
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Exemplar Health Benefits Administrator at (855) 826-3422. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.cms.gov/CCIIO/Resources or see your Summary Plan Description (SPD).

Important Questions	Answers		Why This Matters:
<p>What is the overall deductible?</p>	<p>Network Providers \$3,000/Individual or \$6,000/Family</p>	<p>Out-of-Network Providers \$4,500/Individual or \$9,000/Family</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care services are covered before you meet your deductible.</p>	<p>N/A</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No</p>	<p>No</p>	<p>No. You don't have to meet deductibles for specific services.</p>

<p>What is the out-of-pocket limit for this plan?</p>	<p>Network Providers \$3,000/Individual, \$6,000/Family</p>	<p>Out-of-Network Providers \$6,000/Individual, \$12,000/Family</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p>What is the co-insurance?</p>	<p>0%</p>	<p>50%</p>	<p>Up to the out-of-pocket limit.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties for non-compliance with plan provisions; premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Penalties for non-compliance with plan provisions; premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See https://www.healthlink.com/member/ for a list of network providers.</p>	<p>.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work).</p>
<p>Do you need a referral to see a specialist?</p>	<p>No</p>	<p>No</p>	<p>You can see the specialist you choose without a referral.</p>

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible	50% after Deductible	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Specialist visit	Deductible	50% after Deductible	
	Preventive care/screening/immunization	No charge	50% after Deductible	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible	50% after Deductible	
	Imaging (CT/PET scans, MRIs)	Deductible	50% after Deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.prorxsolutions.com	Generic drugs (Tier 1)	Deductible	N/A	Benefits may vary if more than a 30 day supply is needed.
	Preferred brand drugs (Tier 2)	Deductible	N/A	
	Non-preferred brand drugs (Tier 3)	Deductible	N/A	
	Specialty drugs (Tier 4)	Deductible	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible	50% after Deductible	
	Physician/surgeon fees	Deductible	50% after Deductible	
If you need immediate medical attention	Emergency room care	Deductible		\$500 applies if used for non-urgent services.
	Emergency medical transportation	Deductible	Deductible	
	Urgent care	Deductible	Deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible	50% after Deductible	
	Physician/surgeon fees	Deductible	50% after Deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient and inpatient services	Deductible	50% after Deductible	Behavioral health and mental wellness services that are rendered by a licensed professional in an office visit setting are subject to the same payments as primary care.
	Office visits	Deductible	50% after Deductible	
If you are pregnant	Office visits	No Charge	No Charge	
	Childbirth/delivery professional services	Deductible	50% after Deductible	
	Childbirth/delivery facility services	Deductible	50% after Deductible	
If you need help recovering or have other special health needs	Home health care	Deductible	50% after Deductible	
	Rehabilitation services	Deductible	50% after Deductible	
	Habilitation services	Deductible	50% after Deductible	
	Skilled nursing care	Deductible	50% after Deductible	
	Durable medical equipment	Deductible	50% after Deductible	
	Hospice services	Deductible	50% after Deductible	
If your child needs dental or eye care	Children's eye exam	No Charge	No Benefit	Coverage limited to one exam/year.
	Children's glasses	No Benefit	No Benefit	Per plan provisions
	Children's dental check-up	No Benefit	No Benefit	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture (if prescribed for rehabilitation purposes)
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Birth Control
- Colonoscopy
- Diagnostic Services
- Sterilization for Women
- Transplants (inpatient only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323, extension 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Exemplar Health Benefits Administrator at (855) 826-3422.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 855-826-3422.]

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) **\$3,000**
- [Specialist copayment](#) **\$0**
- [Hospital \(facility\) coinsurance](#) **0%**
- [Other coinsurance](#) **0%**

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$13,615
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) **\$3,000**
- [Specialist copayment](#) **\$0**
- [Hospital \(facility\) coinsurance](#) **0%**
- [Other coinsurance](#) **0%**

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$8,826
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$2,587
Copayments	\$0
Coinsurance	\$413
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$3055

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) **\$3,000**
- [Specialist copayment](#) **\$0**
- [Hospital \(facility\) coinsurance](#) **0%**
- [Other coinsurance](#) **0%**

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,295
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,925
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1925

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: **NOT APPLICABLE**

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.