



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.

Self-Funded Program

A health care **financing solution**

Gain control over health care expenses, and lower your insurance costs now and for years to come, by putting a self-funded health plan to work for your small business. With self funding — directly funding your group's own claims — you pay only for the health care services your group actually uses. If your group's claims expenses are relatively low, your overall savings can be significant.

Self funding made easy

The Self-Funded Program is a set of budgeting tools that makes it easy for you to finance your small business's health care expenses. Your maximum self-funding cost for the plan year is determined up front — and rates are guaranteed not to change, subject to enrollment and benefit changes, so you'll always pay a flat monthly bill.*

Limit your business's financial exposure!

*Employer may be responsible for additional applicable state or federally mandated fees.

We bring it all together

The Self-Funded Program from National General Benefits Solutions includes three key components:



Tools and templates to assist you with establishing and maintaining your own **self-funded health benefit plan** and **claims account**, from which your group's claims are paid



Stop-loss insurance to protect you from higher-than-expected claims



Plan administration by Allied Benefit Systems, a third-party plan administrator with more than 30 years' experience in benefit plan management and administration

With the Self-Funded Program, you get all of the benefits of self funding and none of the hassles — meaning you're free to focus on your business.

The three components of the Self-Funded Program

1-2-3



1. Stop-loss insurance

Your group's claims are paid out of your claims account, which is funded by you with a portion of your monthly payments. (See page 5 for details.) But what happens if claims are larger than expected?

Stop-loss insurance protects your business's assets against larger-than-expected claims by covering you — through direct payments into your claims account — if claims for the plan year exceed pre-determined levels called *stop-loss limits*.

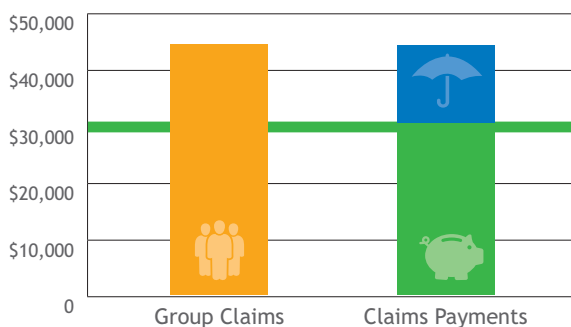
Stop-loss insurance also advances money to your claims account if the claims for any given month exceed your claims account's available balance.

There are two types of stop-loss benefits: aggregate and specific.

Aggregate stop-loss benefit

The aggregate stop-loss benefit protects you against higher-than-expected claims incurred by your **group** as a whole. The **aggregate limit** is equal to your total contribution to the claims account for the plan year. It's calculated based on a census of your group and takes several factors into account, such as the number of members, their age, gender, etc. It is 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 limit, stop-loss insurance covers you, via a deposit into your claims account, for the cost of your group's claims for the remainder of the plan year.



Aggregate Stop-Loss Example

This group has an aggregate limit of \$30,000, indicated by the green line. Claims are paid from the claims account (green bar). If the group's total claims for the plan year (orange bar) exceed the aggregate limit, stop-loss insurance covers the employer for the plan's claims costs for the remainder of the plan year (blue bar).

All examples are for illustration only.

This brochure provides summary information. Please refer to the stop-loss policy or ask your agent for a complete listing of stop-loss benefits, exclusions and terms of coverage. In the event that there are any discrepancies with the information in this brochure, the terms and conditions of the stop-loss coverage documents will govern.

Stop-loss insurance is underwritten and issued by Time Insurance Company.



Stop-loss
insurance
continued on
next page →

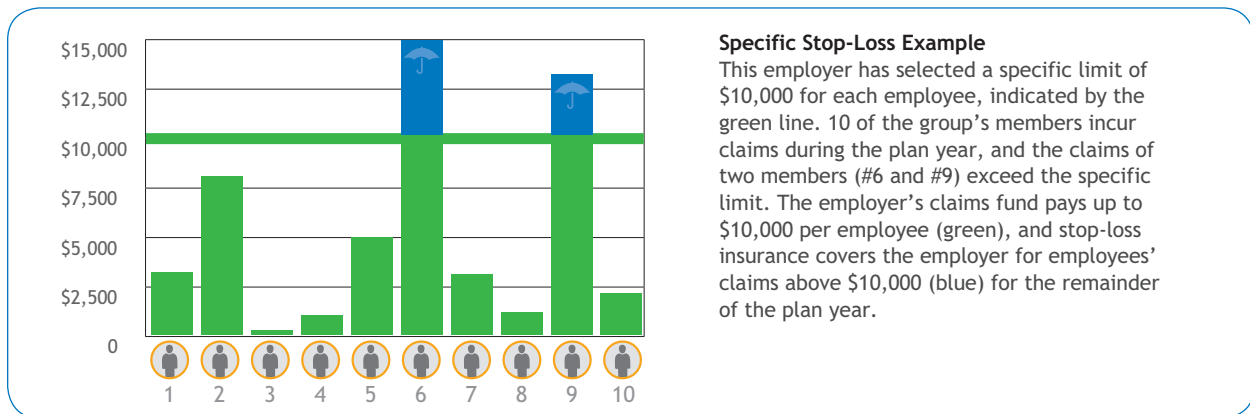


1. Stop-loss insurance, cont.

Specific stop-loss benefit

The specific stop-loss benefit protects against higher-than-expected claims by an **individual** group member. If an individual group member's claims exceed a preselected level called the **specific limit**, stop-loss insurance covers you for the remaining portion of that member's claims for the plan year, via a deposit into your claims account.

The specific limit is chosen by you, and is available in \$10,000, \$15,000, \$20,000, \$25,000, \$30,000, \$40,000 and \$50,000 levels (varies by state).



Specific Stop-Loss Example

This employer has selected a specific limit of \$10,000 for each employee, indicated by the green line. 10 of the group's members incur claims during the plan year, and the claims of two members (#6 and #9) exceed the specific limit. The employer's claims fund pays up to \$10,000 per employee (green), and stop-loss insurance covers the employer for employees' claims above \$10,000 (blue) for the remainder of the plan year.

You won't pay more than what you have planned and budgeted for!

Refund potential!

At the end of the run out period, if your group's claims are less than the aggregate limit, a portion of the difference is refunded to you. Please ask your agent for details.

Note that there is a 6-month run-out period that begins at the end of each plan year to allow for claims from that plan year to be processed. The refund is paid at the end of the run-out period.

Over 50% of our self-funding employers receive a refund!

Source: Self-Funded Program (underwritten by Time Insurance Company)
customer experience as of 2013.



2. Your health benefit plan and claims fund

Your **self-funded health benefit plan** and **claims account** make it easy for you to fund your group's claims. The plan and the fund are owned by you, the small-business employer, and you select the features and options.

There are many plan design templates for you to choose from and customize, which offer your employees options similar to what they might be accustomed to seeing with traditional fully insured plans. See the benefits chart on the next page for details.

- Your monthly payment includes a contribution to your **claims account**. The group's claims are paid out of this fund.
- Depending on how the plan is set up, the employee may have **cost sharing requirements** to satisfy, such as a deductible or coinsurance, before claims are paid from your claims account.
- You are protected from larger-than-expected claims by stop-loss insurance (pages 3-4).
- Best of all, if claims are less than the aggregate deductible at the end of the run out period, you receive cash back.





Your health benefit plan options

Build your health benefit plan

1. Choose your plan

Health plan - many deductible options and first-dollar benefits available

HSA-qualified health plan - premium savings from higher deductibles, plus tax savings from Health Savings Accounts (HSAs)

2. Choose options to build your plan

3. Add Accident Medical Expense (optional)

Pays the first covered expenses for each accidental injury at 100%. You choose the amount: \$500 or \$1,000.

Additional expenses and treatment that occurs more than 90 days after the accident are subject to the plan deductible and coinsurance.

4. Add more tax-saving vehicles (optional)

- Health Reimbursement Arrangement (HRA)
- Premium Only Plan (Section 125 Plan)

All employer-established health benefit plans are minimum essential coverage under the Affordable Care Act.

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

Accidental Medical Expense is an optional benefit available at an additional cost. It is not a voluntary supplemental product. Availability varies by state.

The self-funded health benefit plan is not an insurance product.

Choose options to build your plan

Deductible

Benefit Percentage/Coinsurance

Out-Of-Pocket Maximum

Out-of-pocket maximum includes deductible, coinsurance, office visit copays and prescription copays.

Office Visits (OV)

Prescription Drugs

Covers oral contraceptives.

If your pharmacy charges less than your copay, you pay the lesser amount. See page nine for more details.

Mail order copays are three times the selected copay for a three-month supply.

Plans without a copay include a preferred pricing card for use at participating pharmacies.

Diagnostic Imaging and Laboratory Services

MRI, CT scan, PET scan, ultrasound, EKG, chemotherapy, radiation therapy and dialysis are always subject to deductible and coinsurance.

Plan benefits

Services covered subject to deductible and coinsurance:

Preventive Care

Urgent Care

Emergency Room

Nonemergency use of an emergency room is subject to a 30% benefit penalty.

Outpatient Physical Medicine

Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, and treatment for developmental delay.

Chiropractic Care

Acute and Subacute Rehabilitation Facilities

Skilled Nursing Facility

Home Health Care

Hospice Care

Transplants

Behavioral Health and Substance Abuse

Varies by group size. Please refer to state-specific benefit comparison document.

Use our plan design templates to build a plan that best suits the needs of your business and your employees.

Health plan options	HSA-qualified health plan options
<p>Individual plan: \$500; \$1,000; \$1,500; \$2,000; \$2,500; \$3,000; \$3,500; \$5,000 or \$6,600.</p> <p>Family plan: \$1,000; \$2,000; \$3,000; \$4,000; \$5,000; \$6,000; \$7,000; \$10,000 or \$13,200.</p> <p>Options vary by state. Please see "Family Deductible Accumulations" section on page 10 for details.</p>	<p>Individual plan: \$1,500; \$2,000; \$2,500; \$2,750; \$3,000; \$3,500 or \$5,000</p> <p>Family plan: \$3,000; \$4,000; \$5,000; \$5,500; \$6,000; \$7,000 or \$10,000</p> <p>Options vary by state. HSA family plans have two available deductible accumulation methods: OneDeductible and Individual/Family. Please see "Family Deductible Accumulations" section on page 10 for details.</p>
100%/0%, 90%/10%, 80%/20%, 70%/30% or 50%/50%	100%/0%, 90%/10%, 80%/20%, 70%/30% or 50%/50%
<p>Out-of-pocket maximums available from \$1,000 to \$6,600.</p> <p>Options vary by state.</p> <p>Family maximum is two times the out-of-pocket maximum.</p>	<p>Out-of-pocket maximums available from \$1,000 to \$6,450.</p> <p>Options vary by state.</p> <p>Family maximum is two times the out-of-pocket maximum.</p>
<ul style="list-style-type: none"> No copay — subject to deductible and coinsurance or Copay options (Primary Care Provider/Specialist): \$20/\$35, \$35/\$50 (\$30/\$50 in Colorado) or \$40/\$60 	Covered subject to deductible and coinsurance
<ul style="list-style-type: none"> No copay — subject to deductible and coinsurance <p>For prescription no-copay plans, deductible and coinsurance are applied to the total out-of-pocket maximum.</p> <ul style="list-style-type: none"> Copay options (generic/preferred brand/nonpreferred brand):* <ul style="list-style-type: none"> \$0/\$35/\$50 \$20/\$50/\$75 \$300 deductible for brand, and then \$15/\$45/\$60 or \$15/\$45/\$60 50%/50% coinsurance option <p>Options vary by state.</p>	Covered subject to deductible and coinsurance
<ul style="list-style-type: none"> Covered subject to deductible and coinsurance Paid at 100% option \$500 paid first dollar, additional costs subject to deductible and coinsurance <p>Options vary by state.</p>	Covered subject to deductible and coinsurance
Plan benefits	Plan benefits
Physician Services, Allergy Testing, Professional Air and Ground Ambulance, Outpatient Hospital/Surgical Center, Colonoscopy, Maternity Care, Inpatient Hospital and Durable Medical Equipment	
Preventive services and related office visits are paid at 100% when the service, such as a routine mammogram, well-child exam or immunization, is recommended by the United States Preventive Services Task Force, Centers for Disease Control or Health Resources and Services Administration	
<ul style="list-style-type: none"> Covered subject to deductible and coinsurance If an OV copay is selected, urgent care is subject to a \$50 copay 	Covered subject to deductible and coinsurance
<ul style="list-style-type: none"> Covered subject to deductible and coinsurance If an OV copay is selected, you may also add a \$250 ER copay (this option varies by state) 	Covered subject to deductible and coinsurance
<ul style="list-style-type: none"> Covered subject to deductible and coinsurance 	Covered subject to deductible and coinsurance
<ul style="list-style-type: none"> Limit of 20 visits per year. If an office visit copay applies, then chiropractic services are subject to the Specialist copay. Otherwise, covered subject to deductible and coinsurance. 	Limit of 20 visits per year. Covered subject to deductible and coinsurance
31-day combined benefit, subject to deductible and coinsurance	
31-day benefit, subject to deductible and coinsurance	
50-visit benefit, subject to deductible and coinsurance	
Paid at 100%	Subject to deductible, then paid at 100%
<ul style="list-style-type: none"> Covered subject to deductible and coinsurance at a designated provider \$100,000 lifetime benefit maximum per organ at a nondesignated provider 	
Outpatient: Covered subject to deductible and 50% coinsurance	Inpatient: 30-day benefit, subject to deductible and 50% coinsurance

* When a generic drug exists for a prescription medicine, there will be additional charges for the brand drug. To avoid additional costs, members should ask their doctor to prescribe the generic

Benefits and options may vary by state. Not all plan payment combinations are available.

The amount of benefits depends on the options selected, and the cost will vary with the amount of benefits. Out-of-network provisions apply. See page 10 for details.



3. Plan administration

Your plan is managed and administered by our trusted third-party administrator, Allied Benefits Systems, Inc. (Allied), with more than 30 years of experience in benefit management and administration services.

- Allied manages your claims payments, accounting, customer service and more.
- Allied offers extensive online services and monthly reports that make it easy for you and your employees to access information about your plan.

Allied takes care of the administration for you — so you're free to focus on your business.

Simplified billing

Allied simplifies your billing, too. One flat monthly payment* covers everything — your claims fund contributions, stop-loss insurance premium and administrative services. That bill is guaranteed not to change, subject to enrollment and benefit changes.

*Employer may be responsible for additional applicable state or federally mandated fees.

Allied also administers tax-advantaged options

- **To get the tax advantages of HSAs, select an HSA-qualified plan.** With an HSA, your employees have their own tax-favored savings accounts to save for qualified medical expenses.
- **An HRA gives you tax advantages and control over cash flow no matter which plan you choose.** With an HRA, you directly reimburse employees for a predesignated portion of their qualified medical expenses.
- **A Premium-Only Plan (Section 125 Plan)** allows employees to pay health insurance and other eligible premiums with pre-tax dollars and saves you money on the FICA payroll tax match.

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

More ways for you and your employees to save

No matter which options your self-funded plan includes, you and your employees will have many ways to save on health care services.



Get discounts by using doctors and hospitals in your network

Choose from an array of broad networks, with both local and national networks available — decide what's right for your group. When you and your employees use doctors and hospitals that are part of your network, you get better discounts on the services.



Pay less for prescriptions

When you fill your prescriptions at a participating pharmacy, you and your employees will pay the lowest of:

1. The pharmacy's retail price
2. Your plan's discounted rate, or
3. The amount of your copay

For example, if the discounted rate for a generic is \$22 and you have a \$15 copay, you pay \$15. But if your pharmacy's price is only \$4, then \$4 is all you pay!



Seek convenient care at retail health clinics

Time and money-saving health clinics located inside select retail stores allow you and your employees to walk in for routine care and treatment of non-emergency conditions. Your health benefit plan covers these services the same as services performed by providers in your network.



The Self-Funded Program provides tools for small-business employers to establish a self-funded health benefit plan for their employees. This program includes tools to assist employers with establishing and maintaining a self-funded health benefit plan under the Employee Retirement Income Security Act (ERISA), along with stop-loss insurance provided by Time Insurance Company, and plan administration. The benefit plan is established by the employer and is not an insurance product. Stop-loss insurance for your self-funded plan is underwritten and issued by Time Insurance Company and National Health Insurance Company.

Terms and provisions of the self-funded health benefit plan templates

Out-of-network services

If a covered person seeks non-emergency care at a doctor or hospital that is not part of your network, he or she will not receive network discounts and may incur additional expenses.

For instance, copays are not accepted by doctors and hospitals that are not part of your network, and the covered charges will be handled as any other out-of-network service — subject to the:

- Maximum allowable amount — the most the plan pays for covered services. The covered person will be responsible for any balance in excess of this amount.
- Out-of-network deductible — two times the deductible.
- Out-of-network coinsurance — typically an additional 20% of charges.
- Out-of-network coinsurance out-of-pocket maximum — two times the coinsurance out-of-pocket maximum.

Emergency care benefit

In emergency situations, covered charges will be handled as network services, no matter where services are performed. All charges are subject to the maximum allowable amount.

Affiliated provider services

As long as a covered person uses hospitals and admitting physicians that are part of your network, his/her covered charges will be handled as network services even when affiliated physicians and other health care providers (e.g., radiologists, anesthesiologists, pathologists or surgeons) are not part of your network. All charges are subject to the maximum allowable amount.

Family deductible accumulations

Individual/Family

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

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

OneDeductible

Covered expenses for all family members accumulate toward the family deductible, and benefits begin for all family members once that amount is reached.

Utilization review

When inpatient treatment is needed, the covered person is responsible for calling Time Insurance Company to receive authorization. The toll-free telephone number appears on your ID card. If authorization is not received, a penalty of 30% of the charge up to \$1,000 could be applied. No benefits are paid for transplants that are not authorized. Authorization is not a guarantee of coverage.

Out-of-pocket maximums

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

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

Employment waiting period

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

New Hires

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

- First day of the billing month following the date of full-time employment, when the enrollment request is received within 31 days of this date.

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

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

Deductible credit

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

Exclusions summary

The health benefit plan templates do not provide benefits for:

- Treatment not listed in the Covered Medical Services section of the summary plan description
- Complications of an excluded service
- Charges in excess of any stated benefit maximum
- Treatment reimbursable by Medicare, Workers' Compensation or automobile carriers, or expenses for which other coverage is available
- Treatment of an illness or injury caused by acts of war, felony or influence of an illegal substance
- Routine hearing care, vision therapy, surgery to correct vision, foot orthotics, or routine vision and foot care unless part of diabetic treatment
- Dental care not related to a dental injury
- Non-surgical treatment for TMJ or CMJ other than that described in the contract, or any related surgical treatment that is not pre-authorized
- Any correction of malocclusion, protrusion, hypoplasia or hyperplasia of the jaws
- Treatment of "quality of life" or "lifestyle" concerns including but not limited to obesity, hair loss, restoration or promotion of sexual function, cognitive enhancement and educational testing or training
- Charges for cranial orthotic devices, except following cranial surgery
- Charges for medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the Diabetic Services provision in the Medical Benefits section
- Charges for devices or supplies, except as described under a Prescription Order
- Charges for cosmetic services including chemical peels, plastic surgery and medications
- Charges for prophylactic treatment
- Charges related to health care practitioner-assisted suicide
- Charges for custodial care, private nursing, telemedicine or phone consultations
- Charges for growth hormone stimulation treatment to promote or delay growth
- Charges for diagnosis and treatment of infertility, sex transformation, surrogate pregnancy or sterilization reversal

Exclusions summary, cont.

- Charges for umbilical cord storage, genetic testing, counseling or services
- Charges for treatment of behavioral health or substance abuse, except as otherwise covered in the Behavioral Health and Substance Abuse provision in the Medical Benefits section
- Charges for testing and treatment related to the diagnosis of behavioral conduct or developmental problems
- Charges for alternative medicine, including acupuncture and naturopathic medicine
- Charges for chelation therapy
- Charges for treatment, services, supplies or drugs provided by or through any employer of a Covered Person or the employer of a Covered Person's family member
- Charges for experimental or investigational services
- Charges for drugs not approved by the FDA
- Charges for over-the-counter drugs (unless recommended by the United States Preventive Services Task Force and authorized by a health care provider), drugs obtained from sources outside the United States, and the difference in cost between a generic and brand name drug when the generic is available

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

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

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.

Not for use in Massachusetts.

Stop-loss Policy Forms: 28844 and TSLP.POL.XX

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