



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 Planstin at 888-920-7526. For general definitions of common terms, or other Underlined terms, see the [Uniform Glossary](#).

Important Questions	Answers		Why This Matters:
What is the overall <a href="#">Deductible</a> ?	<u>MEDICAL</u> \$3,500 / Ind \$7,000 / Family	<u>PRESCRIPTION</u> \$1,000 / Ind \$2,000 / Family	Generally, you must pay all of the costs from <a href="#">Providers</a> up to the <a href="#">Deductible</a> amount before this <a href="#">Plan</a> begins to pay. 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 deductible. The medical and prescription deductibles accumulate separately.
Are there services covered before you meet your <a href="#">Deductible</a> ?	Yes. <a href="#">Preventive Services</a> are covered before you meet your <a href="#">Deductible</a> .		This <a href="#">Plan</a> covers <a href="#">Preventive Services</a> even if you haven't yet met the <a href="#">Deductible</a> amount. See a list of covered Preventive Services at located at the ACA website by visiting <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?	No		Not Applicable
What is the <a href="#">Out-of-Pocket Limit</a> for this <a href="#">Plan</a> ?	<u>MEDICAL</u> \$7,100 / Ind \$14,500 / Family	<u>PRESCRIPTION</u> \$1,200 / Ind \$2,100 / Family	The <a href="#">Out-of-pocket Limit</a> is the most you could pay in a plan year for covered services. If you have family members on this <a href="#">Plan</a> , 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. The medical and prescription out-of-pocket limits accumulate separately.
What is not included in the <a href="#">Out-of-Pocket Limit</a> ?	<a href="#">Premiums</a> , <a href="#">Balance Billing Charges</a> , <a href="#">Services not Covered by this Plan</a> , <a href="#">Fees above RBP and/or UCR</a>		Even though you pay these expenses, they don't count towards the <a href="#">Out-of-Pocket Limit</a> .
Will you pay less if you use a <a href="#">Network Provider</a> ?	Not Applicable		This <a href="#">Plan</a> does not use a <a href="#">Provider Network</a> . You may receive covered services from any provider.
Are there prescription services?	Yes		Prescription services are available through Optum Rx. The pharmacy help desk can be reached at 877-633-4461. Start using all features of your prescription card by going to the <a href="#">OptumRx Portal</a> .
Do you need a <a href="#">Referral</a> to see a <a href="#">Specialist</a> ?	No		You can see any <a href="#">Specialist</a> you choose without a <a href="#">Referral</a> .

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care <b>Provider's</b> office or clinic	<a href="#">Primary Care</a> Visit to Treat an Injury or Illness	30% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates.
	<a href="#">Specialist</a> Visit	30% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Preventive Care/Screening/Immunization</a>	No Charge	
If you have a test	<a href="#">Diagnostic Test</a> (X-Ray)	30% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates.
	Lab/Bloodwork	30% Coinsurance <b>AFTER</b> Deductible is Met	
	Imaging (CT/PET Scans, Ultrasounds, MRIs)	30% Coinsurance <b>AFTER</b> Deductible is Met	
If you need drugs to treat your illness or condition <b>More information about <a href="#">Prescription Drug</a> discounts is available at <a href="#">rx.planstin.com</a></b>	Tier 1 - Generic	30% Coinsurance <b>AFTER</b> Deductible is Met	ACA Preventive drugs are covered 100%. After deductible is met, plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Retail: Covers up to a 30-day supply. Mail Order: Covers up to a 90-day supply. Coverage is limited to FDA-approved prescription drugs. If brand named drugs are used when a generic is available, the member must pay the difference in cost plus the applicable coinsurance. Some drugs may require prior authorization or step therapy. Specialty Drugs subject to medical necessity requirements. <b>*Plan pays a maximum of \$500 per Specialty RX. Cost of Specialty RX over the \$500 max plan limit will be the responsibility of the member and will not be applied to the member's deductible or OOP.</b>
	Tier 2 - Preferred Brand	30% Coinsurance <b>AFTER</b> Deductible is Met	
	Tier 3 - Non-Preferred Brand	30% Coinsurance <b>AFTER</b> Deductible is Met	
	Tier 4 – <a href="#">Specialty</a>	30% Coinsurance <b>AFTER</b> Deductible is Met*	
If you have outpatient surgery	Facility Fee / ASC	30% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions.
	Physician/Surgeon Fees	30% Coinsurance <b>AFTER</b> Deductible is Met	
If you need immediate medical attention	<a href="#">Emergency Room Care</a>	30% Coinsurance <b>AFTER</b> Deductible is Met	<b>EMERGENCIES ONLY.</b> After <a href="#">Deductible</a> , plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates.
	<a href="#">Emergency Medical Transportation</a>	30% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Urgent Care</a>	30% Coinsurance <b>AFTER</b> Deductible is Met	Applies to <b>URGENT CARE FACILITIES ONLY.</b> After <a href="#">Deductible</a> , plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates.

[\* For more information about limitations and exceptions, see the plan or policy document at [planstin.com/resources](#).]

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility Fee (i.e., Hospital Room)	30% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions.
	Physician/Surgeon fees	30% Coinsurance <b>AFTER</b> Deductible is Met	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	30% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions.
	Inpatient Services	30% Coinsurance <b>AFTER</b> Deductible is Met	
If you are pregnant	Office Visits	30% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates.
	Childbirth / Delivery Professional Services	30% Coinsurance <b>AFTER</b> Deductible is Met	
	Childbirth / Delivery Facility Services	30% Coinsurance <b>AFTER</b> Deductible is Met	
If you need help recovering or have other special health needs	<a href="#">Home Health Care</a>	30% Coinsurance <b>AFTER</b> Deductible is Met	Home Health Care: Limit of 60 Visits per Member, per Plan Year Rehabilitation Services & Habilitation Services: Limit of 120 Visits (Combined) per Member, per Plan Year and Includes Physical Therapy, Occupational Therapy & Speech Therapy Skilled Nursing Care: Limit of 120 Days per Member, per Plan Year Durable Medical Equipment Limitations: Limited to \$1,000 per Item/Service per, Plan Year  After <a href="#">Deductible</a> , plan pays 70% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions.
	<a href="#">Rehabilitation Services</a>	30% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Habilitation Services</a>	30% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Skilled Nursing Care</a>	30% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Durable Medical Equipment</a>	30% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Hospice Services</a>	30% Coinsurance <b>AFTER</b> Deductible is Met	
	Chiropractor Visits <small>*Limit 12 Visits per Member, per Plan Year</small>	30% Coinsurance <b>AFTER</b> Deductible is Met	
If your child needs dental or eye care	Children's Vision Acuity Screening	No Charge	Plan pays 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan pays <a href="#">UCR</a> rates.
	Children's Glasses	Not Covered	
	Children's Fluoride Varnish	No Charge	Plan pays 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan pays <a href="#">UCR</a> rates.

[\* For more information about limitations and exceptions, see the plan or policy document at [planstin.com/resources](http://planstin.com/resources).]

## 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](#).)

- Abortion
- Acupuncture
- Bariatric Surgery
- Dental Care (Adult)
- Experimental/Investigational Services
- Hearing Aids
- Home Traction Units
- Infertility/Reproductive Treatment
- Immunization for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever
- Laser Assisted in Situ Keratomileusis (LASIK)
- Long Term Care
- Non-Emergency Care when Traveling Outside the US
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Services a Third-Party is Responsible For
- Services Related to Certain Illegal Activities
- Services that are Not Medically Necessary
- Sexual Dysfunction
- Temporomandibular Joint Dysfunction (TMJ)
- Weight Loss Programs

### Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your [Plan](#) document.)

- Chiropractic visits limited to 12 visits per member per plan year and is limited to items and services that are medically necessary and may be subject to limitations.
- Cosmetic Surgery – Please refer to Summary Plan Description for a complete list of exclusions and limitations.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. To continue coverage after it ends, contact: Planstin at 888-920-7526 or [member@planstin.com](mailto:member@planstin.com). Other options to continue coverage are available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 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: Planstin at 888-920-7526 or [member@planstin.com](mailto:member@planstin.com).

### Does this plan provide Minimum Essential Coverage? YES

If you do not have [Minimum Essential Coverage](#) for a month, you will 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 the Minimum Value Standards? YES

If your [Plan](#) does not 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 (888) 920-7526.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 920-7526.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (888) 920-7526.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (888) 920-7526.

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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 Pre-Natal Care and a Hospital Delivery)

■ The Plan's Overall Deductible	\$3,500
■ Specialist Visit [Coinsurance]	30%
■ Imaging [Coinsurance]	30%
■ Lab/Bloodwork [Coinsurance]	30%
■ Hospital (Facility) [Coinsurance]	30%

**This EXAMPLE event includes services like:**

Specialist Office Visits (*Prenatal Care*)  
Imaging (*Ultrasounds*)  
Diagnostic Tests (*Bloodwork Labs*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services (*Including Anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance (30%)	\$2,760
<i>What is NOT Covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$6,360</b>

### Managing Joe's Type 2 Diabetes (A Year of Routine Care of a Well-Controlled Condition)

■ The Plan's Overall Deductible	\$3,500
■ Specialist Visit [Coinsurance]	30%
■ Lab/Bloodwork [Coinsurance]	30%
■ Durable Medical Equipment [Coinsurance]	30%

**This EXAMPLE event includes services like:**

Specialist Office Visits (*Including Disease Education*)  
Diagnostic Tests (*Bloodwork Labs*)  
Durable Medical Equipment (*Glucose Meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance (30%)	\$630
<i>What is NOT Covered</i>	
Limits or exclusions	\$40
<b>The total Joe would pay is</b>	<b>\$4,170</b>

### Mia's Simple Fracture (Emergency Room Visit and Follow Up Care)

■ The Plan's Overall Deductible	\$3,500
■ Specialist Visit [Coinsurance]	30%
■ ER Facility Services [Coinsurance]	30%
■ Durable Medical Equipment [Coinsurance]	30%
■ Rehabilitation/Physical Therapy [Coinsurance]	30%

**This EXAMPLE event includes services like:**

Rehabilitation Specialist Services (*Physical Therapy*)  
Emergency Room Care (*Including Supplies*)  
Emergency Room Diagnostic Tests (*X-Ray*)  
Durable Medical Equipment (*Crutches*)

<b>Total Example Cost</b>	<b>\$4,300</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance (30%)	\$240
<i>What is NOT Covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$3,740</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.