Core Value plans

a reference-based pricing benefits solution for your business

Allstate BENEFITS

The Allstate Benefits Self-Funded Program provides tools for employers owning small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by: Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered. National Health Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation are rated "A+" (Superior) by A.M. Best.

ABGH_1316

TDA FINANCIAL SERVICES INSURANCE PROGRAM

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simple, safe, savings
without compromising on quality

What is Core Value?

Core Value is a reference-based pricing plan, meaning it determines benefits based on a multiple of the Medicare reimbursement rate (or other derived equivalent), regardless of the billed amount. This can reduce the amount paid for your members' claims — which saves money for both you and your group's members.

Simple

One predictable monthly payment — Guaranteed not to increase for a full year.[1]
Hands-off administration — Plan administration is handled by our third party administrator, Allied Benefit Systems. You can rest assured knowing they are taking care of your group's claims payments, accounting, customer service needs, and more.

Safe

Stop-loss Insurance — When your group has higher-than-expected claims, stop-loss kicks in to protect your finances and limit your financial exposure. Terminal Liability Coverage — Added protection for claims that come in for up to 24 months after the end of the plan year – included with most Core Value plan selections.[2]

Savings

Core Value's rates are often lower than self-funded plans with a network, and that helps you save on your monthly costs.
The savings keep adding up! — You may receive money back from your claims account in years when claims are lower than planned.[3]

Quality

The coverage your employees need and expect. All employer-established health benefit plans meet the standards set by the Affordable Care Act. Preventive care coverage aligns with Affordable Care Act requirements and pays first-dollar benefits.

1 As long as there are no changes to your group's benefits or enrollment.
2 Terminal Liability Coverage is optional on 12/12 plans and does not apply in cases of early termination or for Aggregate only plans for groups with 51 or more enrolling employees. Fees may apply. Please refer to the plan proposal for details.
3 See Details and Exclusions.

how Core Value works

Step 1

Plan Education

In order for your reference-based pricing (RBP) plan to be successful, you and your members must understand how it works. We provide all the resources you need to educate your members about their plan.

Step 2

Plan Utilization

There are no network restrictions with Core Value and members can see any provider that accepts the plan. Healthcare Bluebook is included to help members find high-quality, cost-effective providers.

Step 3

Claim Payment

Core Value pays providers a consistent, fair price for services based on a multiple of the Medicare reimbursement rate. After the claim is processed, an Explanation of Benefits (EOB) is sent to members to explain their payment responsibility.

Step 4

Member Advocacy Program (MAP)

This concierge service will answer members' questions. If members are billed for more than the patient responsibility listed on their EOB, MAP works with the provider to negotiate and resolve any discrepancies.

Step 5

Resolution

When a bill is negotiated, a new EOB and letter of resolution are sent so the member is confident any discrepancies have been resolved. MAP's expert team makes member satisfaction a top priority.

Core Value keeps working every step of the way to make sure members get the care they need, at a price that's fair.

how Core Value works

This plan determines benefits based on a multiple of the Medicare reimbursement rate or other derived equivalent.

Core Value determines benefits at the following rates for covered services:

- 130% of the Medicare reimbursement rate* for doctor office visits.
- 150% of the Medicare reimbursement rate* for inpatient services.
- 130% of the Medicare reimbursement rate* for outpatient services.
- 100% of the Medicare reimbursement rate* for dialysis.

Benefit example for an outpatient service:

Not an actual case, presented for illustrative purposes only.

Billed charge for outpatient covered services	$3,376
Medicare reimbursement rate	$1,571.20
Plan maximum allowable amount (MAA) *130% of Medicare reimbursement rate*	$2,042.56[1]
Member coinsurance responsibility (80/20)	$408.51
Plan pays:	**$1,634.05**

With Core Value, the plan reimburses the same amount — no matter which health care provider members choose.

The following services still rely on the use of network providers:

» Pharmacy Benefits:
Members must use the Cigna PBM Network — a network providing access to over 68,000 retail pharmacies.

» Transplants:
This plan uses a list of nationally recognized designated providers.

Product availability varies by state.
* Or other derived equivalent
1 Sometimes members may be balance billed for the amounts in excess of the plan MAA. This is where the Member Advocacy Program can help.

Core Value gives you options with flexibility and access.

Core Value Flex

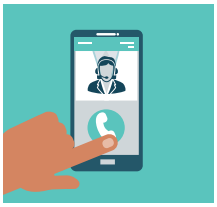
Flex allows you to experience the savings of our Core Value with the flexibility to switch to a PPO network mid-year without a change in your monthly payment.

Core Value Access

Core Value Access gives you the savings of a reference-based pricing plan and access to a network for physicians.

The Member Advocacy Program (MAP)

The Member Advocacy Program (MAP) works to keep your employees informed and represented when unexpected billing occurs. They'll help your employees understand their benefits, use their plans, find providers, and understand their Explanation of Benefits (EOB) documents.



Members may receive a bill for charges that include amounts that exceed the Patient's Responsibility as shown on an EOB. If this happens, members should call the Member Advocacy Program team right away.

The MAP team will work with the provider to resolve any bill discrepancies.[1]

Your employees can call the MAP team anytime!

Value-Added Features

Healthcare Bluebook

Prices for the same procedure can vary up to 500%, depending on the providers your members choose for care.
Healthcare Bluebook™ is a cost and quality navigation tool to help members access quality health care at a fair price. With this easy-to-use service, plan members can shop around for low-cost, high-quality providers — helping you keep your claims costs down.[2]

TELADOC

Teladoc® is a cost-saving service that helps drive medical expenses down.
Members can receive treatment anytime, anywhere, whether they're at work, home, or traveling abroad. Teladoc doctors can give treatment for many common, non-emergency conditions.

1 Non-covered services and certain other charges are not eligible for the program.
2 There is no correlation between the Healthcare Bluebook Fair PriceTM service and a provider accepting the payment made by the Core Value plan.
Healthcare Bluebook is not included with Core Value Access.

take control of your healthcare costs with self-funding

Our Self-Funded Program Can Help

With fully insured health plans, all of your premium is paid to the insurance company. You don't have any control over how that money is spent. You won't see any of those premium dollars again, even in years when your group's claims are less than expected.

With our Self-Funded Program, you may receive money back from your claims account in years when claims are lower than expected.*

* See Plan Details and Exclusions

Fully-Insured Plans

The full payment goes to the insurance company.

Self-Funded Program Monthly Payment

Your single payment is split among the program's three components:

Plan administration

- Manages claims payments.
- Provides reporting to help manage costs.
- Handles all member customer service needs.

Stop-loss insurance

- Protects your finances from higher-than-expected claims.
- Helps you limit your business's financial exposure.

Employer claims account

- Account used to pay employees' claims.
- Stop-loss advances money to your claims account if claims exceed the balance in any given month.

working with Allstate Benefits

You can trust us to help you save.

Allstate Benefits is a national leader in the self-funded space.
Our team of experienced professionals is ready to provide you and your agent with:

- Group market expertise
- Immediate access to support
- Quick resolution of issues
- Hands-on help at time of reissue

ALLIED No-Hassle Plan Administration.

- Allied Benefit Systems LLC, has more than 30 years of experience in benefit management and administration services.
- Allied offers a variety of cost-containment programs that help control claims expenses.
- Allied has a proven record of excellence. it is the only third-party administrator in the U.S. to earn accreditation from the Electronic Healthcare Network Accreditation Commission (EHNAC). Allied also has earned accreditation from URAC in three categories.

See why this agent decided to partner with us.

"I was very pleased with the service and the renewal. I'm looking for new groups to place!"

— Larry, an agent in South Carolina

plan designs

choose from our flexible plan design options

Stop-loss options

Aggregate Deductible	Based on total expected claims, calculated based on the census of your group and other factors such as number of members, age, gender, etc.
Specific Deductible[1]	• $6,500 • $10,000 • $15,000 | • $20,000 • $25,000 • $30,000 | • $40,000 • $50,000 • $100,000

Group-member plan options

Deductible Options[1] Family deductible is two times the individual	• $500 • $1,000 • $1,500[2] | • $2,000[2] • $2,500[2] • $2,750 | • $2,800[2] • $3,000[2] • $3,500[2] | • $5,000[2, 3] • $5,750[3, 4] • $6,250[3, 4] | • $6,600[5] • $7,900[3, 5] • $8,550[3, 5]
Coinsurance Options	• 100% • 90% | • 80% • 70% | • 50%
Out-of-pocket Maximums	$1,000 to $8,550; $1,000 to $7,150 in WA (this includes deductible, coinsurance, and copay amounts)
Office Visits (primary care physician / specialist / urgent care)	• $20 / $35 / $75 • $35 / $50 / $75 • $40 / $60 / $75 | • $25 / Ded. and coins. / $75 • $35 / Ded. and coins. / $75 • $40 / Ded. and coins. / $75 | • $50 / Ded. and coins. / $75 • $50 / $75 / $100[3] • $60 / $100 / $100[3] | • Ded. and coins.
Hospital and Surgery Charges	Applies to deductible and coinsurance
Diagnostic X-ray and Lab Benefit	• Applies to deductible and coinsurance • 100% first-dollar benefit • $500 first-dollar benefit, followed by deductible and coinsurance
Outpatient Physical Medicine / Chiropractic Care	Applies to deductible and coinsurance, limited to 30 visits per plan year

1 Availability varies by state. 2 Health Savings Account (HSA)-compatible options. 3 Not Available in WA. 4 Available with HSA plans only. 5 Not available with $6,500 specific deductible. 6 No out-of-network benefits. 7 When you select this option, there is a 20% increase in the insured's coinsurance responsibility when Non-Preferred Prescription Drugs are purchased. Applies to the following coinsurance options: 90%, 80%, 70%. No coinsurance differential in WA. Refer to your Summary Plan Description for full benefit details.

plan designs

All employer-established health benefit plans meet the standards set by the Affordable Care Act. Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) compatible plan designs are available.

Group-member plan options continued

Subacute Rehab & Nursing Facility	Applies to deductible and coinsurance, limited to 31 days per plan year
Home Health Care	Applies to deductible and coinsurance, limited to 30 visits per plan year
Emergency Room Visit *Note: Copay waived if admitted*	• $250, $350[3], or $500[3] access fee, followed by deductible and coinsurance • $250, $350[3], or $500[3] copay, no deductible or coinsurance (not allowed on HSA plan types) • Applies to deductible and coinsurance
Mental/Behavioral Health and Substance Abuse	**Outpatient, groups 50 and under:** • Applies to deductible and 50% coinsurance. Limited to 40 visits per plan year. **Outpatient, groups over 50:** • Follows plan copay, deductible and coinsurance options chosen. **Inpatient, groups 50 and under:** • Applies to deductible and 50% coinsurance. Limited to 30 days per plan year. **Inpatient, groups over 50:** • Follows plan copay, deductible and coinsurance options chosen.
Prescription Drugs[6] *(generic / preferred / non-preferred)*	**Copay options:** (additional options available) • $15 / $45 / $60 • $20 / $50 / $75 • $0 / $35 / $50 • $5 / $65 / $100[3] • $20 / $65 / $100[3] • Ded. then $20 / $50 / $75[3,4] **Non-copay options:** • Apply to deductible and coinsurance[7] • 50% / 50% coinsurance option
Teladoc® *Included on all plan designs*	Consultations at no additional cost to members with non-HSA plans. HSA plans have a $55 consultation fee. Fee applies to deductible and out-of-pocket maximums.
Accident Medical Expense *Optional benefit*	• $500 • $1,000

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plan details and exclusions

Family deductible accumulations

Individual/Family

Covered expenses for each family member accumulate toward his or her individual deductible and plan payments begin:

- For the family member — once his or her individual deductible is met.
- For all family members — once the combined amounts accumulated toward two or more individual deductibles reach the amount of the family deductible.

Utilization review

When inpatient treatment is needed, the covered person is responsible for calling the 800 number on the card to receive authorization. If authorization is not received, a penalty could be applied. No benefits are paid for transplants that are not authorized. Authorization is not a guarantee of coverage.

Out-of-pocket maximums

The family out-of-pocket maximum is the total dollar amount of covered charges that must be paid by employees and their covered dependents before we will consider any out-of-pocket maximum for all covered persons under the same family plan to be satisfied.

The individual out-of-pocket maximum is the dollar amount of covered charges that must be paid by each covered person before any out-of-pocket maximum is satisfied for that covered person.

Employment waiting period

The employment waiting or affiliation period is the number of consecutive days an employee must be working before he/she is eligible to be covered. The following choices are available: 0, 30, 60, or 90 days.

New hires

For groups with a 0-, 30-, or 60-day employment waiting period, new eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date:

- First day of the billing month following the expiration of the employment waiting period, when the enrollment request is received within 31 days of the effective date.

For groups with a 90-day employment waiting period, newly eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date:

- The first day following the expiration of the employment waiting period, when the enrollment request is received within 31 days of the expiration of the employment waiting period.

Deductible credit

When coverage first begins, credit is given for any portion of a calendar-year deductible satisfied under the employer's prior medical plan during the same calendar year, except when the deductible credit is waived. No credit is given for prior years' deductibles. The deductible credit option can be waived.

Charges ineligible for the Member Advocacy Program

Not all provider billing is eligible for the Member Advocacy Program. Excluded charges include, but are not limited to: Any amounts paid for by the member, charges for non-covered services or charges in excess of a benefit limit; charges for penalties under the plan (such as the 30% penalty for non-emergency use of an Emergency Room); non-emergency medical transportation when an authorized provider is not used, charges that should be bundled with another service charge (such as for the second and subsequent surgeries in the same surgical session and assistant surgeon and surgical assistant charges that should be billed as part of the surgical event). This list is subject to change without notice.

Your member can call the Member Advocacy Team to verify if charges are eligible at 888-306-0905.

Summary of exclusions

The health benefit plan templates do not provide benefits for:

- Treatment not listed in the summary plan description.
- Services by a medical provider who is an immediate family member or who resides with a covered person.
- Charges for services, supplies, or drugs provided by or through any employer of a Covered Person or of a Covered Person's family member.
- Treatment reimbursable by Medicare, Workers' Compensation, automobile carriers, or expenses for which other coverage is available.
- Routine hearing care, vision therapy, surgery to correct vision, foot orthotics, or routine vision care and foot care unless part of the diabetic treatment.
- Charges for custodial care, private nursing, telemedicine, or phone consultations with the exception of Teladoc® or telehealth virtual visits.

plan details and exclusions

- Charges for diagnosis and treatment of infertility except for groups of 51 or more that are administered by Allied or Meritain on the traditional or Allstate Benefits Advantage plans.
- Charges for surrogate pregnancy or sterilization reversal.
- Charges for cosmetic services, including chemical peels, plastic surgery, and medications.
- Charges for umbilical cord storage, genetic testing, counseling, and services.
- Treatment of "quality of life" or "lifestyle" concerns including but not limited to obesity, hair loss, restoration or promotion of sexual function, cognitive enhancement, and educational testing or training.
- Over-the-counter drugs, (unless recommended by the United States Preventive Services Task Force and authorized by a health care provider), drugs not approved by the FDA, drugs obtained from sources outside the United States, and the difference in cost between a generic and brand name drug when the generic is available.
- Complications of an excluded service.
- Charges in excess of any stated benefit maximum.
- Treatment of an illness or injury caused by acts of war, felony, or influence of an illegal substance.
- Dental care not related to a dental injury.
- Non-surgical treatment for TMJ or CMJ other than that described in the contract, or any related surgical treatment that is not pre-authorized.
- Any correction of malocclusion, protrusion, hypoplasia, or hyperplasia of the jaws.
- Charges for cranial orthotic devices, except following cranial surgery.
- Charges for medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the Diabetic Services provision in the Medical Benefits section.
- Charges for devices or supplies, except as described under a Prescription Order.
- Charges for prophylactic treatment.
- Charges related to health care practitioner-assisted suicide.
- Charges for growth hormone stimulation treatment to promote or delay growth.
- Charges for treatment of behavioral health or substance abuse, except as otherwise covered in the Behavioral Health and Substance Abuse provision in the Medical Benefits section.
- Charges for testing and treatment related to the diagnosis of behavioral conduct or developmental problems; charges for applied behavioral analysis
- Charges for alternative medicine, including acupuncture and naturopathic medicine.
- Charges for chelation therapy.
- Charges for experimental or investigational services.

This brochure provides summary information for the health benefit plan templates. Please refer to the summary plan description for a complete listing of the benefits, terms, and exclusions. In the event that there are discrepancies with the information in this brochure, the terms and conditions of the summary plan description and other plan documents will govern.

For more information, or to apply for coverage, contact your insurance agent.

Claims account refund

In years when claims are lower than expected, a portion (or all, depending on your plan selection) of the difference between your group's anticipated and actual claims is credited back to you — and that could add up to significant savings. Refund is subject to any Terminal Liability Coverage fee.

about Allstate Benefits

Allstate Benefits is a leading provider of employee benefit solutions in the U.S. and Canada, protecting more than 8 million individuals with top-rated supplemental and self-funded insurance products. Allstate Benefits is proud to be part of The Allstate Corporation (NYSE: ALL), a Fortune 100 company and the nation's largest publicly held personal lines insurer. Allstate Benefits helps deliver the Good Hands® promise every day with the name that many know and trust. Learn more at www.allstatebenefits.com.

Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation. Allstate Benefits is also a marketing name for products underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where group health is offered. (Home Office, Milwaukee, WI). ©2021 Allstate Insurance Company. www.allstate.com or allstatebenefits.com

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Core Value Flex is available in: AK, AL, AR, AZ, CO*, CT, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VT, WI, WV, WY

Core Value Access is available in: AK, CA, CO*, CT, DE, FL, GA, ID, IL, KS, KY, LA, MA, MI, MN, MO, MS, MT, NC, NE, NJ, NM, NV, PA, SC, TX, UT, VA, WI, WV

Core Value and Core Value Access are only available in CA in the following markets: Los Angeles, Santa Ana, San Diego, Santa Barbara, Fresno

For use for July 1, 2021, and later effective dates.

* In Colorado, the program is available for October 1, 2021, and later effective dates.

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