Nationwide®

Self-Funded Program agent guide

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Welcome to the Self-Funded Program with Nationwide

Nationwide is focused on providing innovative employee benefits solutions to small and midsized businesses. We specialize in providing solutions to employer groups and offer flexible health coverage options to meet the needs of your customers.

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

- Customizable plan designs that make it easy to build better benefits and find the perfect fit for each employer.
- PPO, Copay Only, and Core Value reference-based pricing plans with innovations to help manage costs.
- Value-added features that help keep employee engagement high — and employer costs down.

About this guide

This guide is intended for agents, your training and reference. It contains important information you need to market, sell, and service the Self-Funded Program. You are encouraged to read the guide in its entirety, and to use it as a reference for answering questions and servicing your Self-Funded Program business. If you need additional information not found in this guide, please contact your Nationwide sales representative for assistance.

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

Check with your Nationwide sales representative to ensure you always have the most up-to-date version of this guide.

Important notices

This program includes tools to assist with establishing and maintaining a self-funded health benefit plan under the Employee Retirement Income Security Act (ERISA), along with stop loss insurance and plan administration. Stop loss insurance policies are underwritten by Nationwide Life and Benefits Insurance Company, Columbus OH, in AK, AR, AZ, CT, IL, MA, PA, TX, WI; Integon National Insurance Company in NY; and National Health Insurance Company in CO, WA and all other states where offered.

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

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

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

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

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Program overview

What is the Self-Funded Program?

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

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

The Self-Funded Program with Nationwide helps small to medium-sized employers with 2-500 employees enjoy some of the benefits of self-funding without taking on any added risk. Our program simplifies self-funding, providing quality health care benefits while lowering costs.

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

Our Self-Funded Program offers options employers want most:

- Customizable designs that make it easy to build better benefits and find the perfect fit for each employer.
- PPO, Copay Only, and Core Value reference-based pricing plans with innovative programs to help manage costs.
- Value-added features that help keep employee engagement high and employer costs down.
- Stop loss insurance that protects the employer's assets from higher-than-expected claims.

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

How the Self-Funded Program with Nationwide works

Self-funding combined with stop loss insurance

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

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

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

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

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

What are the employer's costs?

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

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

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

- New York Public Good Pool Surcharge.
- Massachusetts Pediatric Vaccine surcharge.
- Annual Patient Centered Outcome Research Institute (PCORI) fees.

Maximum cost

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

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

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

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

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

Products, services and program features

What's included in the program

Nationwide and the TPAs bring resources and expertise to the Self-Funded Program. Product and administrative systems integrate the roles each play into a seamless service for you and your customers. Plan administration support is easily accessible for you, your customers, and medical providers to reach the appropriate person or area without complication or delay. Please refer to the customer service section for specific contact information.

The following products and services are provided by Nationwide:

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

Stop loss insurance policies are underwritten by Nationwide Life and Benefits Insurance Company, Columbus OH, in AK, AR, AZ, CT, IL, MA, PA, TX, WI; Integon National Insurance Company in NY; and National Health Insurance Company in CO, WA and all other states where offered.

Administrative services

The Self-Funded Program provides access to licensed TPAs that administer the employer plans.

The TPAs and Nationwide work together to provide the employers with:

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

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

Key features

Employer stop loss insurance

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

Note: Two protections are not always issued contingent on whether a group has selected Aggregate Only or Specific Only.

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

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

Stop loss rate and deductible guarantee

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

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

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

Determining stop loss limits

Group plan information is entered into a financial model that calculates the plan's expected claims. Expected claims may be adjusted based on medical underwriting prior to a final-rate offer. The employer's monthly claims account funding (if applicable), stop loss premium, and administrative costs are determined by Nationwide.

Specific stop loss limits are selected by the employer from several options, subject to state law. Both specific and aggregate limits are set in accordance with applicable state laws.

Self-funded benefit plan templates

Nationwide has designed hundreds of plan template options to fit almost any employer's needs.

Optional dental or dental with vision coverage

We offer the option to add dental and vision coverage to all employer self-funded medical plans, except for our Self-Funded plans in the state of Washington. Our dental and vision options are built into the Self-Funded Program as optional coverage with the medical plan. Dental (and vision if selected) coverage is only available with programs administered by Allied Benefit Systems, LLC.

Dental coverage is not provided as a stand-alone offering without self-funded medical coverage. Vision coverage must be selected with dental coverage and is not a stand-alone offering without self-funded medical and dental coverage. Dental and vision coverage is elected along with the medical plan and is built into the same self-insured structure. There are no waiting periods for dental (and vision if selected) benefits beyond what the employer chooses for eligibility under the employee benefit plan.

While dental has separate deductibles from the self-funded medical plan, a deductible credit benefit may apply as long as the appropriate dental information is available.

Groups electing dental or dental with vision coverage

In order for employer groups to be eligible, they must meet the following participation rules:

1. 50% of the employees enrolling in medical coverage must also enroll in dental (and vision, if selected) coverage.
2. A minimum of three employees must enroll in the dental (and vision, if selected) plan.

If the group is offering dental (and vision, if selected) coverage, all eligible employees will be enrolled in the dental (and vision, if selected) plan unless we receive a request to waive the coverage from the employer. Employers can waive coverage for members by providing a list of those members.

ERISA and state-mandated benefits

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

Provider network access

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

Pharmacy benefits

The Self-Funded Program offers network pharmacy benefits through Cigna Payer Solutions. Network benefits are accessed by presenting the ID card at participating pharmacies.

The formulary is updated twice per year, so the most current version of the formulary should be referenced to determine which drugs are covered.

Precertification and utilization review (UR)

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

Health Savings Account (HSA) plan options

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

Health Reimbursement Arrangement (HRA) plan options

The HRA option is only available with programs administered by Allied Benefit Systems, LLC.

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.
The arrangement provided to employees for reimbursement of employer-specified medical expenses authorized by Section 105 of the Internal Revenue Code. These specified expenses can include copays, deductibles, wellness services, and more. HRA advantages for employers include:

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

*Nationwide is not engaged in rendering tax or legal advice. Please see a qualified professional for tax or legal advice.

Section 125

Section 125 Plan, also known as a Premium Only Plan or (POP) allows employers to deduct employees' health plan contributions from their paychecks on a pretax basis. This results in federal, state and local tax savings. This plan is available at no additional cost to the employer. Small employers (fewer than 100 employees) that establish a Section 125 plan may be eligible for an exemption from having to submit the annual Form 5500 filing otherwise required under ERISA.

Quoting and selling our Self-Funded Program

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

Getting a group quote

Quotes are created by your Nationwide Sales Representative and emailed to your office.

What's in the quote?

Group quotes show the following:

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

Submitting a case

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

- Implementation questionnaire – signed by the employer and you.
- Employee enrollment forms on all eligible employees, including any employees in the employment waiting period.
  - NOTE: You must use the most up-to-date enrollment forms. Forms can be accessed by contacting your Sales Representative.
  - Employees not requesting coverage must complete the Waiver of Coverage section on the employee enrollment form.
- New business quote signed and dated by the employer.
- Signed Self-Funded Program Employer Agreement.
- Signed Administrative Services Agreement.
- The employer's last State Quarterly Unemployment Withholding Form (not required on groups of 51 or more enrolling employees).
- Census form listing full-time and part-time employees if a State Quarterly Unemployment Withholding Form is not filed.
- Signed Network Services Agreement (if applicable).
- A copy of the business check made payable to the appropriate TPA.
- A copy of the employer's last bill from the current carrier.
- New York Pool Election form or New York Pool Change form.
- Business Associate Agreement.
- Employer Agreement and Attestation signed by employer and agent.

Additional forms may be required at the time of application.

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

Underwriting guidelines

Plan effective dates

Effective dates are the first day of the month.

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

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

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

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

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

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

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

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

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

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

Misrepresentation

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

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

Responsibility for monthly costs

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

Two billing options are available:

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

Nationwide sales representatives are not authorized to collect subsequent monthly billed amounts.

*Requirement may vary by state, contact your sales representative for details.

Participation requirements

Employers must have a minimum of two 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:

- Coverage under a spouse's employer group health plan.
- Coverage under an individual health plan.
- Coverage as dependent under a parent's health plan.
- Medicare.
- Medicaid I Medical Assistance.
- TRICARE.
- Coverage under an Indian Health Services Program.
- State Health Benefits Risk Pool.
- COBRA coverage.
- Peace Corps or other Federal plan.
- Public health plan of a state, country, or other state political subdivision.

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

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

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

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

Waiting periods

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

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

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

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

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

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

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

Medical underwriting standards

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

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

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

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

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

Eligibility

Group eligibility requirements

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

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

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

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

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

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

The federal agency administering the Medicare program requires administrators of group health plans to provide the Social Security numbers for all employees, spouses, domestic partners and dependents covered by the employer's plan.

Nationwide must request this information to be submitted to comply with the governmental requirements set forth in the Medicare, Medicaid and SCHIP Extension Act of 2007. The information will be reported to the Centers for Medicare and Medicaid Services (CMS). We realize this is sensitive information and have appropriate safeguards in place to protect it. For additional information on the mandatory reporting requirements, you can visit the CMS website at www.cms.hhs.gov.

Medicare eligibility/TEFRA

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

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

Business location

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

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

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

Your sales representative can help determine which business location should be designated as the main business location.

Employee eligibility

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

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

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

Your sales representative can advise you whether a mandate exists in the groups' state.

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

The following are not considered eligible employees under this plan:

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

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

Independent contractors

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

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

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

Carve-outs

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

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

Employee only and dependent only coverage

Employers may choose to cover:

- Eligible employees only, or
- Eligible employees and their child(ren) only.

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

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

Husband and wife groups

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

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

Dependent eligibility

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

Adopted dependents

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

Ask your Nationwide sales representative about our Short Term Medical insurance options for non-eligible employees.

Issuing coverage

Enrollment forms

Send completed enrollment forms and all other required documents to your Nationwide sales representative or directly to:

Fax: 855-247-6910

Email: sfnewbusiness@nationwide.com

Accepting and declining groups

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

If a group is declined for the Self-Funded Program with Nationwide, you will be informed by your sales representative.

Issuing a new group

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

- You will be informed by your Nationwide sales representative.
- The TPA will assist in establishing the employer's plan and a welcome email will be sent to the employer with instructions on how to access the portal.

For new business

A welcome email is sent to the employer once the group is implemented and includes instructions on how to log into the member portal where they can access the following documents:

- Employee Summary Plan Descriptions.
- Employer Guide.
- Stop loss contract.
- Administration forms.

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

Cost

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

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

These factors may vary by state.

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

Workers' compensation

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

Finance and billing

Monthly payments

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

For plans administered by Allied:

- The email will come from notifications@alliedbenefit.com with access to Alliedbenefit.com to view the invoice and access the online bill pay system.

For plans administered by Meritain:

- The email will come from info@businesssolver.com with access to the BenefitSolver enrollment portal to view the invoice.
- For new groups, the first available invoice will be posted on the portal in the second month of the plan.

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

For employers electing the recurring ACH payment option, their accounts will automatically be debited on the first day of each billing month. For Allied, employers must set up recurring ACH by accessing the online bill pay portal through Alliedbenefit.com.

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

For example, if the stop loss insurance was originally effective on the 15th of the month, the billing months begin on the 15th day of the subsequent months.

If payment is not received by the 1st day of the next billing cycle, stop loss coverage and participation in the Self-Funded Program may be terminated.

Adjustments

Adjustments can be made to the group's billing statement to reflect changes in the makeup of the group itself or the self-funded employee health plan. Monthly billing amounts can change if:

- A new employee or dependent is added to the group.
- An employee or dependent is terminated.
- Changes are made to the plan benefits.
- An employee changes the coverage election (e.g. single to family).
- The business moves to a new address.
- The employer's nature of business changes.
- The employer adds/changes the eligible class of employees (must have prior approval).
- The employer adds a subsidiary or affiliated company or division with a census variation of more than 10% (must have prior approval).

Employer claims account management

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

Employer claims account

For plans administered by Allied:

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

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

Funds not used for claim payment accumulate in the employer's account. At the end of the stop loss policy's run-out period, if claims are less than the aggregate limit, a portion of the difference will be refunded to the employer based on the refund percentage selected. In addition, Allied is authorized to pay stop loss insurance premiums and administrative fees from the employer's accounts. Refunds will be processed approximately 60-90 days after the run-out period has ended.

For plans administered by Meritain:

Employer accounts are segregated in a bank account maintained by AMR. These accounts are trust funds and unused funds will accumulate in the employer's account. Any funds remaining at the end of the stop loss policy's run-out period will be refunded via check or ACH.

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

Marketing fees

For Allied business:

- Marketing Fees are paid biweekly either by check or ACH.
- NOTE: When a monthly invoice is paid early, the marketing fee will not be paid until the week of the actual due date.
- The full monthly bill must be paid before marketing fees are paid on that business.
- A monthly statement will be sent along with the check or emailed to the agent if paid via ACH.

For Meritain business:

- Marketing Fees are paid biweekly.
- The full monthly bill must be paid before marketing fees are paid on that business.
- Agents will be notified to log into Comissio to view statements online.

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

Broker of Record (BOR) changes

Nationwide will accept employer group requests to change the Broker of Record on a case provided that the request meets the following guidelines:

- Letter requesting the change signed by an authorized representative of the company.
- Signed Business Associate Agreement.
- Agent must be licensed and appointed in resident state of the group.

For all groups where compensation is currently being paid by Nationwide, payment of compensation will begin on the next available compensation effective date following a 3-day rescission period, which could be up to two (2) months following approval of the BOR change request. The new agent will be allowed to access the group upon approval following the 3-day recission period.

Compensation will be paid to the new agent of record at the same rate of commission paid to the original agent of record as of the date of the transfer.

While the receipt of a Broker of Record change request letter is a prerequisite to honoring any broker change, the fact that the broker has obtained a Broker of Record change request letter from a group does not, in and of itself, obligate Nationwide to pay compensation to the new broker. Nationwide reserves the right to refuse to honor a Broker of Record change request for any reason.

Complete forms and return documents to:
sflicensing@nationwide.com.

Claim submission and service

Advance funding provision

Advance funding is automatically provided with stop loss policies. Advance funding provides reimbursement to the plan's claims account if the claims for any given month of the plan year exceed the claims account's available balance. The plan does not need to have paid claims in excess of stop loss insurance limits and aggregate limits to qualify for advances.

Advances are repaid from subsequent months' payments made into the claim account.

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

Deductible credit

Credit is given for any portion of a calendar year deductible satisfied under the employer's prior plan during the same calendar year. Deductible credit is only provided when the calendar year deductible option is chosen. Employers have the option to waive deductible credit during initial onboarding for a reduction in rate.

Health benefit plan claim submission

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

If the participant assigns benefits to the provider, the TPAs 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 60 days after an expense was incurred.

Precertification requirement

There are a number of medical procedures and specialty drugs that require preauthorization. If preauthorization is not received a claim/prescription may be denied or penalty applied. Please refer to the utilization management guidelines in the summary plan description (SPD).

NOTE: verification of benefits is a separate process than precertification.

Health benefit plan claim payment

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

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

Prescription claims

Participants will pay the appropriate cost sharing amount according to the SPD when using a participating pharmacy.

Stop loss claims

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

Health plan management reports

Employers have access to a secured website where they can view reports showing:

- Claims paid in the current period.
- Current balance in the claims account.
- Funding advances and repayments.

The employer can use this information to track the performance of the Self-Funded Program.

Employers can request additional reports by contacting the account management team.

Servicing existing groups

Enrollment periods

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

1. Initial enrollment.
2. Special enrollment.
3. Annual open enrollment.

Initial enrollment

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

After the initial enrollment period, eligible employees and/or dependents may only apply within the standard guidelines of special enrollment or during the annual open enrollment period.

Special enrollment

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

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

Special enrollment periods are for (please note this list is not all inclusive):

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

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

Nonpayment of premiums, voluntary termination of coverage, or termination of coverage for cause, do not trigger a special enrollment period.

1. An employee, spouse, or dependent child who waived coverage when previously offered due to COBRA or mandated state continuation coverage and that coverage has been exhausted.
2. One of the following Qualifying Life Events occur:
   - Marriage.
   - Birth.
   - Adoption.
   - Legal guardianship.
   - A court orders coverage to be provided for a dependent.

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

Annual open enrollment

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

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

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

For plans administered by Allied:

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

For plans administered by Meritain:

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

Adding employees and dependents

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

Effective dates of coverage for additions

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

Please review the effective date assignment rules listed under the following special enrollment section.

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

Special enrollment

1. Newly eligible employees and their dependents, upon satisfaction of the employment waiting period (excludes groups with a 90 day enrollment waiting period), are eligible for the following effective date:
   - First day of the billing month following the expiration of the employment waiting period, when the enrollment request is received within 31 days of the effective date.
2. For groups with a 0-day employment waiting period, newly eligible employees and their dependents are eligible for the following effective date:
   - First day of the billing month following the date of full-time employment, when the enrollment request is received within 31 days of the effective date.
3. For groups with a 90-day employment waiting period, newly eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date:
   - The first day following the expiration of the employment waiting period, when the enrollment request is received within 31 days of the expiration of the employment waiting period.
4. For marriage, the eligible employee and their dependents are eligible for one of the following effective dates:
   - Date of marriage, when the enrollment request is received within 61 days of the date of marriage; or
   - First day of the billing month following the date of marriage, when the enrollment request is received within 61 days of the effective date.
5. Newly eligible dependents due to birth, adoption/ placement, or legal guardianship are eligible for the following effective date:
   - Date of birth, adoption/placement, or legal guardianship granted by a court, when the enrollment request is received within 61 days of the date of birth, adoption/placement, or legal guardianship granted by a court.
6. Newly eligible dependents due to a Medical Support Court Order are eligible for one of the following effective dates:
   - Date of the Medical Support Court Order, when the enrollment request is received within 61 days of the date of the medical support court order; or
   - First day of the billing month following the court order, when the enrollment request is received within 61 days of the effective date.

   If the enrollment request is received beyond the allotted time frame listed above, the dependent will be enrolled for only the first 31 days from the date of the court order.
7. For loss of, or eligibility for, a Medicaid or State Children's Health Insurance Program (SCHIP), the employee/dependent(s) are eligible for the following effective dates:
   - Date of eligibility for Medicaid or SCHIP coverage.
   - Date of loss of Medicaid or SCHIP coverage.

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

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

Annual open enrollment

Employees and dependents may only enroll during the annual open enrollment period, unless they otherwise qualify for special enrollment.

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

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

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

5. For annual open enrollment, the enrollment form was received by Nationwide after the employer's reissue/annual effective date.

Plan coverage changes

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

For employee plan changes:

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

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

COBRA coverage

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

Billing for COBRA Premium

For plans administered by Allied and Allied is the COBRA administrator:

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

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

For plans administered by Allied and Allied is not the COBRA administrator:

The employer will be billed for the member's COBRA premium. For the member's COBRA premium reimbursement, the employer will need to reach out to their COBRA administrator.

Note: The outside COBRA administrator will to notify Allied monthly of the member's COBRA paid-to date. Claims will not be paid for that member if Allied has not been notified of the member's COBRA paid-to date. The member's paid-to date must be current for claims to be processed.

For plans administered by Meritain and BenefitSolver is the COBRA administrator:

When COBRA administration is elected, the COBRA administrator will bill and collect the premium directly from the member. Qualifying Event notices are available on the BenefitSolver Portal.

For plans administered by Meritain and BenefitSolver is not the Cobra administrator:

When COBRA administration is not elected, the member is billed on the monthly invoice and the employer is responsible for collecting the COBRA premium from the member.

New policy periods

Stop loss policy

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

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

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

Claims account

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

Employers who have unused funds in their claims account will receive a percentage of those funds back in the form of a check after the run-out period expires and the claims have been reconciled.

Administration costs

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

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

Program terminations

Employee terminations

Employee coverage will terminate on the last day of the billing month. The billing month is based on the group's original effective date. For example: If the employee terminates January 10, and your plan's original effective date was the 15th of the month, the employee's coverage will terminate on January 14.

Removing an employee from your plan:

- For plans administered by Allied:
  - You must submit a completed termination form to Allied within 30 days of the employee termination.
  - Termination forms can be accessed at Alliedbenefits.com or from your Account Manager.
  - Completed forms should be emailed to: ABGH.MemberTermination@alliedbenefit.com.
- For plans administered by Meritain:
  - Terminations can be processed in Benefitsolver.com Once the termination is processed, any credit due will appear as a credit adjustment on your next billing statement.
  - Review your next billing statement to ensure the employee was removed from your plan.
  - If you have questions regarding terminated employees, please contact Nationwide Account Management team at 888-659-1859 for assistance.

Early terminations

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

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

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

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

Early/midyear terminations

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

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

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

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

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

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

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

Web portals

Self-Funded Portals are available to agents and employers to administer the following functions:

- Send email to newly eligible members and dependents to enroll online.
- Process member terminations.
- Demographic updates.
- Add newborns.
- View tiered rates.

Accessing the agent portal:

1. Go to agentportal.nationwide.com.
2. You must have a My Agent account to use the portal. If you already have access to the Agent Back Office or Agent Management System, you can use your current username and password and do not need to register.
3. If you do not have a My Agent account, please contact NWAccountSupport@nationwide.com so we can send you a welcome letter from our Agent Management System, which will contain a link for you to register.

Each of the administrators; Allied and Meritain provide a member portal for ease of administration.

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

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

- Agents and employers have access to:
  - View ID cards.
  - View plan documents, such as the Summary Plan Descriptions and Summary of Benefit Coverage.
  - View invoices. Employers can pay their monthly invoices online by setting up a one-time payment or recurring ACH.
  - View group reports such as claims summary and census reporting.
  - View monthly Claims Account summaries.
  - Access preferred provider networks and pharmacy provider links.
  - Find in-network doctors and hospitals.
- Members have access to:
  - Check claims status.
  - View ID cards and other plan documents.
  - Find in-network doctors and hospitals.
  - Estimate costs of provider services and prescription drugs.
  - Compare providers.

For business administered by Meritain, the BenefitSolver enrollment portal www.benefitsolver.com is available to agents and employers to:

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

Agents and employers should contact the Account Management Team for documents not available on www.benefitsolver.com.

Members have access the TPA's member portals to:

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

For plans administered by Meritain, members should go to:

- www.mymeritain.com

Customer service

For general plan administration and to access administrative forms, agents and employers can contact our Nationwide account management team.

Hours:

Monday through Friday: 8:00 a.m. to 5:00 p.m. CT

Phone: 1-888-659-1859

Email: NWSelfFunded@nationwide.com

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

Fax: 855-247-6910
Email: sfunderwriting@nationwide.com

TPA member services:

Allied

Hours:

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

Phone: 888-292-0272

MAP Team (for Core Value plans): 888-306-0905

Meritain

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

Phone: 800-925-2272

Marketing materials

Available for download on the Nationwide website at nationwide.com

Nationwide

111 W Pleasant Street
Milwaukee, WI 53212

Nationwide®

The Self-Funded Program through Nationwide provides tools for employers owning small to midsized 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 policies are underwritten by Nationwide Life and Benefits Insurance Company, Columbus OH, in AK, AR, AZ, CT, IL, MA, PA, TX, WI; Integon National Insurance Company in NY; and National Health Insurance Company in CO, WA and all other states where offered. Product availability and specific provisions may vary by state.

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