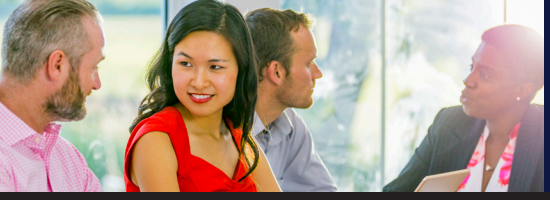


Your Search for Affordable and Quality Health Care is Over

INTRODUCING A SELF-FUNDED

EMPLOYEE BENEFITS PROGRAM

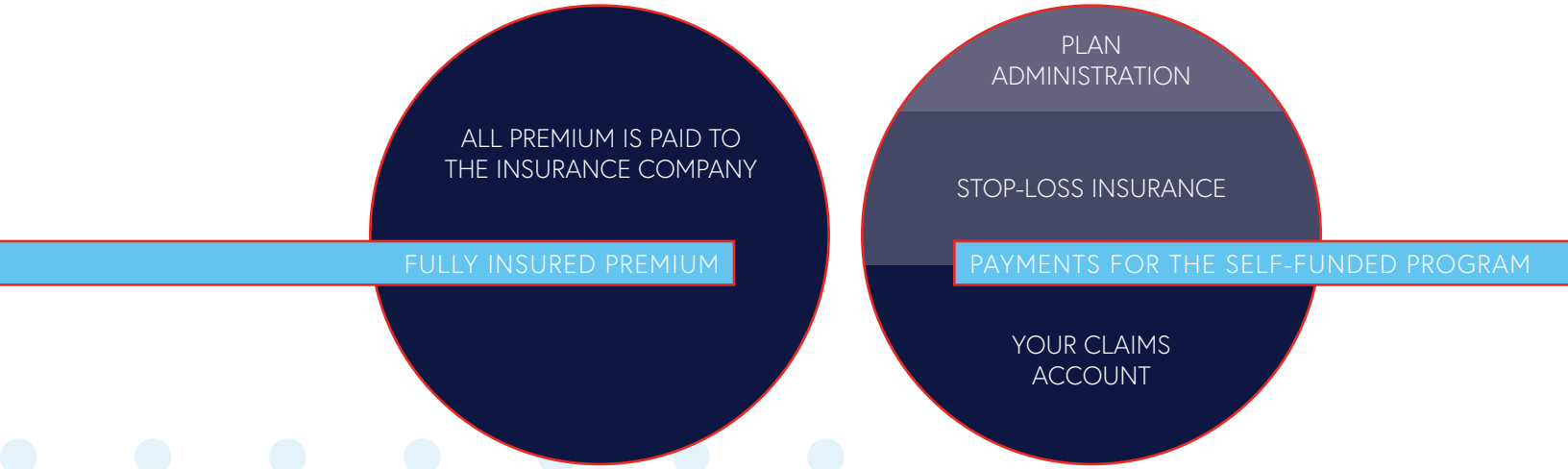
FOR SMALL GROUPS

Offered exclusively through
Vermont and NH's UBA Partner

The Richards Group
FINANCIAL, INSURANCE & HR SOLUTIONS

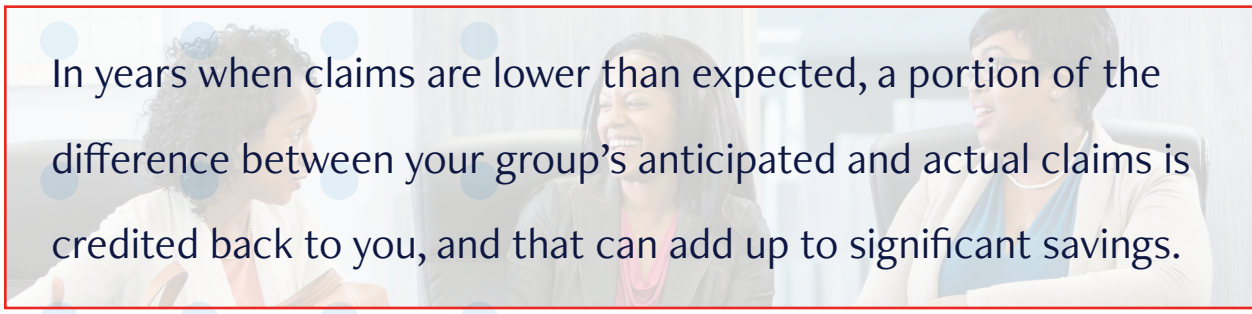
SELF-FUNDING HELPS YOU GAIN CONTROL OF YOUR HEALTH PROGRAM EXPENSES WHILE PROVIDING QUALITY BENEFITS TO YOUR EMPLOYEES. BY COMBINING THE COST SAVINGS OF SELF-FUNDING WITH THE FLEXIBILITY OF OUR PLAN DESIGNS, OUR SELF-FUNDED PROGRAM GIVES YOU QUALITY BENEFITS AND THE COST SAVINGS YOU'RE LOOKING FOR.

SEE THE DIFFERENCE



When you have a fully insured health plan, all of your premium is paid to the insurance company. You don't have 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.

When you self-fund, 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 can add up to significant savings.

LIMIT YOUR FINANCIAL EXPOSURE

National General Benefits Solutions

Stop-loss insurance provides extra protection for you and your business. When your group has higherthan-expected claims, stop-loss insurance kicks in to protect your business's finances.

Our self-funded program offers both specific and aggregate stop-loss coverage. Specific stop-loss insurance provides protection against high claims from any single individual. Aggregate stop-loss insurance provides protection against higher-than-expected claims for the entire group.

Terminal Liability Coverage provides added protection for claims that come in for 24 months after the end of the plan year.

QUALITY BENEFITS AND FINANCIAL PROTECTION ARE JUST THE BEGINNING. WE OFFER PROGRAMS AND PLAN DESIGNS TO FIT YOUR GROUP'S NEEDS.

Terminal Liability Coverage is not available in Washington, is optional on 12/12 plans, and does not apply in cases of early termination. Fees may apply. Please refer to the plan proposal for details. A Terminal Liability Reserve fee of 3% is withdrawn from the employer's claim account prior to issuing any applicable claim account refund.

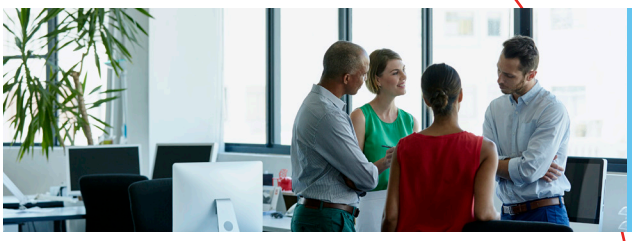
The National General Benefits Solutions (NGBS) Self-Funded Program provides tools for employers owning small- to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. Stop-loss insurance for the NGBS Self-Funded Program is underwritten and issued by National Health Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation.

SOLVED: YOUR GROUP'S HEALTH COVERAGE

OUR PROGRAM OFFERS A SOLUTION FOR EMPLOYEE BENEFITS BUILT FOR YOUR BUDGET. WITH US, YOU CAN CONTROL YOUR HEALTH CARE EXPENSES WITHOUT SACRIFICING QUALITY.

FLEXIBILITY

We offer thousands of plan designs and add-on features so you can build a health plan to fit your business model and member' needs.



PLAN MANAGERS

Our plan managers handle daily maintenance of your plan so you don't have to! This leaves you to focus on growing your business.

SUPPORT

Our teams of experienced professionals are ready to provide you and your employees top notch support before, during, and after sale.

STOP-LOSS INSURANCE

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

SOLUTIONS

WE'RE THE WHOLE PACKAGE

FROM ADMINISTRATION TO CUSTOMER SERVICE, WE KEEP YOUR PLAN RUNNING SO YOU CAN KEEP UP WITH YOUR BUSINESS.

ACCESS TO QUALITY NETWORKS

You'll have access to both national and local networks. More network options mean your employees get the health care that is right for them.

WHEN YOU WORK WITH US, YOU GET TELADOC AND VITALITY AT NO ADDITIONAL COST.

TELADOC®

A more affordable option for seeking care for common conditions, available 24 hours a day, 7 days a week.

WELLNESS

Vitality® is a simple, intuitive wellness program to promote healthy lifestyles for employees.

PRESCRIPTION BENEFITS

Cigna Pharmacy Management® offers your members tools to manage their prescription needs.

INDUSTRY **LEADERS** ARE AVAILABLE TO YOU

THE INDUSTRY'S MOST RECOGNIZED AND MARKET LEADING BRANDS ARE HERE TO SUPPORT YOUR UNIQUE GROUP HEALTH CARE NEEDS.

NETWORKS

Cigna® Preferred Provider Network

Aetna Signature Administrators®

STOP-LOSS

National General Benefits Solutions

THIRD-PARTY ADMINISTRATOR

ALLIED

HEALTH & WELLNESS

TELADOC™

Vitality™

Stop-loss insurance for the NGBS Self-Funded Program is underwritten and issued by National Health Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation.

The Cigna PPO Network and Cigna Pharmacy Benefit Management are offered through Cigna's contractual relationship with National General. Cigna is an independent company and not an affiliate of National General Benefits Solutions, Allied Benefits Systems, Aetna Signature Administrators, Clever RX, Teladoc, or Vitality. All other products are offered by or through United Benefit Advisors or these parties and are not affiliated with Cigna.

ACCESS TO **QUALITY** NETWORKS

THROUGH A NATIONAL GENERAL BENEFITS SOLUTIONS PARTNERSHIP, YOUR MEMBERS GET THE QUALITY HEALTH CARE THEY NEED WITH THE FREEDOM TO CHOOSE THEIR PROVIDER. WITH THIS PROGRAM, YOU CAN CHOOSE FROM TOP NATIONAL NETWORKS INCLUDING:

Aetna Signature Administrators®

Aetna Signature Administrators (ASA) works with leading TPAs to provide network and medical management services that complement the TPAs' administrative capabilities. ASA provides members access to a world-class health care network. It is one of the largest and most respected health benefits companies in the United States, serving over 37 million people. The Aetna PPO network is a national network with over 1.2 million health care professionals and over 6,000 hospitals participating. With ASA, your employees have a comprehensive network that's flexible and easy to use, with great discounts.

Cigna® Preferred Provider Network

Cigna is a global health services company with 165 million customer and patient relationships and more than 74,000 employees worldwide. The Cigna PPO Network* provides access to more than one million health care providers and 6,300 hospitals nationwide. Cigna is the only national health plan to achieve "Certified" status for both physician and hospital quality through NCQA's Physician and Hospital Quality (PHQ) survey.

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ACCESS TO **LOCAL** NETWORKS

IN ADDITION TO ACCESS TO QUALITY NATIONAL NETWORKS LIKE AETNA SIGNATURE ADMINISTRATORS AND THE CIGNA. PPO NETWORK*, YOU GET ACCESS TO LOCAL NETWORKS ACROSS THE COUNTRY. OUR EXPERTS WILL HELP YOU FIND THE NETWORK THAT FITS THE NEEDS OF YOUR BUSINESS AND YOUR EMPLOYEES.

*The Cigna PPO Network refers to the network of providers (doctors, hospitals, and specialists) contracted as part of the Cigna PPO Network for Shared Administration.

Cigna is an independent company and not an affiliate of National General or United Benefit Advisors.

ADMINISTRATION

ALLIED

Allied Benefits Systems, Inc. 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.

ACCOUNT MANAGEMENT

Your dedicated Account Manager helps keep your plan running smoothly. Your Account Manager is here to help and will:

- **Resolve escalated service issues.** You'll have your questions answered and calls responded to within 24 hours.
- **Help you understand state and federal fee requirements.** It includes administration of these fees.
- **Provide a mid-year plan review to examine your claims.** This keeps you on track and eliminates any surprises at time of reissue.
- **Assist with the reissue process.** Your consultation will include alternate plan options to optimize cost savings and benefits.

CASE MANAGEMENT

With quality Utilization Management and Case Management solutions, coverage is designed to help control your health care costs. With a self-funded plan, we understand that every health care dollar counts. Our programs include:

- **Case Management Services** to help navigate high-cost catastrophic and complex cases — offering cost savings by providing timely discharge planning, alternative treatment options, negotiated rate reductions, and steerage to in-network providers.
- **Utilization Management Services** to review medical necessity ensuring quality and appropriateness of care while maximizing cost savings.
- **High-Dollar Claim Reviews and Payment Integrity** to identify and review the accuracy of high claims. Not available with the Cigna PPO network.

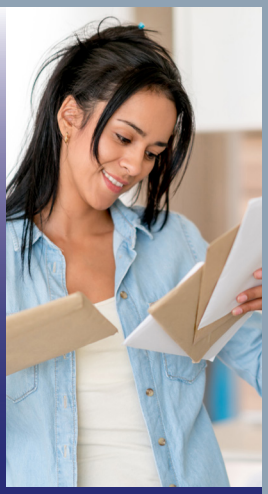
PRESCRIPTION **BENEFITS**

CIGNA PHARMACY MANAGEMENT® DELIVERS INNOVATIVE PRODUCTS COUPLED WITH PHARMACY EXPERTISE TO HELP DRIVE VALUE AND IMPROVED CLINICAL OUTCOMES. CIGNA OFFERS A LOW NET COST FORMULARY STRATEGY, PRICING TRANSPARENCY, CLINICAL AND SPECIALTY EXPERTISE, AND COMPREHENSIVE MEMBER SUPPORT. WITH CIGNA PHARMACY MANAGEMENT, YOUR EMPLOYEES HAVE ACCESS TO MYCIGNA.COM.

PRICE A MEDICATION

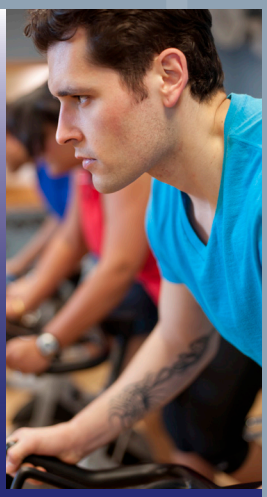
Look up prescriptions to compare prices. The tool shows lower-cost alternatives like home delivery or generics.

PHARMACY HOME DELIVERY



Members can learn more about home delivery options and order refills of prescriptions.

HEALTH MANAGER



Access to articles, support groups, and other resources to help members get healthy and stay healthy.

PHARMACY SEARCH

The wide range of filters will help members find the best in-network pharmacy location.

YOUR **OPTIONS**

WE GIVE YOU THE PLAN OPTIONS AND THE FLEXIBILITY YOU NEED TO STAY ON TOP OF YOUR GROUP'S HEALTH BENEFITS COSTS, WHILE OFFERING THE INNOVATIVE, PERSONALIZED HEALTH FEATURES EMPLOYEES WANT. • YOUR PLAN WILL INCLUDE ONE PREDICTABLE MONTHLY PAYMENT AND PLAN ADMINISTRATION IS HANDLED FOR YOU. THIS LEAVES YOU TO FOCUS ON YOUR BUSINESS.

PPO

By combining self-funding with network discounts and out-of-network benefits, our PPO plan gives you simplicity and cost savings. This option is most similar to a traditional fully insured plan, with the advantages of a self-funded plan.

- Access to in-network discounts and benefits as well as tiered benefits when going out-of-network.
- Preventive services paid at 100% when received from in-network providers, as recommended by the Affordable Care Act.
- The Allied Advocate program is available with the PHCS network to pack even more savings into the plan and protect members against hard-hitting claims.*

NETWORK ONLY

The Advantage plan offers access to in-network and emergency benefits only.

By eliminating the option to go out-of-network, there are great savings on health care costs for you and your employees.

With access to the best networks nationwide, you can be confident your employees will have access to the care they need.

REFERENCE-BASED PRICING

Go beyond self-funding. Your savings add up fast with the Core Value plan.

A reference-based pricing plan, Core Value pays providers based on a multiple of the Medicare reimbursement rate1. Because it does not use a network2, your employees have the freedom to use any health care provider they choose. Pharmacy and transplant services still rely on the use of network providers.

Both you and your employees benefit from steep savings on health care costs with reference-based pricing.

* Allied Advocate is available in CO, IL, KS, MA, MI, MN, OH, SC, TX, WI, and WY.

1 In instances when a service is not priced by Medicare, reimbursement is based on a derived equivalent.

2 Core Value Access allows member utilization of the PHCS Practitioner and Ancillary network.

ADDED **FEATURES**

Teladoc® is a cost-saving benefit employees will actually use. Teladoc helps drive medical costs down while providing quality health care your employees will love.

Teladoc gives your members access to U.S. board-certified doctors so they can get quality care when they need it. No more waiting in line at urgent care and taking time away from your members. The minute an employee feels sick, they can request a consultation.

A healthier workplace can lead to increased productivity and employee satisfaction. Vitality® helps employees analyze their lifestyle to show them exactly where to focus. Vitality helps to set achievable health and lifestyle goals. It features an engaging online member portal, an integrated wellness network, and a variety of health activities and rewards for healthy behaviors.

WE OFFER THESE FEATURES AT NO ADDITIONAL COST

ALL THE PERKS, WITHOUT THE EXTRA EXPENSE

FEATURES

FAMILY DEDUCTIBLE ACCUMULATIONS

Individual/Family

Covered expenses for each family member accumulate toward his or her individual deductible and plan payments 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 number 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 employees and their 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 expiration of the employment waiting period, when the enrollment request is received within 31 days of the effective 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 first day following the expiration of the employment waiting period, when the enrollment request is received within 31 days of the expiration of the employment waiting period.

DEDUCTIBLE CREDIT

When coverage first begins, credit is given for any portion of a calendar-year deductible satisfied under the employer's prior medical plan during the same calendar year, except when the deductible credit is waived. No credit is given for prior years' deductibles. The deductible credit option can be waived.

CHARGES INELIGIBLE FOR THE MEMBER ADVOCACY PROGRAM

Not all provider billing is eligible for the Member Advocacy Program. Excluded charges include, but are not limited to: Any amounts paid for by the member, charges for non-covered services or charges in excess of a benefit limit; charges for penalties under the plan (such as the 30% penalty for non-emergency use of an Emergency Room); non-emergency medical transportation when an authorized provider is not used, charges that should be bundled with another service charge (such as for the second and subsequent surgeries in the same surgical session and assistant surgeon and surgical assistant charges that should be billed as part of the surgical event). This list is subject to change without notice.

Your member can call the Member Advocacy Team to verify if charges are eligible at 888-306-0905.

SUMMARY OF EXCLUSIONS

The health benefit plan templates do not provide benefits for:

- Treatment not listed in the summary plan description.
- Services by a medical provider who is an immediate family member or who resides with a covered person.
- Charges for services, supplies, or drugs provided by or through any employer of a Covered Person or of a Covered Person's family member.
- Treatment reimbursable by Medicare, Workers' Compensation, automobile carriers, or expenses for which other coverage is available.
- Routine hearing care, vision therapy, surgery to correct vision, foot orthotics, or routine vision care and foot care unless part of the diabetic treatment.
- Charges for custodial care, private nursing, telemedicine, or phone consultations with the exception of Teladoc® services if purchased as part of your plan.
- Charges for diagnosis and treatment of infertility except for groups of 51 or more that are administered by Allied or Meritain on the traditional or National General Benefits Solutions Advantage plans.
- Charges for surrogate pregnancy or sterilization reversal.
- Charges for cosmetic services, including chemical peels, plastic surgery, and medications.

- Charges for umbilical cord storage, genetic testing, counseling, and services.
- 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.
- Over-the-counter drugs, (unless recommended by the United States Preventive Services Task Force and authorized by a health care provider), drugs not approved by the FDA, 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.
- Complications of an excluded service.
- Charges in excess of any stated benefit maximum.
- Treatment of an illness or injury caused by acts of war, felony, or influence of an illegal substance.
- 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.
- 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 prophylactic treatment.
- Charges related to health care practitioner-assisted suicide.
- Charges for growth hormone stimulation treatment to promote or delay growth.
- 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 applied behavioral analysis
- Charges for alternative medicine, including acupuncture and naturopathic medicine.
- Charges for chelation therapy.
- Charges for experimental or investigational services.

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.

CLAIMS ACCOUNT REFUND

In years when claims are lower than expected, a portion (or all, depending on your plan selection) of the difference between your group's anticipated and actual claims is credited back to you — and that could add up to significant savings. Refund is subject to any Terminal Liability Coverage fee.

CONTACT US FOR MORE INFORMATION

For Employers with 25+ Employees - Please contact Deb Loughlin at DLoughlin@TheRichardsGRP.com

For Employer with <25 Employees – Please contact Jessi Jacobs at JJacobs@TheRichardsGRP.com

The Richards Group
FINANCIAL, INSURANCE & HR SOLUTIONS

UBA Partner Firm