We make Benefits Better.

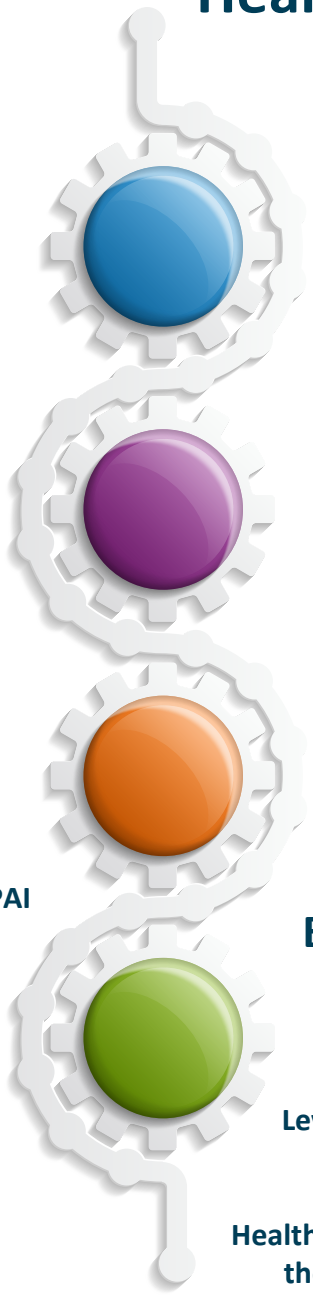
Change the Game with a Level Funding Health Plan

Know Your Score

Up-front assessment of group's health risk.

Review employee health history to evaluate risk.

Level Funding is for healthy groups of 30-150 employees.



Follow the Money

Self-insured plan with a fixed monthly budget - similar to a fully-insured plan.

Pay one fixed monthly payment that includes:

- claim account fund
- stop loss insurance to cover excssive claims, and
- plan administration, including broker services

Prevent Surprises

If claims exceed claim fund, stop loss insurance advances the difference.

Once claims are settled for the plan year PAI returns surplus to the employer - and stop loss covers any deficit.

Most years most groups see a surplus.

Enjoy Your Own Private Pool

Fully-insured premiums are "pooled" to pay claims in other groups.

Level-funded groups pay for their own claims, not the "community pool."

Health management services help members improve their health and slow your health care spend.

We make Benefits Better.

Planned Administrators Inc. (PAI) is a full service third party administrator located in Columbia, South Carolina. Since 1981 PAI has earned a reputation for self-funding expertise, leading edge technology, and legendary customer care. Many of our clients have been utilizing PAI services for decades.

Many of our staff have been with us for decades as well. You'll find our associates knowledgeable, efficient and charming. Yes, charming. This is South Carolina after all. PAI is small enough that you'll know your contacts by name, yet part of a large, health insurance group, providing enormous resources.

We put it all together with you and your broker. Consider all that PAI can provide:

- Administration of self-funded, level funded, fully-insured, limited benefits, temporary health and supplemental plans.
- Reference-based pricing program (Value-Based Plan) reduces plan cost by 35% or more compared to PPO Plans. Members enjoy 99.2% provider participation.
- Value-Based Plan Concierge Team gives members provider quality and cost data with full freedom of choice. Members never pay a non-participating provider benefit penalty, a higher non-par MOOP, or a balance bill.
- Pharmacy benefit management through cost effective PBMs including savings on expensive specialty drugs.
- Utilization review and large case management services to optimize care at an appropriate cost.
- Monthly reports help you understand how your plan is running and aid in designing the best benefits for your group.
- Population health management addresses the 20% of your members who generate 80% of your claims.

We make Benefits Better.

Stop loss coverage from our preferred carriers protects your claim fund against higher than expected claim payments.

Value added options like HRAs, FSAs, ancillary benefits and voluntary employee benefit programs.

Optional online portal for employee self-service, administrator suite, and customer service call center.

ACA 6055 and 6056 employer data reporting requirements services.

PAI systems are cutting edge from companies such as Trizetto, RedCard and PAI Analytics.

Management team of four with combined 130+ years of experience in health benefits for groups and individuals.

Maximize the value of your benefits and minimize your costs. Let's talk today!

We make Benefits Better.

Value-Based Plan Claims Savings Metrics

The Value-Based Plan creates pricing transparency, reduced member out-of-pocket, and health plan savings. The employer total plan cost can be as much as 35% lower than conventional PPO network plans.

Providers earn a reasonable profit margin above the Medicare reference amount – 140% of Medicare reference for hospitals and 120% for physicians. All providers are eligible for full benefits.

Members have free and open provider choice – no network restrictions or non-network benefit reductions.

Discounts Much Better than PPO Network Plans

PPO network plans typically reduce provider charges by 30% to 50% while Value-Based Plan clients currently achieve average discounts of ***70% below billed charges***. For example:

Hospital Claim	PPO Plan	Value-Based Plan
Where we begin:	**$40,000**	**$9,000**
	billed charges	actual cost
Plan payment:	**$22,000**	**$12,600**
	discount of 45%	cost + 40% profit
Employer pays claim at 90%:	**$19,800**	**$11,340**
Employee pays coinsurance at 10%:	**$2,200**	**$1,260**

Protect Your Members from Balance Bills

Value-Based Plan members never pay a provider balance bill for charges in excess of the allowed amount. In the rare event that a member receives a balance bill, we negotiate plan payment in full. All plan payments are allowable charges eligible for stop loss coverage. By law (Federal Fair Credit Reporting Act), a provider may not report the member to credit bureaus, nor attempt collection.

With traditional PPO network plans, one in six hospital patients comes home to receive an unexpected balance bill. With the Value-Based Plan, fewer than one in fifty hospital claims generates a balance bill. Overall, fewer than one in five hundred Value-Based Plan claims generates a balance bill, and members do not have to pay.

Option A: Member Concierge Service for Physician Appointments

Your employer group PPO health plan comes with a provider directory with zero information on quality or cost. Value-Based Plan offers a free Concierge service to help members identify the best providers based on costs, quality outcomes and geographic proximity. Prior to your appointment, the Concierge will confirm with the physician their acceptance of your plan, or find an alternative physician who will.

Option B: Access a Physician PPO Network

For ease of transition to a Value-Based Plan, employers may choose to include the convenience and access of a PPO network just for physicians, as they provide the majority of medical services.

Level Funding Program Highlights:

Telemedicine Services through Teladoc

Teladoc is the largest provider of telehealth medical consultations in the USA, providing members 24/7 access to affordable healthcare via phone and video consultations – whenever they need it, from wherever they are. Necessary prescriptions are sent to your pharmacist. And the consultation comes with zero out-of-pocket cost.

Americans can't get timely doctor appointments. The result? They go to costly ER and urgent care clinics, or they wait. Then spend half a day away from work for a 4-minute visit. And there is no time limit to a Teladoc consultation.

Teladoc physicians are board-certified in internal medicine, family practice, emergency medicine and pediatrics.

PAI Pharmacy Benefits powered by OptumRx®

Pharmacy spending represents a significant and growing portion of health care costs. That is why our preferred partner is PAI Pharmacy Benefits powered by OptumRx®. Optum is an independent company that provides pharmacy benefit management (PBM) services on behalf of PAI. Our pharmacy solution is one of the largest PBM offerings available, with access to more than 68,000 pharmacies nationwide and serving more than 13.5 million members. By creating better health care connections, PAI helps your members realize improved care, lower costs and a better overall experience.

Tools and Programs

Never sacrificing care for cost, our tools and programs are chosen and managed by a team of medical directors, pharmacists and clinical professionals to ensure the member pharmacy experience we offer extends the best clinical and therapeutic benefit at the most reasonable cost. Ask how our tools and programs bring added value and enhance your member experience:

- Drug card
- Drug lists
- Optum® Specialty Pharmacy
- Mail-order pharmacy
- Drug management programs

Give your employees and their families the best health care at the best price

We make Benefits Better.

Level Funding Program Details:

Employer Group Health Risk Evaluation – Is Level Funding Right for Your Group?

Level Funding self-insured plans abide by different rules than fully insured plans. Level Funding plans are subject to underwriting review and approval of each employer group.

If your group demographics and health status indicate favorable risk, then a Level Funding program could be an optimal solution. However, if they are unfavorable, then a fully insured plan could be the better option.

Unlike fully insured plans, in which the bulk of the premium is "pooled" to pay catastrophic claims for the community at large, your Level Funding claim account only pays for the benefits that your employees and dependents actually use. Level Funding plans transfer the risk of catastrophic claims more efficiently through stop loss insurance. Why pay for other groups' claims?

Experience (since 1974) has shown that 4 out of 5 employer groups typically qualify for underwriting approval.

One Fixed Monthly Payment + Full Accounting + Full Return of Unspent Claim Funds

No one likes surprises, particularly on your group health plan. PAI Level Funding provides a 12-month guarantee that your monthly payment fully funds your group health plan with no additional exposure. And after each year's program term, PAI returns 100% of any leftover claim fund (surplus) directly to the employer. It's your money.

- ***Your monthly payment remains fixed for 12 full months - only varies with enrollment changes***
- ***A portion of your payment funds a claim account from which routine benefits are paid***
- ***We report to you monthly the exact amount your account paid out in benefits***
- ***Specific stop loss insurance reimburses any individual's large medical benefit payments***
- ***If plan benefits exhaust your account, then aggregate stop loss advances "overdraft" funds***
- ***Stop loss protection extends for 12 months after plan year to cover all "run-out" claims***
- ***Once "run-out" is complete, PAI returns 100% of the account surplus to the employer***

Many Level Funding clients tell us "heads you win, tails you break even." And heads comes up most years.

Value-Based Plan
Level Funding Benefit Plan Options

	Plan #	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	H11	H12	H13	H14
	Deductible	$1,500	$2,000	$3,000	$2,000	$2,500	$3,500	$2,500	$3,000	$4,000	$5,000	$3,000	$5,000	$6,650	$7,350
	Family Ded.	$3,000	$4,000	$6,000	$4,000	$5,000	$7,000	$5,000	$6,000	$8,000	$10,000	$6,000	$10,000	$13,300	$14,700
	Coinsurance	90%	90%	90%	80%	80%	80%	70%	70%	70%	70%	100%	100%	100%	100%
	Out of Pocket Maximum	$2,500	$3,000	$3,500	$4,000	$5,000	$6,000	$6,500	$7,000	$7,350	$7,350	$3,000	$5,000	$6,650	$7,350
	Family OOP	$5,000	$6,000	$7,000	$8,000	$10,000	$12,000	$13,000	$14,000	$14,700	$14,700	$6,000	$10,000	$13,300	$14,700
Copays	Primary Care	$25	$25	$25	$30	$30	$30	$45	$45	$45	$45	--	--	--	--
	Specialist	$50	$50	$50	$60	$60	$60	$90	$90	$90	$90	--	--	--	--
	Retail Clinic	$25	$25	$25	$30	$30	$30	$45	$45	$45	$45	--	--	--	--
	Urgent Care	$50	$50	$50	$60	$60	$60	$90	$90	$90	$90	--	--	--	--
	ER	$300	$300	$300	$400	$400	$400	$500	$500	$500	$500	--	--	--	--
Pharmacy	Generic	$10	$10	$10	$10	$10	$10	$10	$10	$10	$10	--	--	--	--
	Preferred	$25	$25	$25	$40	$40	$40	$60	$60	$60	$60	--	--	--	--
	Non-Preferred	$50	$50	$50	$75	$75	$75	$100	$100	$100	$100	--	--	--	--
	90-day Mail Service	2.5x	2.5x	2.5x	2.5x	2.5x	2.5x	2.5x	2.5x	2.5x	2.5x	--	--	--	--

Preventive services required under the PPACA are covered at no out-of-pocket expense. Unless otherwise indicated, physician office copays include charges for diagnostic tests, labs,imaging, pathology, radiology, supplies and injections associated with the physician office visit. Copays do not apply to the deductible. Copays apply to the Out of Pocket Maximum limits. Outpatient surgical, diagnostic, and therapeutic services, inpatient hospitalization, home health care, skilled nursing facilties, and durable medical equipment expenses are covered subject to deductible and coinsurance. Plans H11-H14 all benefits are subject to the plan deductible and coinsurance.

Plans C1-C10: dependent coverage individual deductibles are "embedded." Coinsurance begins for a member who meets the individual deductible.

Plans H11-H14: dependent coverage deductibles are "aggregate." Any combination of family members may meet the family deductible.

Precertification is required for all inpatient and some outpatient services. If Precertification is not obtained, appropriate benefits will be paid after 50% reduction in the Reasonable and Allowed Amount.

All plans include Concierge Services through an episode of care, providing provider cost and quality information.
All plans include Teladoc telemedicine services at no additional cost or copay. Teladoc is not insurance.

PAI Pharmacy Benefits powered by OptumRx®.
All plans Specialty Rx subject to OptumRx® and participating providers plan deductible and coinsurance.

The Plan of Benefits document is the final determination of benefits.

revised09/16/2022

Participation

- We require 75% of all eligible* employees participate in the plans for 50 and fewer lives enrolled and 60% of all eligible employees participate in plans for 51 or more lives enrolled. If the employer contributes 100% of the employee premium, we require 100% participation.
- Participation will be verified throughout the lifetime of the account.

* Eligible employees are those full-time employees who do not have coverage elsewhere.

Ineligible and Special Consideration Groups/Industries

- ***Ineligible:***

  Multiple Employer Trust
  Multiple Employer Welfare Associations
  Associations
  Taft-Hartley Trusts
  Employee Leasing Firms
  Professional Employer Organizations
  Human Resource Management Companies

- ***Special Consideration:***

  Religious Organizations
  Metal/Coal Mining
  Oil and Gas Exploration/Extraction
  Tobacco Stores and Products
  Explosives
  Asbestos Products
  Long Haul Trucking
  Commercial Sports
  Legal Services
  Medical Services

Quote Requirements:

Manual quotes are available for groups with 30-150 lives without experience. Some states may require higher minimum life counts. The rates are contingent upon the completion of enrollment forms. Enrollment forms do not have to be completed in order to receive a quote, however they may be completed for a pre-qualified rate.

The following information is required to receive a quote:

- *Group Name, Address(es), SIC.*
- *Employee Census to include birth date, gender, coverage tier, city, state, employee zip codes*
- *Desired Plan/Product Designs and PPO Network*
- *Desired Specific Deductible and Incurred/Paid Contract (Standard 12/24)*

If the group has 50+ employees and experience is available, the additional requirements are as follows:

- *Monthly paid claims and corresponding enrollment for the past 24 months.*
- *Detailed shock loss data to include details for all claims paid at or above 50% of the specific deductible*
- *The current schedule of benefits to include plan change information within the past 24 months.*
- *Current and renewal rates, specific levels and contracts to include specific and aggregate premium rates, aggregate factors, administration fee (with all included services).*

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