Self-Funded Program Core Value Plan

Put a reference-based pricing plan to work for your small- to medium-sized business

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.

National General Benefits Solutions

NGBS-BROCHURE-COREVALUE

Introducing: A realistic approach to employee health benefits

Core Value makes it easy for you to put a self-funded health benefit plan to work for your business

We designed every aspect of our program to deliver maximum savings potential.

Ready to gain control of your health care expenses while providing quality benefits to your employees? It's possible with Core Value. By combining the cost-lowering qualities of self-funding with a reference-based pricing plan, Core Value gives you the simplicity and savings you're looking for.

What makes Core Value special? Core Value is a reference-based pricing plan, meaning it pays providers based on a multiple of the Medicare reimbursement rate (or other derived equivalent), regardless of the billed amount. This can reduce the amount paid for your members' claims — which would save money for both you and your group's members. Plus, plan administration is handled for you, leaving you to focus on running your business. You simply provide your level, monthly payment, and we handle the details.

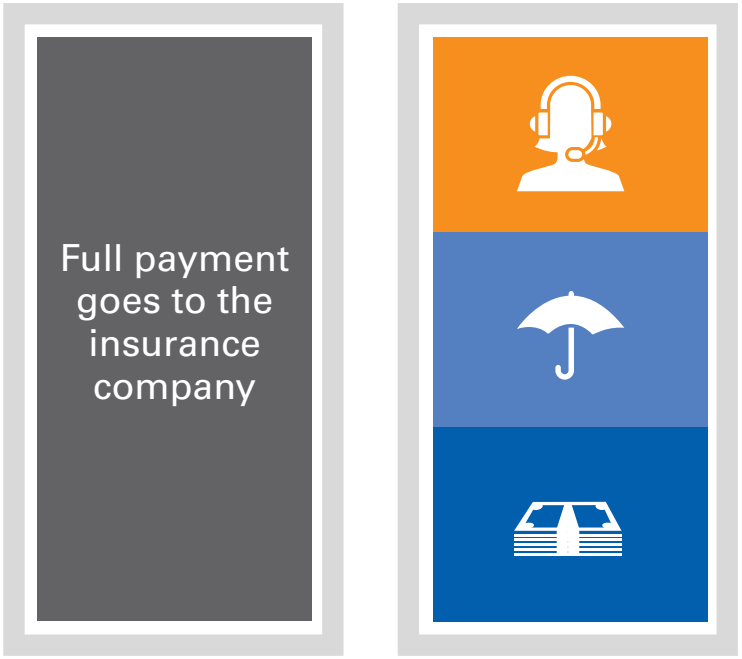
You can trust us to help you save. National General Benefits Solutions is a national leader in the self-funded space. Our team of experienced professionals are ready to provide you and your agent with:

- Group market expertise
- Immediate access to support
- Quick resolution of issues
- Hands-on help at time of reissue

You may be overpaying for group health care benefits

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

Our Self-Funded Program is different. Your single monthly payment is split among the program's three components.



Plan administration

- Manages claims payments
- Provides reporting to help manage costs

Stop-loss insurance

- Protects your finances from higher-than-expected claims
- Helps you limit your business's financial exposure

Employer claims account

- Account used to pay employees' claims
- Stop-loss advances money to your claims account if claims exceed the balance in any given month

You may receive money back from your claims account in years when claims are lower than expected*

* See pages 8 & 9 for more details

Simple. Safe. Savings.

Starting with our Self-Funded Program, Core Value gives you even more control over your health benefit costs

With our Core Value, you get to experience the advantages of self-funding without taking on added risk. It's an easy way for you to lower your costs while providing quality health care benefits to your employees.

Core Value gives you the same flexible plan design options as our standard Self-Funded Program and adds tools that help you reduce costs.

CORE VALUE KEY ADVANTAGES:

One, predictable monthly payment

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

Member Advocacy Program

The Member Advocacy Program works to keep your employees informed and represented when unexpected billing occurs. They'll help your employees understand their benefits, use their plans, find providers, and understand their Explanation of Benefits (EOB) documents

Terminal Liability Coverage: Provides added protection for claims that come in for 24 months after the end of the plan year – and is included with most Core Value plan selections*

Quality benefits

- All employer-established benefit plans are minimum essential coverage
- Preventive care coverage aligns with Affordable Care Act requirements and pays first-dollar benefits

Teladoc services

Providing access to a U.S. board-certified doctor 24-hours a day, seven days a week. Teladoc offers a more affordable and convenient way to access doctors for diagnoses and treatment of many common illnesses

* Terminal Liability Coverage is optional on 12/12 plans and does not apply in cases of early termination or for Aggregate only plans for groups with 51 or more enrolling employees. Fees may apply. Please refer to the plan proposal for details.

Provide quality benefits for less

Go beyond self-funding — Your savings add up fast with our Core Value Plan

In addition to the features of our Self-Funded Program, Core Value is designed to help you save even more.

Core Value is a reference-based pricing plan, which means it pays providers based on a multiple of the Medicare reimbursement rate.*

Core Value's rates are often lower than traditional self-funded plans, and that helps you save on your monthly costs

Plan members have the freedom to use any health care provider they choose.

- The following services still rely on the use of network providers:
  - » Pharmacy Benefits: Members use the Cigna PBM Network — a network providing access to over 68,000 retail pharmacies**
  - » Transplants: This plan uses a list of nationally recognized designated providers

Here's how it works:

Benefit example:

Not an actual case, presented for illustrative purposes only.

Billed charge for covered services	$3,376
Medicare reimbursement rate	$1,571.20
Plan Maximum Allowable Amount (MAA) *130% of Medicare reimbursement rate*	$2,042.56[1]
Member Coinsurance Responsibility (80/20)	$408.51
Plan pays:	$1,634.05

Core Value pays the following rates for covered services:

- 130% of the Medicare reimbursement rate* for Doctor Office visits
- 150% of the Medicare reimbursement rate* for Inpatient Services
- 130% of the Medicare reimbursement rate* for Outpatient Services
- 100% of the Medicare reimbursement rate* for Dialysis

* Or other derived equivalent

** Does not provide out-of-network benefits

1 Sometimes members may be Balanced Billed for the amounts in excess of the plan MAA. This is where the Member Advocacy Program can help to negotiate an agreed upon amount with the provider

Plan highlights

Your employees can depend on the Core Value Member Advocacy Program

Members may receive a bill for charges that include amounts which exceed the Patient Responsibility. If this happens, members should call the Member Advocacy Team right away.

The Member Advocacy Team will work with the provider to resolve any bill discrepancies*

Your employees can reach the Member Advocacy Team by calling 888-306-0905.

More features. More savings.

Core Value provides extra convenience and savings to your employees by including access to Teladoc

- Your employees can talk to a U.S. board-certified doctor 24 hours a day, 7 days a week. They can receive treatment anytime, anywhere, whether they're at work, home, or traveling abroad
- Teladoc offers prompt treatment with a median call-back time of 10 minutes and costs much less than a trip to urgent care or the emergency room
- Teladoc doctors can diagnose and treat many medical conditions, including cold and flu symptoms, allergies, ear infections, sinus problems and more

* Non-covered services and certain other charges are not eligible for the program. See pages 8 & 9 for more details.

Choose from our flexible plan design options

All employer-established health benefit plans meet the standards set by the Affordable Care Act. Health Savings account (HSA) and Health Reimbursement Arrangement (HRA) options are available.

Stop-loss options

AGGREGATE DEDUCTIBLE	Based on total expected claims, calculated based on the census of your group and other factors such as number of members, age, gender, etc.
SPECIFIC DEDUCTIBLE[2]	• $6,500 • $10,000 • $15,000 / • $20,000 • $25,000 • $30,000 / • $40,000 • $50,000 • $100,000

Group-member plan options

DEDUCTIBLE OPTIONS *Family deductible is two times the individual*	• $500 • $1,000 • $1,500[3] • $2,000[3] / • $2,500[3] • $2,750[3] • $3,000[3] • $3,500[3] / • $5,000[3] • $6,600[4] • $7,900[4, 8]
COINSURANCE OPTIONS	• 100% • 90% / • 80% • 70% / • 50%
OUT-OF-POCKET MAXIMUMS	$1,000 to $7,900; $1,000 to $7,150 in WA *(this includes deductible, coinsurance and copay amounts)*
OFFICE VISITS *Primary-care physician / specialist / urgent care*	• $20 / $35 / $75 • $35 / $50 / $75 • $40 / $60 / $75 / • $25 / Ded. and co-ins. / $75 • $35 / Ded. and co-ins. / $75 • $40 / Ded. and co-ins. / $75 / • $50 / Ded. and co-ins. / $75 • $50 / $75 / $100[8] • $60 / $100 / $100[8] / • Ded. and co-ins.
HOSPITAL AND SURGERY CHARGES	Applies to deductible and coinsurance
DIAGNOSTIC X-RAY AND LAB BENEFIT	• Applies to deductible and coinsurance • 100% first-dollar benefit • $500 first-dollar benefit, followed by deductible and coinsurance
OUTPATIENT PHYSICAL MEDICINE / CHIROPRACTIC CARE	Applies to deductible and coinsurance, limited to 30 visits per calendar year
SUBACUTE REHAB & NURSING FACILITY	Applies to deductible and coinsurance, limited to 31 days per calendar year
HOME HEALTH CARE	Applies to deductible and coinsurance, limited to 30 visits per calendar year
EMERGENCY ROOM VISIT *Note: Copay waived if admitted*	• $250, $350[8] or $500[8] access fee, followed by deductible and coinsurance • $250, $350[8] or $500[8] copay, no deductible or coinsurance (not allowed on HSA plan types) • Applies to deductible and coinsurance
MENTAL/BEHAVIORAL HEALTH AND SUBSTANCE ABUSE	**Outpatient, groups 50 and under:** • Applies to deductible and 50% coinsurance. Limited to 40 visits per year **Outpatient, groups over 50:** • Follows plan copay, deductible and coinsurance options chosen / **Inpatient, groups 50 and under:** • Applies to deductible and 50% coinsurance. Limited to 30 days per year **Inpatient, groups over 50:** • Follows plan copay, deductible and coinsurance options chosen
PRESCRIPTION DRUGS[5] *Generic / Preferred / Non-Preferred*	**Copay options:** *(additional options available)* • $15 / $45 / $60 • $20 / $50 / $75 • $0 / $35 / $50 / • $5 / $65 / $100[8] • $20 / $65 / $100[8] • Ded. then $20 / $50 / $75[6,8] / **Non-copay options:** • Apply to deductible and coinsurance[7] • 50% / 50% coinsurance option
TELADOC *Included on all plan designs*	Consultations at no additional cost to members with non-HSA plans. HSA plans have a $45 consultation fee. Fee applies to deductible and out-of-pocket maximums.
ACCIDENT MEDICAL EXPENSE *Optional benefit*	• $500 • $1,000

2 Availability varies by state
3 Health Savings Account (HSA)-compatible options
4 Not available with $6,500 specific deductible
5 No out-of-network benefits
6 Available with HSA plans, only
7 When you select this option, there is a 20% increase in the insured's coinsurance responsibility when Non-Preferred Prescription Drugs are purchased. Applies to the following coinsurance options: 90%, 80%, 70%. No coinsurance differential in WA
8 Not Available in WA
Refer to your Summary Plan Description for full benefit details.

Plan details and exclusions

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.

About National General

National General Benefits Solutions

National General Holdings Corp. (NGHC), headquartered in New York City, is a specialty personal lines insurance holding company. National General traces its roots to 1939, has a financial strength rating of A- (excellent) from A.M. Best, and provides personal and commercial automobile, homeowners, umbrella, recreational vehicle, motorcycle, lender-placed, supplemental health and other niche insurance products.

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

National General Benefits Solutions is focused on providing cutting-edge benefits solutions to small and mid-size businesses.

Visit us on the web at:

ngicbenefits.com

For use for September 1, 2019, and later effective dates.

Core Value is available in: AK, AZ, CT, DE, FL, GA, IA, IL, IN, ID, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NE, NC, ND, NJ, NM, NV, OH, OK, OR, PA, SC, SD, TN, TX, VA, VT, WA, WI, WV and WY

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