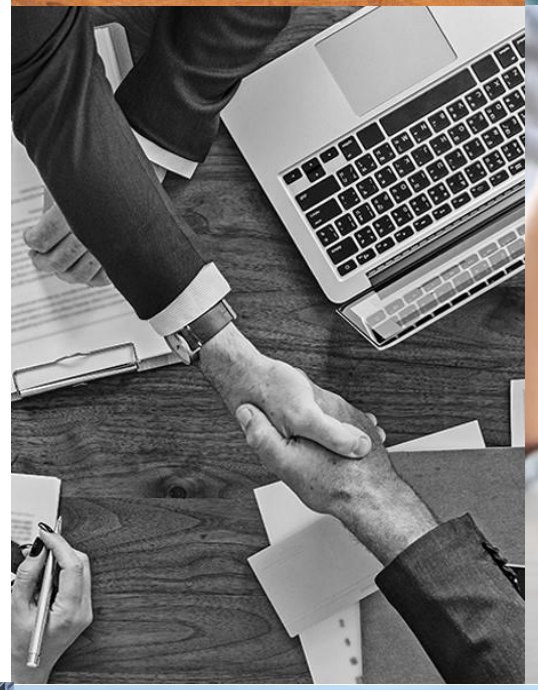
National General
Benefits Solutions

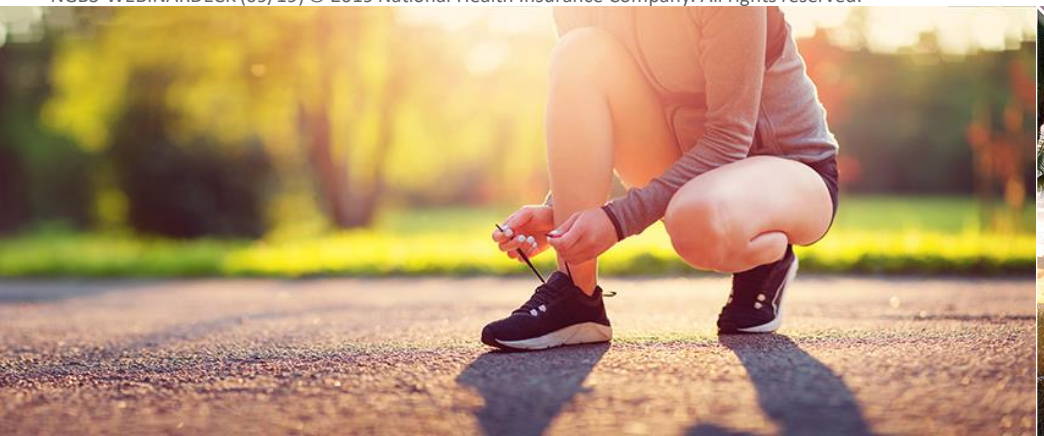
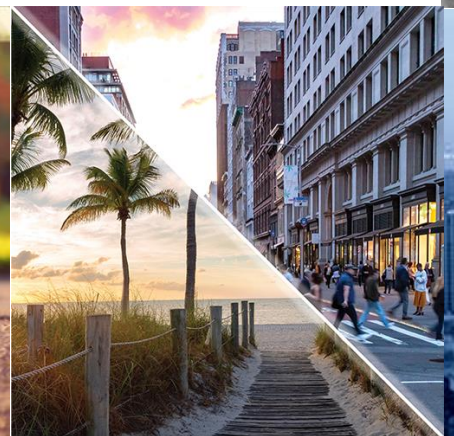
A LOOK AT WHAT'S NEW AT NATIONAL GENERAL

JUSTIN TAYLOR

DISTRICT MANAGER






THE STRENGTH BEHIND US

National General Holdings Corp.

- A publicly traded company with approximately $4.6 billion in annual revenue
- Auto, Home, Life, A&H, Lending, etc.
- Financially strong
  - Underwriting companies are Rated A- (excellent) by AM BEST
- Approaching $1B A&H Block

NATIONAL GENERAL BENEFITS SOLUTIONS SELF-FUNDED PROGRAM

National General Benefits Solutions

Our innovative program designs offer employers:

Flexibility

1000s of plan designs with quality benefits

Expertise

Our teams have 16 years of experience in the self-funded market

Easy Administration

TPAs manage the day-to-day and offer tools so you can manage costs

Why Self Funding?

- Industry changes causing rise in health insurance premiums

Rising health care costs

Plan designs not meeting customers' needs

- Some plans have narrowed PPO networks and lack of options; plans may not fit the needs of the employees

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How does it work?

Traditional fully insured premium

NGBS Self-Funded Program payment break-out

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Sample Level Funded Quote

Plan Name	Plan 1
Deductible Individual (In Network/Out of	$2,500/$5,000
Deductible Family (In Network/Out of	$5,000/$10,000
Coinsurance (In Network/Out of Network)	80%/60%
Total Ind Plan OOP Maximum (Net/Non-Net)	$5,000/$10,000
Total Fam Plan OOP Maximum (Net/Non-Net)	$10,000/$20,000
Family Deductible Accumulation method	Individual/Family Deductible
PCP/Spec Copay	$35/$50
Network	Aetna Signature Administrators ® PPO
OP Surgery	Deductible and Coinsurance
Rx Coverage	$15/$45/$60
DXL	Paid at 100%
ER Treatment	Deductible and Coinsurance
AME	N/A
Deductible and OOP Accrual Period	Calendar Year
Run Out Period	6 Months
HSA Qualified	No
Total Premium	$9,324.13

Stop-loss limits

Cost per employee and family

Cost breakdown by component

Stop Loss Insurance Limits	
	Plan 1
Specific Limit	$30,000.00
Annual Aggregate Limit	$50,855.76
Monthly Bill	
Employee	$404.52
Employee + Spouse	$1,031.51
Employee + Child	$788.81
Family	$1,334.90
Stop Loss Premium	$2,801.71
Admin, Sales and General Expenses	$2,284.44
Claim Account	$4,237.98
Total	$9,324.13

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Market Niches

Target Groups:

- Sweet Spot: 3-24 enrolled
- 2-50 UW via medical apps
- Flexible Participation/Eligibility
- 1099 Groups
- Carve outs
- Multi location

Top Industry Verticals:

- Hospitality
- Food Services
- IT
- Construction
- Agriculture
- Retail

NO INDUSTRY RESTRICTIONS!

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Underwriting and Questions to Ask

- What are we looking for?
  - Groups that make sense
  - They don’t need to be perfect
  - Many of the most common conditions are standard (zero rating)
- What drives rate increases?
  - Expensive medications
  - Expensive ongoing conditions
  - High risk conditions (even if ongoing claims are insignificant)
- What will we provide?
  - Accurate underwritten rates reflecting the risk of the group as a whole

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Underwriting and Questions to Ask

- Don’t be afraid to ask
  - Most small employers know if an employee is going through a serious medical condition
  - “Do you know of anything serious or ongoing within the group?”
- Use your rep
  - Full access to the underwriting guide
  - We can save everyone time if the group is not a good fit

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Other Unique Features

- Turnaround time
  - Quote – 24 hours
  - Underwriting – 48 hours
  - New group installation – 3 to 5 business days
- Full time eligibility – 20 to 40 hours
- Flexible Plan Designs – over 100k
- Reporting Assistance – 1094/1095 forms
- Network Flexibility – Aetna ASA, Cigna PPO, LocalPlus, PHCS, and many others
- Free COBRA admin
- Flexible Commissions – Starting at 7%

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Submitting a Quote

- Case is Competitive
  - Provide group census to your NGBS partner for a base rate quote
  - Present to the Employer
  - Your Rep will help you present
- Group wants to complete medical apps
  - Paper or Electronic
  - 24-48 hour turnaround time with final rates
- Final Rates/Submit to Issue
  - Employer paperwork- One simplified fillable PDF
  - Once TPA gets the information, temp ID cards are out in 3-5 business days

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Core Value – What is it?

- Open Network – no network restrictions
  - Uses medicare reimbursement rates as a reference and prices claims based on a multiple of that rate
- Lowers claim cost with lower reimbursements – based on % of Medicare
  - 150% inpatient; 130% outpatient
  - RX- Cigna PBM
- **20% Premium savings in most markets vs. PPO**

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Claims Example

Example for Routine Exam	Billed amount	Traditional PPO MAA	Core Value MAA 130% of Medicare reimbursement rate	Plan covers
PPO plan	$458.00	$252.43		$252.43
Core Value	$458.00		$199.78	$199.78
Example for Outpatient Surgery	**Billed amount**	**Traditional PPO MAA**	**Core Value MAA 130% of Medicare reimbursement rate**	**Plan covers**
PPO Plan	$3,376.52	$2,336.40		$2,336.40
Core Value	$3,376.52		$1,545.56	$1,545.56

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What if I Get a Balance Bill?

The Member Advocacy Program

- A concierge team designed specifically for Core Value members
- If you get a balance bill in the mail, contact the MAP team right away
- If the bill is determined to be a balance bill, they'll work with the provider to correct and/or negotiate a resolution
  - Regardless of the outcome, a member will never have to pay the balance bill

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EOB Example

If you receive a bill, we're here to help

With this plan, you may receive a bill from your provider for amounts above your Patient Responsibility.

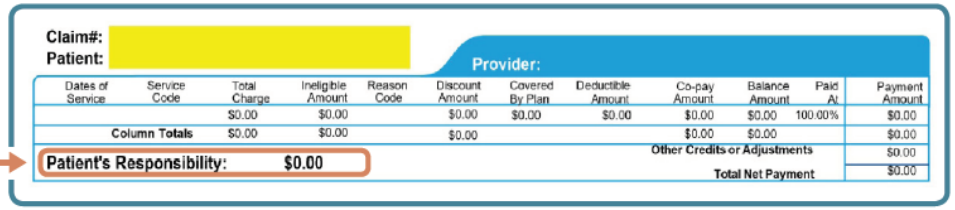
If this happens, call us today!

Your Member Advocacy Team Phone Number

888-306-0905

Check your bill against your EOB.

1. Locate the "Patient's Responsibility" on your EOB.
2. If your provider bills more than your portion, call us right away.



Claim#:
Patient:
Provider:

Dates of Service	Service Code	Total Charge	Ineligible Amount	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Balance Amount	Paid At	Payment Amount
		$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	100.00%	$0.00
Column Totals		$0.00	$0.00		$0.00			$0.00	$0.00		$0.00
								Other Credits or Adjustments			$0.00
Patient's Responsibility:		$0.00						Total Net Payment			$0.00

The Member Advocacy Team will work with your provider to resolve any bill discrepancies.

Remember, we're here to help.

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How Your Core Value Plan Works

You're in Good Hands!

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Your plan pays providers based on a multiple of the Medicare reimbursement rate[1] for each service you receive. There is no network[2], so you can go to any provider you want. Here's how it works:

1

Seek Care

You can go to any doctor or hospital[2]; simply show your Medical ID card to the provider. If they have any questions, they can call the Customer Service number on the back of your card.

2

Receive Your EOB

You will receive an Explanation of Benefits (EOB) showing your Patient Responsibility. This includes copays, coinsurance, charges for non-covered services and deductible amounts.

3

Review Your Bill

Your provider will send you a bill for any amounts due to them. This bill should not exceed the Patient Responsibility as shown on your EOB.

4

When to Call

If your bill shows an amount that exceeds the Patient Responsibility on your EOB, call the MAP Team immediately.

888-306-0905

5

The Team Gets to Work

MAP will work with your provider to resolve any inconsistencies on your bill. Afterward, you'll receive a letter explaining the resolution.

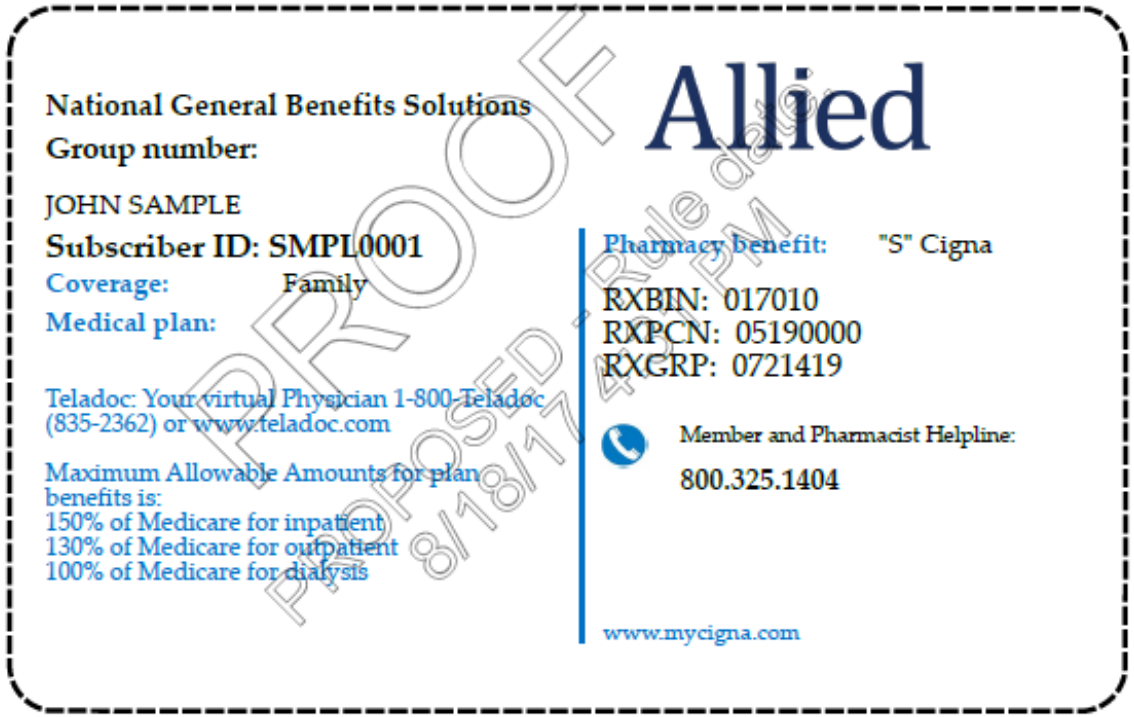
The Member Advocacy Program[3] (MAP) is here to:

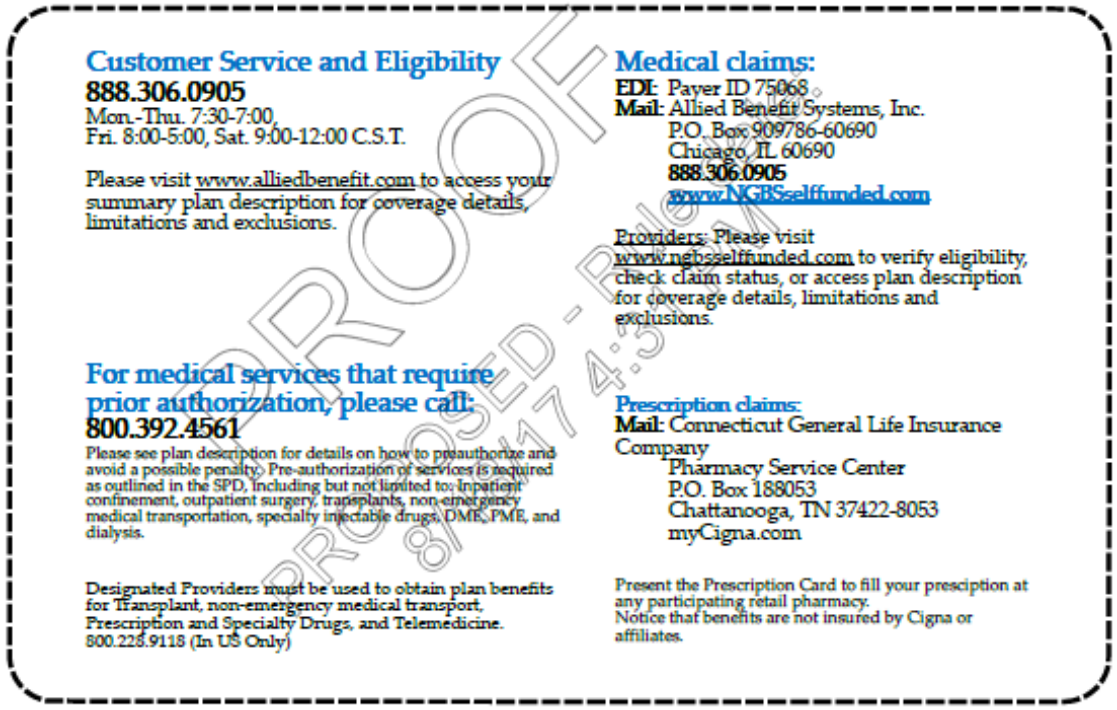
- Answer questions about billing
- Clarify your EOB
- Find providers
- Help you understand your benefits and how to use your plan

Call at 888-306-0905

1 Or a derived equivalent of the Medicare reimbursement rate.
2 Pharmacy benefits and transplants still rely on the use of network providers.
3 Non-covered services and certain other charges are not eligible for the program.

I.D. Card Example





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Core Value – Healthcare Bluebook

Did you know?

Prices for the same procedure can vary up to 500% depending on where you go.

The choice is clear!

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Core Value – Teladoc

Teladoc provides 24/7 access to U.S. board-certified doctors, through the convenience of phone, video or mobile app visits.

- Talk to a doctor anytime, anywhere
- Prompt treatment – average call back time is 10 minutes
- Prescriptions can be sent directly to member's pharmacy

A Full Suite of Core Value Products

Bringing together real cost savings and quality employee benefits

Core Value

Our reference-based pricing plan that pays based on a multiple of the Medicare reimbursement rate (or derived equivalent)

Delivering great savings potential for clients!

Core Value FLEX

Allows employers to experience the savings of our Core Value plan with the FLEXIBILITY of switching to a PPO network mid-plan year.

NEW Core Value Access

Provides the cost savings of a reference-based pricing plan with ACCESS to a network for physician services.

PHCS PPO WITH ALLIED ADVOCATE

Proprietary claim management strategy from Allied, successful since 2005.

Now available with the NATGEN PHCS PPO Plans

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ALLIED ADVOCATE

CONCIERGE AND ADVOCACY FOR EMPLOYEES

> “I’ve never had the privilege of having such a helpful person in my court like this. She seriously just calls to check in, chat, encourage, find doctors, explain things … basically anything that might remotely be involved in the situation. She is an angel and seriously has taken so much stress out of the situation. I can’t imagine having to figure most of this out myself.”

- Allied Member

The Allied Advocate program works within a traditional PPO plan of benefits with a focus on ensuring members have access to the care they need at a cost that is appropriate and reasonable.

This proprietary claim management strategy is now fully integrated with select plans through National General Benefits Solutions self-funded program. Allied Advocate combines clinical expertise with best-in-class proprietary technologies that translate into solutions with profound impact on plan costs. Launched in 2005, Allied Advocate has over a decade of proven success in managing large-claim expenses on behalf of the plan.

THE COST-CONTROL STRATEGY

The Allied Advocate program focuses on the 4 percent of total claims that tend to drive 50 percent of the total plan costs.

Allied Advocate Impacts:

- Ambulance charges exceeding $2,500
- Inpatient hospital charges exceeding $10,000
- Infusion therapy charges exceeding $1,500
- Outpatient hospital charges exceeding $2,500
- Outpatient ambulatory surgical center charges exceeding $2,500
- Physician charges exceeding $5,000
- Renal dialysis charges

HOW IT WORKS

1. Each day, the Allied Advocate team identifies claims triggered by the program.
2. Once a potential claim is identified, a letter is sent directly to the member introducing their Advocate and outlining how the claim will be processed.
3. The Advocate tracks each claim impacted by the program.
4. If the provider attempts to balance bill the member, the Advocate will protect the member and negotiate an appropriate settlement with the provider.

HELP THEM CUT COSTS WHERE IT MATTERS

Lower Claims Spend

Control costs for the 4% of total claims that can drive up to 50% of total plan spend.

An Advocate for Employees

Personalized assistance with aggressive management of high health care expenses ensuring deeper discounts.

Up-front Savings

Offering our lowest PPO rates available in each market.

How Can We Help

- What resources can we provide?
- How can we help support your success?
- What are your biggest challenges in partnering with National General?

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Thank you

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