



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 and issued by Time Insurance Company and National Health Insurance Company.

National General Benefits Solutions Self-Funded Program

The Self-Funded Program is an exciting approach to self-funding a health benefit plan for small business employers. National General Benefits Solutions is a market leader in offering solutions to the health benefit needs of small-business employers.

While we have made every effort to provide you with complete and current information about the administration of your Self-Funded plan, this guide is subject to change without notice. Active policies and procedures will take precedence over the information contained in this guide.

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 thoroughly and to use it as a working reference in answering questions and servicing group business. If you need additional information or the manual does not address an issue, please contact your National General Benefits Solutions representative for further direction. Please note that this manual is subject to change without notice. A complete and updated copy of the current manual is available and can be downloaded from Find a Form on TICagent.com. Select Self-Funded as the line of business, and then select your state.

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 for these self-funded plans is underwritten and issued by Time Insurance Company.

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

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

The 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.

Table of Contents

Overview

What is the Self-Funded Program?	4
Providing the Opportunity to Benefit	4
Providing Accurate Information	4

How the Self-Funded Program Works

Self-Funding Combined with Stop Loss Insurance	4
What are the Employer’s Costs?	4
Maximum Cost	5
What if Claims are More than the Balance the Employer has Contributed?	5
Products and Services	5
The Insurance Company	5
Allied Benefit Systems, Inc. (Allied): Administrative Services	5
Key Features: Employer Stop Loss Insurance	5
Aggregate Stop Loss Benefit	5
Specific Stop Loss Benefit	6
Rate and Deductible Guarantee	6
How are Aggregate, Annual Employer Contributions and Specific Stop Loss Limits Determined?	6
Key Features: Self-Funded Benefit Plan	6
ERISA and State Mandated Benefits	6
Provider Network Access	6
Pharmacy Benefits	6
Key Features: Pre-Certification and Utilization Review (UR)	6
Key Features: Optional Health Savings Account (HSA) Plan	6
Key Features: Optional Health Reimbursement Arrangement (HRA) Plan	6

Quoting and Selling Self-Funded Programs

Simple to Quote	7
What’s in the Quote?	7
Quoting Very Small Groups	7
Presenting the Case	7
Evaluating Groups: Underwriting and Sales Support	7
Submitting a Case	8

Underwriting Guidelines

Plan Effective Date	8
Responsibility for Monthly Costs	9
Participation Requirements	9
Valid Waivers	9
Waiting Periods	9
Medical Underwriting Standards	9

Eligibility

Gathering Requirements	10
Group Eligibility	10
Employee Eligibility	10
Independent Contractors	11

Carve Outs	11
Employee Only and Dependent Only Coverage	11
Husband and Wife Employment	11
Dependent Eligibility	11
Adopted Dependents	11
Avoid Delays	11
Accepting and Declining Groups	12
Issuing a New Group	12
Cost	12
Workers’ Compensation	12
Continuation Coverage	12
Medicare Eligibility/TEFRA	13

Financial and Billing

Monthly Payment by the Employer	13
Claims Account	13
Employer Fund Accounting	13
Commission Payments	13

Claim Submission and Service

Advance Funding Provision	13
Deductible Credit	13
Health Benefit Plan Claim Submission	13
Health Benefit Plan Claim Payment	14
Prescription Claims	14
Stop Loss Claims	14
Health Plan Management Reports	14

Servicing Existing Groups

Enrollment Periods	14
Initial Enrollment	14
Special Enrollment	14
Annual Open Enrollment	15
Adding Employees/Dependents	15
Effective Dates of Coverage — Additions to Existing Group	15
Special Enrollment	15
Annual Open Enrollment	16
Plan Coverage Changes	16
Continuation Coverage	16
Billing for Continuation Premium	17

New Policy Periods

Stop Loss Premium	17
Claims Account	17
Administration Costs	17
Termination	17
Early/Mid-year Termination	18

Website Portal

Customer Service

Overview

What is the Self-Funded Program?

The Self-Funded Program is a self-funded health benefit program providing small group employers with a convenient and secure opportunity to save on health care expenses for their employees and dependents. Employer health plans established and funded by individual employers are governed by federal law. The Self-Funded Program brings together products and services from various sources needed by small group employers to establish and administer their self-funded health plans. This program is intended for use by employers with a minimum of five employees.

National General Benefits Solutions is committed to offering quality services to help small group employers obtain the best health care financing for their needs and circumstances.

Providing the Opportunity to Benefit

Self funding provides employers with the ability to pay for those benefit options selected. With the Self-Funded Program, a small business employer may save substantially by offering a self-funded plan and protecting business assets with stop loss insurance. It's an affordable option for clients, and an advantageous option for your portfolio.

The Self-Funded Program includes unique features to meet employers' needs for convenience and security. Please see the following discussion, "How the Self-Funded Program Works," for product details.

Providing Accurate Information

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.

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 plan sanctioned under 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 benefits 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, so even if a group's claims become larger than projected, the employer's financial risk does not increase. These amounts, respectively, are called the "aggregate deductible," and the "specific (for each covered individual) deductible."

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. This monthly billed amount covers all financial responsibilities for their employer plan. The monthly billing amount 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 such administrative services as customer service, claims administration, agent commissions, 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 remain in the 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 during calendar years 2013 through 2019
- The Transitional Reinsurance Program Assessment Fee, imposed by PPACA and used to fund the transitional reinsurance program, which is designed to help stabilize premiums for coverage in the individual market during calendar years 2014 through 2016

Allied will provide the count the employer should use when doing this tax filing each year.

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 (percentage varies by state).

What if Claims are More Than the Balance the Employer has Contributed?

At times, covered claims can exceed the amount the employer has deposited in the employer claim account maintained by Allied. In this case, the stop loss policy advances the amount of the shortfall. Ordinarily, advances are repaid from deposits made into the employer's claim account 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

National General Benefits Solutions and Allied both bring resources and expertise. Product and administrative systems integrate the roles they each play into 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 Insurance Company

The following products and services are provided by Time Insurance Company:

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

Allied Benefit Systems, Inc. Administrative Services

Allied is a licensed third-party administrator that administers employer plans of all sizes.

Allied provides:

- ERISA plan documentation for employer plans
- 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 and HIPAA administration
- Customer service (for employers, employees, medical providers and producers)
- Health plan management reports that assess the Plan's performance
- HRA and HSA administration

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 for the employer's health benefit plan. 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 deductible is equal to the employer's total contribution to the claims fund for the plan year. It's calculated based on a census of the group, and based on the total expected claims for the plan year for all group members. If the group's overall claims for the plan year exceed the aggregate deductible, our stop loss insurance covers the employer, via a deposit into the employer's claim account, for the cost of the group's claims for the remainder of the plan year. (See "Financial and Billing" on page 12.)

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 deductible — a preselected level chosen by the employer — our stop loss insurance covers the employer for the remaining portion of that member's claims for the plan year, via a deposit into the employer's claim account.

Rate and Deductible Guarantee

Stop loss premium rates, annual employer contribution and specific deductibles may be guaranteed for one year at a time (subject to adjustments for changing plan census, plan changes and other plan-initiated changes). Guarantee terms and periods appear in the Schedule of Insurance of the stop loss policy.

Applicable rate guarantees are shown on the stop loss policy's Schedule of Insurance. Composite rates determined at issue or reissue may be changed mid-plan year only upon employee census change of more than 20%. We can reserve the right to change composite rates when:

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

How are Aggregate, Annual Employer Contributions and Specific Stop Loss Limits Determined?

Group plan information is entered into a financial model that calculates the plan's expected claims. Expected claims may be adjusted based on medical underwriting prior to a final rate offer. The employer's monthly 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.

Key Features: Self-Funded Benefit Plan Templates

National General Benefits Solutions has designed a variety of PPO plan template options to fit almost any small employer's needs. Plan designs are based on the most popular plans sold through the Self-Funded Program markets and have been refined based on suggestions by producers.

ERISA and State Mandated Benefits

Self-funded employer plans are not required to offer coverages mandated by state law, however, federal law mandates do apply. Despite their exemption from state mandated benefit laws, the 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. Because these plans include no gatekeeper requirements, no referral is necessary to see specialist providers.

Pharmacy Benefits

The Self-Funded Program offers network pharmacy benefits through CVS Caremark, which 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 health sales site at TICagent.com.

Key Features: Pre-Certification and Utilization Review (UR)

Medical management staff can be reached through the Self-Funded Program's toll-free phone line. Medical management policies and procedures are URAC-certified and comply with new Department of Labor ERISA claim payment rules.

Key Features: Optional Health Savings Account (HSA) Plan

An optional HSA plan is offered with high deductible plan options designed to comply with federal requirements. Essentially, an HSA plan is a tax-advantaged health plan that can make health insurance more affordable. An HSA plan includes our low-cost, high-deductible plan and a tax-favored* HSA that can be used to offset the deductible. With an HSA plan, a group could enjoy extensive health care expense coverage plus all the cost-saving benefits of self funding.

Key Features: Optional Health Reimbursement Arrangement (HRA) Plan

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.

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

These specified expenses can include copays, deductibles, wellness and more. 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 size group
- Able to self fund and split the funding on a portion of the deductible
- The employer creates a more attractive package for employees who may be reluctant to accept a high-deductible plan

Note: All forms must be completed and submitted to Allied before any claim payment can be generated.

Quoting and Selling our Self-Funded Programs

This section contains information and answers to frequently asked questions about quoting and submitting new business. It is intended to provide step-by-step advice to make your job easier. However, our sales support staff is available to answer questions and help assess business situations.

Simple to Quote

The Self-Funded Program has a web-based proposal system for self-funded proposals. Proposals will be run by the National General Benefits Solutions sales representative supporting your territory and emailed to your office. Please contact your sales representative for more information about the proposal process.

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
- Administration cost
- Monthly claim account funding
- Aggregate and specific deductibles
- Group rate
 - Rates per employee and coverage requested
 - Composite rate – single, employee and spouse, employee and children, family

Quoting Very Small Groups

If the quote shows aggregate and specific deductibles 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 deductible allowed by law. In such a case, the aggregate deductible cannot be set lower than the specific deductible. Therefore, the group would be required to fund the amount shown, even though it is likely the group would save substantially, based on its actual claims. This situation is less likely as the number of employees, spouses and other dependents grows and where more expensive coverage is chosen.

Presenting the Case

You know your clients' needs and motivations best. However, many agents who have become successful with the Self-Funded Program follow the same general themes presenting the program to clients and prospects:

- The Self-Funded Program can offer a great savings opportunity
- Self-funding has saved money for other small groups — in 2013, 50% of National General Benefits Solutions (Time Insurance Company) groups received a refund at the end of their plan year

Evaluating Groups: Underwriting and Sales Support

If you are unsure whether a group will qualify when underwritten, our underwriters will prescreen particular conditions or answer questions for you or your clients. We are committed to helping you become familiar with our underwriting criteria and process (see the following section "Underwriting Guidelines," for details).

Our underwriters are experienced with small group business and are specially trained for these plans. We have developed specific standards for underwriting. Therefore, it may be prudent to ask questions of our underwriters, even where experience suggests an unfavorable answer.

1. Target your prospects by focusing on eligible groups in the five-and-over market
2. Discuss the Self-Funded Program using the point-of-sale materials provided
3. Gather employer information needed to generate a proposal
4. Complete the proposal
5. Present the proposal along with application materials

Submitting a Case

Once a group commits to applying for the Self-Funded Program, the following items must be submitted for underwriting.

1. Employer application signed by the employer and you
2. Employee enrollment forms on all eligible employees, including any employees in the waiting period. Employees not requesting coverage must complete the Waiver of Coverage section on the employee enrollment form
3. New business proposal (quote) signed and dated by employer
4. Signed Risk Management Services Agreement
5. Signed Administrative Services Agreement
6. The employer's last State Quarterly Unemployment Withholding Form
7. Census form (24311) listing full-time and part-time employees if a State Quarterly Unemployment Withholding Form is not filed
8. Signed Network Services Agreement (if applicable)
9. The full first month's maximum payment payable to Allied Benefit Systems, Inc.
10. A copy of the employer's last bill from the current carrier
11. New York Pool Election form or New York Pool Change form.
12. Reinsurance form
13. Business Associate Agreement
14. Census Attestation signed by employer and agent

Request additional forms by contacting the Supply Department at 800.800.1212, ext. 8325

Important: Employees must allow all eligible employees to enroll in the plan regardless of their health statuses. Agents should not encourage employers to act otherwise due to the significant legal risk to the employer.

Underwriting Guidelines

Plan Effective Date

Effective dates shall begin on the first or the fifteenth of the month for all groups. Completed employee enrollment forms should be received at 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 applications are incomplete or received late. However, we will accommodate your clients to the best of our ability if applications are received late. Enrollment forms must be postmarked prior to the requested effective date in order for the employee to receive consideration for enrollment on the group's effective date.

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 complete documentation before this review can be completed. If information needed to finalize a case is not received by Underwriting 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 who intend to enroll with the group have submitted an enrollment form and are on the proposal. Enrollment forms are also required for any employees that need to satisfy the waiting period before enrolling (although they are not listed on the quote). If an employee and/or dependent does not enroll at initial enrollment, they are not eligible to enroll until the group's reissue date, unless they qualify for Special Enrollment.

If it is later discovered that relevant facts about a group, employee or dependent have been omitted or misstated, the following actions may occur once complete and correct information is submitted:

1. We will review and determine whether to change any terms of coverage.
2. If National General Benefits Solutions would not have issued coverage if the correct facts were known, coverage may be voided or terminated.
3. If the relevant facts affect the premium, an adjustment of premium back to the effective date may be made on the employer's bill.

Responsibility for Monthly Costs

The employer must contribute at least 50%* of the monthly cost for each employee. The employer may pay all or part of the monthly cost for each dependent's portion of the employees' health benefit costs at the option of the employer. The employer is responsible for all payments associated with the Self-Funded Program. Two billing options are available to choose from: automatic debit of the employer's designated account or direct billing. The employer is responsible for remitting all billed amounts when due. Subsequent monthly charges will be billed by Allied and must be submitted directly to Allied. National General Benefits Solutions representatives are not authorized to collect subsequent monthly charge amounts.

*For state variation, contact your sales representative

Participation Requirements

- Employers must have a minimum of five participating employees
- Employers must enroll at least 75% of all eligible employees after considering valid waivers or 50% of all eligible employees regardless of waivers

Valid Waivers

Comprehensive major medical coverage including:

1. Coverage under a spouse's employer group health plan
2. Coverage under an individual health plan
3. Coverage as dependent under a parent's health plan
4. Medicare
5. Medicaid / Medical Assistance
6. TRICARE
7. Coverage under an Indian Health Services Program
8. State health benefits risk pool
9. COBRA coverage
10. Peace Corp or other Federal plan
11. Public health plan of a state, country or other state political subdivision

For an eligible employee or dependent to have a valid waiver, he or she must submit satisfactory proof of the other coverage. To provide this proof, the Waiver of Coverage section of the employee enrollment form must be fully completed, and the following information must be provided:

- Reason for waiving our coverage
- The name and telephone number of the carrier providing the other coverage
- Although not required, a copy of the medical ID card of the other carrier expedites processing

Waiting Periods

Waiting periods for future employees of 0, 30, 60 or 90 days are available.

For employees in the waiting period, the employer has two options at the time of group submission: 1) enroll all eligible employees, or 2) require that all eligible employees satisfy the selected waiting period before their coverage becomes effective.

Regardless of the option chosen, at the time of group submission, an enrollment or waiver form is required for all eligible employees, including those in the waiting period. Waiting periods may be chosen for different classes of employees.

Effective dates generally fall on the first of the group's billing month. Review the Effective Dates of Coverage — Additions to Existing Groups section for complete details.

Future eligible employees must:

1. Satisfy the waiting period in effect as of their date of full-time employment.
2. Abide by the waiting period in effect as of their date of full-time employment. Waiting periods may not be waived for any employee.
3. Employees and dependents choosing to waive coverage must complete the Waiver of Coverage section of the employee enrollment form.

The waiting period may be changed once per 12-month period. The new waiting period will apply to all eligible employees hired on or after the effective date of the change.

Medical Underwriting Standards

All eligible employees and their dependents, regardless of whether they are in waiting periods or waiving coverage, must complete applications for consideration. The underwriting team reserves the right to investigate medical conditions as it considers 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 are contacted before any coverage is issued. If questions arise during underwriting, a telephone call may be made to you or the employee.

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 premium surcharge retroactive to the effective date of the group. Health questionnaires have been developed to help expedite the number of medical details post submission and minimize the need to request medical records.

The health questionnaires are listed below:

- Alcohol
- Arthritis/Fibromyalgia
- Cancer/Tumor
- Congenital Heart Conditions
- Disability
- Heart Attack, Bypass or Angioplasty
- Heart Murmur/MVP/Arrhythmias
- Heart Palpitations or Heart Valve Disease
- Neurology/Seizures
- Thalassemia
- Ulcerative Colitis

If an enrollee indicates any of these medical conditions on the employee enrollment form, have the enrollee complete the appropriate health questionnaire and submit it along with the enrollment form. You can obtain these questionnaires from our website at TICagent.com.

Eligibility

Gathering Requirements

To assist you and your client when additional information is required during the enrollment process, a member of the Requirement Team will contact the group or employees to obtain the necessary information. This is a highly qualified and customer-focused staff. The Requirement Team will work directly with the group contact and employees to obtain the requirements needed to finalize your case. Utilizing the Requirement Team not only provides you with more time, it helps to ensure compliance with privacy laws.

Group Eligibility

The Self-Funded Program is designed for employers that have no fewer than five full-time employees.

Employer groups formed primarily for the purpose of purchasing insurance are not eligible. 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. Groups that no longer meet these requirements because of census changes or other factors will be terminated.

- The business must have been in existence for a minimum of six months and be a viable business at the time of application.
- Seasonal businesses are not eligible. "Seasonal" is defined as operating fewer than six months every calendar year.

The Main Business location is where the "headquarters" is physically located unless there is a higher number of eligible employees working elsewhere at another location. In that case, the employer is allowed to choose the main location (between the headquarters location or the location with the highest number of eligible employees).

Some states require that the main location be determined strictly by the state with the highest number of eligible employees. In these states, the employer does not have the option of choosing the main location. Your sales representative can determine which state would be the main 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 hours (must be 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.

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

The following are not considered eligible employees under this plan (this list is not inclusive):

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

* Ask your National General Benefits Solutions representative about Short Term Medical insurance for temporary employees.

To be an eligible employee, there must be a formal employer-employee relationship that can be confirmed by demonstrating that the employer pays FICA wages and that wages are reported on federal form W-2 or a form 1099.

Independent Contractors

If the employer wants to provide health insurance 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 are both 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 insurance for only certain segments of their employees (e.g., management vs. non-management) not based on part-time status, we strongly suggest they contact their legal and tax counsel about the implications of doing so. There are 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 spouse 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 Employment

A husband and wife group, with no other employees, is not considered a small employer and 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 unmarried children of the employee who are legally listed as dependents for income tax purposes, or for whom a court order requires the employer to provide health insurance. Children must be age 25 or less. 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. Please provide legal documentation.

Avoid Delays

Below is a list of the most commonly missed items when submitting group applications. Omitting any of these items causes a delay in approval and issuance:

1. The first month's payment, payable to Allied Benefit Systems, Inc. Note: Checks are not cashed until group coverage is issued
2. A copy of the employer's most recent billing statement from the current carrier for the period up to the requested effective date
3. State Quarterly Unemployment Withholding form
4. Missing information on Employee Enrollment forms (those enrolling, in the waiting period, and waiving coverage), such as:
 - Signature
 - Date
 - Medical questions left blank
 - Details to medical questions answered "yes"
 - Waiver of Coverage section not completed
 - Employee and/or dependent's name(s), birth date and social security number.
5. Missing information on employer application, such as:
 - Signatures
 - Dates
 - City and state
6. A copy of the group proposal (form must be signed and dated)
7. Signed risk management and administrative services agreements or other required forms
8. Signed NY payor election form

Send a check for the first month's bill to:

Allied Benefit Systems, Inc.
200 West Adams Suite 500
Chicago, IL 60606
Attention: Accounting Department

Send the completed application and other required documents to your National General Benefits Solutions representative or directly to:

National General Benefits Solutions
P.O. Box 2069
Milwaukee, WI 53201-2069

Fax: 763.577.4921

Email: sfnewbusiness@ngic.com

Accepting and Declining Groups

Acceptance of groups applying for the 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 Allied 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 Self-Funded Program, the agent will be informed by a National General Benefits Solutions representative.

Note: No stop loss coverage is in effect until accepted in writing. Caution your group against canceling other health coverage until accepted for stop loss insurance.

Issuing a New Group

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

- You, as the agent, will be informed by your National General Benefits Solutions representative.
- Allied will establish the employer's plan and an email will be sent to the employer within two business days welcoming them to the new plan, which will include instructions on how to log into the **NGBSselffunded.com** website. There they'll be able to 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 as to how to access their plan information.

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 primarily on the specific benefit plans the group has selected, and other factors. These include the following, but may vary by state:

- Age of employees
- Preferred provider network chosen
- Geographic location of the business
- Eligibility of employees for Medicare coverage
- Medical history of employees and dependents
- Expected future medical claims

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 a change in rates. The monthly trend factor is built into the proposal software program.

Workers' Compensation

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

Continuation of Coverage

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

The federal agency administering the Medicare program requires administrators of group health insurance plans to provide to their insurance company the Social Security numbers for all employees, spouses, domestic partners and dependents covered by their plan. National General Benefits Solutions must request this information 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 cms.hhs.gov.

Medicare Eligibility/TEFRA

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

Groups that have had 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.

Financial and Billing

Monthly Payment by the Employer

Each month, the employer will receive a notice that their monthly invoice is available for viewing at NGBSselffunded.com. The email will come from: notifications@alliedbenefit.com. The employer is billed for the stop loss insurance premium, administrative fees and required claim account contributions.

The bill 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. If the stop loss insurance was originally effective on the fifteenth of the month, the first day of the billing month falls on the fifteenth.

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

Claim Account

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

Employer Fund Accounting

Claim account claims are segregated in the employer's name in a bank account and maintained by Allied. These accounts are the employer's property until used for authorized purposes such as 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 deductible, the employer will receive a percentage of the difference via a check (percentage varies by state).

In addition, Allied is authorized to pay stop loss insurance premiums and administrative fees from the employer's accounts.

Commission Payments

Commissions are paid weekly. Note: When a premium is paid early, the commission is not paid until the week of the due date.

Claim Submission and Service

Advance Funding Provision

Monthly 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' plan payments 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. The deductible credit does not apply to the family out-of-pocket maximum.

Health Benefit Plan Claim Submission

Participants 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. If the participant assigns benefits to the provider, Allied 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.

If an inpatient hospital stay or surgery is planned, the participant needs to follow the instructions for precertification or preauthorization, which are

included in his or her Summary Plan Description. Penalties may be incurred if a precertification is not obtained.

Health Benefit Plan Claim Payment

As the primary risk bearer, the plan is responsible for all claim decisions. Neither Allied nor the insurance company, as 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 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

At a participating pharmacy, participants will pay the appropriate copayment according to the Summary Plan Description.

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.

Log on to TIChealthsales.com to obtain a pharmacy out-of-network claim form.

Stop Loss Claims

In addition to administering the plan's claims, Allied also processes the plan's stop loss claims. Allied tracks each plan's claims payments on its system to determine when aggregate or specific limits are reached and a stop loss insurance claim needs to be filed. Under its Administrative Service Agreement with the employer, Allied 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

Employers have access through a secured website to reports showing claims paid in the current period, the current balance in the claim account, and 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 would have cost.

Enrollment Periods

There are three time periods when eligible employees and/or dependents are allowed to enroll for coverage; Initial, Special, or Annual Open Enrollment.

Initial Enrollment

Employees and dependents may enroll in coverage when the group applies for coverage with National General Benefits Solutions. The enrollment forms must be received during the underwriting process. Once a group has been issued the Initial Enrollment period is closed. Eligible employees and/or dependents may only apply during either the Annual Open Enrollment period, as indicated below, or apply within the standard guidelines of Special Enrollment.

Special Enrollment

Special enrollment refers to a period of time during which eligible employees may apply for coverage for themselves and their eligible dependents. Employees and/or dependents may enroll in coverage due to a Qualifying Life Event (QLE) or those who apply timely after satisfying the waiting period. A Special Enrollment period begins when:

1. An eligible employee has satisfied his/her waiting period.
2. An employee, spouse or dependent child who waived coverage when previously offered because of other health insurance 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

(Nonpayment of premiums, voluntary termination of coverage, or termination of coverage for cause do not allow special enrollment.)

3. An employee, spouse or dependent child waived coverage when previously offered because of COBRA continuation or mandated state continuation and that coverage has been exhausted.
4. One of the following life events occur:
 - Marriage
 - Birth
 - Adoption
 - Legal guardianship
 - A court orders coverage to be provided for a dependent

When a life event 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 Child Health Plan (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 and 30 days after the group's annual effective date. During this time, eligible employees may enroll in coverage, provided they have satisfied the employment waiting period.

Adding Employees/Dependents

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

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

Effective Dates of Coverage – Additions to Existing Group

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

Please review the effective date assignment rules below. Effective dates will fall on the first 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 ninety-day enrollment waiting period), are eligible for the following effective date:
 - a) 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 zero-day employment waiting period, newly eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date:
 - a) 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 ninety-day employment waiting period, newly eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date:
 - a) The first day following the expiration of the employment waiting period, when the enrollment request is received within 61 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:
 - a) Date of marriage, when the enrollment request is received within 61 days of the date of marriage; or
 - b) First day of the billing month following the date of marriage, when the enrollment request is received within 31 days of the effective date.
5. Newly eligible dependents due to birth, adoption/ placement, or legal guardianship are eligible for the following effective date:
 - a) 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
6. Newly eligible dependents due to a medical support court order are eligible for one of the following effective dates:
 - a) 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

- b) 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 plan or State Child Health Plan (SCHIP), the employee/dependent(s) are eligible for the following effective dates:

- a) Date of eligibility for Medicaid or SCHIP coverage.
- b) 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:
 - a) Date of the qualifying event, when the enrollment request is received within 31 days of the date of the qualifying event; or
 - b) 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/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 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 individual will be postponed and 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 marriage, the enrollment request was received more than 31 days following the first available effective date.
4. For newly eligible dependents (birth, adoption/placement, legal guardianship, medical support court order), the enrollment request was received more than 61 days following the first available effective date.

5. For all other qualifying events, the enrollment request was received more than 31 days following the first available effective date.

Plan Coverage Changes

1. Employers may request changes to their self-funded plan to offer another plan design available through the Self-Funded Program
2. Employers may request a change to their self-funded employee plan once during any 12-month period
3. Employee requests to change plans (if the employer offers multiple plan options) are allowed as defined below:
 - a. Groups with a calendar year deductible: employees can change plans at time of reissue or January 1
 - b. Groups with a policy year deductible: employees can change plans at time of reissue
4. All change requests should be submitted in writing, signed and dated by the employer
5. Request should be submitted 70 days prior to the effective date to ensure benefits are paid correctly and employees to be notified 30 days prior to the effective date of the change(s)
6. The premium adjustment may not appear on the next billing notice
7. A change to a health benefit plan is effective the first day of the billing month following the date the request is approved
8. A change to a health benefit plan with a higher level of benefits (e.g., upgrading from the 50/50 plan to the 30/70 plan) must be approved by the underwriting department

Continuation Coverage

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

In addition, employers with fewer than 20 employees are offered the same benefits as COBRA under the Self-Funded Program. Notification of continuation must be received in writing by Allied. Employees on continuation are only eligible for medical coverage. Additional information is contained in the employee's Summary Plan Description.

Billing for Continuation Premium

Both the employer and member on Continuation will be billed for the premium. When the employee pays their premium, a reimbursement check will be cut 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.

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 and changes in health status among members of the employer's group, changes in coverage and 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.

Claim Account

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

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.

Administration Costs

The fee charged by Allied for claim administration, customer service and other services may be adjusted annually.

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

Termination

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 Allied on the date it is due
- The number of employees insured in a group is fewer than two persons
- 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 it 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 written request for termination

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, his or her 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 date in the future.

Early/Mid-year Termination

In the event the employer's stop loss coverage terminates mid-plan year for any reason, 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 deductibles remain in effect for the shortened policy period.

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

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

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

If we have provided advance funding, any outstanding advance funding amounts due us will be withheld prior to the return of any funds in the employer claims account or unearned premium. 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.

After recoupment by us of any outstanding advance funding, remaining unearned policy premium and employer account balance that has been paid for periods beyond the termination date, if any, will be refunded to the employer.

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

Website Portal

A member portal is available for agents, employers and members. Agents can access this through **TICagent.com**, by selecting the self funded product tab. Employers and members can access through **NGBSselffunded.com**.

Below is an outline of information available on the website for:

Agents

- View Benefit Summary, Summary Plan Descriptions and Summary of Benefit Coverage
- View group reports such as claims summary, census and large claim
- Access to preferred provider networks and pharmacy provider links
- View claim account levels

Employers

- Check claims status
- View ID cards, invoices and other plan documents
- View claims fund reports
- Find in-network doctors and hospitals
- Estimate costs of provider services and prescription drugs
- Compare providers

Members

- 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

Customer Service

For assistance with underwriting, service or information, please contact us using the information below:

Phone

Agents [Employers/Employees]: 888.292.0272

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.

Fax

For Underwriting (new submitted groups and enrollment requests for new employees):
763.577.4921

For signed reissue group quotes, EFT requests, etc.:
312.906.8443

For paper claim submissions:
312.906.8359

For eligibility changes or questions:
312.602.6272

To submit completed Member Termination Form(s):
312.416.2860

E-mail

NGBS.claims@alliedbenefit.com

NGBS.eligibility@alliedbenefit.com

NGBS.SelfFunded@alliedbenefit.com

NGBS.commission@alliedbenefit.com

NGBS.MemberTermination@alliedbenefit.com

Mail

200 West Adams, Suite 500
Chicago, IL 60606

Website

TICagent.com

NGBSselffunded.com

Marketing Materials

Available for download, only. Go to Find a Form on TICagent.com for marketing materials.



National General Benefits Solutions

501 West Michigan
Milwaukee, WI 53203

Stop-loss insurance for the National General Benefits Solutions Self-Funded Program is underwritten and issued by Time Insurance Company and National Health Insurance Company. National Health Insurance Company (incorporated in 1965) has been rated as "A-" (Excellent) by A.M. Best.

Stop Loss Policy forms 27426, 27427, 28844, 28845

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