Optimyl
BENEFITS

Optimyl Benefits

Level-Funded Health Plans Built for Small Business

Broker Use Only - Not for Distribution

About Optimyl Benefits

Who we are

- Specialists in providing medical and dental level-funded solutions to employers with 2 to 300 employees
- Integrator that provides unique and seamless access to the most recognized and trusted brands in the industry, including:
  - Crum & Forster, an "A" (Excellent) rated stop loss carrier by AM Best (2021) that has been in business since 1822
  - Allied, one of the largest independent national TPAs, with deep expertise in small group level-funded
  - A variety of network solutions, including top tier broad national networks, local high-performance networks, reference-based pricing partners, and hybrid options
  - Top-tier PBMs, including CVS and Cigna

What makes Optimyl unique

Savings – delivering significant savings to the right clients via a lower monthly bill as well as the potential for a refund of unused claim funds on the back end.

Transparency – helping employers understand plan performance, including insight into Rx rebates, and guiding members through technology and rewards to lower cost, higher quality providers.

White glove service – providing top tier service both pre-sale and post-sale with dedicated support.

Plan flexibility – offering customizable benefit designs while keeping administration simple with a one-stop-shop package.

Network flexibility - from PPO to EPO, broad to narrow, RBP and RBP hybrid options.

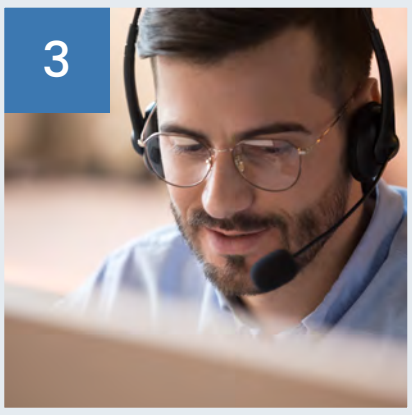
Tech flexibility - offering proprietary online tools but willing to work with third party tools or paper.

How Level-Funding Works

Level-funded products help solve many of the historical complaints of small employers purchasing fully insured coverage. With fully insured products, employers have low levels of transparency and flexibility, and any profits created when claims are low are kept by the insurance company.

Level-funding works differently. As a self-funding arrangement, claims are paid directly from your claims account and unused amounts are eligible to be refunded to you. Stop loss insurance is included in the package to help protect you from large claims and keep cash flow predictable. If claims exceed your claims account funding at any point in the year, stop loss will advance funds into your account. Regardless of the level or timing of claims, your monthly bill will remain one level payment that does not change during the year. The primary cash flow risk is whether or not you will get a refund.

Under a level-funded product, your monthly bill will include three components:



1. Claims Account Funding – This is your money and these amounts pre-fund your maximum claims exposure for the year in monthly 1/12 increments. At the end of the year, depending on the option you select, you could receive 50-100% of the remaining unused funds after the claims runout period.

2. Stop Loss Premiums – Premiums are paid to the stop loss carrier in exchange for protection from claims above expected and provide the coverage that puts the "level" in level-funding.

3. Administrative Fees – These amounts pay for the ongoing administration of your plan, including customer service, claims adjudication, reporting, network access, and broker fees.

Flexible Plan and Program Options

Tailor your plan to your group's specific budget and needs. All options meet the applicable requirements of the Affordable Care Act (ACA).

Plan Design Options	**Deductible** (Family is 2x Individual; Out-of-network is 2x in-network)	$250 $500 $750 $1,000 $1,500 $2,000 $2,500 $3,000 $3,500 $4,000 $4,500 $5,000 $5,500 $6,000 $6,500 $7,000 $7,500 $8,000 $8,500 $9,000
	Deductible Type	**Embedded** - each covered family member only needs to satisfy their individual deductible. **Integrated** - the entire family deductible must be met by any combination of family members before any benefits are payable for any individual.
	Coinsurance (in-network/out-of-network)	100%/70%, 90%/60%, 80%/50%, 70%/50%, 50%/50%
	Out-of-Pocket Maximum	$250 $500 $750 $1,000 $1,500 $2,000 $2,500 $3,000 $3,500 $4,000 $4,500 $5,000 $5,500 $6,000 $6,500 $7,000 $7,500 $8,000 $8,500 $9,000
	Office Visits (primary care physician/specialist)	$20/$40, $25/$50, $30/$60, $35/$70, $40/$80, $50/$100, Deductible/coinsurance
	Urgent Care	$100 or Deductible/coinsurance
	Emergency Room	Deductible/coinsurance, $300 copay, $500 copay, $300 access fee then D/C, or $500 access fee then D/C
	Diagnostic X-Ray and Lab	Deductible/coinsurance, subject to PCP copay, 100%, or 100% for $500 then D/C
	Teladoc	Physician Only or Physician + Behavioral Health
	Prescription Drugs (generic/preferred brand/non-preferred brand)	$0/$30/$50, $5/$35/$60, $10/$40/$70, $15/$45/$75, $20/$50/$100, Deductible/coinsurance
Stop Loss & Program Options	**Specific Deductible**	$6,500 $10,000 $15,000 $20,000 $25,000 $30,000 $35,000 $40,000 $50,000 $75,000 $100,000 AggOnly
	Contract Basis (incurred period/paid period)	12/21, 12/15, 12/12, 24/12
	Rx Rebate Pass Through	0%, 50%, or 100%; Renewal contingency optional
	Delayed Admin Fee (fee/refund)	0%/100% or 50%/50%; Renewal contingency optional

- Member per-visit costs apply to Teladoc for HSA-qualified plans
- Specialty drugs are subject to deductible/coinsurance, not copays
- For CVS plan templates, the 3-tier prescription drug options become 2-tier options
- Specific deductible option availability varies by state
- Only employers above 50 lives are permitted to choose a contract basis other than 12/21

Flexible Network Options

Optimyl Benefits offers five types of network plans that vary by level of savings, network breadth, and how the provider is paid.

LESS SAVINGS

PPO (Preferred Provider Organization)

- The traditional option that most health insurance carriers offer
- Broad national networks
- Out-of-network providers are covered, but at higher levels of cost-sharing (higher deductibles, coinsurance, out-of-pocket costs that the member is responsible for)

EPO (Exclusive Provider Organization)

- Similar to PPO plans, only members cannot go out-of-network
- Broad national networks
- Out-of-network providers are not covered, except in certain situations outside of the member's control
- Some savings vs PPO

HPN (High Performance Network)

- Local networks that are narrower and focused around 1-2 hospital systems in a given geographic area
- Out-of-network providers are covered as well, but at higher levels of cost-sharing (higher deductibles, coinsurance, out-of-pocket costs that the member is responsible for)
- Significant savings vs PPO

RBP/PPO Hybrid

- Hybrid option, blending RBP and PPO approaches
- Reference-based pricing for facilities to drive savings, with a broad national network for higher frequency claims from physician and ancillary providers
- Savings in between PPO and RBP

RBP (Reference Based Pricing)

- Innovative approach in the market that reimburses providers at a multiple above the levels Medicare reimburses for services
- No provider networks are involved, other than for transplants and pharmacy benefits, and members can see any provider
- Strongest savings vs PPO

MORE SAVINGS

Customer Experience with Reference-Based Pricing

Reference-based pricing plans can create significant savings for employers and members vs PPO due to how the plan payments work. On an RBP plan, providers are reimbursed at a multiple above the levels Medicare reimburses for services. These multiples are 150% for Inpatient Services and 130% for Outpatient Services and while higher than Medicare, they are often lower than traditional commercial network payment levels. As these plans do operate differently from traditional PPO plans, Optimyl Benefits will walk members step by step throughout the healthcare journey.

Review educational materials – Optimyl will provide the same standard items provided to groups with PPO plans, such as the SPD, SBC, and an overview of online management tools. Members will also receive RBP-specific materials to help them understand how to use their plan, such as an introduction to their Advocacy team and online shopping tools.

Shop for services – Members can seek out services from any provider on an RBP plan, with the option of relying on the assistance of our online shopping tools and/or our Advocacy team to locate high quality providers.

Payment of claims – Providers are reimbursed at either 150% or 130% of Medicare levels, providing a fair margin for any particular claim, but typically at lower margins than a PPO contract. The RBP payment can create savings for both the employer and the employee. See the chart below for an example for an Inpatient claim.

Post-payment questions – Providers may have questions on how the plan works or how the payment amount was derived. Occasionally, providers may also attempt to balance bill the member for the remaining amount of billed charges above and beyond what the plan paid. This is when the member should engage the Advocacy team who will take over the interaction with the provider. Members are not responsible for balance bills related to plan payment levels, nor do they have to handle any explanations or negotiations with providers.

	Provider Receives	Plan Pays	Member Pays
PPO Allowed Amount	$20,000	$14,400	$5,600
RBP Allowed Amount	$15,000	$10,400	$4,600

Example for a hypothetical $40,000 billed charge inpatient hospital stay where provider bills at 400% of Medicare, the PPO discount is 50%, and the member has a $2,000 deductible, 80% coinsurane, and $8,000 OOP max.

Within outpatient services, durable medical equipment, infusion, dialysis, and ambulance are all reimbursed at 100% of Medicare.

Optimyl BENEFITS + ALLIED

Best-in-Class Service

Between our Account Management team, our easy-to-use online tools, and our partner Allied, you're setup for success with best-in-class customer service.

We've built an Account Management team dedicated to supporting employers like you.

- Each group is assigned an account manager as their direct point of contact
- Account managers help you navigate onboarding, ongoing service, and renewals
- This team is happy to work directly with your broker, if requested, to take any work off your hands

We've built easy-to-use online tools for self-management of your plan.

- Proprietary benefit administration platform to handle ongoing additions, terminations, and eligibility changes
- Healthcare service shopping experience with real-time accumulators and price compares, with the capability to administer rewards that incentivize smart shopping in health care
- Online portal to see plan documents and plan performance, providing the transparency you are seeking

We've partnered with one of the best Third Party Administrators in the business to handle claims and member service – Allied:

- Deep expertise specifically in small group level-funding
- Has been supporting employers for 40+ years
- Is the largest remaining independent TPA in the country

Optimyl Benefits–Dental

Optimyl BENEFITS

Bundled Dental for Savings and Simplicity

Plan Features

- Built directly into the level-funded plan to simplify and create savings
- Bundled administration with medical, including the ability to bundle bill with Vision
- Opportunity to receive a refund on unused claims fund amounts after the plan year
- Broad national network with over 780,000 access points – Cigna Dental PPO SA Plus
- Available to groups with as little as 2 enrolling employees

	Basic Plan		Enhanced Plan	
Benefit Category	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Preventive Services (Not subject to deductible; no waiting period) Exams, cleanings, x-rays, flouride, sealants	100%	100%	100%	100%
Basic Services (Subject to deductible; no waiting period) Simple extractions, space maintainers, endodontics	80%	80%	80%	80%
Major Services (Subject to deductible; no waiting period) Periodontics, oral surgery, endodontics Crowns, inlays, onlays, dentures, bridges	50% 50%	50% 50%	80% 50%	80% 50%
Orthodontic Services Dependent children under 19 only	50%	Not Covered	50%	Not Covered
Deductible and Maximums Annual Deductible (per person/per family) Annual Benefit Maximum (per person) Lifetime Orthodontic Benefit Maximum (per person)	$50/$150 $1,000 $1,000		$50/$150 $2,500 $1,500	

Employers must bundle dental with medical. This offering is not available stand-alone.

Reimbursement for out-of-network providers is capped at the maximum allowable charge, and non-network dentists may bill the member for the difference between our allowance and their charge.

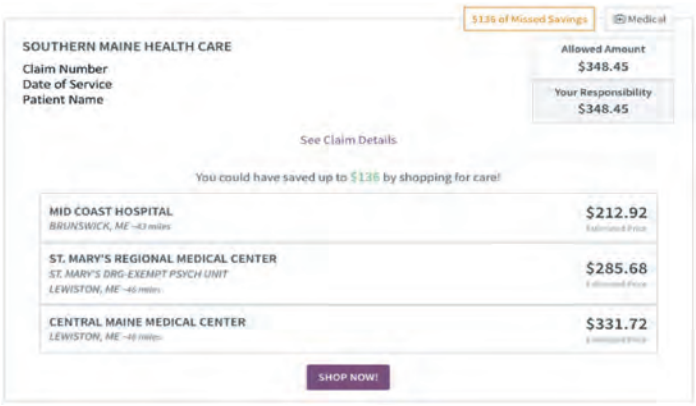
See Summary Plan Description (SPD) for a list of exclusions. If there are any differences between this brochure and the SPD, the SPD is the final authority.

Unique Capabilities and Consumerism Tools

At Optimyl, consumerism meets technology, allowing plan participants to comparison shop, save, and be financially rewarded through Optimyl's industry leading and unique shared savings program.

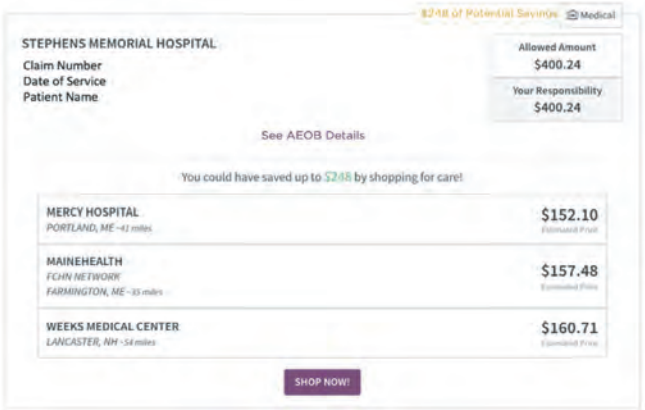
Retrospective Shopping

- ✓ Powered by TALON, our platform re-shops every EOB for the same exact episode of care
- ✓ Email/ SMS Message notifications to the member when a missed savings opportunity arises



Prospective Shopping

- ✓ Prospective Shopping opportunity to change to a new, high-value provider per Advanced EOB
- ✓ Completely confidential – only seen by the TALON system and the member



Encounter Estimates, not just procedures

Patented Dynamic Rewards Platform – MyMedicalRewards™

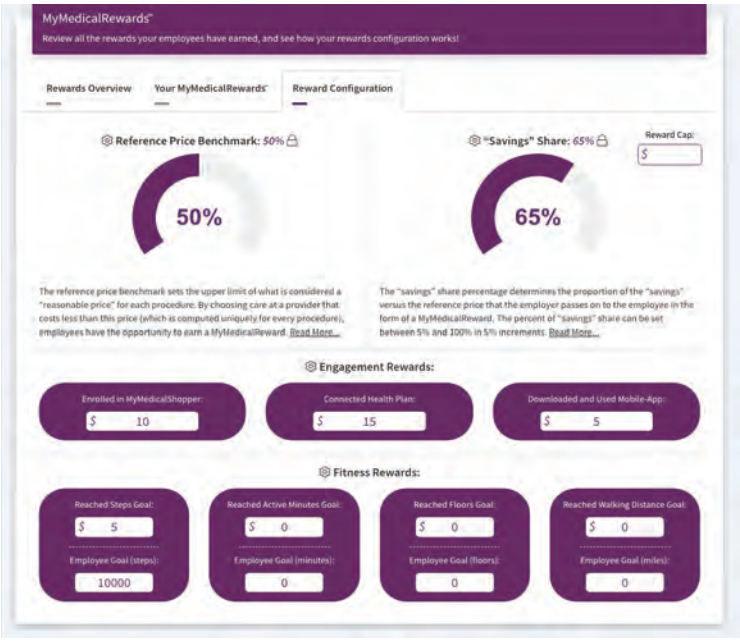
No Surprise Shopping™
Looks beyond procedure cost

MERCY HOSPITAL
NUCLEAR STRESS TEST

Encounter Estimate Calculated using these procedures

Procedure Name	Likelihood	Weighted Price
NUCLEAR STRESS TEST	100%	$1,662
PROFESSIONAL FEE	100%	$95
CARDIOVASCULAR STRESS TEST: TRACING ONLY	51%	$183
TC99M SESTAMIBI	50%	$213
NON-HEU TC-99M ADD-ON/DOSE	49%	$645
REGADENOSON INJECTION	35%	$444
HOSPITAL OUTPATIENT CLINIC VISIT	17%	$14
TTE WITH DOPPLER	16%	$285
→ Professional Fee		$14
TYPICAL OTHER COSTS		$228
	Encounter Estimate	$3,783

Please note that medical prices change periodically, and can vary greatly based on your insurance carrier. We recommend that you confirm pricing with the medical provider when making your appointment.



Optimyl Benefits Wellness Program

Optimyl Benefits Wellness, powered by Marquee Health, provides clients with an outcomes-driven suite of health and wellness services that support the improvement and maintenance of a healthy lifestyle.

Optimyl Benefits recognizes the benefits of a holistic approach to optimal health. We provide program participants with the tools, resources, motivation, and one-on-one instruction necessary to achieve the perfect balance of physical, financial, and mental well-being.

Key Components

- Overall Program Administration
- Health Risk Assessments
- Intervention and Engagement Programs
- Customizable Wellness Portal
- eConnect® Telehealth Platform
- Team and Individual Competitions
- Telephonic and Web-Based Health Coaching
- Incentive Management
- Financial and Behavioral Health Consultation
- Animo—Digital Cognitive Behavioral Therapy (dCBT) Tool

Core

The Core model is a structured, turnkey wellness solution for clients of any size. All programs include access to a resource-heavy wellness portal and app, an HRA, dCBT, team and individual competitions, and health promotions.

Enhanced

The Enhanced model is an activity-based model that includes the features of the Core model, plus risk evaluation, targeted outreach, and incentive administration.

Proven Results

The Optimyl Benefits Enhanced model delivers meaningful results for employers and individuals:

- 6.1% average annual medical cost trend reduction.
- 7.7% reduction in Per Member Per Month (PMPM) cost.
- Participants returned to work eleven days sooner from a Workers Compensation incident; 17 days sooner from STD.

Exclusions and Limitations

This page is a summary of certain exclusions and limitations contained within the plan templates and broader program. Prior to signing up for coverage, you should read the Summary Plan Description, the Stop Loss Policy, the Proposal, and the Program Management Agreement for the exhaustive list of exclusions and limitations, as well as other important details.

The Summary Plan Description contains limitations, including but not limited to:

- Inpatient Rehabilitation, Skilled Nursing Facility, and Subacute Rehabilitation services are subject to a 30-day limit, combined
- Outpatient Rehabilitation and Habilitative Services are subject to a 30-day visit limit, combined
- Home Health services are subject to a 45-day limit
- Hospice Care services are subject to a 180-day limit
- For groups with less than 50 employees, Mental Health/Substance Abuse services are subject to a 30-day limit Inpatient, a 30-day visit limit Outpatient, and are subject to 50% coinsurance
- This program includes utilization management services, which require prior authorization for certain services and assess a penalty for accessing certain services without prior authorization

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The Summary Plan Description contains exclusions, including but not limited to:

- For groups with less than 50 employees, Infertility Treatment is excluded
- For groups that choose the EPO network option, care provided by out-of-network providers is excluded
- For groups that choose to carve-out Specialty drugs, they will be excluded
- The prescription drug formulary prioritizes generics, does not cover brand drugs not included on the formulary, and may assess a penalty if a brand is filled when a generic could have been substituted
- Care that is experimental, investigative, cosmetic, or otherwise not medically necessary
- Routine dental, vision, or hearing care, unless dental and vision are specifically elected
- Care to address quality of life or lifestyle concerns
- Alternative medicine
- Injuries caused by acts of war, commission of a felony, or under the influence of illegal substances
- Care that is covered by another payer, if applicable, such as Medicare or Worker's Compensation

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You can select how pharmacy rebates are distributed to you at the end of the plan year. If you choose to have a renewal contingency and do not renew, you will receive no rebates. Also, if you terminate in the middle of the plan year, you forfeit these amounts.

You can select how surplus claim fund amounts are distributed to you at the end of the plan year. If you choose to have a renewal contingency and do not renew, you will receive no refund.

This program does not include certain Federal or State mandated fees in the monthly bill, including but not limited to the PCORI assessment

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Level-Funded Health Plans for Small Business

Interested in a proposal? Give us a call at 1-800-621-0748
or e-mail us at info@optimyl.com

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