefits, Essentials is able to offer substantially lower costs than the popular Freedom Traditional Plan. Members get the coverage they need while enjoying the freedom to go to any provider for services.

PPO Plans

Our PPO plans feature a variety of benefit options. You can custom build a plan to fit your needs from a choice of copays, deductibles, coinsurances and out-of-pocket maximums. With deductibles from $500 to $10,000, you can select the benefit and contribution that's right for your group.

Direct Primary Care Plans

All Funding Advantage level-funded major medical plans integrate with a Direct Primary Care (DPC) plan and can lower total costs for the employer and employees. By removing benefits for services already handled by the DPC, we significantly lower the costs of the major medical plan. We also discount the rates for the positive impact of Direct Primary Care on plan utilization and wellness. The savings from integration and wellness frees up sufficient costs to cover most DPC monthly costs with money left over.

More Benefit Plan Options

Benefit Plan Options Continued

HSA Qualified Plans

Allied provides comprehensive solutions using the “triple tax savings” of Health Savings Accounts (HSAs) and our quality benefit plans. HSAs work with high deductible health plans (HDHPs) to provide a great alternative to traditional health plans.

HSAs make sense for a lot of people. The cash savings of an HDHP can be used to provide the funding for a tax-favored HSA. HSA contributions are tax-deductible, the earnings in the savings account are allowed to grow tax-free, and any money spent on qualified medical expenses is tax-free, providing you with powerful “triple tax savings” to help you with your medical costs. HSA plans may be done using either the Freedom Essentials, Freedom Traditional or PPO Plan options.

Cost Saver (a limited benefit plan)

Cost Saver is an affordable option for all size groups and features Minimum Essential Coverage with unlimited outpatient benefits and fixed indemnity benefits for surgeries and inpatient care. This plan is for any group unable to afford full major medical plans or for large groups trying to manage the Affordable Care Act employer mandate. See the Cost Saver brochure at *www.alliednational.biz/3131.pdf* for complete plan details.

Minimum Essential Coverage (MEC) (a limited benefit plan)

MEC, MEC Plus and MEC Advantage are affordable options that feature Minimum Essential Coverage which satisfy the ACA employer mandate to provide minimum essential coverage and eliminates the Part A penalty for applicable large employers. MEC Plus and MEC Advantage buy-up options stack additional benefits on top of the 100% coverage for preventive services.

What is ERISA?

Your Funding Advantage health plan is primarily governed by federal ERISA laws (ERISA is the Employer Retirement Income Security Act which governs employee welfare plans). ERISA establishes minimum standards for retirement, health and other welfare benefit plans. ERISA plans do not have to follow state benefit mandates resulting in lower costs and expenses.

What is an ERISA Plan?

To your employees, the ERISA plan of benefits described in the Summary Plan Description (SPD) is the standard health benefit plan description they are used to seeing with a fully insured plan. Multiple benefit options for copays, deductibles, and out-of-pocket costs are available so that you can build a plan of benefits that fits your needs. An SPD is provided to each insured employee detailing their benefits.

Benefit Plan Features & Options

Pregnancy Coverage

Included for all groups.

Occupational Coverage

Owners, partners and corporate officers not covered by Workers' Compensation are covered on a 24-hour basis.

$500 Supplemental Accident Benefit Option

Pays 100% of charges incurred due to an accident, up to a $500 benefit (not available with HSA Qualified Plans).

Outpatient Prescription Drug Benefit Options

The following outpatient prescription drug benefit options are available with the Funding Advantage major medical plans:

Formulary Plans

Standard Rx formulary plans are available with a variety of Rx deductible options (or no deductible). Formulary plans are also available without Specialty Drug coverage.

Deductible Integrated Plans

Outpatient prescription Rx benefits are subject to the plan's major medical deductible. After satisfaction of the deductible, prescription benefits are covered under the formulary plan. All HSA-eligible plans with prescription coverage are Deductible Integrated Plans.

Generic Only Plan

The Generic Only Plan has a $15 copay per generic prescription with no limit on the number of prescriptions and no Annual Maximum Benefit per calendar year. Brand name drugs are available at a discounted rate.

Discount Only Plan

A discount card is provided to access applicable drugs at a discounted rate. This benefit option does not offer outpatient prescription drug coverage.

High-Cost Drug Program

For those members with Formulary and Deductible Integrated Plans, High-Cost Drug Program assists eligible members in obtaining high-cost drugs or therapies in a cost-effective manner while reducing waste and improving clinical outcomes. Enrollment in the High-Cost Drug Program is mandatory for all eligible members to receive coverage for high-cost drugs (any tiers) over $500 per fill and for all specialty drugs (tier 4). Failure to enroll requires the covered person to pay the full cost of the drug or treatment. Eligible members enrolled in the High-Cost Drug Program may receive reduced or waived copays. If no coverage is available under the program, standard copays apply. To be eligible for the High-Cost Drug Program, the sponsoring employer simply needs to elect to offer prescription drug coverage. This program is not available when the plan does not cover pharmacy benefits or provides a discount-only benefit. Drugs must also be eligible under the formulary to be covered under the High-Cost Drug Program.

Health Care Services

Allied HealthCare Assistant

Benefit provided to all major medical plan members at no cost

Allied HealthCare Assistant is an umbrella of health care services provided to all members and their families with their Funding Advantage major medical plan. This suite of services was created to ensure our members have the absolute best access to the best health care in the country.

For more information, members can visit *www.alliednational.com/assistant* or call 844-287-6078 when they need guidance. HealthCare Assistant will determine which support services best meet members' needs and will work with them throughout their health care journey.

Allied HealthCare Assistant can help you:

- Understand your diagnosis.
- Find the right doctor who specializes in your health condition.
- Get the best treatment for your specific needs.
- Manage any specialty drug you are taking.
- Taking multiple medications? You might be a candidate for DNA testing to help you get the right drug doses.
- Manage diabetes for a healthy life.
- Get support with behavioral health issues.
- Access high-quality imaging at no cost to members.

HealthChoices

Optional benefit for major medical plans

The HealthChoices benefit option provides Funding Advantage members with an immediate monthly premium discount.

HealthChoices exists to get our members to the right diagnosis, the right treatment plan and right provider for an optimal medical outcome. An Allied HealthCare Assistant helps members find the appropriate care when they are in need of:

- Diabetes and lifestyle management.
- Behavioral health management – Both coaching and inpatient stays.
- Bundled pricing for non-emergency outpatient surgery or imaging.
- Specialty drug management – Both education and possibility of reduced pricing.

HealthChoice members should make sure their providers prenotify us at 866-317-5273 (option 3) anytime the provider recommends:

- Joint replacements or surgeries (knee, hip, shoulder, etc.)
- Spinal surgeries or procedures (laminectomy, spinal fusions, foraminotomy, diskectomy, disk replacement, implants)
- Cardiac interventions (angioplasty, stents, pacemakers) or surgeries (bypass, valve replacement)
- Other surgeries, gall bladder, digestive system
- Complex imaging, like MRIs and CT Scans

Learn more: *www.alliednational.com/healthchoices*

Benefit Enhancement Features

The following features are part of your benefit plan.
** Benefit is available with major medical plan options only (not Cost Saver or MEC).*

Lab Testing Discounts

This program provides outpatient lab testing to Funding Advantage major medical plans at no charge to your employee. Costs will be reduced if performed at a Quest Diagnostics facility or a doctor's office that sends the tests to a Quest Diagnostics, LabCorp or American Esoteric facility. Employees and dependents may still use any lab they choose for services, but discounts are only applicable when these lab facilities are used. If you are covered under a Health Savings Account (HSA) plan, you will receive lab services at discounted rates that will be automatically applied to your HSA deductible. Once the deductible is satisfied, lab benefits are paid at 100%.

Member Discounts

The Abenity discount program provides our insured members with an elite collection of local and national discounts from thousands of hotels, restaurants, movie theaters, retailers, florists, car dealers, theme parks, national attractions, concerts and events. Members register online. Visit: *allied.abenity.com.*

Telehealth Visits

You can see a doctor from your phone or laptop 24/7. Your plan has the Cura TeleHealth & Wellness benefit. Telehealth is an efficient way to manage most acute and chronic conditions without having to go to a doctor's office. The cost is covered by your health plan or, if you have an HSA, it's a low-cost alternative to an office visit. Call 620-740-2872 to register.

Freedom Plan Balance Bill Support

Freedom Plan members have the support of Allied's Elite Experience Team to help them navigate their Reference-Based Pricing health plan. Members can contact the team if a new provider doesn't recognize the non-PPO Freedom health plan, which allows members to see any provider without penalty. The Elite Experience Team will work with the provider to explain the benefits and all aspects of the health plan. Members also can contact the Elite Experience Team if they receive a balance bill from a provider. Freedom Plan members are responsible only for copays, deductibles and coinsurance as shown in the Explanation of Benefits. Members are not responsible for any balance billing from providers who won't accept the reimbursement levels of the plan. If a member receives a balance bill, they should immediately call Allied's Elite Experience team at 866-332-1987 or email a copy of the bill to *elite@alliednational.com*.

Eligible Expense Summary

The following outlines the general plan of benefits designed into Funding Advantage. For more information, including limitations and exclusions, please review the Summary Plan Description (SPD). A sample is available from your agent.

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 total benefit of $500 per visit. The Freedom Essential benefit is $250 per visit. Expenses in excess of the maximum benefit, diagnostic testing and x-rays not performed in the doctor's office are subject to deductible and coinsurance. 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.

Urgent Care Services
Benefits payable same as for doctor's office visits after the urgent care copay (not applicable to HSA plans).

Emergency Room Services
Subject to deductible and coinsurance.

Out-of-Network Charges from Non-PPO Providers (not applicable to Freedom plans):
Paid at lesser of 80% or in-network coinsurance if injury or sickness occurs outside the PPO service area while traveling for 90 days or less, while permanently residing outside the service area, while attending school full-time outside the service area (dependent child only), or when receiving services at a PPO hospital from a non-PPO provider. These charges apply to in network deductible and total out-of-pocket maximum.

Routine Exams, Preventive Services and Immunizations for Children
Paid at 100%. Subject to schedule of visits as established by law.

Calendar Year Maximum Treatment Days
For inpatient hospital confinement for nervous, emotional or mental disorders or disease care (including substance abuse): 31 days. Paid same as any other illness.

Benefit per Human Organ or Tissue Transplant
When using an approved Center of Excellence, transplants are covered as any other condition. If insured person is not using a Center of Excellence, benefits are limited to 50% of charges to maximum benefit of $100,000. Human organ or tissue transplant from a donor: $10,000.

Lifetime Maximum Benefit for Hospice Care
One benefit period not to exceed six months.

Implantable Devices
Implantable devices such as pace makers or artificial joints are limited to a maximum eligible expense of 150% of the provider's cost for the device.

Pregnancy Care Benefit
(covers all dependants including children)
Payable same as any other sickness.

Complications of Pregnancy
Payable same as any other sickness.

Well Baby Care
Two days payable same as any other sickness.

Calendar Year Maximum Outpatient Visits

- 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 year
- Orthopedic manipulation including massage therapy and acupuncture - 20 visits per year
- Outpatient care for nervous, emotional or mental disorders or disease (including substance abuse) - 26 visits per year

Out-of-Network Limitations (not applicable to Freedom plans)

Office Visit and Urgent Care Copay
Subject to applicable out-of-network deductible and coinsurance.

Deductible
Additional deductible: Two times in-network deductible. No family limit for out-of-network deductibles.

Total Out-of-Pocket Maximum
Additional, equal to two times in-network total out-of-pocket maximum. Family limit is two times individual limit.

See the Summary Plan Description for complete details.

Plan Provisions

The following describes Funding Advantage plan benefits and requirements. Exact provisions for the plan are contained in the Summary Plan Description (SPD). Each covered employee will receive an SPD, which contains a detailed explanation of the plan provisions. Final rates and eligibility for all groups are determined at the time of underwriting. DO NOT cancel current coverage until your new group coverage has been approved in writing by Allied. Contact 888-767-7133 for up-to-date information and to discuss special underwriting situations.

Participation, Contribution Requirements and Eligibility

Funding Advantage requires participation by 75% of eligible employees AFTER valid waivers for other coverage OR 50% of the eligible employees in the group without regard to waivers, whichever is easier for the group to meet.

Eligibility

An eligible employee is a person directly employed and actively at work (including approved medical leave) on a full-time basis in the regular business of the employer, and compensated by the employer with regular periodic wages for service. Full time is 30 hours per week unless the employer wishes to define a lower limit for all employees. Retiree coverage is available when approved by underwriting. Eligible dependents are an employee's legal spouse who is not legally separated or divorced from the employee and is not a member of the Armed Forces, and an employee's children, including stepchildren, legally adopted or foster children, under the age of 26.

Waivers

Waivers must be completed for ALL eligible employees and/or dependents not enrolling for coverage. If the waiver is because of qualifying existing coverage, the waiver will not count against the calculation of the group's participation. An employee's failure to complete a waiver could jeopardize his or her future rights to coverage.

Takeover Benefits

Credit will be granted for deductible amounts satisfied under a prior Creditable Coverage during the 90 days prior to the effective date or current calendar year, whichever is greater.

Underwriting (for major medical plans)

Underwriting is required for all size groups to determine appropriate rates and claim funding. Based on the size of the group, requirements are:

- For 2-11 enrollees — Each employee and their dependent are required to complete an Individual Health Questionaire enrollment form which will be used to assess the risk profile of a group to determine appropriate rates.
- For 12+ enrollees — A simplified enrollment census containing basic information for each covered individual (employees and dependents) is required to obtain a firm (but not final) rate. Disclosure forms are required for each covered individual to obtain a final underwritten rate.

Prescription Drug Coverage (for major medical plans)

Employees who have major medical plans should show their ID cards at participating pharmacies across the nation, including most of the major national chains. Participants also may purchase maintenance drugs through the mail. For more information, please visit Allied at *www.alliednational.com* and look under prescription benefit information in the member menu. Benefits vary based on plan selected.

The Following Prescription Drug Restrictions Apply

- Copay, deductible and coinsurance amounts for Rx benefits do not count toward satisfaction of deductible under the plan, except under the deductible integrated benefit option.
- Benefits are based upon the contracted price or the maximum allowable cost as determined by the prescription drug card service. The maximum allowable charge is the ceiling price set by the prescription drug card service on the generic equivalents of a brand-name drug.
- If a brand-name drug is prescribed with no substitutions allowed, the insured member pays the applicable brand-name copay and coinsurance. If a brand-name drug is requested by the insured when the prescription allows generic substitutions, the insured is also responsible for the additional cost difference between the brand-name drug and the generic alternative.

Pre-Notification (for Major Medical Plans)

Funding Advantage assists employees and their families with medical education, high-risk monitoring programs, and coordination of doctor and hospital treatment plans. These services help ease a patient through the medical process and control expenses.

Pre-Notification Required at Least 7 Days Prior for ALL

- Outpatient services (exceeding $5,000)
- Inpatient admissions
- Pregnancies (within 30 days of diagnosis)
- Specialty drugs and high cost drugs
- Facility-to-facility transfers by air

In an emergency, prenotification required within 48 hours.

Plan administered by:

ALLIED™ NATIONAL
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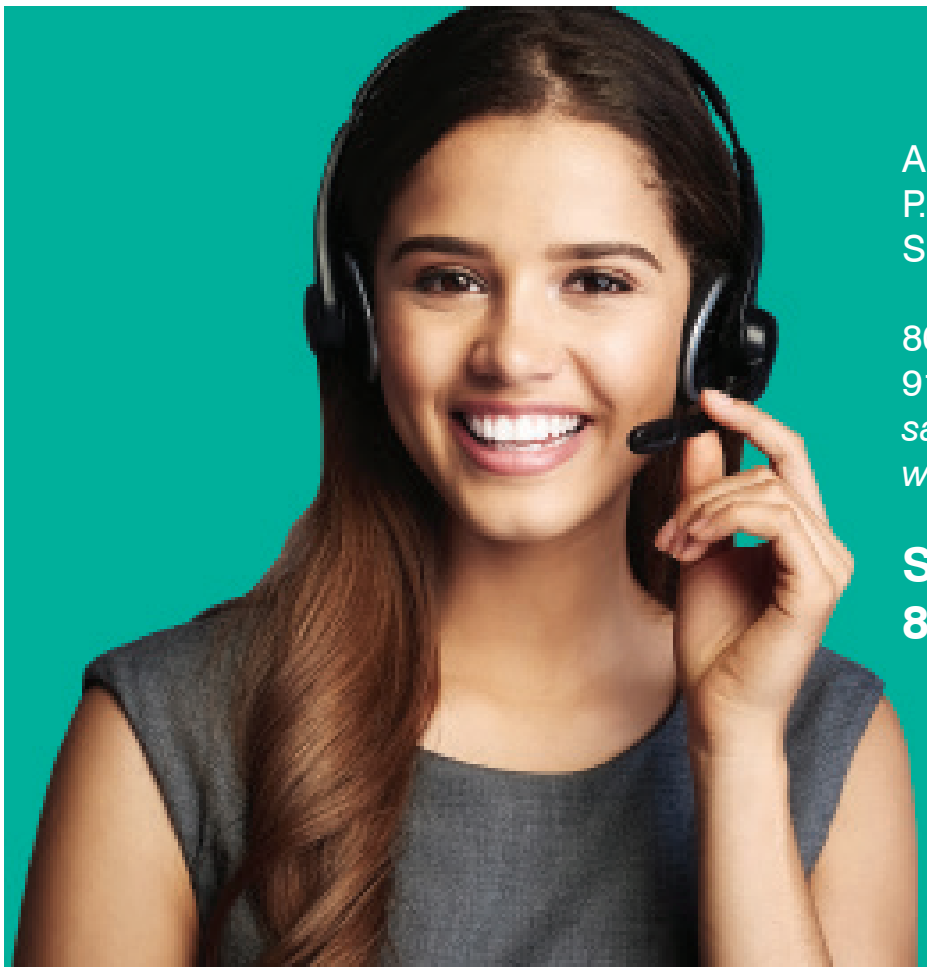
Founded in 1970, Allied National is one of the nation's oldest and most experienced third-party administrators. As the small group benefit experts, Allied works with small business employers to provide unique and affordable group health benefits. Allied National is a 90 Degree Benefits Company, a subsidiary of Blue Cross Blue Shield of Alabama.



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