



GUIDE TO LEVEL FUNDING

Effective 04/01/22



Plan administered by:



www.alliednational.com

Funding Advantage Benefit Consultant & Employer Guide

This guide is designed to provide the benefit consultant and employer with sufficient information to successfully install and manage Allied National's Funding Advantage level-funded programs.

Topics Covered By This Guide:

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Funding Advantage Overview and Highlights

Funding Advantage is designed as an easy-to-implement and simple-to-administer program to transition employers from fully insured medical plans to the use of self funding in a risk-limited environment. It is also ideal for employers who currently self fund, but want better cash flow protection or better plan administration through a level-funded plan.

Defined and Managed Risk – The employer's risk for large claims is managed up front through the purchase of stop-loss insurance.¹ Standard provisions include coverage for claims paid after the end of the plan year (no terminal liability exposure).

Cash Flow Management – Funding Advantage is a level-funded plan where the employer pays for their maximum exposure over 12 level monthly payments. This provides maximum stability to the employer with no cash calls or additional funding requirements.

Pre-Packaged Plan – All necessary materials (including the benefit plan design, the Employee Retirement Income Security Act (ERISA) Summary Plan Description (SPD), appeals processing, stop-loss insurance and appropriate documentation for all federal filings) are included with Funding Advantage. No additional bank accounts are required.

Claim Fund – After the claim run-out period (see "Claim Run-Out and Excess Claim Funds"), remaining funds are released or rolled over to the next year as a credit. This is the essence of level funding – money not spent on benefits remains with the employer's benefit plan, not the insurance company's money.

¹ This is a brief description of the terms of the plan. Please see the SPD for Funding Advantage for complete details.



Important Information About Funding Advantage

Funding Advantage is a program of services for level-funded group health plans, specifically developed for employees with good health experience. Level-funded plans are governed by the federal ERISA, are exempt from compliance with most state health insurance laws, and may exclude certain benefits mandated by state law.

Plan administration is performed by Allied National LLC, a licensed third-party administrator. However, only non-fiduciary, ministerial administrative acts, duties and responsibilities are delegated to Allied National via an independent business relationship with the employer. The employer remains the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee under ERISA and is responsible for all coverage determinations and benefit payments. Allied National is not an ERISA fiduciary, has no obligation to fund benefit payments and does not insure the plan.

Funding Advantage stop-loss insurance coverage is provided by A+ or A rated carriers based on group size and location.

Funding Advantage proposals are not a solicitation to purchase stop-loss coverage but an illustration of total monthly costs under Allied's level-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. Specimen stop-loss policies are available upon request. The stop-loss carrier is not an ERISA fiduciary. No stop-loss coverage is in effect until written approval is received. Existing health plan coverage should not be canceled until stop-loss approval is confirmed.

This guide is subject to change without notice and includes only summary information and representations about Funding Advantage. It is not a complete or detailed disclosure of plan benefits, plan administration or the stop-loss coverage. Refer to the SPD and stop-loss insurance policy for details or call Allied National at 800-825-7531.



What Makes Level-Funded Plans Work

For employers to realize the advantages of level funding, they must have a healthy risk pool, the potential to have better than expected claims two out of every three years and be financially stable. If these conditions are met, employers will enjoy significant savings over a fully insured plan in the long run. If employees consume health care benefits in excess of expected claim costs, there will be no savings to the employer and a fully insured plan that pools risk across multiple employers is a better option.

What Makes for a Successful Level-Funding Program?

Overall Employee and Dependent Health

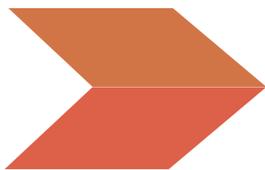
If there are significant acute care risks (such as current cancers or pending surgeries) or significant chronic care risks (such as a significant number of employees who smoke, have diabetes or are obese), claims are likely to be greater than expected. In the long run, promoting good employee health will reduce the employer's costs.

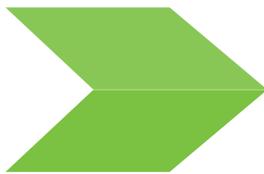
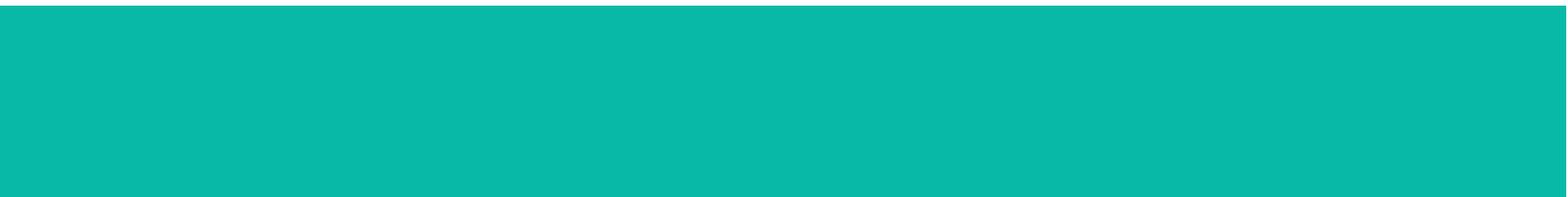


Please note that it is considered discriminatory to hire or fire employees based on the health status of the employee or his/her dependents. Employers can, however, be involved with these employees to help encourage healthy lifestyle changes and prudent health care consumption.

Health Care Consumption Patterns Are Important.

If employees view their health care benefits as entitlements, and consume without regard to costs, then average claims per employee are going to be higher than expected. One common area where prudent plan design can incent desirable outcomes exists in the choice between brand name drugs and generics. Outpatient prescription drugs can account for 20% of total plan costs, and wasteful prescription practices can increase overall plan costs by 5% or more. Another example is the choice of more expensive therapies before trying lower cost therapies. Employers receive reports explaining how care is being consumed, and information on how to educate employees on ways to reduce health care costs without sacrificing quality care.





Low Plan Participation Can Increase Total Employer Costs

When participation is low, enrollment usually leans toward those with health problems. An employer can actually lower total plan expenses by contributing enough of an employee's plan costs to encourage more employees to enroll. The contributions from the healthy employees will be used to fund benefits for those that are not healthy. Those claims are going to exist and require payment, so why not have more employees contributing to plan costs?



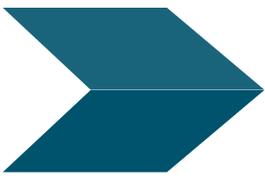
Good Plan Designs Can Lower Consumption: Poor Plan Designs Can Increase Consumption

The more an employee has to pay out-of-pocket, the more likely they are to be careful consumers. "Skin in the game" is a good thing. Even when a rich plan with a low deductible is desired by the employer, adding a longer coinsurance corridor will lower direct costs and consumption. A \$500 deductible with \$2,500 additional out-of-pocket will save more than the same deductible with only \$1,000 out-of-pocket, not only because the employee has to pay more of the total cost for any one claim, but because the employee may decide not to get a particular medical service. Allied's studies show that even 20% cost sharing through coinsurance and deductibles is enough to reduce health care consumption. Once an employee is at 100% benefits there's no financial impediment to consuming more care the rest of the plan year.



Long-Term Financial Stability and Commitment For Plan Year Is Critical

Unlike fully insured plans where coverage can be moved or dropped at any time, there is a financial exposure to the employer for terminating off plan year (see the employer stop-loss section for additional information). It is important that the employer be financially healthy and confident they can maintain the plan for the entire year. Also, not every year is going to be a winner. Even a healthy group will have years with abnormally high claims, but normally over a three- or four-year period the employer with a healthy risk pool will save significant dollars.



Coverage Proposals

To better understand Funding Advantage, start with the coverage proposal. Like traditional fully insured plans, the total cost for Funding Advantage is based on the employer's census of participating employees and dependents, along with the actual benefits being provided. The Funding Advantage proposal provides general plan information, along with expected and maximum cost summaries and ERISA plan benefit information.

Cost Summary

Costs for the Funding Advantage plan are divided into three categories:

Claim Fund – This is the employer's fund used to pay routine claims. The employer's total annual maximum exposure is determined as part of the proposal. Included in the claim fund, and covered by the stop-loss insurance, are vendor expenses such as bill review/negotiation, case management and other cost containment programs.

Insurance – This coverage protects the employer by setting limits to claims paid from the claim fund.

- **Specific Stop Loss** – This provides protection against the total claims from any one individual during the plan year. If total employer paid claims exceed the specific stop-loss deductible, the insurance begins to pay these claims for the balance of the plan year.
- **Aggregate Stop Loss** – This provides protection against the total claims from the entire group during the plan year. If total employer paid claims exceed the aggregate stop-loss deductible, the insurance will then pay all claims for the remainder of the plan year.

Administrative & Sales Costs – This monthly cost covers the administrative and sales expenses of the plan. This includes claims processing, billing, underwriting, customer service, PPO fees (if applicable) and monthly claims reporting. It also covers compensating the employer's benefit consultant for their role in establishing and maintaining the plan. There will never be additional fees required from the employer.

ERISA Benefit Plan

This describes the health plan benefits selected for the covered employees and their dependents. The Funding Advantage plan provides a wide range of benefit alternatives for the employer so they can best meet their own benefit and cost needs.

Plans Available

Freedom Hybrid – Members may see a physician in their PPO network or go out of network without any penalties. They also may visit any health care facility. Facilities and non-PPO providers are reimbursed based on a multiple of Medicare allowable prices.

Freedom Traditional – There are no preferred providers or networks required. Members still receive the value of PPO-like discounts for medical services. The Traditional Plan pays physicians at 125% of Medicare allowable reimbursement and facilities at 150% of Medicare allowable. If there's a disagreement between Allied and a provider about the fee, we negotiate directly to ensure there is no "balance bill" amount. The only out-of-pocket expenses for covered services are normal deductibles and coinsurance. Allied National provides a legal support service at no cost to members who have been balance billed.

Freedom Essentials – A low-cost major medical option offering many of the benefits of our Freedom Traditional Plan. Like the Traditional Plan, Essentials features a Legal Support service for those who are balance billed.

Preferred Provider Organization (PPO) Plans – These are "traditional" PPO-style plans with deductible options starting at \$500. There are multiple copay, coinsurance and out-of-pocket options available with each deductible.

MEC – Coverage for all preventive services as listed by the U.S. Preventive Services Task Force.

Cost Saver – A limited benefit plan that offers office visits and rich outpatient benefits like a major medical plan, with scheduled cash payments for surgery and hospitalization.

Direct Primary Care – A major medical wrap plan that supports a relationship with members' direct primary care physicians. It eliminates duplication of premium expenses.

HSA Qualified High Deductible Plans – Employers can sponsor plans that are compatible with HSA tax rules.

Enrollment and Underwriting Requirements

The agent and employer must submit the following items to enroll a group and begin the underwriting process. A Funding Advantage new case submission must be sent to Allied a minimum of 10 working days before the requested effective date. Underwriting can take up to three weeks depending on completeness of a submission and how quickly missing information is received. To be considered a submission, the employer information statement, current plan information (benefits, current and 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 only and not handled as a new case submission.

Employers

1. Please complete, sign and date the employer information statement.
2. Have each of your employees complete, sign and date an employee enrollment form. All new hires on or before the effective date of coverage also must complete enrollment even if still in a waiting period. All groups under 100 employees must complete the application health information. Groups over 100 employees with major medical-appropriate experience information can complete the non-health enrollment card. Check to see that all questions on the applications are answered completely and accurately. **Online enrollment is available – call Allied Sales Support for details.**
3. 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.
4. Include a preprinted company check made out to Allied National for the first month's costs as shown on the rate proposal.
5. For groups with fewer than 50 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 with information necessary to verify employee participation and eligibility.
6. Groups with a current health plan - include your most current billing statement that includes your renewal rates from your current carrier.
7. Please give all of the above pieces to your agent, so he or she can send the forms to Allied to begin processing.

Agents

1. All papers from the employer and their employees (see list on the left) must be signed, dated and received by Allied in one packet by mail, email or fax before the requested first-of-the-month effective date.
2. You must be appointed with the appropriate stop-loss carrier. If not, please contact Allied Sales Support at 888-767-7133.
3. In addition, submit a copy of the benefit and rate proposal used for the group.
4. Submit all pieces from the employer to the addresses below. When submitting forms by fax or email, forms must be legible. Forms filled out by hand must be done with ink.
5. Send all completed forms to your local Allied representative or mail to:
Allied National Underwriting Department
P.O. Box 29187, Shawnee Mission, KS 66201-9187
6. Deliveries requiring a street address:
Allied National
4551 W. 107th St. #100, Overland Park, KS 66207
Underwriting Fax: 913-945-4397
underwriting@alliednational.com



Flow of Funds and Monthly Accounting



Each month the employer will receive:

- 1. A Billing Statement** looks like a traditional bill and shows the total due for each covered employee and dependent. This will be sent to the employer approximately 10 days before the due date, and payment for all charges is due no later than 30 days following the due date. The bill is comprised of fixed costs (stop-loss insurance and sales and administrative expense) and claim fund contribution.
- 2. An Accounting Statement** showing the employer's payments to the plan to date and how these payments have been allocated between stop-loss premiums, sales and administrative fees, and claim fund contributions. This report also shows benefits paid and stop-loss insurance payments received. The employer's monthly accounting or expense treatment for a level-funding program may be different than for a fully insured plan. With a fully insured plan the payment is always expensed when it's made – it is no longer the employer's money. With Funding Advantage, the employer has a choice as to when to expense the employer's portion of the payment that is allocated to the claim fund and to treat that amount as an asset of the employer or to treat the entire payment as an asset of the ERISA plan and immediately expensed. The accounting issue is specifically how to treat the employer's portion of the contribution to the claim fund. All employee contributions are always immediately expensed and become assets of the ERISA plan. Allied recommends each employer discuss with an accountant how to record each month's payments.

Claims Utilization Reports

Unlike a fully insured plan, employers with Funding Advantage can influence future claim costs by educating themselves and their employees on how to conserve claim dollars. Staying below the claim fund maximum and minimizing the employer's cost of benefits maximizes the employer's refund.

Allied's Claim Utilization Report will provide the employer a high-level, easy-to-understand picture of which services are driving benefit plan costs. Money can be saved by looking for non-preferred brand name drugs that should be switched to brand name drugs, or brand name drugs that should be switched to generics. Member education of the true costs of outpatient drugs can lower the employer's monthly benefit cost by 5-10%. Are members consuming care in the most appropriate setting possible for office visits, urgent care visits and emergency room visits?

As the plan administrator, the employer can request detailed reports showing expenditures down to the individual person. Allied will not provide specific diagnosis or treatment information for any individual. Only information that indicates where services were incurred will be provided unless the employer obtains HIPAA authorizations from each employee.

Claim Run-Out and Excess Claim Funds

A hidden trap for employers new to self-funding is the concept of claim run-out. Funding Advantage protects employers from this risk. The claim run-out feature handles claims that happen during the plan year, but may not be paid until after the plan year ends. For example, assume the plan year runs January through December, and an employee goes to the hospital in December. That hospital bill will likely not be received or paid until January or February, so the hospital bill is incurred during the plan year but not paid until the next plan year.

In a traditional self-funded plan, claims are accounted for when they are paid. If the employer decides to go back to a fully insured plan the next year, they're still responsible for paying claims incurred during the plan year. Allied's Funding Advantage program provides for this eventuality in two ways. First, the stop-loss policy and claim fund covers any bill incurred during the plan year as long as it is paid within nine months following the end of the plan year. This period of time allows for the normal occurrence of late claims. Second, instead of tying the employer's claim fund up for the maximum time required for all claims to clear, unused funds are released nine months after the end of the plan year. In the event there are any pending claims at that time, some or all of the claim fund may be held until those claims are resolved. Once the claim fund has been released, late claims will be treated as current plan year expenses if the employer's plan is still active. If the employer's plan is not still active then the aggregate stop-loss insurance will pay the claims.

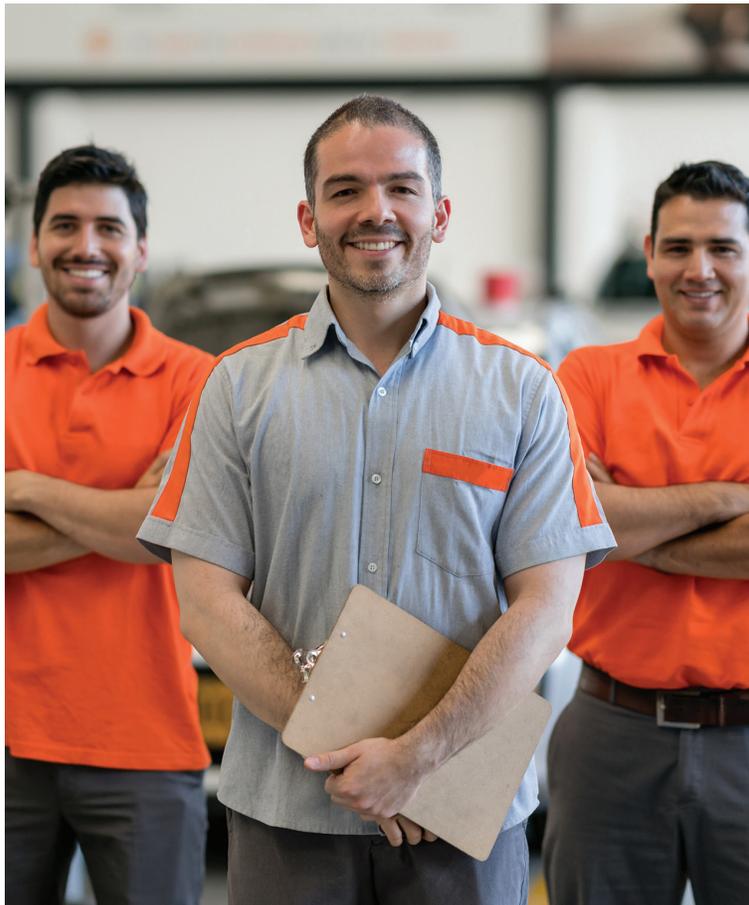
Once the claim run-out period is completed, the money remaining in the employer's claim fund (for that plan year) can be released. It can either be returned directly to the employer (any amounts that have become assets of the ERISA plan only can be used for the benefit of the plan beneficiaries and are not available for use by the employer for any other purpose) or rolled over as a credit to the current plan year. The employer decides how the remaining money is used (within the limits required by ERISA).

Employer Stop-Loss Policy

When moving from a fully insured medical plan, the typical employer utilizes employer stop-loss insurance to protect their plan from exposure to a large claim on an individual, or when total claims for the year are significantly greater than expected. Funding Advantage provides the employer with two types of stop-loss coverage – specific and aggregate.

Specific stop-loss coverage is for when any one individual has large claims. Once that individual's total claims exceed the specific deductible, the rest of the claim is covered by the stop-loss coverage. By default, the specific deductible for smaller groups for the first year of coverage in Funding Advantage is \$10,000.

Aggregate stop-loss coverage is designed to protect the employer when the total claims for the group reach a certain level. Aggregate stop-loss coverage begins covering all future claims once the total claims funded by the employer exceed a certain dollar amount (the aggregate deductible). It is by using aggregate stop-loss insurance that the employer's total maximum expenses can be established in advance. The dollar amount of the aggregate deductible is a percentage of the expected claims that were calculated as part of the coverage proposal. Once the aggregate deductible amount is determined, it is expressed as a dollar per employee or dependent per month.



Characteristics of Funding Advantage Stop-Loss Policies:

Designed to Cover Claims incurred during the 12-month plan year. If the stop-loss policy is terminated early, there is no coverage under the policy. Aggregate coverage is terminated and no specific losses will be covered beyond what has already been paid.

Returns Unused Claim Funds nine months after the end of the plan year (if there are any claims pending at that time, some or all of the claim funds may be held pending resolution of those claims). After any unused claim funds have been released, any additional eligible claims received will be assigned to the current plan year for active groups or covered under the aggregate stop-loss policy for inactive groups.

Have an Aggregate Accommodation Provision to advance funds to cover benefits when the employer's total claims exceed their accumulated maximum exposure as calculated for any given time in the plan year. For example, if six months into the plan year, the aggregate claims costs are more than half of the calculated annual maximum exposure, an accommodation loan would be made to fund claims payments. In a level-funded plan, the accommodation loan is paid off through the employer's normal monthly payments.

Monthly Stop-Loss Premiums (per employee) are guaranteed during the plan year unless the employer's employee base changes by 10% or more (depending on the stop-loss insurance coverage).

Policies Are Issued For One Plan Year (12 months); assume payment of premiums for entire plan year and are not guaranteed renewable.

Aggregate Coverage contains a requirement that the employer fund a minimum dollar amount of claims each year before aggregate benefits are available (minimum aggregate deductible). This minimum amount is typically 80-90% of the employer's maximum exposure for the plan year based on the first month of enrollment and is designed to accommodate a reasonable decrease in plan participants during the year. However, in the event the employer fails to maintain the policy for the entire plan year, there is no stop-loss protection. In the event of early termination, the employer must continue to fund claims incurred during the period the plan was in force and will be required to reimburse the insurance company for any funds advanced under the accommodation provision.



Important Things to Know

Please be aware of the following important topics, which are not addressed elsewhere in this guide. Contact Allied with your questions, because a successful plan is aided by a knowledgeable client.

- In the event the employer's enrollment changes dramatically (10-15%), the critical plan components (stop-loss premiums and maximum claim fund) will be reviewed to see if the employer's exposure is less than the minimum aggregate deductible. If so, stop-loss premiums and the aggregate deductible will be recalculated to avoid additional exposure to the employee. The new amounts may be more or less, depending on the change in enrollment, and will reflect the average risk exposure during the plan year.
- Benefit expenses include the costs of outside vendors used to reduce claim costs. These vendors may be paid a percentage of the actual claim savings, a fee per action (such as performing a peer review), by the hour or per employee. Allied has vendors to assist with out-of-network claims, complex case care management (for example, premature babies and organ transplants), bill review (to verify provider billing accuracy) and others, all designed to contain the cost of benefits without subjecting your employees to additional financial exposure. Since these services reduce the cost of benefits, they are treated as a claim cost payable from the employer's claim fund and covered by the employer stop-loss policies.
- Employers not using fully insured plans often request help in establishing the "premium equivalent" amount to use for employee cost sharing, to charge for dependent coverage and for COBRA continues. Under Funding Advantage the employer's maximum cost has been established. This amount may be used to establish each employee's contribution to their own coverage, as well as that of their dependents. If this amount is used as the basis to determine the employee's cost share, then it is also the appropriate amount to charge for COBRA coverage.
- As the actual risk holder, the employer is ultimately responsible for all claim decisions. The employer engages Allied as a third-party administrator to process claims for them and gives Allied the authority to make claim decisions on their behalf. All claims approved by Allied will be paid according to the terms of the Summary Plan Description (SPD) and all claims paid according to the terms of the SPD will be covered by the stop-loss insurance. Allied will not pay any claim not covered according to the terms of the SPD unless expressly requested and authorized by the employer. If the employer does elect to pay a claim that falls outside the scope of the plan document, the cost of that claim will not



be applied toward stop-loss deductibles nor covered by the stop-loss insurance, and additional funds will be required from the employer to cover that claim.

➤ At renewal, the employer's stop-loss coverage and claim fund requirements will be underwritten based on current claim exposures. Stop-loss coverage renewals are not guaranteed; however, Allied's Funding Advantage plan will always provide the employer a renewal option. The employer's biggest exposure in a self-funded plan is the challenge in renewing coverage when a large claim is present. Known large claims have to be paid for by the employer's plan in some fashion. The cost of the stop-loss insurance may be increased to cover the risk or the costs can be added to the claim fund and that individual's specific deductible modified to exclude some or all of their costs. Rather than building the cost of large claims into the stop-loss premium (which is grossed up for expenses, profits and premium tax), it is less expensive to include the cost in the claim fund and adjust that individual's specific deductible. Also, by doing this, if the exposure goes away (employee termination, death or the cure costs are less than expected) the employer retains the savings. The self-funded employer may find total plan costs with a large known claim to be unaffordable and it may be beneficial to return to the fully insured market where large claims are pooled across all employers. This is particularly

advantageous to employers eligible for guarantee issue coverage. They may find significant savings by returning to the fully insured market.

- Class exclusions – ERISA regulations generally assume all full-time employees are eligible for coverage. Self-funded plans may not discriminate in favor of highly compensated employees. If you are excluding any class of full-time employees, your tax adviser should determine if the eligibility structure is potentially discriminatory.
- COBRA administration – Allied does not provide full COBRA administration services. We will provide you with a complete packet of the required notifications and forms. It is the employer's obligation to provide the appropriate notifications to any employee or dependent who loses coverage. Allied does provide COBRA billing for the employer free of charge. If the employer elects this, Allied will bill the COBRA employee for their cost under the plan.
- ERISA requires employers with self-funded benefit plans to be insured against fraudulent loss of funds through a fidelity bond. Allied strongly recommends that the employer also have Fiduciary Liability coverage in place. The employer should consult with their property and casualty insurance agent to arrange for this coverage.

Glossary

Accommodation – The stop-loss insurance coverage will advance funds to the employer in the event there is insufficient money in the employer’s claim fund to pay a claim (total paid claims exceed plan year to date – maximum claim exposure). Funds will be advanced and repaid from future contributions to the claim fund. Under the Funding Advantage plan, the stop-loss insurance will pay the initial claim without requiring the employer to fund it.

Employer Claim Fund – This fund holds the employer’s money to cover their claim liability. The fund balance will be tracked by plan year. Nine months after the end of the plan year, any remaining money from that plan year can be returned to the employer as either a lump sum payment or applied to future plan year payments. In the rare event a claim is pending at the end of the run-out period, the release of funds may be delayed.

Maximum Claim Cost – At the time of enrollment a group’s maximum claim costs are determined based on the benefit plan selected and the health and assessment of the group. This “aggregate corridor” is determined by group size and any state requirements for aggregate stop-loss minimums. This Maximum claim cost is also known as the aggregate deductible (or aggregate attachment point) and represents the point at which the employer’s plan stops paying benefits and the Aggregate stop-loss coverage begins to pay benefits.

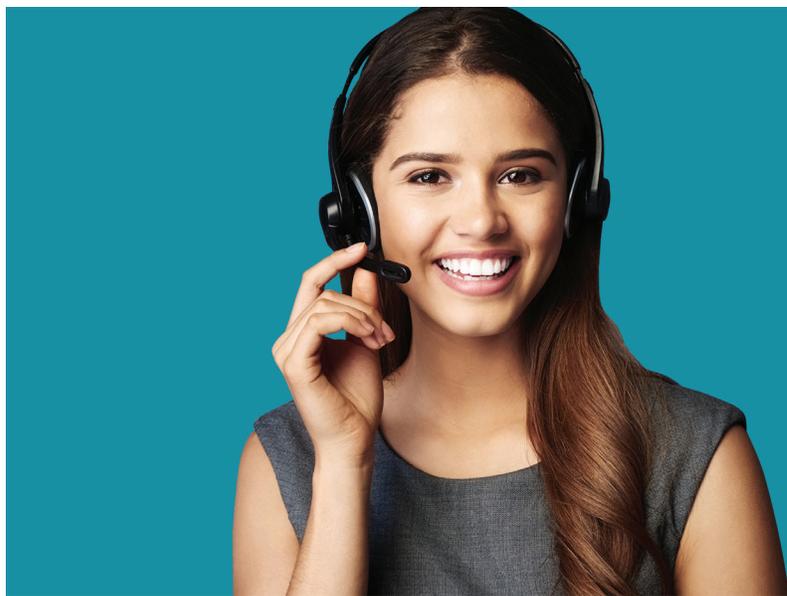
Monthly Billed Costs – This amount is the total cost for each rate class (Employee Only, Employee and Spouse, Employee and Child(ren), Family). The monthly cost is the sum of the stop-loss insurance, the claim fund amount selected, and administrative and sales expenses. This is the amount that will be billed to the employer.

Plan Year – The stop-loss coverage plan year is based on the effective date of the coverage and runs for 12 months from that date. Claims are applied to the stop-loss insurance based on the plan year. The Funding Advantage ERISA plan benefits are based on a calendar year (benefits like deductible and coinsurance costs are all calendar year). Effective dates of coverage may only be on the first day of the month.

Stop-Loss Insurance – The employer purchases stop-loss insurance in order to limit the employer’s risk under the ERISA benefit plan. Two forms of stop-loss insurance exist and will be used in the Funding Advantage plan.

- Specific Stop-Loss Insurance protects the employer from large claims generated by any one individual. If an individual has claims exceeding the specific deductible, then the specific insurance will reimburse the employer for the balance of all claims for that individual.
- Aggregate Stop-Loss Insurance protects the employer when the total claims for the group exceed a set level for the plan year. Once claims exceed this set level, aggregate insurance pays claims for the remainder of the plan year.

Summary Plan Description (SPD) – This is the document that governs the employer’s benefit plan. The SPD’s structure and contents are driven by federal law (ERISA) and the specifics of the benefit structure. The SPD determines the employee’s benefits and rights under the employer’s plan, and also determines the employer’s duties and obligations as the plan sponsor. A sample of the SPD is available on your Self-Service Site.



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