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. For employers in the NGBS Self-Funded Program, stop-loss insurance is underwritten by: Integon National Insurance Company in CO, CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Self-Funded Program Core Value Plan

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

* Or other derived equivalent. See page 7 for more details.
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.

- **Fully insured premium**
  - Full payment goes to the insurance company

- **Self-Funded Program monthly payment**

- **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

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:**

**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.

**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: 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.*

* 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.
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.*

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.

<table>
<thead>
<tr>
<th>Billed charge for covered services</th>
<th>$3,376</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare reimbursement rate</td>
<td>$1,571.20</td>
</tr>
<tr>
<td>Plan Maximum Allowable Amount (MAA) 130% of Medicare reimbursement rate</td>
<td>$2,042.56¹</td>
</tr>
<tr>
<td>Member Coinsurance Responsibility (80/20)</td>
<td>$408.51</td>
</tr>
<tr>
<td>Plan pays:</td>
<td>$1,634.05</td>
</tr>
</tbody>
</table>

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 (MAP)

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

The MAP team will work with the provider to resolve any bill discrepancies.¹

Your employees can reach the Member Advocacy Program 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 receive treatment anytime, anywhere, whether they’re at work, home, or traveling abroad.
• Prompt treatment with a median call-back time of 10 minutes.
• Teladoc doctors can give treatment anytime, anywhere, for many common, non-emergency conditions.

Healthcare Bluebook™

We’ve partnered with Healthcare Bluebook to offer you and your employees a clear way to save. Healthcare Bluebook is a cost and quality steerage tool to help members access quality health care at a fair price. With this easy-to-use tool, plan members can shop around for low-cost, high-quality providers — helping you keep your claims costs down.²

¹ Non-covered services and certain other charges are not eligible for the program. See pages 8 & 9 for more details.
² There is no correlation between the Healthcare Bluebook Fair Price™ service and a provider accepting the payment made by the Core Value plan. Not included with Core Value Access.
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.

AGGREGATE DEDUCTIBLE

SPECIFIC DEDUCTIBLE

DEDUCTIBLE OPTIONS

Based on total expected claims, calculated based on the census of your group and other factors such as number of members, age, gender, etc.

- $6,500
- $10,000
- $15,000
- $20,000
- $25,000
- $30,000
- $40,000
- $50,000
- $100,000

- $500
- $1,000
- $1,500
- $2,000
- $2,500
- $3,000
- $3,500
- $4,000
- $4,500
- $5,000
- $5,500
- $6,000
- $6,500
- $7,000
- $7,500
- $8,000
- $8,500

COINSURANCE OPTIONS

OUT-OF-POCKET MAXIMUMS

OFFICE VISITS

HOSPITAL AND SURGERY CHARGES

DIAGNOSTIC X-RAY AND LAB BENEFIT

OUTPATIENT PHYSICAL MEDICINE / CHIROPRACTIC CARE

SUBACUTE REHAB & NURSING FACILITY

HOME HEALTH CARE

EMERGENCY ROOM VISIT

MENTAL/BEHAVIORAL HEALTH AND SUBSTANCE ABUSE

PRESCRIPTION DRUGS

TELADOC

ACCIDENT MEDICAL EXPENSE

Stop-loss options

Group-member plan options

* Available for January 1, 2021, and later effective dates.
1 Availability varies by state.
2 Health Savings Account (HSA)-compatible options.
3 Not Available in WA.
4 Available with HSA plans only.
5 Not available with $6,500 specific deductible.
6 No out-of-network benefits.
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. 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.
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.

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.
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. For employers in the NGBS Self-Funded Program, stop-loss insurance is underwritten by: Integon National Insurance Company in CO, CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered. (Rev. 09/2020) © 2020 National General Insurance. All rights reserved.

Core Value is not available in: CO, DC, HI, MD, NY, RI
Core Value is only available in CA in the following markets: Los Angeles, Santa Ana, San Diego, Santa Barbara, Fresno

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. For employers in the NGBS Self-Funded Program, stop-loss insurance is underwritten by: Integon National Insurance Company in CO, CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered. (Rev. 09/2020) © 2020 National General Insurance. All rights reserved.