National General
Benefits Solutions

Lower your health benefit costs with **Core Value**

Core Value helps you save

Core Value is a reference based pricing plan, meaning it pays providers based on a multiple of the Medicare reimbursement rate*, regardless of the billed amount. Many providers accept the plan payment as a full and fair payment for the claim.

You still have the same flexible plan design options as our standard Self-Funded Plan, making it easy for you to choose the plan that best fits your group's needs. Core Value's rates are often lower than traditional self-funded plans, and that helps you save on your monthly costs.

And, there are no networks associated with this plan — plan members have the freedom to use any provider they choose. However, the following services still rely on the use of network providers:

- Pharmacy Benefits: Works the same as with other NGBS Self-Funded Programs. 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

This plan design, combined with the other benefits of our Self-Funded Program, help keep your monthly payment predictable and less costly — while you and your employees still get the same quality of care and benefits you expect.

* Or other derived equivalent

Continued on next page

National General gives you the support you need, **when you need it**

When you select the Core Value plan from National General Benefits Solutions, you and your members get access to the Member Advocacy Program.

The program includes a dedicated Member Advocacy Team to assist with:

- Finding providers
- Questions regarding benefits
- Claim status updates
- Billing questions and disputes

Core Value also provides you with:

- Flexible plan designs: Choose the plan that works best for your group
- Access to Teladoc®: Providing your members with access to less costly, more convenient health care for common conditions
- An extended protection period: The plan includes a 9-month run-out period and a Terminal Liability rider for an additional 15 months of stop-loss insurance protection for claims incurred during the coverage period

We do the work so you don't have to.

The NGBS Self-Funded Core Value plan is managed and administered by our trusted Third Party Administrator: Allied Benefits Systems, Inc. (Allied). In addition to the Member Advocacy Program that is accessible with this plan, Allied offers extensive online services and monthly reporting that make it easy for you and your employees to find information about the plan. While Allied handles the day-to-day, you can focus on your business.

Here's how Core Value pays benefits

Core Value pays for 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

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)	$2,042.56[1,2]
Member Coinsurance Responsibility (80/20)	$408.51
Plan pays:	$1,634.05

1 130% of the Medicare reimbursement rate

2 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.

Not all provider billing is eligible for the Member Advocacy Program. Excluded charges include, but are not limited to: charges for non-covered services or charges in excess of a benefit limit; charges for non-emergency use of an Emergency Room; non-emergency medical transportation when an authorized provider is not used, charges for the second and subsequent surgeries in the same surgical session; and assistant surgeon and surgical assistant charges. This list is subject to change without notice. Call the Member Advocacy Team to verify if charges are eligible.

Your health plan benefits available with Allied

All employer-established health benefit plans meet the standards set by the Affordable Care Act.

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[3]	• $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[4] • $2,000[4] • $2,500[4] • $2,750[4] • $3,000[4] • $3,500[4] • $5,000[4] • $6,600[5] • $7,150
COINSURANCE OPTIONS	• 100% • 90% / 10% • 80% / 20% • 70% / 30% • 50% / 50%[6]
OUT-OF-POCKET MAXIMUMS	$1,000 to $7,150 *(this includes deductible, coinsurance and copay amounts)*
OFFICE VISITS *(Primary-care physician / specialist)*	• $20 / $35 • $35 / $50 • $40 / $60 • $25 / Ded. and coinsurance • $35 / Ded. and coinsurance • $40 / Ded. and coinsurance • $50 / Ded. and coinsurance • Ded. and coinsurance
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	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 access fee, followed by deductible and coinsurance • $250 co-pay, no deductible or coinsurance (not allowed on HSA plan types) • Applies to deductible and coinsurance
URGENT CARE	• $75 copay, then 100% • 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. Limited to 30 days per year
PRESCRIPTION DRUGS[7] *(Generic/Preferred/Non-Preferred)*	**Copay options:** • $15/$45/$60 • $20/$50/$75 • $0/$35/$50 **Non-copay options:** • Apply to deductible and coinsurance[8] • 50% / 50% coinsurance option (not available in Washington)
TELADOC	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

3 Availability varies by state
4 Health Savings Account (HSA)-compatible options
5 Not available with $6,500 specific deductible
6 Not available with all networks
7 No out-of-network benefits

8 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% / 10%, 80% / 20%, 70% / 30%. *Refer to your Summary Plan Description for full benefit details.*

The Self-Funded Program provides tools for small-business employers 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 National General Benefits Solutions Self-Funded Program is underwritten and issued by National Health Insurance Company, Time Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation.