
 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, please visit [www.nhpri.org](http://www.nhpri.org) or by calling 1-855-321-9244. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-855-321-9244 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>In-network \$2,300</b> Individual/ <b>\$4,600</b> Family <b>Out-of-network \$6,900</b> Individual/ <b>\$13,800</b> Family	If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> Preventive care, primary care, specialist visit, emergency room, urgent care, prescription drugs in tier 1, 2, 3, 4, 5, & 6 and outpatient services for mental health, behavioral health, and substance use	For example, this plan covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	<b>No</b>	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In-network \$5,500</b> Individual/ <b>\$11,000</b> Family <b>Out-of-network \$16,500</b> Individual/ <b>\$33,000</b> Family	If you have other family members in this plan, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> See <a href="https://www.nhpri.org/find-a-doctor/">https://www.nhpri.org/find-a-doctor/</a> or call 1-855-321-9244 for a list of network providers.	This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your plan pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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 Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 copay/office visit	50% coinsurance	None
	<a href="#">Specialist</a> visit	\$55 copay/visit	50% coinsurance	<a href="#">Preauthorization</a> may be required. Acupuncture and chiropractic care is limited to 12 visits a year.
	<a href="#">Preventive care/screening/</a> Immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% coinsurance	50% coinsurance	No charge for in-network preventive laboratory tests associated with <a href="#">preventive visit</a>
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	Preauthorization may be required
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.nhpri.org">www.nhpri.org</a>	Low Cost Maintenance Generics	\$5 copay/prescription	Not Covered	For up to a 30-day supply
	Other Generics +	\$10 copay/prescription	Not Covered	For up to a 30-day supply
	Preferred Brands Maintenance	\$35 copay/prescription	Not Covered	For up to a 30-day supply
	Brands	\$50 copay/prescription	Not Covered	For up to a 30-day supply
	High Cost and Specialty	\$200 copay/prescription	Not Covered	For up to a 30-day supply
	Covered Non Preferred	\$200 copay/prescription	Not Covered	For up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	Preauthorization may be required
	Physician/surgeon fees	0% coinsurance	50% coinsurance	Preauthorization may be required

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 Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 copay/visit	\$250 copay/visit	None
	<a href="#">Emergency medical transportation</a>	0% coinsurance; \$50 max per trip	0% coinsurance; \$50 max per trip	None
	<a href="#">Urgent care</a>	\$55 copay/visit	55 copay/visit	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Preauthorization may be required
	Physician/surgeon fees	0% coinsurance	50% coinsurance	Preauthorization may be required
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 copay/office visit	50% coinsurance	Preauthorization may be required
	Inpatient services	0% coinsurance	50% coinsurance	Preauthorization may be required
<b>If you are pregnant</b>	Office visits	\$55 copay/visit	50% coinsurance	Cost sharing does not apply for in-network preventative services
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	0% coinsurance	Not Covered	Preauthorization may be required
	<a href="#">Rehabilitation services</a>	\$55 copay/visit	50% coinsurance	Limit to 24 visits a year
	<a href="#">Habilitation services</a>	\$55 copay/visit	50% coinsurance	Limit to 24 visits a year
	<a href="#">Skilled nursing care</a>	0% coinsurance	Not Covered	Preauthorization may be required
	<a href="#">Durable medical equipment</a>	0% coinsurance	Not Covered	Preauthorization may be required
	<a href="#">Hospice services</a>	0% coinsurance	50% coinsurance	Preauthorization may be required
<b>If your child needs dental or eye care</b>	Children's eye exam	\$55 copay/visit	50% coinsurance	Limit of once per year
	Children's glasses	No Charge	50% coinsurance	Limit of one pair of frames and lenses, or one pair of contact lenses, per year

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 Provider (You will pay the most)	
	Children's dental check-up	No Charge	Not Covered	None

### Excluded Services & Other Covered Services:

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Coverage provided outside the United States. See <a href="http://www.nhpri.org">www.nhpri.org</a></li> </ul>

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside of the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

**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: HealthsourceRI [www.healthsourceri.com](http://www.healthsourceri.com) or you can call 1-855-840-4774.

**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 on how 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 your state insurance department at 1-855-747-3224 or by email at [HealthInquiry@ohio.gov](mailto:HealthInquiry@ohio.gov), the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Does this plan provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the 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 **1-855-321-9244**.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-855-321-9244**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-855-321-9244**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-855-321-9244**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-855-321-9244**.

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

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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](#) \$2300
- [Specialist](#) copayment \$55
- 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*)

<b>Total Example Cost</b>	<b>\$12,640</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,300
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,310</b>

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

- The [plan's](#) overall [deductible](#) \$2300
- [Specialist](#) copayment \$55
- 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*)

<b>Total Example Cost</b>	<b>\$5,580</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,800</b>

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

- The [plan's](#) overall [deductible](#) \$2300
- [Specialist](#) copayment \$55
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>