Presented by Allstate Benefits

Self-Funded Medical Plan Proposal

September 10, 2021

Agent: Rob Stenzel
Phone: (310) 270-8744
Email:

Rep Name: Roger Bennett
Email: Roger.Bennett@NGIC.COM

Proposal For: **TEACH, Inc.**

This is not an insurance contract, nor does it guarantee coverage or effective date. Only the actual contract provisions will prevail. See the plan brochures for coverage and option details. This quote must be presented by a State-licensed agent and is subject to approval.

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1 Zip Code: 89130
Location Type: Main

Plan/Rate Summary

Please review this proposal. If you are ready to move forward, contact your Licensed Agent or Sales Representative to discuss the next steps.
Plans quoted in this proposal: 6

Plan Name	LocalPlus PPO 1	LocalPlus PPO 2	LocalPlus HSA
Plan Type	Traditional	Traditional	Traditional
Medical Plan Design	SELF-FUNDED PPO COPAY PLAN	SELF-FUNDED PPO COPAY PLAN	SELF-FUNDED HSA PPO PLAN
Individual Deductible	$3,500 In-network/$7,000 Out-of-network	$2,000 In-network/$4,000 Out-of-network	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network	$4,000 In-network/$8,000 Out-of-network	$7,000 In-network/$14,000 Out-of-network
Coinsurance	70% In-network/40% Out-of-network	80% In-network/50% Out-of-network	70% In-network/40% Out-of-network
Total Ind Plan OOP Maximum	$8,550 In-network/$25,650 Out-of-network	$6,600 In-network/$19,800 Out-of-network	$7,000 In-network/$21,000 Out-of-network
Total Fam Plan OOP Maximum	$17,100 In-network/$51,300 Out-of-network	$13,200 In-network/$39,600 Out-of-network	$14,000 In-network/$42,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible	Individual/Family deductible	Individual/Family deductible
PCP/Specialist Visit	$40/$60 copay, then covered at 100%	$35/$50 copay, then covered at 100%	Deductible and coinsurance
Teladoc®	No charge	No charge	No charge
Urgent Care Visit	$75 copay, then covered at 100%	$75 copay, then covered at 100%	Deductible and coinsurance
Medical Network	Cigna LocalPlus	Cigna LocalPlus	Cigna LocalPlus
OP Surgery	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Pharmacy Benefit Manager	CIGNA PBM	CIGNA PBM	CIGNA PBM
Rx Coverage (Generic/Brand/Non-preferred brand)	$20/$65/$100	$20/$50/$75	Deductible and 70% for generic 70% for brand 50% for non-preferred brand
DXL	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
ER Treatment	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
AME	N/A	N/A	N/A
Deductible and OOP Accrual Period	Calendar Year, deductible credit included	Calendar Year, deductible credit included	Calendar Year, deductible credit included
Run Out Period	6 months	6 months	6 months
Delayed Administration Fee	50%	50%	50%
HSA Eligible	No	No	Yes
Wellness Program	No	No	No
Dental	No	No	No
Total Cost	$6,667.55	$7,496.96	$6,344.76

Plan Selection Notes:

- Total plan out-of-pocket maximum includes deductible, coinsurance and any Rx or Medical copayments.
- This self-funded health benefit plan template meets Minimum Value.
- Plan includes Terminal Liability coverage for 24 months after the end of the plan year. A terminal liability coverage reserve fee will be taken at the end of the run-out, calculated as 3% of any remaining claim account surplus prior to any claim account refund. Terminal

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1 Zip Code: 89130
Location Type: Main

Plan/Rate Summary

Please review this proposal. If you are ready to move forward, contact your Licensed Agent or Sales Representative to discuss the next steps.
Plans quoted in this proposal: 6

Liability coverage is not provided in cases of early termination.

- If claims are less than the aggregate deductible at the end of the run-out period, the employer may be eligible for a refund. Refund amounts, if any, are based on the refund selection at the time of issue or re-issue, as applicable. NOTE: Terminations prior to the end of the plan year will result in forfeiture of the remaining claim fund and no refund will be provided.

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1 Zip Code: 89130
Location Type: Main

Plan/Rate Summary

Please review this proposal. If you are ready to move forward, contact your Licensed Agent or Sales Representative to discuss the next steps.
Plans quoted in this proposal: 6

Plan Name	Aetna PPO 1	Aetna PPO 2	Aetna HSA
Plan Type	Traditional	Traditional	Traditional
Medical Plan Design	SELF-FUNDED PPO COPAY PLAN	SELF-FUNDED PPO COPAY PLAN	SELF-FUNDED HSA PPO PLAN
Individual Deductible	$3,500 In-network/$7,000 Out-of-network	$2,000 In-network/$4,000 Out-of-network	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network	$4,000 In-network/$8,000 Out-of-network	$7,000 In-network/$14,000 Out-of-network
Coinsurance	70% In-network/50% Out-of-network	80% In-network/50% Out-of-network	70% In-network/50% Out-of-network
Total Ind Plan OOP Maximum	$8,550 In-network/$25,650 Out-of-network	$6,600 In-network/$19,800 Out-of-network	$7,000 In-network/$21,000 Out-of-network
Total Fam Plan OOP Maximum	$17,100 In-network/$51,300 Out-of-network	$13,200 In-network/$39,600 Out-of-network	$14,000 In-network/$42,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible	Individual/Family deductible	Individual/Family deductible
PCP/Specialist Visit	$40/$60 copay, then covered at 100%	$35/$50 copay, then covered at 100%	Deductible and coinsurance
Teladoc®	No charge	No charge	No charge
Urgent Care Visit	$75 copay, then covered at 100%	$75 copay, then covered at 100%	Deductible and coinsurance
Medical Network	Aetna Signature Administrators ® PPO	Aetna Signature Administrators ® PPO	Aetna Signature Administrators ® PPO
OP Surgery	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Pharmacy Benefit Manager	CIGNA PBM	CIGNA PBM	CIGNA PBM
Rx Coverage (Generic/Brand/Non-preferred brand)	$20/$65/$100	$20/$50/$75	Deductible and 70% for generic 70% for brand 50% for non-preferred brand
DXL	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
ER Treatment	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
AME	N/A	N/A	N/A
Deductible and OOP Accrual Period	Calendar Year, deductible credit included	Calendar Year, deductible credit included	Calendar Year, deductible credit included
Run Out Period	6 months	6 months	6 months
Delayed Administration Fee	50%	50%	50%
HSA Eligible	No	No	Yes
Wellness Program	No	No	No
Dental	No	No	No
Total Cost	$7,401.18	$8,691.51	$6,987.92

Plan Selection Notes:

- Total plan out-of-pocket maximum includes deductible, coinsurance and any Rx or Medical copayments.
- This self-funded health benefit plan template meets Minimum Value.
- Plan includes Terminal Liability coverage for 24 months after the end of the plan year. A terminal liability coverage reserve fee will be

The Allstate Benefits Self-Funded Program provides tools for 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.

Plan/Rate Summary

Please review this proposal. If you are ready to move forward, contact your Licensed Agent or Sales Representative to discuss the next steps.
Plans quoted in this proposal: 6

taken at the end of the run-out, calculated as 3% of any remaining claim account surplus prior to any claim account refund. Terminal Liability coverage is not provided in cases of early termination.

- If claims are less than the aggregate deductible at the end of the run-out period, the employer may be eligible for a refund. Refund amounts, if any, are based on the refund selection at the time of issue or re-issue, as applicable. NOTE: Terminations prior to the end of the plan year will result in forfeiture of the remaining claim fund and no refund will be provided.

Allstate BENEFITS

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Zip Code: 89130

Location Name: Location 1
Location Type: Main

Stop-Loss Insurance and Financial Details			
	LocalPlus PPO	**LocalPlus PPO**	**LocalPlus HSA**
Specific Attachment Point	$40,000.00	$40,000.00	$40,000.00
Annual Aggregate Attachment Point	$44,000.76	$44,000.76	$44,000.76
Monthly Bill Medical			
Employee	$336.75	$378.64	$320.45
Employee + Spouse	$1,010.22	$1,135.90	$961.31
Employee + Child	$841.86	$946.58	$801.10
Family	$1,279.61	$1,438.80	$1,217.66
Stop-loss Premium	$1,562.22	$2,032.61	$1,411.06
Admin, Sales and General Expenses	$1,438.60	$1,797.62	$1,266.97
Claims Account	$3,666.73	$3,666.73	$3,666.73
Total	$6,667.55	$7,496.96	$6,344.76

Stop-Loss Insurance and Financial Details			
	Aetna PPO 1	**Aetna PPO 2**	**Aetna HSA**
Specific Attachment Point	$40,000.00	$40,000.00	$40,000.00
Annual Aggregate Attachment Point	$44,000.76	$46,319.76	$44,000.76
Monthly Bill Medical			
Employee	$373.80	$438.97	$352.93
Employee + Spouse	$1,121.38	$1,316.89	$1,058.76
Employee + Child	$934.49	$1,097.41	$882.31
Family	$1,420.42	$1,668.05	$1,341.10
Stop-loss Premium	$2,032.10	$2,656.93	$1,834.78
Admin, Sales and General Expenses	$1,702.35	$2,174.60	$1,486.41
Claims Account	$3,666.73	$3,859.98	$3,666.73
Total	$7,401.18	$8,691.51	$6,987.92

Allstate BENEFITS

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1 Zip Code: 89130
Location Type: Main

Self-Funded Dental Plan Options (Allied TPA only)

Self-funded dental is only available with medical coverage and is not a standalone product. The tables below illustrate the differences between dental plans and show pricing based on two separate network options. One dental plan and network may be purchased per employer. **Rates are subject to change based on enrollment.**

	Dental Plan Designs (only available with medical)			
Key Features	**Value Plan**	**Select Plan**	**Premier Plan**	**Choice Plan******
Individual Deductible^	$100 ($100)	$100 ($100)	$50 ($50)	$100
Preventive Services*	100% (60%) No Deductible	100% (70%) No Deductible	100% (70%) No Deductible	100% No Deductible
Basic Services**	80% (50%)	80% (60%)	90% (70%)	80%
Major Services***	Not covered	50% (40%)	50% (40%)	50%
Orthodontics	Not covered	Not covered	Not covered	Not covered
Annual Maximum	$1,500	$1,500	$1,500	$1,500
Waiting Period	None	None	None	None

	Dental Portion of Cost - Aetna Dental® Administrators			No Network
Tiered Rates	**Value Plan**	**Select Plan**	**Premier Plan**	**Choice Plan**
EE	$27.00	$34.71	$38.96	$52.59
ES	$80.99	$104.13	$116.89	$157.79
EC	$67.48	$86.77	$97.39	$131.48
Fam	$102.58	$131.90	$148.06	$199.86
Total Dental Cost †	$534.50	$687.24	$771.38	$1,041.32

	Dental Portion of Cost - Cigna Dental PPO SA			No Network
Tiered Rates	**Value Plan**	**Select Plan**	**Premier Plan**	**Choice Plan**
EE	$26.74	$34.38	$38.64	$52.59
ES	$80.20	$103.13	$115.92	$157.79
EC	$66.82	$85.94	$96.59	$131.48
Fam	$101.58	$130.64	$146.84	$199.86
Total Dental Cost †	$529.30	$680.68	$765.04	$1,041.32

Key

† Total Dental Cost is calculated off the census information from the medical quote and assumes no one waives dental coverage. The official quote may have minor rounding differences.

^ ( ) Out of network value

* Routine exams, cleanings (6 months), fluoride treatments, sealants, bitewing x-rays

** Minor Restorative Services - Fillings, extractions, etc.

*** Replacement of prosthodontics, dentures, crowns, and inlays, endodontic procedures, periodontics procedures, major restorative procedures, oral surgery

**** No network used for Out of Network (OON) and Choice Plans

Allstate BENEFITS

Employee Census

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021 Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Total Employees: 11 **Total Employees Eligible:** 11 **Total Employees Enrolling:** 11

Medical	LocalPlus PPO 1		LocalPlus PPO 2		LocalPlus HSA		Aetna PPO 1	
	Rate	Enrollment	Rate	Enrollment	Rate	Enrollment	Rate	Enrollment
Employee (EE)	$336.75	6	$378.64	6	$320.45	6	$373.80	6
Employee + Spouse (EE+SP)	$1,010.22	0	$1,135.90	0	$961.31	0	$1,121.38	0
Employee + Child (EE+CH)	$841.86	4	$946.58	4	$801.10	4	$934.49	4
Employee + Family (EE+FM)	$1,279.61	1	$1,438.80	1	$1,217.66	1	$1,420.42	1

Medical	Aetna PPO 2		Aetna HSA	
	Rate	Enrollment	Rate	Enrollment
Employee (EE)	$438.97	6	$352.93	6
Employee + Spouse (EE+SP)	$1,316.89	0	$1,058.76	0
Employee + Child (EE+CH)	$1,097.41	4	$882.31	4
Employee + Family (EE+FM)	$1,668.05	1	$1,341.10	1

Monthly Rate Breakdown by Employee				
Member Name	LocalPlus PPO 1 Cost	LocalPlus PPO 2 Cost	LocalPlus HSA Cost	Aetna PPO 1 Cost
Moore, Andrea F(50), CH: 2	$841.86	$946.58	$801.10	$934.49
Piet, Gina F(47), CH: 3	$841.86	$946.58	$801.10	$934.49
Aab, Tiffany F(45), CH: 1	$841.86	$946.58	$801.10	$934.49
O'Rane , Forrester F(32)	$336.75	$378.64	$320.45	$373.80
Strickland, Katie F(26)	$336.75	$378.64	$320.45	$373.80
Chavez, Harmony F(44)	$336.75	$378.64	$320.45	$373.80
Davis, Megan F(38), CH: 1	$841.86	$946.58	$801.10	$934.49
Moore, Benjamin M(19)	$336.75	$378.64	$320.45	$373.80
Terranova, Samantha F(22)	$336.75	$378.64	$320.45	$373.80
Hubble, Nicole F(36)	$336.75	$378.64	$320.45	$373.80
Metzel, Tricia F(43), SP M(49), CH: 2	$1,279.61	$1,438.80	$1,217.66	$1,420.42
Monthly Total	$6,667.55	$7,496.96	$6,344.76	$7,401.18

Allstate BENEFITS

Employee Census

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021 Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Total Employees: 11 **Total Employees Eligible:** 11 **Total Employees Enrolling:** 11

Monthly Rate Breakdown by Employee		
Member Name	**Aetna PPO 2 Cost**	**Aetna HSA Cost**
Moore, Andrea F(50), CH: 2	$1,097.41	$882.31
Piet, Gina F(47), CH: 3	$1,097.41	$882.31
Aab, Tiffany F(45), CH: 1	$1,097.41	$882.31
O'Rane , Forrester F(32)	$438.97	$352.93
Strickland, Katie F(26)	$438.97	$352.93
Chavez, Harmony F(44)	$438.97	$352.93
Davis, Megan F(38), CH: 1	$1,097.41	$882.31
Moore, Benjamin M(19)	$438.97	$352.93
Terranova, Samantha F(22)	$438.97	$352.93
Hubble, Nicole F(36)	$438.97	$352.93
Metzel, Tricia F(43), SP M(49), CH: 2	$1,668.05	$1,341.10
Monthly Total	$8,691.51	$6,987.92

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021

Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

LocalPlus PPO 1	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Cigna LocalPlus www.cigna.com
Individual Deductible	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	70% In-network/40% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$5,050 In-network/$18,650 Out-of-network
Total Individual out-of-pocket maximum	$8,550 In-network/$25,650 Out-of-network
Total Family out-of-pocket maximum	$17,100 In-network/$51,300 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	$40 primary care provider copay, then covered at 100%/$60 specialist copay, then covered at 100%
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs Generic copay/Preferred brand copay/Nonpreferred brand copay (Mail order services included)	$20/$65/$100
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	$75 copay, then covered at 100%
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance
Maternity	Deductible and coinsurance

The Allstate Benefits Self-Funded Program provides tools for 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.

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021
County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021
Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 70% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021

Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

LocalPlus PPO 2	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Cigna LocalPlus www.cigna.com
Individual Deductible	$2,000 In-network/$4,000 Out-of-network
Family Deductible	$4,000 In-network/$8,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	80% In-network/50% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$4,600 In-network/$15,800 Out-of-network
Total Individual out-of-pocket maximum	$6,600 In-network/$19,800 Out-of-network
Total Family out-of-pocket maximum	$13,200 In-network/$39,600 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	$35 primary care provider copay, then covered at 100%/$50 specialist copay, then covered at 100%
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs Generic copay/Preferred brand copay/Nonpreferred brand copay (Mail order services included)	$20/$50/$75
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	$75 copay, then covered at 100%
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance
Maternity	Deductible and coinsurance

The Allstate Benefits Self-Funded Program provides tools for 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.

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021
County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021
Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 70% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021

Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

LocalPlus HSA	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Cigna LocalPlus www.cigna.com
Individual Deductible	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	70% In-network/40% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$3,500 In-network/$14,000 Out-of-network
Total Individual out-of-pocket maximum	$7,000 In-network/$21,000 Out-of-network
Total Family out-of-pocket maximum	$14,000 In-network/$42,000 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	Deductible and coinsurance
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs When generic is available, but a non-preferred brand is purchased, the member will be responsible for the difference in price. (Mail order services included)	Deductible and 70% for generic 70% for brand 50% for non-preferred brand
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	Deductible and coinsurance
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance
Maternity	Deductible and coinsurance

The Allstate Benefits Self-Funded Program provides tools for 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.

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021
County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021
Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 70% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021 Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Aetna PPO 1	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Aetna Signature Administrators ® PPO www.aetna.com/asa
Individual Deductible	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	70% In-network/50% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$5,050 In-network/$18,650 Out-of-network
Total Individual out-of-pocket maximum	$8,550 In-network/$25,650 Out-of-network
Total Family out-of-pocket maximum	$17,100 In-network/$51,300 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	$40 primary care provider copay, then covered at 100%/$60 specialist copay, then covered at 100%
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs Generic copay/Preferred brand copay/Nonpreferred brand copay (Mail order services included)	$20/$65/$100
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	$75 copay, then covered at 100%
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance

The Allstate Benefits Self-Funded Program provides tools for 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.

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021
County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021
Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Maternity	Deductible and coinsurance
Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 50% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021 Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Aetna PPO 2	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Aetna Signature Administrators ® PPO www.aetna.com/asa
Individual Deductible	$2,000 In-network/$4,000 Out-of-network
Family Deductible	$4,000 In-network/$8,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	80% In-network/50% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$4,600 In-network/$15,800 Out-of-network
Total Individual out-of-pocket maximum	$6,600 In-network/$19,800 Out-of-network
Total Family out-of-pocket maximum	$13,200 In-network/$39,600 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	$35 primary care provider copay, then covered at 100%/$50 specialist copay, then covered at 100%
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs Generic copay/Preferred brand copay/Nonpreferred brand copay (Mail order services included)	$20/$50/$75
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	$75 copay, then covered at 100%
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance

The Allstate Benefits Self-Funded Program provides tools for 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.

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021
County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021
Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Maternity	Deductible and coinsurance
Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 50% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021

Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Aetna HSA	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Aetna Signature Administrators ® PPO www.aetna.com/asa
Individual Deductible	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	70% In-network/50% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$3,500 In-network/$14,000 Out-of-network
Total Individual out-of-pocket maximum	$7,000 In-network/$21,000 Out-of-network
Total Family out-of-pocket maximum	$14,000 In-network/$42,000 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	Deductible and coinsurance
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs When generic is available, but a non-preferred brand is purchased, the member will be responsible for the difference in price. (Mail order services included)	Deductible and 70% for generic 70% for brand 50% for non-preferred brand
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	Deductible and coinsurance
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance
Maternity	Deductible and coinsurance

The Allstate Benefits Self-Funded Program provides tools for 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.

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021
County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021
Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 50% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

The following information applies to all the plans contained in this Proposal:

Additional Information

Utilization Review

When inpatient treatment is needed, the covered person is responsible for calling to receive authorization. The toll-free telephone number appears on the insurance ID card. If authorization is not received, a penalty will be applied. Please refer to the SPD for specific details. No benefits are paid for transplants which are not authorized. Authorization is not a guarantee of coverage.

Deductible Credit

When coverage first begins, credit is given for any portion of a calendar-year deductible satisfied under the prior plan during the same calendar year, except when the deductible credit is waived. However, no credit is given for past policy-year deductibles.

If a dental option is selected, deductible credit may also be available.

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 date of full-time employment, when the enrollment request is received within 31 days of this 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 90th day following the date of full-time employment, when the enrollment request is received within 31 days of the expiration of the employment waiting period.

If a dental option is selected, the same new hire waiting period will apply.

Medical Exclusions Summary

- For Advantage plans, any charges that are provided or performed by a Health Care Practitioner, facility, or supplier that is not identified for the Health Care Provider Network as a Participating Provider, Participating Pharmacy, Specialty Pharmacy Provider, or Designated Transplant Provider. This exclusion does not apply to PPO plans that cover charges for treatment provided or performed by either Participating Providers (In-network) or Non-Participating Providers (Out-of-network).
- 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® services if purchased as part of your plan, or Telehealth (virtual) visits
- 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 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 (specific to medical coverage)
- 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 (except when optional acupuncture and naturopathic medicine coverage is purchased)
- Charges for chelation therapy
- Charges for experimental or investigational services

This form contains a partial summary of information for the health benefit plan templates. For a complete listing of employee health benefits, exclusions and limitations please refer to the summary plan description. Please refer to the stop-loss policy for a complete listing of employer stop-loss benefits, exclusions and terms of coverage. In the event that there are discrepancies with the information in this form, the terms and conditions of the coverage documents will govern.