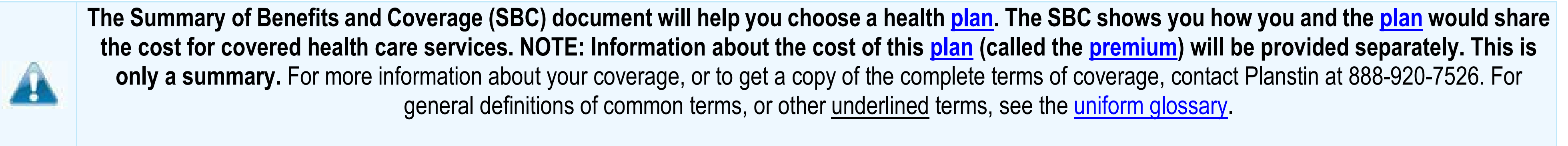

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. 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 deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Not applicable**	This plan covers certain preventive services without cost sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No**	This plan does not have a deductible.
What is the out-of-pocket limit for this plan?	**Not applicable**	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	**Not applicable**	This plan does not have an out-of-pocket limit on your expenses
Will you pay less if you use a network provider?	**Not applicable**	This plan does not use a provider network. You can receive covered services from any provider. Plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay 100% usual and customary charges (UCR).
Are there prescription services?	**Yes**	Prescription services 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 OptumRx portal.
Do you need a referral to see a specialist?	**No**	You can see the specialist you choose without a physician referral.

[* For more information about limitations and exceptions, see the plan or policy document at www.Planstin.com.]

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
If you visit a health care provider's office or clinic	Primary care visit to treat aninjury or illness	$20 copay/visit	Plan pays for a max of 5 primary care visits per plan year. Plan will pay 150% of Medicare reimbursement rates or 100% of UCR.
	Specialist visit	$50 copay/visit	Plan pays for a max of 5 specialist visits per plan year. Plan will pay 150% of Medicare reimbursement rates or 100% of UCR.
	Preventive care / screening / immunization	No charge	Preventive services as outlined by the ACA and shown on healthcare.gov, will be paid at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay 100% of UCR. If you receive a bill from your provider for preventive services, please contact Planstin at 888-920-7526. 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	Diagnostic test (x-ray)	$50 copay/x-ray	Plan pays for a max of 5 x-rays per plan year. Plan will pay 150% of Medicare reimbursement rates or 100% of UCR.
	Lab/Blood work	$10 copay/lab	Plan pays for a max of 10 labs per plan year. Plan will pay 150% of Medicare reimbursement rates or 100% of UCR.
	Imaging (CT/PET scans, MRIs)	$200 copay/test	Plan pays for a max of 2 imaging tests per plan year. Plan will pay 150% of Medicare reimbursement rates or 100% of UCR.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at rx.planstin.com	Tier 1 - Generic	$10 copay	Plan pays up to a maximum of $150, per Rx, per month.
	Tier 2 - Preferred brand	$25 copay	Plan pays up to a maximum of $150, per Rx, per month.
	Tier 3 - Non-preferred brand	$50 copay	Plan pays up to a maximum of $150, per Rx, per month.
	Tier 4 - Specialty	Excluded	May be excluded from coverage or subject to prior authorization through OptumRx.
If you have outpatient surgery	Facility fee (e.g., ambulatorysurgery center)	Not covered	
	Physician/surgeon fees	Not covered	
If you need immediate medical attention	Emergency room care	Not covered	
	Emergency medical transportation	Not covered	
	Urgent care	$50 copay/visit	Plan pays for a max of 5 urgent care visits per plan year. Plan will pay 150% of Medicare reimbursement rates or 100% of UCR.

[* For more information about limitations and exceptions, see the plan or policy document at www.Planstin.com.]

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	
	Physician/surgeon fees	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	$50 copay/visit	Copays apply to specialist visit limit. Plan pays for a max of 5 specialist visits per plan year. Plan will pay 150% of Medicare reimbursement rates or 100% of UCR.
		No charge **through Amaze Health**	Amaze Health membership offers treatment by phone, online chat, or in person. Contact Amaze Health at 720-577-5251.
	Inpatient Services	Not covered	
If you are pregnant	Office visits	$50 copay/visit	Copays apply to specialist visit limit. Plan pays for a max of 5 specialist visits per plan year. Plan will pay 150% of Medicare reimbursement rates or 100% of UCR.
	Childbirth / delivery professional services	Not covered	
	Childbirth / delivery facility services	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	
	Rehabilitation services	Not covered	
	Habilitation services	Not covered	
	Skilled nursing care	Not covered	
	Durable medical equipment	Not covered	
	Hospice services	Not covered	
	Chiropractor visits	$50 copay/visit	Copays apply to specialist visit limit. Plan pays for a max of 5 specialist visits per plan year. Plan will pay 150% of Medicare reimbursement rates or 100% of UCR.
If your child needs dental or eye care	Children’s vision acuity screening	No charge	Plan will pay up to 150% of Medicare reimbursement rates or 100% of UCR. If you receive a bill from your provider for preventive services, please contact Planstin at 888-920-7526.
	Children’s glasses	Not covered	
	Children’s fluoride varnish	No charge	Plan will pay up to 150% of Medicare reimbursement rates or 100% of UCR. If you receive a bill from your provider for preventive services, please contact Planstin at 888-920-7526.

[* For more information about limitations and exceptions, see the plan or policy document at www.Planstin.com.]

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 • Adult Dental Care • Adult Vision Care • Anesthetic • Bariatric Surgery • Cancer • Durable Medical Equipment	• Emergency Room Services • Essure • Home Health Care • Hospice Services • Hospital Admission or Facility Fees • Infertility Treatment • Inpatient or Outpatient Surgery	• Labor and Delivery • Long Term Care • Pathology • Rehabilitation Services • Skilled Nursing Care • Tubal Ligation • Vasectomy

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Doctor visits, limited by number of visits per plan year. • Routine labs and diagnostic imaging, limited by number of tests per plan year. • All covered services are capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay 100% of UCR. • If you receive a bill from your provider for preventive services, please contact Planstin at 888-920-7526.

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: Planstin at 888-920-7526. 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 http://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: Planstin at 888-920-7526.

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 the Minimum Value Standards? NO

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.

Provider Claims Processing

Except as otherwise required under state or Federal regulations, the maximum amount the plan is obligated to pay for services provided by a provider will be the lesser of the provider's billed charges for covered services and an amount determined by one or more of the following, which we may sometimes modify to maintain the reasonableness of the Payable Amount:

- The expected or estimated charges of facilities of a similar type when providing the same or similar goods andservices reported on the claim.
- The amount a Healthcare Practitioner, facility, or supplier of a similar type and/or in the same geographic area bills for the same or similar goods and services, based on a combined profile of derived and actual submitted charge data and relative values.
- Using amounts calculated based on what Medicare would reimburse for the services billed.
- The amount derived by applying comparable markups from facilities of a similar type and/or in the same geographic area to the estimated costs.

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 with a Provider)

- **The plan's overall deductible** **$0**
- **Specialist Visit Copay** **$50**
- **Imaging Copay** **$200**
- **Lab Copay** **$10**
- **Hospital (facility) *[Not Covered]*** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care) x5*
Diagnostic tests (*ultrasounds) x2*
Diagnostic tests (*blood work labs) x10*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services *(including anesthesia)*

Total Example Cost	**$6,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$750
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,150
The total Peg would pay is	**$3,900**

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

- **The plan's overall deductible** **$0**
- **Primary Care Visit Copay** **$20**
- **Tier 2 Rx Copay** **$25**
- **Lab Copay** **$10**
- **Durable Med Equipment *[Not Covered]*** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education) x2*
Diagnostic tests *(blood work labs) x5*
Prescription drugs *(monthly) x12*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$1,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$390
Coinsurance	$0
What isn't covered	
Limits or exclusions	$825
The total Joe would pay is	**$1,215**

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

- **The plan's overall deductible** **$0**
- **Specialist Copay** **$50**
- **ER Facility Services *[Not Covered]*** **0%**
- **Durable Med Equipment *[Not Covered]*** **0%**

This EXAMPLE event includes services like:
Rehabilitation Specialist services *(physical therapy) x5*
Emergency room care *(including supplies)*
Emergency room Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*

Total Example Cost	**$3,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,000
The total Mia would pay is	**$2,250**

The plan would be responsible for the other costs of these EXAMPLE covered services.