Our Royalty Series Health Plans
Platinum plan designs at Bronze level pricing

The Exemplar Royalty Series give many employers a dynamic solution to the rising costs and limitations of today's health insurance market. We are excited to offer affordable and comprehensive coverage for small employers down to as little as 5 lives and large employers with 100's of lives.

With twelve different Metallic Health Plan offerings, we have a wide variety of options for groups of all sizes and needs:

- Available for employer groups domiciled in 47 states
- Reinsurance provided by one of the top Reinsurers in the world, AM Best "A" Excellent
- Available to groups as small as 5 enrollees
- Level Funded Program
- Consistently the most competitive rates in the industry
- Traditional PPO networks
- Reference Based Pricing options without all the "hassle"
- Quick Turn Around Times
- 0%, 50%, 100% of the remaining claim fund returned to the employer after contract period
- No Employer contribution requirement
- No Group participation requirements
- ACA Compliant Plans

The Majority Of Our Groups Are Rated Directly Off Of Your Company Census, Little To No Underwriting.

Group Guidelines

- Minimum Group Size: 5
- Participation: No Participation Requirements
  - Cobra Participation: No more than 10%
  - Retirees: Not Covered
  - Employees outside US: Not Covered
  - 1099 Employees: Not Covered
- States that are ineligible: New York, Hawaii & Washington

We have two standard network options. One option is a traditional PPO offering through the First Health Network and our second option is using the PHCS practitioner network and a Reference Based Pricing Model for facilities. The way EHBA and Hi-Card approach the RBP model has revolutionized RBP and the way healthcare is utilized and paid for. We have all but eliminated the traditional challenges with RBP. See below to learn what separates our RBP model from everyone else.

*Note if using a traditional PPO network high card is not needed.

HICard

Plantinum Benefits at Bronze Rates

CHANGE IS HERE. NOW.

A new way to offer reference base pricing plans
Without **ALL** the challenges

PROGRAM BENEFITS

- Most competitive heathcare rates in the industry
- 100% transparency for all costs in the process
- Secure and portable health records 24/7
- Personal ownership and control of access to medial records
- Positive identification at initial registration
- Faster treatment and medical care
- No more filling out long forms and waiting for admittance
- Audit trail through a course of treatment that crosses multiple organizations

Plus more!

Employers

Brokers

Patients

Insurance Carriers

Hospitals

Our New Program

Hi-Card changes the way Employers, Patients, Hospitals, Brokers and Insurance Carriers work together.

ALL Hi-Card Plans will offer ACA-Compliant Platinum level benefits at Bronze tier rates.

This is an exclusive program! Only select companies meeting specific guidelines are eligible to participate in our program.

HI Card Health Network

is not like any other Reference Based Pricing vendor in the marketplace today. **We are directly involved** through the entire cycle; from the Underwriting, Sales, Distribution, Pre-Certification, and Provider Communication to ultimately the payment of the Claim. We believe that the only way to ensure Patient satisfaction is to be involved with every step of the Healthcare process. First off, all of our programs utilize Physicians Only Networks to manage 80% of the claims which drive 20% of the Plan spend. Why would we want to get in the middle of you and your current Primary Care Physicians? We don't

We only want to impact the 20% of claims that drive 80% of your Plan spend

How do we do that? **We get involved** even before there is a claim being presented to the Payor. We are PROACTIVE whereas all of our competitors are REACTIVE, waiting until the claim has blown up, the Membersare getting Balance Billed, and they are most likely being sent to collections.

ACCURATE. ANYTIME. ANYWHERE

To learn more about be our Royalty Series please call 1-855-826-EHBA
Exemplar Health Benefit Administrators | 1107 West Market Center Drive, High Point, NC 27260

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Life of a claim - RBP Patient Experience

Patient's Step-by-Step Process

Patient walks in to see their Primary Care Physician because their knee has been very sore. Doctor evaluates the Patient who is 60 years old. It is determined that the Patient needs to see an Orthopedic specialist and a referral is made.

Patient sees the Ortho who comes to the conclusion that the patient needs to have their knee replaced. The Ortho tells his team to obtain a Pre-certification

Where HI Card Shows Up

Doctors Office logs into their personal HI Card Provider Portal and makes a Pre-certification request through the system for Patient's knee replacement.

HI Card's Pre-authorization Team reviews the data, agrees with the doctor's assessment for a knee replacement, and approves the Pre-certification.

At that approval time, HI Card's Pre-certification team:

Informs the Provider that they are Out-Of-Network and a claim reimbursement should be agreed upon prior to services being performed.

Confirms the Provider's office contact person that will be coordinating with the HI Card Negotiation Advocate.

The HI Card's Negotiation Advocate will immediately contact the appropriate person to see if they can negotiate an acceptable claim reimbursement.

If YES

They will send a Single Case Agreement with the reimbursements included to get signed. Upon receipt of the signed agreements, services get scheduled and the agreements go to the TPA to reprice the claim when it comes in (per the contract).

If NO

They are unable to negotiate an acceptable reimbursement amount, the HI Card Advocacy team starts working on Plan B, finding another Provider that will work with us on an acceptable claim reimbursement.

- If a Provider is found that will work with us, we will provide this referral as an option to the Patient.
- If the Patient declines the new Provider, then we will only pay what we are negotiated with the Plan B Provide, no matter what The Patient may be balance billed at this point.
- In many cases, we waive Patient deductibles if they accept Plan B, knowing it may be an inconvenience.

The HI Card's Negotiation Advocate will immediately contact the appropriate person to see if they can negotiate an acceptable claim reimbursement

- Patient receives Pre-certification.
- Patient's surgery takes place.
- Patient receives bill.
- Bill is settled

Summary of Benefits

	Platinum 100	Platinum 101	Platinum 102	Gold 200	Gold 201	Gold 202
Deductible (Indiv - Family) [1]	$250 / $750	$1,250 / $3,750	$0 / $0	$1,000 / $3,000	$3,000 / $9,000	$3,250 / $9,750
Deductible Type	Embedded	Embedded	N/A	Embedded	Embedded	Embedded
Plan Type	Co-pay	Co-pay	Co-pay	Co-pay	HSA	Co-pay
Primary/ Specialist/ Urgent Care	$25 / $45 / $45	$25 / $45 / $45	$25 / $45 / $45	$15 / $40 / $40	0%	$30 / $50 / $50
Wellness / Preventative	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
X-Ray / Lab	20%	0%	0%	0%	0%	0%
Emergency Room [2]	20%	$300 Copay	$300 Copay	$300 Copay	0%	$400 Copay
Co-Insurance	20%	0%	0%	0%	0%	0%
OOP Max (Indiv - Family)	$1,250 / $3,750	$1,250 / $3,750	$1,250 / $3,750	$3,500 / $10,500	$3,000 / $9,000	$3,250 / $9,750
In-Patient Hospitalization	20%	0%	0%	0%	0%	0%
Out-Patient Surgery	20%	$100 Copay	$100 Copay	$100 Copay	0%	$150 Copay
Prescription Drugs T1	$0	$0	$0	$0	After deductable 0% coinsurance	$0
Prescription Drugs T2	$35 or 25%*	$35 or 25%*	$35 or 25%*	$35 or 25%*		$35 or 25%*
Prescription Drugs T3	$75 or 25%*	$75 or 25%*	$75 or 25%*	$75 or 25%*		$75 or 25%*
Prescription Drugs Spec	$200 or 30%	$200 or 30%	$200 or 30%	$200 or 30%	Not Covered	$200 or 30%

1. Deductible applies to all services that indicates Coinsurance
2. $500 Penalty applies if used for non-urgent services
* Whichever is greater
Facility services have to be preauthorized for benefits

This is a summary overview of benefits - please refer to your Summary Benefits of Coverage (SBC) or Plan Document for a more detailed explanation of benefits. If any discrepancies exist between these documents, the Plan Document will be the controlling document.

	Silver 300	Silver 303	Silver 3302	Bronze 403	Bronze 404	Bronze 405
Deductible (Indiv - Family) [1]	$2,000 / $4,000	$2,000 / $4,000	$3,000 / $9,000	$1,000 / $12,700	$6,000 / $12,000	$8,000 / $16,000
Deductible Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Plan Type	Coinsurance	HSA	Co-pay	Co-pay	HSA	Co-pay
Primary/ Specialist/ Urgent Care	20%	20%	$35 / $55 / $55	$40 / $80 / $60	30%	$50 / $120 / $100
Wellness / Preventative	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
X-Ray / Lab	20%	20%	20%	30%	30%	30%
Emergency Room [2]	20%	20%	20%	30%	30%	$500 Co-Pay / 30% Coinsurance
Co-Insurance	20%	20%	20%	30%	30%	30%
OOP Max (Indiv - Family)	$6,000 / $12,700	$4,000 / $8,000	$6,350 / $12,7000	$6,350 / $12,700	$6,900 / $13,800	$8,550 / $17,100
In-Patient Hospitalization	20%	20%	20%	30%	30%	30%
Out-Patient Surgery	20%	20%	20%	30%	30%	30%
Prescription Drugs T1	$0	$0	$0	$0	After deductable 0% coinsurance	$0
Prescription Drugs T2	$35 or 25%*	$35 or 25%*	$35 or 25%*	$35 or 25%*		$35 or 25%*
Prescription Drugs T3	$75 or 25%*	$75 or 25%*	$75 or 25%*	$75 or 25%*		$75 or 25%*
Prescription Drugs Spec	$200 or 30%	$200 or 30%	$200 or 30%	$200 or 30%	Not Covered	$200 or 30%

1. Deductible applies to all services that indicates Coinsurance
2. $500 Penalty applies if used for non-urgent services
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Facility services have to be preauthorized for benefits

This is a summary overview of benefits - please refer to your Summary Benefits of Coverage (SBC) or Plan Document for a more detailed explanation of benefits. If any discrepancies exist between these documents, the Plan Document will be the controlling document.

Frequently Asked Questions

Where can I go to obtain additional information about the program?

You can go to www.exemplarhba.com , you can call 855-826-EHBA, or reach out to us via email at tim.hawley@exemplarinsuranceassociates.com and we will contact you within 24 hours.

Are there limits to the number of plans?

Groups may select up to 2 of our 12 standard plans to offer their employees, both plans must be RBR or both must be PPO.

What group sizes are eligible?

5 to 100 enrolled employees, no other participation requirements.

What if I have a group that is too large?

Just let us know and we can work with you to obtain a Traditional Specific and Aggregate Stop Loss Proposal.

Will you accept Claims information in Lieu of Health Applications?

Claims data is not required to receive a quote for groups under 100 lives

Are there any ineligible industries?

- Groups with Non-ERISA Plans
- MEWA's
- Groups without a singular employer/ employee relationship
- Indian Tribes/Nations
- Underground Mining
- Non Taft-Hartley Unions
- Legal Firms

Can we match in-force plans?

Our program has 12 ACA qualified plans that are available. A group may choose up to 2 of those plans to offer employees.

What makes up the fixed costs?

Fixed costs typically include TPA Fees, Network Fees which include Utilization Review/Case Management, Program Management Fees, and Producer Compensation (as applicable).

How does the claim fund work?

Funding is paid monthly into the Employer's Claim Fund. For incurred claims the Employer Claim Fund is used to pay those adjudicated claims. At the end of the contract term, normally referred to as the run-out period, the TPA will conduct an audit of the Employers Claim Fund. Employers upon selecting a plan have three choices with any surplus, a 0%, 50%, or 100%. Depending on the selection any surplus in the Employers Claim Fund will be returned to the employer at the end of the run out period.

What is the contract period?

Groups, from their effective date, are written on a 12 month incurred and 18 months paid (12/18) contract.

What networks are available?

Our plans have 2 network options to choose from. A standard PPO network plans typically use the First Health Network. Our second option is using the PHCS practitioner network and Hi-Card RBP for facilities.

Can I choose more than one network?

If an employer offers 2 plans to their employees both plans must be on the same network pricing – i.e. both plans must be on PHCS + High-Card or both must be on the PPO network.

Frequently Asked Questions

What is Reference Based Reimbursement (RBR)?

Reference Based Reimbursement (RBR), also commonly known as Cost Plus Pricing, offers self-funded health plans a defined benefit structure based on a review of or "referencing" other forms of reimbursement for Provider services. There is no defined "In- Network" list for members to look at and make sure that they must go to one of those Providers or they have an "Out-of-Network" penalty they need to deal with. All Providers are considered "In-Network" in an RBR program. It is designed to provide fair and reasonable reimbursements to Providers based on various pricing data sets, one being Medicare.

- Providers to learn more about the prevailing costs of health care services
- Both plan members and providers to take the initiative in learning the true costs of health care services and avoid the substantial variations in pricing that can exist
- Employee engagement ushers in simpler, more transparent health care pricing
- Consumers to review pricing information in advance

How do I obtain an Illustrative Proposal?

To obtain an illustrative proposal we need both group information and census data. The Group information needed: Employers Name, Full Physical Address, SIC Code or Nature of Business. Census data needed: First and Last Name of Employee, Gender, DOB, Home Zip Code, and Coverage Tier (E, ES, EC, F) if known. If you need a census template please email tim.hawley@exemplarinsuranceassociates.com.

How do I obtain a Final Proposal?

The majority of our underwriting is done off of the group census. If the group census is underwritten with in predefined risk score tolerances, no additional information is needed and a firm quote will be emailed. If during the underwriting process individuals are "flagged" an EHBA employee application will be required to finalize the quote.

How long is a quote good for?

Proposal with Final Medical Underwriting cannot be issued more than 60 days prior to the effective date.

ALL EXEMPLAR ROYALTY SERIES PLANS ARE ADMINISTERED BY

EXEMPLAR

HEALTH BENEFITS ADMINISTRATOR

EHBA
1107 West Market Center Drive
High Point, NC 27260
www.exemplarhba.com