See plan inserts for specific product details and plan options

Self-Funded Program

A health-benefit program designed for your small- to medium-sized business

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

NGBSBrochure

National General
Benefits Solutions

Big-business benefits. Small-business price.

The National General Benefits Solutions Self-Funded Program lets you enjoy the benefits of self-funding while we handle the details

Rethinking your employee health-benefit plan? Directly funding your own health-benefit plan can help you control your group's health care costs — now, and for years to come.

Not only does our Self-Funded Program usually cost less than a more traditional health benefit plan, it's built to ensure your savings continue:

- Your money in your claims account goes exclusively to your group's claims expenses
- If your group's claims are less than expected, your savings can be significant
- If your group's claims are larger than expected, stop-loss insurance protects your finances
- You have the opportunity to receive money back if you don't use all the funds from your claims account

By choosing our Self-Funded Program, you gain access to our unique, complete package of services and insurance protection that takes the uncertainty and guesswork out of self-funding:

✔ Expert guidance

Our experienced Sales and Account Management Teams offer you and your agent marketplace expertise to ensure you're getting the plan that's best for your group and provide the plan-administration support you need

✔ Flexible benefit options

We help you select your health benefit plan options from a wide range of health-plan designs to fit the needs of your group

✔ Compliance

- All employer-established benefit plans are minimum essential coverage, so employees will not be subject to the individual tax penalty
- Preventive services are paid at 100% when received from in-network providers, as recommended by the Affordable Care Act

✔ One, predictable monthly payment

We determine your maximum cost for the year up-front, and your monthly costs are guaranteed not to increase for a full year as long as there are no changes to enrollment or benefits*

✔ Complete plan administration and support

Payments of claims, customer service and claims reporting is all done for you, leaving you to focus on your business

✔ Protection from larger-than-expected claims

When your group's claims are larger than expected, stop-loss insurance kicks in to protect your finances. You never have to pay more than what you planned for

* Additionally, the group must remain active for the full contract period.

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Simple. Safe. Savings.

Self funding used to be a concept only available to large employers. Not anymore.

Business owners like you enjoy the advantages of self funding. And now, with our Self-Funded Program, you get to experience those advantages without taking on added risk. It's an easy way for you to lower your costs while providing quality health care benefits to your employees.

SELF-FUNDED PROGRAM KEY ADVANTAGES:

One, predictable monthly payment

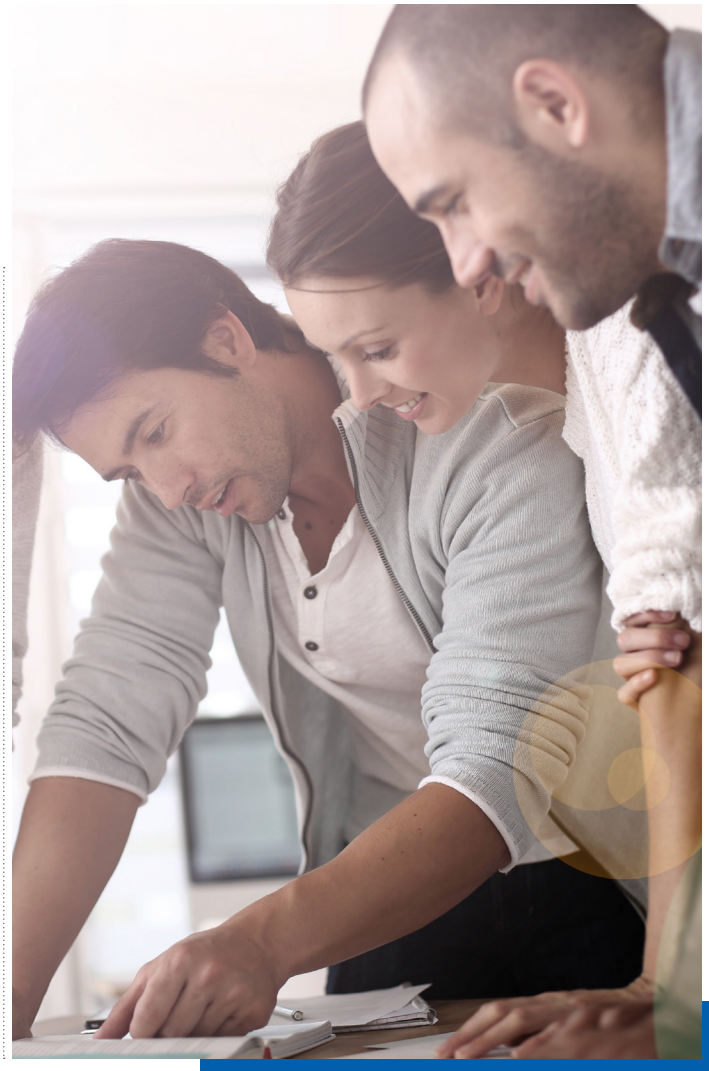
Your monthly payment is determined upfront and guaranteed not to increase for a full year as long as there are no changes to your group's benefits or enrollment

Plan administration and account management

Payments of claims, customer service and reporting is all done for you, leaving you to focus on your business

Quality benefits

- All employer-established benefit plans are minimum essential coverage, so employees will not be subject to the individual tax penalty
- Preventive services are paid at 100% when received from in-network providers, as recommended by the Affordable Care Act



Are you overpaying for group health care benefits?

Where do your premium dollars really go?

With fully insured health plans, all of your premium is paid to the insurance company. You don't have any control over how that money is spent. You won't see any of those premium dollars again, even in years when your group's claims are less than expected.

Our Self-Funded Program is different. Some of your monthly payment is used to run the daily administration of your plan, but portions of it are also used to pay your stop-loss insurance premium and to build your claims account. In years when claims are lower than expected, a portion of the difference between your group's anticipated and actual claims is credited back to you — and that adds up to significant savings.

Fully insured premium

Payments for our Self-Funded Program

How does it work?

We make it easy for you to put a self-funded health benefit plan to work for your business

For your everyday convenience, this plan behaves just like a more traditional, fully insured health benefit plan. You provide your level, monthly payment, and we handle the details.

The difference lies in where your premium dollars go. We manage your program to make sure you get the savings and simplicity you need by splitting your premium among the program's three components.

THE SELF-FUNDED PROGRAM'S THREE COMPONENTS

Plan administration

A third-party administrator handles the day-to-day functions of the program

Our third-party administrators will:

- Manage claims payments
- Provide reporting to help manage costs
- Handle your group members' customer service needs

Stop-loss insurance

When your group has higher-than-expected claims, stop-loss insurance kicks in to protect your finances

Stop-loss insurance:

- Protects your finances from higher-than-expected claims
- Helps you limit your business's financial exposure
- Includes a terminal liability rider, which protects for 12-18 months after the run-out period.[1]

Claims account

Money used to pay claims incurred during the coverage period.

Your claims account:

- Holds the funds needed to pay employees' claims
- Is protected from larger-than-expected claims with stop-loss insurance
- If your group's claims are less than expected, we refund a portion of the difference between the balance of your claims account and your group's actual claims

1 Coverage term varies based on selected run-out period duration

Your business. Your plan.

Health benefit plans with features your group will actually use

We provide flexible options to help you select the plan designs that will benefit your group the most.[2]

- Deductible options range from $500 to $7,150[3]
- Coinsurance options: 100%, 90%, 80%, 70% and 50%[3]
- Multiple office-visit copay options
- Health Savings account (HSA) and Health Reimbursement Arrangement (HRA) options available[4]
- Access to large, national networks, with discounts for using in-network doctors and hospitals
- Prescription copay options available
- Preventive care coverage aligns with Affordable Care Act requirements
- COBRA administration for all groups with more than 20 members at no additional charge
- Urgent-care and emergency-room copay options
- First-dollar diagnostic x-ray and lab options

2 Not all benefit options available with all plans
3 Availability varies by state
4 HSA and HRA availability varies by third-party administrator

National General
Benefits Solutions

Benefits available with Allied, your third-party administrator

Allied Benefits Systems, Inc. (Allied) provides your group with efficient administrative services and support

Your plan is managed and administered by our trusted third-party administrator, Allied Benefits Systems, Inc. Allied offers extensive online services and monthly reports that make it easy for you and your employees to access information about your plan.

With more than 30 years of experience in benefit management and administration services, you can rest assured knowing Allied is taking care of your group's claims payments, accounting, customer service needs, and more.

When you select an Allied plan, you get:

Plan administration

Allied handles your group's claims, customer service and claims reporting, leaving you to focus on your business

Broad network access

Your employees gain access to the Aetna® Signature Administrators PPO Network, Cigna PPO Network, First Choice Network, and more

Customer service

Allied has dedicated teams ready to help your group members get the most out of their plans

See reverse side for benefit plan details

Your health plan benefits available with Allied

All employer-established health benefit plans meet the standards set by the Affordable Care Act.

Stop-loss options

AGGREGATE DEDUCTIBLE	Based on total expected claims, calculated based on the census of your group and other factors such as number of members, age, gender, etc.
SPECIFIC DEDUCTIBLE	• $10,000 • $15,000 • $20,000 • $25,000

Group-member plan options

DEDUCTIBLE OPTIONS *Family deductible is two times the individual. Out-of-network deductible is two times the in-network deductible*	• $500 • $1,000 • $1,500[1] • $2,500[1] • $3,000[1] • $3,500[1] • $5,000[1]
COINSURANCE OPTIONS	• 100% • 90% / 10% • 80% / 20% • 70% / 30% • 50% / 50%[2]
OUT-OF-POCKET MAXIMUMS	$1,000 to $6,500 *(this includes deductible, coinsurance and copay amounts)*
OFFICE VISITS *(Primary-care physician/specialist)*	• $20 / $35 • $35 / $50 • $40 / $60 • Subject to deductible and coinsurance
CHIROPRACTIC CARE	• Limited to 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.
HOSPITAL AND SURGERY CHARGES	Applies to deductible and coinsurance
DIAGNOSTIC X-RAY AND LAB BENEFIT	• Applies to deductible and coinsurance • 100% first-dollar benefit
OUTPATIENT PHYSICAL MEDICINE	Applies to deductible and coinsurance, limited to 30 visits per calendar year
SUBACUTE REHAB & NURSING FACILITY	Applies to deductible and coinsurance, limited to 31 days per calendar year
HOME HEALTH CARE	Applies to deductible and coinsurance, limited to 30 visits per calendar year
EMERGENCY ROOM VISIT *Note: Copay waived if admitted*	• Applies to deductible and coinsurance
URGENT CARE	• $50 copay, then 100% • Applies to deductible and coinsurance
MENTAL/BEHAVIORAL HEALTH AND SUBSTANCE ABUSE	**Outpatient, groups 50 and under:** • In-network: Applies to deductible and 50% coinsurance. Limited to 40 visits per year • Out-of-network: Applies to deductible and 30% coinsurance. Limited to 40 visits per year **Outpatient, groups over 50:** • Follows plan copay, deductible and coinsurance options chosen **Inpatient, groups 50 and under:** • In-network: Applies to deductible and 50% coinsurance. Limited to 30 days per year • Out-of-network: Applies to deductible and 30% coinsurance. Limited to 30 days per year **Inpatient, groups over 50:** • Follows plan copay, deductible and coinsurance options chosen. Limited to 30 days per year
PRESCRIPTION DRUGS *(Generic/Preferred/Non-Preferred)*	**Copay options:** • $15/$45/$60 • $20/$50/$75 • $0/$35/$50 **Non-copay options:** • Apply to deductible and coinsurance
ACCIDENT MEDICAL EXPENSE (OPTIONAL BENEFIT)	• $500 • $1,000

1 Health Savings Account (HSA)-compatible options

2 Not available with Aetna® Signature Administrators PPO Network or Cigna OAP Network

Refer to your Summary Plan Description for full benefit details. Out-of-network provisions apply.

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Terms and provisions of this program

Out-of-network services *(out-of-network terms and provisions do not apply to NGBS Advantage)*

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. This applies to prescriptions that are filled by an out-of-network provider as well.

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.

Emergency care benefit for Advantage plan

Covered charges will be handled as network services, no matter where the services are performed, subject to any applicable Maximum Allowable Amounts. When the facility is out-of-network, the plan will cover the member's transfer to an in-network facility once the member is stabilized. All follow-up visits after the condition has stabilized will be treated as non-emergency treatment and services under the plan.

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.

Utilization review

When inpatient treatment is needed, the covered person is responsible for calling the 800# on the card to receive authorization. If authorization is not received, a penalty 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.

National General
Benefits Solutions

Who we are

We focus on providing small- and mid-sized employers with benefits options previously only available to large employers

Self-funding used to be a concept only available to large employers.
We're here to change that.

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 has health coverage options available in all 50 states, as well as the District of Columbia.

✔ 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

✔ Well-established financial strength

- National General is a leading provider of insurance products with more than $2.3 billion in annual revenue
- Our underwriting companies are rated as "A-" (Excellent) by A.M. Best

National General Holdings Corp. (NGHC) is a specialty personal lines insurance holding company. Through their subsidiaries, NGHC provides personal and commercial automobile insurance, recreational vehicle and motorcycle insurance, supplemental health insurance products and other niche insurance products in the U.S. and internationally. National General was built through a combination of organic growth and opportunistic acquisitions, and is expected to continue to grow through accretive M&A opportunities.

See reverse for more information

A program with the hands-on support you need

Our experienced team of sales professionals is ready to help you and your agent find the right plan

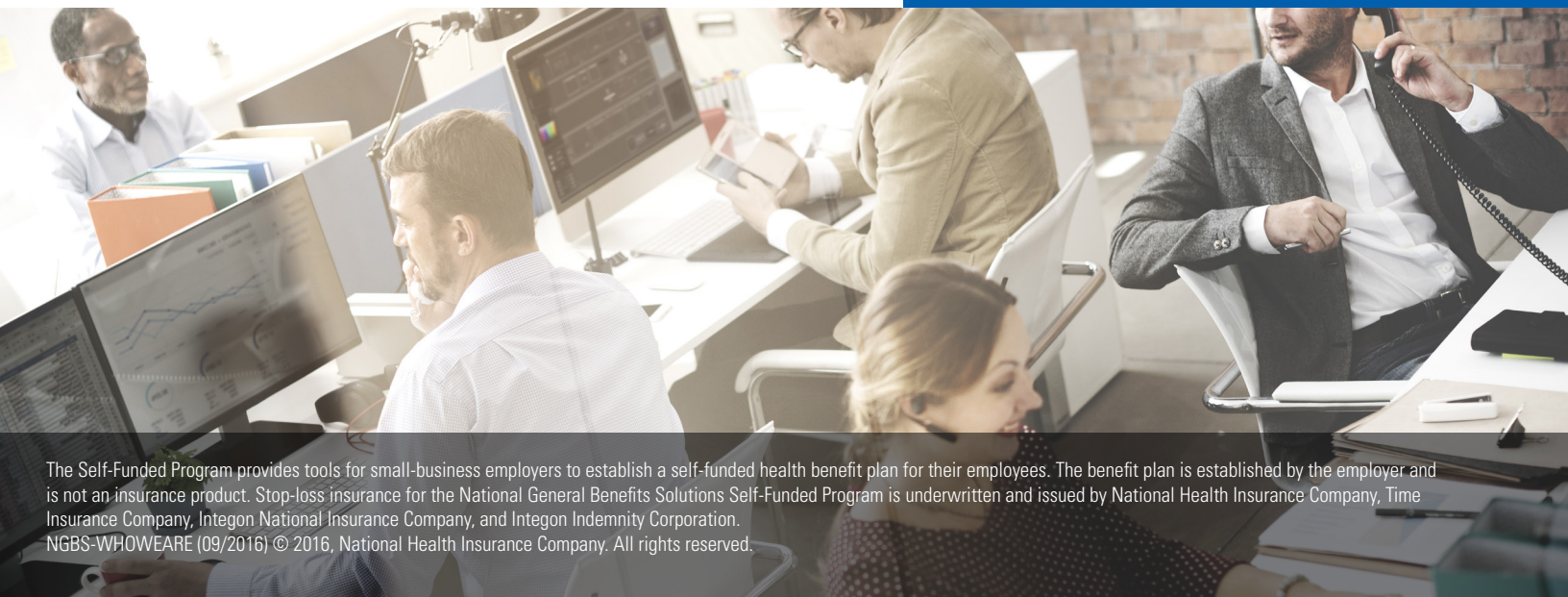
We want you to get the most savings possible out of your plan while providing your group with the benefits they need. That's why we have dedicated teams of sales and marketing professionals ready to provide you and your agent with:

- Group market and self-funded benefit plan expertise
- An easy and fast quoting process
- Direct guidance during the plan-selection process to help you get the right plan for your group

Count on our trusted team of dedicated Account Managers to keep your plan running smoothly

Our experienced team of Account Managers is ready to help answer any questions and resolve any issues. Our Account Managers support you by:

- Resolving escalated service issues
- Answering your questions and responding to your calls within 24 hours
- Assisting you through the reissue process
  - » Consultation regarding alternate plan options to optimize cost savings and benefits
  - » Rate relief options
  - » Commitment to finding the best option for your group
- Helping you understand state and federal fee requirements:
  - » We'll help you administer these fees
- Providing mid-year plan reviews to examine your claims and help you know what to expect at renewal — eliminating surprises



National General Benefits Solutions

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, is the trade name for products underwritten by Time Insurance Company, National Health Insurance Company (incorporated in 1965), Integon National Insurance Company (incorporated in 1987), and Integon Indemnity Corporation (incorporated in 1946). Together, these three companies are authorized to provide health insurance in all 50 states, including the District of Columbia, and have all been rated as A- (Excellent) by A.M. Best. Each underwriting company is financially responsible for its respective products.

NGBS is focused on providing cutting-edge benefits solutions to small and mid-size businesses.