FUNDING® ADVANTAGE

A Level-Funding Solution for Small Groups

Plan Brochure – Effective 9/1/2018






Plan administered by:

ALLIED® NATIONAL

www.alliednational.com

Do you receive money back from your insurer for being healthy?

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 provides coverage for large claims and caps your maximum exposure.

1. Stop-loss insurance protects you when an employee has a serious claim or more employees have claims during the year than you can afford to pay.
2. Each month you make a payment that covers the fixed costs of your plan: Stop-loss insurance and the administrative and sales fees.
3. Level Funding: You pay your fixed costs and then fund your claim fund monthly with 1/12 of your maximum annual cost. You never have to pay more than this maximum amount. You are never subject to a cash call if claims go past your current maximum contribution.
4. After all claims have been paid for the plan year (after the nine-month run-out period), any unused dollars in your claim fund are yours to use as you want – to be refunded or used to lower costs for the next year.

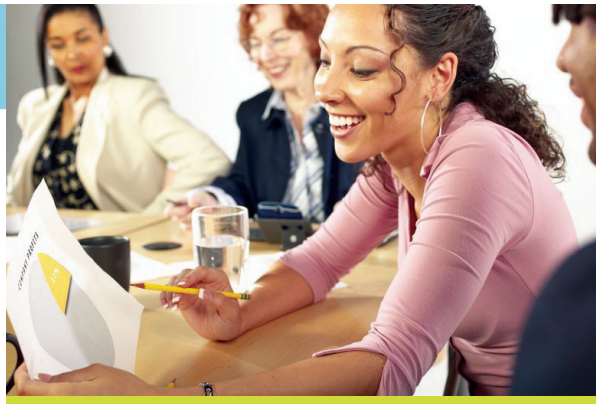
How is This Plan Different?

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.

Self funding allows you to keep the savings when your group is healthy while stop-loss insurance caps your exposure. Level monthly 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.

What are the Advantages of the Funding Advantage Plan?

- You don't buy insurance for benefits that you don't use. Unspent claim dollars are yours at the end of the plan year.
- Stop-loss insurance fully protects you from larger claims. You will never have to pay more than the maximum exposure.
- Level funding means there are no surprise payments – just one monthly fee.
- Your plan is an ERISA plan that is exempt from some of the federal Affordable Care Act regulations.



What are My Risks With This Plan?

With Funding Advantage level funding, your only risk when you get to the end of the plan year is that you won't receive money back. 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.

Your only risk is not receiving money back at the end of the year!

Pride in WHO We Are

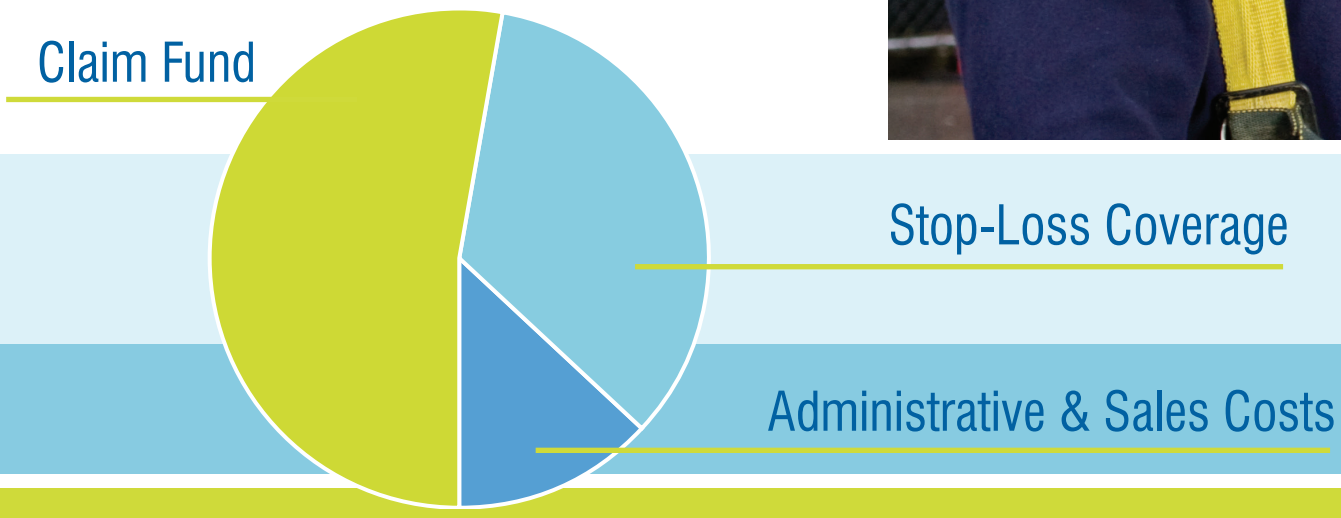
Allied National ... Today and Tomorrow

Allied National is an administrative organization that works with major national insurance companies to provide quality benefit plans for employers and individuals. Since 1970, as a family-owned company, we take pride in our history of fast and friendly service to our customers.

How Funding Advantage Works

There are three types of costs:

- ***Claim Fund***
  Covers employees' health care claims
- ***Stop-Loss Coverage***
  Protects employer from unexpected claims
- ***Administrative & Sales Costs***
  Covers processing and reporting



Your Claim Fund

With level funding, you'll never pay more than the maximum claim cost for the plan year. Each month you pay 1/12 of your MAXIMUM annual claim costs for your 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 for refund or for expenses in your next plan year as you determine.

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. There are no cash calls or additional charges. As monthly payments are made any extra funds will be used to repay the accommodation loan.

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). With this information, you can design your plan to hold costs down at renewal.

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 by providing the nine-month run-out period.

Stop-Loss Coverage

Stop-loss coverage protects you from larger claims. The insurer pays for larger claims so the money does not come out of your claim fund.

- 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.

Administrative and Sales Costs

These are the costs you pay for the administration of your group's health plan. This includes underwriting, claims processing and monthly claim fund reporting. Compensation is also 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.

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.

What are My Plan Options?

Funding Advantage has a wide array of options (see page 7):

Major Medical Options

- **Freedom –** Provides true choice of any provider (no PPO panels) with the savings and protections of a typical PPO plan; plus an HSA qualified option. Reimbursement to providers is reference based on a multiple of Medicare reimbursement levels.
- **PPO –** Traditional PPO coverage plans.
- **HSA Qualified –** High deductible plans that qualify for Health Savings Accounts.

Limited Benefit Options

- **MEC –** Coverage for all preventive services as listed by the U.S. Preventive Services Task Force.
- **Cost Saver –** A limited benefit plan that covers office visits and rich outpatient benefits like a traditional major medical plan, with scheduled cash payments for surgery and hospitalization.

As you choose benefits, like higher deductibles, they have a significant impact on your monthly costs. Your claim fund and stop-loss insurance coverage costs will vary with your choice of ERISA benefits.

Allied HealthCare Assistant

Allied HealthCare Assistant is an umbrella of health care services available to members and their families. This suite of services was created to ensure our members have the absolute best access to the best health care in the country. This service is provided to Funding Advantage major medical plan members by Allied National and their employer. 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. For instance:

- Understand your diagnosis.
- Find the right doctor who specializes in your health condition.
- Get the best treatment for your specific needs.
- Receive second opinions from top doctors.
- Manage any specialty drug you are taking.
- If you are taking multiple medications, you might be a candidate for DNA testing to help you get the right drug doses and combination.
- Manage diabetes for a healthy life.
- Get support with behavioral health issues.

Benefit Plan Options

Freedom Plan

- 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 deductibles and coinsurance.

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.

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 Plan or PPO Plan options.

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

Our plan provides 100% coverage for all preventive services as listed by the U.S. Preventive Services Task Force. There are no deductibles, copays or annual or lifetime limits. A list of these services can be found at *www.hhs.gov/healthcare/prevention/index.html. This plan satisfies the ACA employer mandate to provide minimum essential coverage and eliminates the Part A penalty for applicable large employers.*

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.

Benefit Plan Features and Options

Pregnancy Coverage: Mandatory 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: Pays 100% of charges incurred due to an accident, up to a $500 benefit (not currently 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:

- **Discount Only:** No outpatient prescription drug coverage.
- **Generic Only:** Generic: $15 copay per prescription. No limit on number of prescriptions. No Annual Maximum Benefit per calendar year. Brand name: Provided at Allied's contracted discount.
- **Deductible Integrated Benefit Options:** Outpatient prescription drug benefits subject to the plan's major medical deductible. After the deductible, prescription benefits are covered under the formulary plan. There are two plan options. Option one: benefits subject to normal copays; option two: copays are waived for tiers 0, 1 and 2.
- **Formulary Plans:** The base formulary plan is as shown in the chart. The formulary plan is available with a variety of deductibles.

Rx Formulary Plan Benefits		
Tier	**Description**	**Patient Pays**
0	Prescribed Over the Counter (Claritin, Alavert, Zyrtec & Prilosec)	$3 Copay
1	Generic	$10 Copay
2	Brand-name Formulary	$30 Copay
3	Brand-name Non-Formulary	$50 Copay
4	Specialty Pharmacy*	10% coinsurance; Up to maximum $200 per fill

*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. For more formulary information, visit Allied online at *www.alliednational.com*.

Note: The 90-day mail order supply is available for two times the normal copay.

Benefit Enhancement Features

The following features, and the costs for them, are built into your benefit plan and included in your monthly charges.

HealthCare Assistant*: This program supports our members through every encounter with the health care system by providing the resources they need for the best results. Members can call 844-287-6078 or visit *member.alliednational.com* when they have a serious illness and need guidance. HealthCare Assistant will determine which support services best meet their needs and will work with them throughout their health care journey. For instance:

- If you or your dependent has diabetes, HealthCare Assistant can help you find free testing supplies.
- If you need surgery, HealthCare Assistant can help you find a Center of Excellence or even seek a second opinion before surgery.
- The service also has experts who can provide guidance about a mental or behavioral health situation.

MeMD*: This benefit allows members to contact health care professionals 24/7 to diagnose and treat minor ailments via phone, tablet or computer. Physicians are U.S. board certified and have been authorized to prescribe medications. To contact a provider any time of the day, call 855-236-9411 or go through your online *member.alliednational.com* account.

Lab Card®: This program provides outpatient lab testing to Funding Advantage major medical plans and Cost Saver plans at no charge to your employee and at a greatly discounted charge to the plan when performed at a Quest Diagnostics facility or a doctor's office that sends the tests to a Quest Diagnostics facility. If you do not use the card, you will be responsible for the deductible, coinsurance or copay for laboratory charges. HSA High Deductible Health Plans also are enrolled in the Lab Card program; members can receive and pay for **discounted** lab services that will be automatically applied to the HSA deductible. Once the deductible is satisfied, Lab Card benefits are then paid at 100%. Visit: *www.alliednational.com/labcard*

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/perks/*

*** Benefit is available with major medical plan options only.**

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. Expenses in excess of the $500 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.

Urgent Care Services*: Are subject to the doctor's office visit copay plus $20 (urgent care copay). Benefits payable same as for doctor's office visits after the urgent care copay (not applicable to HSA plans).

** Copays do not apply to standard plan deductibles or coinsurance out-of-pocket maximums. They do apply towards the ACA mandated total maximum out-of-pocket ($6,600 in 2015 for self-only coverage, $13,200 for family coverage) unless the employer has requested a plan design with a higher total maximum out-of-pocket.*

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 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.

Calendar Year Maximum Aggregate Benefit (except as otherwise indicated in the Schedule of Benefits): As mandated by Federal law. For Plan Years beginning after:

- 1/1/2014 and later - Unlimited

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.

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

See the Summary Plan Description for complete details.

Plan Provisions

The following information describes Funding Advantage plan benefits and requirements. Exact provisions for the plan are contained in the Summary Plan Description. Each covered employee will receive a Summary Plan Description, 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 Allied Sales Support at 888-767-7133 for up-to-date information and to discuss special underwriting situations.

Participation, Contribution Requirements and Eligibility

A minimum of two covered employees is required, and a minimum employee participation of 75% of eligible employees must be enrolled. Any employee who waives coverage because they have a qualifying existing coverage is not counted in participation totals (unless the qualifying coverage is another plan with that same employer). At least 50% of the full-time employees must participate in the plan for the group to be eligible. The employer must contribute a minimum of 25% of each employee's contribution costs; there's no minimum participation requirement for dependents.

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 at least 30 hours per week unless otherwise specified. 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)

Health Risk Assessments are done for all size groups to determine appropriate rates and claim funding.

- Groups of less than 100 lives must complete individual medical questionnaires for their health assessment.
- Groups of more than 100 lives may submit three years of experience data that includes old premiums paid, claims paid and large claim information.

Prescription Drug Coverage (for major medical plans)

Each employee will receive a prescription drug ID card that can be used at participating pharmacies across the nation, including most of the major national chains. Participants may also 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 do not count toward satisfaction of deductible and out-of-pocket costs 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)

The Funding Advantage plan assists the employee and his or her family with medical education, high-risk monitoring programs, and coordination of treatment plans with doctors and hospitals. These services help ease a patient through the medical process and control expenses to the benefit of all participants.

We request that participants give pre-admission notification in the following instances:

- Within 30 days from the date of diagnosis of a pregnancy
- Outpatient services exceeding $5,000
- Inpatient admission and treatment
- Human organ or tissue transplants
- Facility-to-facility air ambulance

Group Enrollment Requirements

The following items are needed from the agent and employer to enroll a group and begin the underwriting process for major medical plans. Allied's guideline for a timely Funding Advantage new case submission is a minimum of 10 working days before the requested effective date. Typical 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 must also complete enrollment even if still in a waiting period. All groups under 100 employees must complete the application health information for major medical plans. 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 Underwriting 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 above list) 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 for information.
3. In addition, submit a copy of the benefit and rate proposal used for the group.
4. Please submit all pieces from the employer to 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 done with ink.

Send all completed forms to your local Allied representative or mail to:

Call Allied Sales Support to Apply Online!
888-767-7133

For deliveries requiring a street address, mail to:

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 all required items with legible, fully completed forms.*

Allied National
Underwriting Department
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About Allied

Allied National is an administrative organization that works with major national insurance companies, providing quality benefit plans for employers and individuals since 1970. As a family-owned company, we take pride in our history of fast and friendly service to our customers. Our personal service is what sets us apart from the large companies in the industry.

Allied appreciates and preserves the idea of value. We believe the best way to deliver outstanding value is not to just offer great products and pricing, but to back our products with excellent service.

Allied has a tradition of trust. We build all our relationships and base all our services on this trust. Delivering high-quality, high-value employee and individual benefit plans is our purpose, and maintaining superb customer service is our goal. Factor in more than 45 years of experience managing benefit plans and it's easy to see that Allied means good value.

We have committed ourselves to excellence. We fulfill this commitment in many ways, in everything we do. We genuinely respect others, and we treat our customers with the consideration inherent to a privately-owned business in the heart of America.

ALLIED® NATIONAL

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