The Self-Funded Program provides tools for small-business employers 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. Stop-loss insurance for the National General Benefits Solutions Self-Funded Program is underwritten by National Health Insurance Company, Time Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation.

National General Benefits Solutions Self-Funded Program

National General Benefits Solutions (NGBS) is focused on providing innovative employee benefits solutions to small- and mid-sized businesses. NGBS specializes in providing solutions to employer groups and offers flexible health coverage options to meet the needs of your clients.

We're a proven leader in the self-funded market

- ✓ Our sales and product experts have years of experience working in the self-funded space
- ✓ We place a heavy emphasis on adapting to the changing market and continually providing updated solutions for the future

About This Manual

This manual is intended for agents' training and reference. It contains important information you need to market, sell, and service the Self-Funded Program. Agents are encouraged to read the manual in its entirety and to use it as a reference for answering questions and servicing your National General Benefits Solutions Self-Funded Program business. If you need additional information not found in this guide please contact your National General Benefits Solutions Sales Representative for assistance.

While we make every effort to provide you complete and current information about the enrollment and administration practices of our Self-Funded Program, this guide is subject to change without notice. Active policies and procedures will take precedence over the information contained in this guide.

Please continue to work with your National General Benefits Solutions Sales Representative to ensure you always have the most up-to-date version of this guide.

Important Notices

This program includes tools to assist with establishing and maintaining a self-funded health benefit plan under the Employee Retirement Income Security Act (ERISA), along with stop-loss insurance and plan administration. Stop-loss insurance policies for employers establishing self-funded plans under this program are underwritten and issued by National Health Insurance Company, Integon Indemnity Corporation, Integon National Insurance Company and Time Insurance Company.

Plan administration is performed by a licensed third-party administrator.

No stop-loss coverage is in effect until approval is received from Underwriting. Existing coverage should not be cancelled until approval is confirmed.

The self-funded plan may be exempt from certain state law requirements and may not include all benefits required by state law for fully insured health insurance plans. Please refer to the Summary Plan Description (the Plan) for complete details.

This guide includes summary information and representations about this program's stop loss coverage. It is not a complete or detailed disclosure of that coverage, its benefits, exclusions or limitations. Refer to the policy of stop loss insurance for complete details.

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Program Overview

What is the Self-Funded Program?

The Self-Funded Program is a self-funded health benefit program providing small-to-medium-sized businesses a convenient and safe way to provide more affordable health care benefits to their employees and their families.

Employer health plans established and funded by individual employers are governed by federal law. All employer-established benefit plans are minimum essential coverage, so employees will not be subject to the individual tax penalty.

The National General Benefits Solutions Self-Funded Program brings together the products and services from various sources to help small-to-medium sized business employers to establish and administer their self-funded health plans.

> Remember, the most important service you provide to your clients is complete information about their options. The decision to self-fund should be made only when the employer has a complete understanding of how self-funding works.

Our Self-funded Program is set up to provide tools for small- to medium-sized employers, so they can enjoy the benefits of self-funding without taking on added risk.

Stop-loss insurance protects the employer's assets from higher-than-expected claims.

Our Self-Funded Program offers customizable plan designs that make it easy to find the right fit for each employer.

You and your clients can rely on our experienced team of sales professionals and Account Managers. They're ready to provide their expertise before, during, and after the sale.

Our program simplifies self-funding — giving employers the opportunity to provide quality health care benefits to their employees while lowering their overall cost.

How the National General Benefits Solutions Self-Funded Program Works

Self-Funding combined with stop-loss insurance

Employers who participate in the Self-Funded Program establish an employer health benefit plan governed largely by federal law. The employer plan establishes rules for employee and dependent participation in health coverage and defines the benefit plan offered to the group.

In a self-funded arrangement, the employer assumes responsibility for the cost of the benefits included in the Summary Plan Document (SPD). Each participating employee receives a copy of the SPD, which includes benefit information similar to a fully insured group certificate of coverage.

Through the Self-Funded Program, the employer is issued stop-loss insurance that reimburses the employer for expenses that exceed pre-determined levels. These amounts, respectively, are called the "aggregate limit," and "specific limit".

- Aggregate limits apply to the whole group
- Specific limits apply to each covered individual

Even if a group's claims become larger than projected, the employer's financial risk does not increase.

What are the Employer's Costs?

With the Self-Funded Program, participating employers pay a monthly bill, similar to the monthly billing an employer might be accustomed to with a traditional fully-insured plan. The monthly billed amount covers all financial responsibilities for their employer plan. The monthly bill has three components:

1. Stop-loss premium – this amount covers insurance to reimburse the employer for any covered expenses over the aggregate and specific deductibles.
2. Administrative costs – this is the charge for administrative services such as customer service, claims administration, agent Marketing Fees, case management, access to provider networks, and others.
3. Monthly claim account funding – employers make monthly payments to provide for their groups' anticipated claims for the year. These funds are considered general assets of the employer.

In addition to the monthly bill, the employer may be responsible for additional state and federal fees, which could include:

- The Patient Centered Outcomes Research Institute Fee (PCORI), an annual fee imposed by PPACA to fund research, assessed for plan years 2012 through 2019
- New York Public Good Pool Surcharge
- Massachusetts Pediatric Vaccine surcharge

Maximum Cost
The maximum self-funding cost for the year is determined up front. Even if a group's claims become larger than projected, the employer's costs do not increase. Stop-loss protects the employer's assets.

At the end of the run-out period, if claims are less than the aggregate deductible, the employer will receive a percentage of the difference.

What if claims are more than the balance in the claims account?

At times, covered claims can exceed the amount the employer has deposited in the employer claim account maintained by the TPA. In this case, the stop-loss policy advances the amount of the shortfall.

Ordinarily, advances are repaid from the employer's monthly payments in following months. If an employer terminates the stop-loss policy before advances are repaid, the employer will be liable for unpaid amounts up to the aggregate deductible.

Products and Services and Program Features

What's included in the Program

National General Benefits Solutions and the Third Party Administrators bring resources and expertise to the Self-funded Program. Product and administrative systems integrate the roles each play into a seamless service for you and your customers. Administration is accessed through a single mail and phone system that enables you, your customers, and medical providers to reach the appropriate person or area without complication or delay.

The following products and services are provided by National General Benefits Solutions:

- Stop-loss insurance for employers*
- Marketing and sales support
- Risk management and actuarial services
- Access to Medical Management (precertification medical review, case management)
- Access to substantial health care discounts through contracted medical and pharmacy networks, as well as pharmacy benefit managers

* Stop loss insurance policies are issued and underwritten by National Health Insurance Company, Integon National Insurance Company, Integon Indemnity Corporation, or Time Insurance Company

Administrative Services

The Self-Funded Program provides access to three licensed Third-party Administrators (TPA) that administer the employer plans.

The TPA's and National General Benefits Solutions work together to provide the employers with:

- ✓ ERISA plan documentation
- ✓ Summary Plan Descriptions, Benefit Summaries and Summary of Benefit Coverage
- ✓ ID cards for covered employees
- ✓ Billing for all fees, stop-loss premiums, and employer contributions for claims
- ✓ Setup for banking and accounting for customer claim accounts
- ✓ Claims processing and payments
- ✓ COBRA administration
- ✓ Customer service for members and medical providers
- ✓ Customer service (for employers and agents)
- ✓ Health plan management reports that assess the Plan's performance
- ✓ HRA and HSA administration is available with some plans

NOTE: Neither the insurance company nor the TPA acts in the capacity of an ERISA fiduciary. Employers are not prevented from seeking or establishing independent business relationships with either company, independent of the Self-Funded Program, or with any other company for services related to their health plans, including employee benefit consultants.

Key Features

Employer Stop-loss Insurance

Employer stop-loss is insurance issued to the employer. Stop-loss does not pay benefits to employees. It reimburses the employer plan when claims costs exceed pre-established limits based on expected claims. Stop-loss insurance offers two protections for self-funded employer plans.

1. **Aggregate Stop-loss Benefit:** The aggregate stop-loss benefit protects the employer against higher-than-expected claims incurred by the group as a whole. The aggregate limit is equal to the employer's total contribution to the claims account for the plan year. It is calculated based on a census of the group and on the total expected claims costs for the plan year. If the group's overall claims costs for the plan year exceed the aggregate limit the stop-loss insurance covers the employer via a deposit into the claims account, for the cost of the group's claims for the remainder of the year. (See "Finance and Billing" section).
2. **Specific Stop-loss Benefit:** The specific stop-loss benefit protects the employer against higher-than-expected claims by an individual group member. If an individual group member's claims exceed the specific limit (a level chosen by the employer during the group implementation) our stop-loss insurance covers the employer for the remaining portion of that member's claims costs for the plan year via a deposit into the employer's claim account.

   If the quote shows aggregate and specific limits of the same amount it is because the group's expected costs are so low that the annualized funding amount is not as much as the minimum specific limit required by law. In such a case, the aggregate limit cannot be set lower than the specific limit. Therefore, the group would be required to fund the amount shown even though it is likely the group may not actually incur that level of claims. This situation is less likely as the number of employees, spouses, and dependents grows and when more expensive coverage is chosen.

Stop-loss Rate and Deductible Guarantee

Stop-loss premium rates, annual employer contribution, and specific deductibles may be guaranteed for one year at a time.

Rates determined at issue or for a new policy period may be changed mid plan year only upon employee census changes of more than 10%. We also reserve the right to change rates when:

- The business moves to a new address
- Changes are made to the plan's benefits

Determining Stop-loss Limits

Group plan information is entered into a financial model that calculates the plans expected claims. Expected claims may be adjusted based on medical underwriting prior to a final-rate offer. The employer's monthly claims account funding, stop-loss premium, and administrative costs are determined by National General Benefits Solutions. Specific stop-loss limits are selected by the employer from several options, subject to state law. Both specific and aggregate limits are set in accordance with applicable state laws.

Self-Funded Benefit Plan Templates

National General Benefits Solutions has designed hundreds of plan template options to fit almost any small employer's needs.

ERISA and State Mandated Benefits

Self-funded employer plans are not required to offer coverages mandated by state law, however federal mandates do apply. Despite their exemption from state mandated benefit laws, our Self-Funded Program designs include many of these benefits for competitive reasons.

Provider Network Access

The Self-Funded Program offers access to National General Benefits Solutions' contracted medical provider networks at preferred rates. The plans do not have gatekeeper requirements; therefore no referral is necessary to see specialist providers.

Pharmacy Benefits

The Self-Funded Program offers network pharmacy benefits through Cigna Payer Solutions. Cigna processes all network and out-of-network pharmacy claims. Network benefits are accessed by presenting the ID card at participating pharmacies.
Out-of-network pharmacy claims must be submitted with a special claim form which can be downloaded from the myCigna.com website.

Pre-Certification and Utilization Review (UR)

Medical Management staff can be reached by calling the number on the back of the members Medical ID cards. Medical management policies and procedures are URAC-certified and comply with Department of Labor ERISA claim payment rules.

Health Savings Account (HSA) plan options

HSA compatible plans are high-deductible plans designed to comply with federal requirements. Employers and employees can make pre-tax contributions into an HSA, which can be used to pay for qualified medical expenses and can help offset the deductible. With an HSA compatible plan, a group could enjoy health care expense coverage plus all the cost-saving benefits of an HSA.

Health Reimbursement Arrangement (HRA) plan options
The HRA option is offered with Allied TPA services only.

An HRA is an employer-funded (tax deductible*) arrangement provided to employees for reimbursement of employer-specified medical expenses authorized by Section 105 of the Internal Revenue Code.

These specified expenses can include copays, deductibles, wellness services, and more. HRA advantages for employers include:

- Tax-deductible contributions
- No need to pre-fund the account
- Employer is allowed to retain ownership of the funds if the employee terminates
- Great flexibility in HRA plan designs
- HRAs are available to any qualifying size group
- Employer is able to contribute and split the funding on a portion of the deductible
- The employer creates a more attractive package for employees who may be uncomfortable with a high-deductible plan

*National General Benefits Solutions is not engaged in rendering tax or legal advice. Please see a qualified professional for tax or legal advice.

Quoting and Selling

This section contains answers to frequently asked questions about quoting and submitting new business. It is intended to provide step-by-step guidance and make your job easier. Our Sales and Account Management teams are also available to answer questions and help assess business situations.

Getting a group quote
Proposals (quotes) are created by your National General Benefits Solutions Sales Representative and emailed to your office.

What's in the Quote?
Group quotes show the following:

- Plan selection and effective date
- The components of the maximum monthly cost to the employer
- Stop-loss premium amount
- Plan administration monthly cost
- Monthly claim account contribution
- Aggregate and specific limits
- Group rates include:
  - per employee costs based on the selected coverage
  - rates for employee only, employee and spouse, employee and children, and family

Submitting a Case
Once a group commits to applying for the Self-Funded Program, the following items must be submitted to our underwriting team:

- Implementation Questionnaire – signed by the employer and you
  - NOTE: The Time Insurance Company Employer Application should be used in the states of Missouri and Washington
- Employee enrollment forms on all eligible employees, including any employees in the employment waiting period
  - NOTE: You must use most up-to-date enrollment forms. Forms can be accessed by contacting your Sales Representative
  - Employees not requesting coverage must complete the Waiver of Coverage section on the employee enrollment form
- New business proposal (quote) signed and dated by employer
- Signed Self-Funded Program Employer Agreement
- Signed Administrative Services Agreement
- The employer's last State Quarterly Unemployment Withholding Form (not required on groups > 51 or more enrolling employees)
- Census form listing full-time and part-time employees if a State Quarterly Unemployment Withholding Form is not filed
- Signed Network Services Agreement (if applicable)
- A copy of the business check made payable to the appropriate TPA
- A copy of the employer's last bill from the current carrier
- New York Pool Election form or New York Pool Change form
- Business Associate Agreement
- Employer Agreement and Attestation signed by employer and agent
- For Cigna and Meritain administered plans, if COBRA administration is elected: COBRA Administrator Documents (Third Party Authorization, COBRA Service Agreement, and COBRA census)

Additional forms may be required at time of application.

Important Information:
Employers must allow all eligible employees to enroll in the plan regardless of their health status.

Underwriting Guidelines

Plan Effective Date

Effective dates are the first day of the month.

- Exception: Groups administered by Allied are also eligible to enroll for a 15th of the month effective date if replacing other group coverage

Completed employee enrollment forms must be received by National General Benefits Solutions at least 15 days prior to the requested effective date. This allows the Underwriting Department sufficient time to decide on the acceptance and rating of the proposed group and to finalize estimated claim account requirements.

- We cannot guarantee timely action if enrollment forms are incomplete or received late. However, we will accommodate your clients to the best of our ability when enrollment forms are received late

Enrollment forms cannot be dated more than 90 days prior to the requested effective date.

Please make sure your client understands that National General Benefits Solutions will review the case before making any final determinations including approving coverage, assigning an effective date, or changing any terms of coverage.

The Underwriting Department must receive all completed documentation before this review can take place. If information needed to finalize a case is not received by the Underwriting Department after appropriate follow ups have been performed, the case will be closed.

It is critical that you review the census information with the group to verify all employees who intend to enroll with the group have submitted an enrollment form and are included on the proposal, including those employees in the waiting period.

Enrollment forms are also required for any employees that need to satisfy the waiting period before enrolling (even though they are not listed on the quote). If an employee and/ or dependent do not enroll during the initial enrollment period, they are not eligible to enroll until the group's reissue date, unless they qualify for Special Enrollment.

Note: Stop-loss coverage will not be effective until approval is received from Underwriting.

Always caution your clients against canceling other health coverage until they receive acceptance of the stop-loss policy.

Misrepresentation

If it is later learned that relevant facts about a group, employee, or dependent have been omitted or misstated, complete and correct information must be submitted immediately. The following actions may occur (this list is not comprehensive):

- We will review and determine whether to change any terms of coverage
- If National General Benefits Solutions would not have issued coverage if the correct facts were known, coverage may be voided or terminated
- If the relevant facts affect the monthly cost, a billing adjustment may be made back to the effective date

Responsibility for Monthly Costs

The employer is required to contribute at least 50%* of the monthly cost for each employee. The employer may decide whether to pay all or part of the monthly cost for dependent's portion of the health benefit costs. The employer is responsible for making all payments associated with the Self-Funded Program.

Two billing options are available:

1. Automatic debit of the employer's designated account
2. Direct billing – with direct billing, the employer is responsible for remitting all billed amounts when due. Subsequent monthly charges will be billed by the administrator and must be submitted directly to them

National General Benefits Solutions Sales Representatives are not authorized to collect subsequent monthly billed amounts.

*Requirement may vary by state, contact your Sales Representative for details.

Participation Requirements

Employers must have a minimum of two or three participating employees depending on the TPA and plan selection.*

Employers must enroll at least 75% of all eligible employees after considering valid waivers or 50% of all eligible employees regardless of waivers.

*Allied Benefits, Inc. requires a minimum of two participating employees. Cigna and Meritain require a minimum of three participating employees.

Valid Waivers

Comprehensive major medical coverage including:

- Coverage under a spouse's employer group health plan
- Coverage under an individual health plan
- Coverage as dependent under a parent's health plan
- Medicare
- Medicaid I Medical Assistance

- TRICARE
- Coverage under an Indian Health Services Program
- State Health Benefits Risk Pool
- COBRA coverage
- Peace Corp or other Federal plan
- Public health plan of a state, country, or other state political subdivision

Eligible employees or dependents with have a valid waiver, must submit adequate proof of other coverage.

The Waiver of Coverage section of the employee enrollment form must be fully completed, and the following information must be provided:

- Reason for waiving coverage
- The name and telephone number of the carrier providing the other coverage

Providing a copy of the previous carrier medical ID card will help expedite the process.

Waiting Periods

The options for employment waiting periods are of 0, 30, 60 or 90 days.

For employees in waiting periods, the employer has one of two options at time of submission:

- Enroll all eligible employees*, or;
- Require all eligible employees to satisfy the selected waiting period before their coverage becomes effective

At the time of group submission an enrollment or waiver form is required for all eligible employees, including those in the waiting period, regardless of the option chosen.

Varied waiting periods may be selected for different classes of employees (i.e. management vs non-management).

The waiting period may only be changed at time of reissue (annual effective date). The new waiting period will apply to all eligible employees hired on or after the effective date of the change.

*Groups with 25 or more enrolling employees are not allowed to waive the waiting period at time of group submission

Medical Underwriting Standards

All eligible employees and their dependents enrolling for coverage, regardless of whether they are in the waiting period, must complete enrollment forms for consideration.

Accurate and fully completed enrollment forms, including health questions, help expedite the underwriting process. Our Underwriting Department will contact you or the employee if any information is incomplete or missing.

The Underwriting Department reserves the right to investigate medical conditions as they deem necessary, including but not limited to, requiring a blood or urine profile and/or an attending physician's statement.

If the group cannot be issued as applied for, you will be contacted before any coverage is issued.

It is important that all medical history and pertinent information regarding the employee, spouse, and dependents be fully disclosed on the employee enrollment form. Failure to do so may result in rescission of stop-loss coverage or a surcharge retroactive to the effective date of the group.

Eligibility

Group Eligibility Requirements

The Self-Funded Program is designed for employers that have no fewer than:

- Two full-time employees for plans administered by Allied
- Three full-time employees for plans administered by Cigna or Meritain

At the time of application, no more than 20% of the total employees in the business may be on COBRA or other Continuation of Coverage.

In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

Employer groups formed primarily for the purpose of purchasing insurance are not eligible.

Seasonal businesses are not eligible. "Seasonal" is defined as operating fewer than six months every calendar year.

Groups that no longer meet these requirements because of census changes or other factors are subject to termination.

The federal agency administering the Medicare program requires administrators of group health plans to provide the Social Security Numbers for all employees, spouses, domestic partners and dependents covered by the employer's plan. National General Benefits Solutions must request this information to be submitted to comply with the governmental requirements set forth in the Medicare, Medicaid and SCHIP Extension Act of 2007. The information will be reported to the Centers for Medicare and Medicaid Services (CMS).

We realize this is sensitive information and have appropriate safeguards in place to protect it.

For additional information on the mandatory reporting requirements, you can visit the CMS website at www.cms.hhs.gov.

Medicare Eligibility/TEFRA

For employers with 19 or less full-time and part-time employees, the employer's Self-Funded plan pays eligible benefits secondary to Medicare.

Groups that have 20 or more full-time and part-time employees working each day during 20 or more weeks of the current or preceding calendar year fall under the federal legislation referred to as Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA determines premium and reimbursement guidelines. Under TEFRA rules, the employer's plan is the primary insurer and Medicare is secondary.

Business location

A group's main business location is generally the state where the company's headquarters is physically located (provided employees are actively working at that location). If the company has multiple locations and another location has a higher number of eligible employees (whether enrolling or not), the employer may choose the main business location to be:

- The business headquarters, or
- The location with the highest number of eligible employees

NOTE: Some states may require the main business location to be the location with the highest number of eligible employees. In these states, the employer does not have the option to choose.

Your Sales Representative can help determine which business location should be designated as the Main Business location.

Employee Eligibility

The employer has the right, at the time of issuance, to establish eligibility requirements for the group by selecting the number of required hours worked per week (between 20 and 40) for an employee to be considered eligible for coverage.

- If the employer does not select a full-time eligibility requirement, eligibility will be administered based on 30-hours per week.

Note: Some states mandate eligibility requirements. In these states, the employer does not have the option to choose.

Your Sales Representative can advise you whether a mandate exists in the groups' state.

A partner, proprietor, or corporate officer of the employer is eligible if he or she performs services for the employer on a full-time basis, as defined by the plan, at any of the employer's business establishments.

The following are not considered eligible employees under this plan:

- Leased employees
- Temporary or seasonal employees
- Subcontractors
- Personal employees (e.g., nannies, gardeners)
- Employees who are not paid a wage
- Part-time employees

This is not an all-inclusive list; other eligibility requirements may be applied.

Ask your National General Benefits Solutions Sales Representative about our Short Term Medical insurance options for non-eligible employees.

Independent Contractors

If the employer wants to provide health coverage to independent contractors, sometimes referred to as 1099 employees, we strongly suggest they contact their legal and tax counsel about the implications of doing so. There could be legal and tax consequences for making such a decision.

For example, it may negate the classification of that person as an "independent contractor," which could result in tax implications to the employee and the contractor.

In addition, the tax treatment of the employer and contractor contributions to the health plan is not the same as for employees.

Carve Outs

If the employer provides health coverage for only certain segments of their employees, for example management vs. non-management, we strongly suggest they contact their legal and tax counsel about the implications of doing so. There may be both legal and tax consequences for making such a decision.

For example; the plan may not pass non-discrimination testing which will have tax implications.

Employee Only and Dependent Only Coverage

Employers may choose to cover:

- eligible employees only; or
- eligible employees and their child(ren) only

This election can be made at the time of initial enrollment or the employer may change their election once in any 12-month period.

The employer must complete the Employee and Dependent Only Coverage agreement.

Husband and Wife Groups

A husband and wife group, with no other employees, is not eligible to enroll.

A husband and wife group is only eligible to enroll when there is a common law employee. A common law employee is any other employee who meets the IRS definition of an employee.

Dependent Eligibility

Eligible dependents include the lawful spouse and natural born children of the employee, stepchildren, legally adopted children, or dependents for whom a court order requires the employer to provide insurance coverage. Children must be age 25 or younger, unless they are certified as disabled. If divorced, the former spouse is not eligible for coverage.

Adopted Dependents

An adopted child is eligible as a dependent when the Self-funded plan participant has agreed to assume total or partial responsibility of support for a child in anticipation of adoption or legal physical placement of the child in the home. Legal documentation is required.

Issuing Coverage

Enrollment Forms

Send completed enrollment forms and all other required documents to your National General Benefits Solutions Sales Representative or send directly to:

- Mail: National General Benefits Solutions

  Self-Funded Underwriting Department

  501 W. Michigan Street

  Milwaukee, WI 53203
- Fax: (763)577-4921 or;
- Email to: sfnewbusiness@ngic.com

Accepting and Declining Groups

Acceptance of groups applying for the NGBS Self-Funded Program is determined by the insurance company that underwrites the stop-loss insurance. When a group is accepted for stop-loss insurance, the insurance company and TPAs will provide services to the group. Groups that elect not to abide by the policies, terms and conditions of the Self-Funded Program, whether accepted or declined, are not prevented from approaching any of the above service vendors to seek an alternative arrangement.

If a group is declined for the NGBS Self-Funded Program, you will be informed by your Sales Representative.

Issuing a New Group

When your client's group is accepted to participate in the Self-Funded Program:

- You will be informed by your National General Benefits Solutions Sales Representative
- The TPA will establish the employer's plan and an email will be sent to the employer

For business administered by Allied:

A welcome email is sent to the employer within four business days and includes instructions on how to log into the Member portal where they can access to the following documents:

- Employee Summary Plan Descriptions
- Employer's Guide
- Stop-loss contract
- Administration forms
- ID Cards (hard copies will be mailed to each employee)

- Employees will be mailed their ID cards along with information on how to access their plan documents

For business administered by Cigna or Meritain:

A welcome email is sent to you and employer within seven to ten business days and includes a New Business Employer Kit

- National General Benefits Solutions Account Management team will call the employer to review plan documents and provide instructions on accessing the enrollment portal
- Employers should contact their Account Manager for documents not available on the Benefitsolver enrollment portal
- Employees will be mailed their ID cards along with information on how to access their plan documents

Note: Whenever the employer's email is not provided materials will be mailed through the U.S. Postal Service.

Cost

The monthly cost charged to an employer group depends on the benefit plan selected and other factors that include, but not be limited to:

- Age of all enrolling members
- Provider network selection
- Geographic location of the business
- Medicare eligibility of employees
- Medical history of employees and dependents
- Expected medical claims cost for the plan year

These factors may vary by state.

New business rates for stop-loss insurance are "trended" monthly to account for medical inflation. It is important to remember this when deciding upon an effective date of coverage for the business. Changing the effective date to a later date may result in rate changes.

Workers' Compensation

Owners and employees are generally not covered for work-related injuries. However, in states where business owners may opt out of workers' compensation, the owner would be covered for work-related injuries.

Finance and Billing

Monthly Payments

Each month, the employer will receive an email notice that their monthly invoice is available for viewing:

For plans administered by Allied:

- The email will come from notifications@alliedbenefit.com with access to Alliedbenefit.com to view invoice

For plans administered by Cigna or Meritain:

- The email will come from info@businesssolver.com with access to Benefitsolver enrollment portal to view the invoice

The employer is billed monthly for the stop-loss insurance premium, administrative fees and required claim account contributions. The billed amount is due on the first day of each billing month.

For employers electing the ACH payment option, their accounts will automatically be debited on the first day of each billing month.

The billing month is established from the original effective date of coverage.

> For example, if the stop-loss insurance was originally effective on the fifteenth of the month, the billing months begin on the fifteenth day of the subsequent months.

If payment is not received within 31 days of the due date, stop-loss coverage and participation in the Self-Funded Program may be terminated.

Employer Claims Account Management

Employers participating in the Self-Funded Program must agree to pay a monthly amount for anticipated claims costs for the employer's health plan. This amount is based on expected claims costs. We estimate each group's expected claims cost at initial underwriting and each subsequent new plan year. In addition, expected claims cost may be re-estimated during the plan year, due to changes in the members that are covered under the employer plan or upon occurrence of events that may indicate significant change in expected claims.

Employer Claims Account

For plans administered by Allied:

The employer's claims contributions are segregated in a bank account and maintained by Allied.

These accounts are the employer's property until used for authorized purposes such as a claim payment. By signing the Administrative Services Agreement with Allied at the time of enrollment, the employer authorizes Allied to pay claims from the employer's account.

Funds not used for claim payment accumulate in the employer's account. At the end of the stop-loss policy's run-out period, if claims are less than the aggregate limit, a portion of the difference (percentage varies by state) will be refunded to the employer. In addition, Allied is authorized to pay stop-loss insurance premiums and administrative fees from the employer's accounts.

For plans administered by Cigna or Meritain:

Employer accounts are segregated in a bank account maintained by AMR. These accounts are trust funds and unused funds will accumulate in the employer's account. Any funds remaining at the end of the stop-loss policy's run-out period will be paid as an invoice credit, provided the group is still active. If the group has terminated, any excess amounts will be refunded via check or ACH.

The employer should use any refunded for the general benefit of the employees.

Marketing Fees
For Allied business:

- Marketing Fees are paid weekly
- Note: When a monthly invoice is paid early, the marketing fee will not be paid until the week of the actual due date
- The full monthly bill must be paid before marketing fees are paid on that business

For Cigna and Meritain business:

- Marketing Fees are paid monthly
- The full monthly bill must be paid before marketing fees are paid on that business

NOTE: For subsequent plan years, agents must have an active appointment at the time of reissue to continue receiving marketing fee payments.

Claim Submission and Service

Advance Funding Provision
Advance funding is automatically provided with stop-loss policies. Advance funding provides reimbursement to the plan's claims account if the claims for any given month of the plan year exceed the claims account's available balance. The plan does not need to have paid claims in excess of stop-loss insurance limits and aggregate limits to qualify for advances. Advances are repaid from subsequent months' payments made into the claim account.

Advances are only available if the plan's stop-loss insurance premiums and monthly claim account contributions are paid-to-date.

Deductible Credit
Credit is given for any portion of a calendar-year deductible satisfied under the employer's prior plan during the same calendar year. Deductible credit is only provided when the calendar year deductible option is chosen.

Health Benefit Plan Claim Submission
For plans administered by Allied, members are not required to submit claim forms in order to make a claim for benefits; bills from health care providers are accepted as an indication of loss.

For plans administered by Cigna or Meritain, members are required to submit claim forms.

If the participant assigns benefits to the provider, the TPA's will pay benefits under the employer's self-funded plan directly to that provider.

The itemized bills should always include the group number. If family members have the same first name, the date of birth and Social Security Number should be indicated for the claimant.

All medical bills should be sent within 90 days after an expense was incurred.

Precertification Requirement
There are a number of Medical procedures and Specialty drugs that require preauthorization. If preauthorization is not received a claim/prescription may be denied or penalty applied. Please refer to the Utilization Management guidelines in the SPD.

Health Benefit Plan Claim Payment
As the primary risk bearer, the plan is responsible for all claim decisions. Neither the TPA, nor the stop-loss insurance carrier will interfere in the plan's decision. However, since the plan's decision may be binding on later decisions to pay similar claims, it may be prudent for the plan to ask the stop-loss insurance company to determine whether the claim or one like it would be reimbursable under the stop-loss insurance. By doing this, the plan may avoid the risk that stop-loss coverage may not reimburse amounts that have become the plan's obligation after stop-loss limits are reached.

In addition, should a plan elect to override the denial of a claim payment, the dollar amount paid will be considered income to the participant. In such case, the employer must add this amount as "bonus" wages on the employee's W-2.

Prescription Claims
Participants will pay the appropriate cost sharing amount according to the Summary Plan Description when using a participating pharmacy.

Pharmacy out-of-network charges are based on the amount the plan would have paid a network pharmacy for the covered drug, less the network copayment, coinsurance and any applicable ancillary charges.

Stop-Loss Claims
In addition to administering the plan's claims, the TPA also processes the plan's stop-loss claims. Each plan's claims payments are tracked to determine when aggregate or specific limits are reached and a stop-loss insurance claim needs to be filed. Under the Administrative Service Agreement with the employer, the TPA is responsible for filing stop-loss claims on the plan's behalf. When stop-loss claims are paid, they are credited directly to the plan's account so claims against the plan can be paid immediately.

Health Plan Management Reports
For plans administered by Allied
Employers have access to a secured website where they can view reports showing;

- Claims paid in the current period

- Current balance in the claims account
- Funding advances and repayments.

The employer can use this information to track the performance of the self-funded program against what fully insured health insurance plan to see the savings.

For plans administered by Cigna or Meritain
Employers will receive a reconciliation report from National General Benefits Solutions on a monthly basis. The report provides data on year-to-date premium versus claims expenses.

Employers can request additional reports by contacting the Account Management Team.

Servicing Existing Groups

Enrollment Periods

There are three periods when eligible employees and/ or dependents are allowed to enroll for coverage:

1. Initial Enrollment
2. Special Enrollment
3. Annual Open Enrollment

Initial Enrollment
The initial enrollment period refers to the period when new groups are enrolling for coverage under the Self-Funded Program. All employee enrollment forms must be received during the underwriting process. Once a group has been issued, the Initial Enrollment period is closed.

After the Initial Enrollment period, eligible employees and/or dependents may only apply within the standard guidelines of Special Enrollment or during the Annual Open Enrollment period.

Special Enrollment
Special enrollment refers to a period when eligible employees and/or their eligible dependents may apply for coverage under the plan. Employees and/or dependents may enroll for coverage during this period if they have:

- Satisfied the groups employment waiting period or;
- Have a Qualifying Life Event (QLE).
  - An employee who experiences the QLE must enroll in order for other family members to qualify for special enrollment.

Special Enrollment periods are for*:*

1. Eligible employees who have satisfied their waiting period
2. An employee, spouse, or dependent child who waived coverage during Initial or Annual Enrollment Periods because of other health insurance, and loses that coverage due to one of the following reasons:
   - Legal separation
   - Divorce
   - Death
   - Termination of employment
   - Reduction in the number of hours of employment
   - Employer contributions toward the other coverage has terminated
   - Any loss of eligibility
   - No longer resides or works in the service area and no other benefit package is available
   - Cessation of dependent status (employee is also entitled to special enrollment period)
   - Plan no longer offers benefits to the class of similarly situated individuals that includes the individual

   Documented proof of Loss of Coverage for Qualifying Life Events must be submitted.

   Nonpayment of premiums, voluntary termination of coverage, or termination of coverage for cause, do not trigger a special enrollment period.
3. An employee, spouse, or dependent child who waived coverage when previously offered due to COBRA or mandated state continuation coverage and that coverage has been exhausted.
4. One of the following Qualifying Life Events occur:
   - Marriage
   - Birth
   - Adoption
   - Legal guardianship
   - A court orders coverage to be provided for a dependent

   When a QLE occurs, employees and their dependent(s) are eligible to enroll.
5. An employee or dependent has a loss of, or eligibility for, a Medicaid plan or State Children's Health Insurance Program (SCHIP).

Annual Open Enrollment

For each subsequent plan year, an annual open enrollment period is offered. The annual open enrollment period runs 30 days prior to the group's annual effective date. During this time, eligible employees may enroll in coverage, provided they have satisfied the employment waiting period. Enrollment requests received after the group's annual effective date will be denied.

> Note: Enrollment forms should not be completed and/or submitted prior to the employee's date of full-time employment

Employees/dependents are billed based on their effective date of coverage.

For plans administered by Allied:

- If the effective date is the 1st through 10th of month – they are billed for entire month.
- If the effective date is the 11th through end of month – they are billed the beginning of the following billing month.

For plans administered by Cigna or Meritain:

- If the effective date is the 1st through 15th of month – they are billed for entire month.
- If the effective date is the 16th through end of month – they are billed beginning of the following billing month.

Adding Employees and Dependents

An employee or dependent that meets the eligibility requirements can enroll for coverage by submitting a completed, signed, and dated employee enrollment form, including completion of all medical questions.

Effective Dates of Coverage for Additions

The assigned effective date for an applicant depends on the date the enrollment request is received by National General Benefits Solutions and is subject to underwriting approval.

Please review the effective date assignment rules listed under the following Special Enrollment section.

Effective dates will fall on the first day of the group's billing month unless otherwise noted.

Special Enrollment

1. Newly eligible employees and their dependents, upon satisfaction of the employment waiting period (excludes groups with a 90 day enrollment 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
2. For groups with a 0-day employment waiting period, newly eligible employees and their dependents 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 the effective date
3. 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
4. For marriage, the eligible employee and their dependents are eligible for one of the following effective dates:
   - Date of marriage, when the enrollment request is received within 61 days of the date of marriage; or
   - First day of the billing month following the date of marriage, when the enrollment request is received within 61 days of the effective date
5. Newly eligible dependents due to birth, adoption/ placement, or legal guardianship are eligible for the following effective date:
   - Date of birth, adoption/placement, or legal guardianship granted by a court, when the enrollment request is received within 61 days of the date of birth, adoption/placement, or legal guardianship granted by a court

   If the enrollment request for a newborn is received beyond the allotted time frame listed above, the dependent may be covered for a limited time period from the date of birth, according to the contract provision. There are no provisions for adopted children or guardianships if they enroll late.
6. Newly eligible dependents due to a Medical Support Court Order are eligible for one of the following effective dates:
   - Date of the Medical Support Court Order, when the enrollment request is received within 61 days of the date of the medical support court order; or
   - First day of the billing month following the court order, when the enrollment request is received within 61 days of the effective date

   If the enrollment request is received beyond the allotted time frame listed above, the dependent will be enrolled for only the first 31 days from the date of the court order.

7. For loss of, or eligibility for, a Medicaid or State Children's Health Insurance Program(SCHIP), the employee/dependent(s) are eligible for the following effective dates:
   - Date of eligibility for Medicaid or SCHIP coverage.
   - Date of loss of Medicaid or SCHIP coverage.

   The enrollment request must be received within 60 days of the loss of, or eligibility for, Medicaid or SCHIP coverage.
8. For all other qualifying events (see Enrollment Periods section), the eligible employee and their dependents are eligible for one of the following effective dates:
   - Date of the qualifying event, when the enrollment request is received within 31 days of the date of the qualifying event; or
   - First day of the billing month following the qualifying event, when the enrollment request is received within 31 days of the effective date.

Annual Open Enrollment
Employees and dependents may only enroll during the annual open enrollment period, unless they otherwise qualify for Special Enrollment.

- Employees must have satisfied the group's employment waiting period in order to enroll in coverage.
- The enrollment request must be received within 30 days prior to the annual effective date. Those received after that date must wait until the next annual open enrollment period.
- The effective date for an individual enrolling during the annual open enrollment period will be that of the group's annual effective date.

When one of the following situations occurs, the enrollment will be postponed and the employee or dependent must enroll during the annual open enrollment period:

1. An employee who was eligible to enroll at initial enrollment and did not enroll at such time.
2. For newly eligible employees, the enrollment request was received more than 31 days following the first available effective date.
3. For newly eligible dependents (marriage, birth, adoption/ placement, legal guardianship, medical support court order), the enrollment request was received more than 61 days following the first available effective date.
4. For all other qualifying events, the enrollment request was received more than 31 days following the first available effective date.

Plan Coverage Changes

Employers may request a change to their self-funded employee plan only at time of reissue (annual effective date). Requests to change policy year are not allowed. This is selected at the time of initial group submission only.

For plans administered by Allied:
Employee requests to change plans (if the employer offers multiple plan options) are allowed as defined below:

- Groups with a calendar year deductible: employees can change plans at time of reissue or January 1 (or January 15th, depending on billing cycle)
- Groups with a policy year deductible: employees can change plans at time of reissue

For plans administered by Cigna and Meritain:
Plan changes are only allowed on the annual effective date (reissue date).

- All change requests should be submitted in writing, signed and dated by the employer
- The monthly cost adjustment will appear on the next billing notice after the change is processed
- A change to a health benefit plan is effective the first day of the billing month following the date the request is approved
- A change to a health benefit plan with a higher level of benefits (e.g., upgrading from the 50/ 50 plan to the 80/60 plan) may need approval by the Underwriting Department

COBRA Coverage

Self-funded plans must comply with the COBRA Continuation mandate. COBRA Continuation mandate applies to groups with 20 or more employees.

Billing for COBRA Premium

For plans administered by Allied:
Both the employer and member on COBRA will be billed for the premium. When the employee pays their premium, a reimbursement check will be sent to the employer at the end of the month.

Note: In situations where the employer has paid the premium but the member hasn't, no claims will be paid for that member if they haven't remitted their premium yet. The member's paid--to-date must be current for claims to be processed.

For plans administered by Cigna or Meritain:
When COBRA administration is elected, the COBRA administrator will bill and collect premium directly from the member. When COBRA administration is not elected, the member is billed on the monthly invoice and the employer is responsible for collecting the COBRA premium from the member.

New Policy Periods

Stop-Loss Premium
Employers may receive an offer for a subsequent stop-loss policy period following each year of coverage. Rates for this policy period reflect:

- Claims experience
- Changes in health status of members of the employer's group
- Changes in coverage
- Changes to the makeup of the group, including age increases, census changes and other objective differences
- In addition, changes in the experience and characteristics of the overall stop-loss block are considered.

Subsequent policy periods do not represent a renewal, but an issuance of a new stop-loss policy.

Claims Account
Required claims account contribution is adjusted at the start of the new plan year based on changes in anticipated claim costs for the coming year.

For plans administered by Allied:
Employers who have unused funds in their claims account will receive a percentage of those funds back in the form of a check when the run-out period expires.

For plans administered by Cigna or Meritain:

- Groups that reissue with us will be credited on a future invoice
- Groups that terminate coverage will receive their credit in the form of a check

Administration Costs
The fee charged by the TPAs for claim administration, customer service and other services may be adjusted annually.

National General Benefits Solutions may adjust charges for underwriting services, medical management, which includes precertification, utilization review and other claim-related services, and other services. These changes will be reflected in the monthly billed administration fees.

Program Terminations

An employer group's stop-loss coverage and participation in the Self-Funded Program can be terminated upon notice for any of the following reasons:

- Any portion of the monthly payment is not received by the TPA on the due date
- The number of employees insured in a group is fewer than the contract or state requirements
- There is evidence of fraud or misrepresentation
- There is non-compliance with plan or stop-loss policy provisions
- The business is no longer engaged in the same business that it was on the date the plan was effective
- The group fails to meet participation requirements
- All stop-loss coverage in the state in which the group is located is terminated
- The business moves to a state where the Self-Funded Program is not offered
- The group submits a voluntary 31 day advance written request for termination
- Termination of the group's arrangement with the TPA, unless approved by us

The Patient Protection and Affordable Care Act (PPACA) added restrictions on the rescission of coverage, which is defined as a cancellation or termination of coverage that has a retroactive effect. PPACA prohibits plan sponsors and issuers from rescinding coverage unless there is fraud or intentional misrepresentation of a material fact. This requirement is not limited to rescission based on misrepresentation of medical history. It also includes retroactive terminations of coverage in the "normal course of business."

> For example, if an employee is enrolled in a plan and makes the required contribution, their coverage cannot be retroactively terminated even if the employee was mistakenly enrolled and is not eligible for coverage. The employee's coverage can only be terminated on a future date.

Early/Mid-year Terminations

In the event the employer's stop-loss coverage terminates mid plan year, the date of termination becomes the end of the policy period. The run-out period will commence on the termination date.

The full specific and aggregate limits remain in effect for the shortened policy period.

In cases where the aggregate limit has been adjusted due to changes in the number of covered participants under the plan, the aggregate limit in effect as of the termination date will be determined as the average of the aggregate limit in effect for each month of the policy period.

Stop-loss benefits for eligible expenses in excess of the specific and aggregate limits and incurred before the termination date of coverage will be eligible for payment if claim has been received within the run-out period, and the specific and aggregate limits have been paid.

The employer continues to bear all responsibility for plan eligible expenses under the applicable specific and aggregate limits.

If we have provided advance funding, any outstanding advance funding amounts due will be withheld prior to the return of any funds due back to the employer. If such funds are insufficient to satisfy the amounts owed to us, all remaining outstanding advance funding must be repaid to us by the end of the run-out period.

Any expenses incurred by the plan, after the policy termination date, are not eligible expenses and are not eligible for claims under the stop-loss policy.

Web Portals

Each of the administrators; Allied, Cigna, and Meritain provide a member portal for ease of administration. The web portals can be accessed through the National General Benefits Solutions website at www.ngbsselffunded.com/members

For business being administered by Allied, the TPA portal is available to agents, employers, and members.

Below is an outline of information available on the Allied portal:

- Agents and Employers have access to:
  - View ID cards
  - View invoices and other plan documents, such as the Summary Plan Descriptions and Summary of Benefit Coverage
  - View group reports such as claims summary and census reporting
  - View monthly Claims Account summaries
  - Access preferred provider networks and pharmacy provider links
  - Find in-network doctors and hospitals
- Members have access to:
  - Check claims status
  - View ID cards and other plan documents
  - Find in-network doctors and hospitals
  - Estimate costs of provider services and prescription drugs
  - Compare providers

For business administered by Cigna or Meritain, the Benefitsolver enrollment portal is available to agents and employers to:

- View invoices and other plan documents, such as the Summary Plan Descriptions and Summary of Benefit coverage
- View group census reports
- Process member terminations
- Check eligibility status
- Download enrollment forms

Agents and Employer's should contact the Account Management Team for documents not available on BenefitsSolver.com

Members have access the TPA's member portals to:

- Check claim status
- Get cost estimate
- Find in-network doctors and hospitals

For plans administered by Cigna, members should go to:

- www.mycigna.com

For plans administered by Meritain, members should go to:

- www.mymeritain.com

Customer Service

For general plan administration and to access administrative forms, agents and employers can contact our NGBS Account Support Specialist Team

Hours (Central time):

- Monday through Friday: 8:00 a.m. to 5:00 p.m.
  - Call (888)659-1859
  - Email: NGBSSelfFunded@ngic.com

All Underwriting inquiries should be sent to the Underwriting Department via:

- Fax: (763)577-4921
- Email: sfunderwriting@ngic.com

For questions regarding Marketing Fees

- For Allied business
  - Call (888)292-0272
  - Email NGBS.commissions@alliedbenefit.com
- For Cigna or Meritain business
  - Call (888)659-1859
  - Email ngbsselfunded@ngic.com

Marketing Materials

Available for download on the National General Benefits Solutions website at www.ngbsselffunded.com

TPA Member Services:

ALLIED

Hours (Central time):

- Monday through Thursday: 7:30 a.m. to 7:00 p.m.
- Friday: 8:00 a.m. to 5:00 p.m.
- Saturday: 9:00 a.m. to 12:00 p.m.

Phone: (888)292-0272

CIGNA

Hours

- Customer service reps are available 24 hours a day/7 days a week

Phone: (800)244-6224

MERITAIN

- Customer service reps are available 24 hours a day/7 days a week

Phone: (800)925-2272

National General Benefits Solutions
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National General Holdings Corp. (NGHC) is a publicly traded company with approximately $2.5 billion in annual revenue. The companies held by NGHC provide personal and commercial automobile insurance, recreational vehicle and motorcycle insurance, homeowner and flood insurance, self-funded business products, life, supplemental health insurance products, and other niche insurance products.

National General Benefits Solutions (NGBS), a part of NGHC, markets products underwritten by Time Insurance Company, National Health Insurance Company, Integon National Insurance Company and Integon Indemnity Corporation. National Health Insurance Company, Integon National Insurance Company and Integon Indemnity Corporation have all been rated A- (Excellent) by A.M. Best Rating Services, Inc. Each underwriting company is financially responsible for its respective products.

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